

**A Step-by-Step
Guide to Dialectical
Behavior Therapy**

DBT made simple

A quick-start guide to help clients

- Connect with the present moment
- Balance emotions
- Manage crises
- Improve relationships

SHERI VAN DIJK, MSW

"DBT Made Simple is an incredibly useful book that distills key elements of DBT into a clear, concise, and practical guide. Illuminating clinical examples bring to life several DBT strategies and principles, and practitioners will appreciate the many useful forms and handouts provided in this book. I recommend this book to students and mental health professionals seeking a concise, practical introduction to DBT."

—Alexander L. Chapman, PhD, RPsych, author of *The Borderline Personality Disorder Survival Guide* and associate professor in the department of psychology at Simon Fraser University, Burnaby, BC, Canada

"Over the years, practitioners of dialectical behavior therapy have been searching for different training resources to deliver DBT in the therapy room in an effective way. Van Dijk's book provides a fantastic contribution to DBT literature for one main reason: her approach to DBT is hands-on. *DBT Made Simple* is full of clinical applications, illustrative examples, sample dialogues, and troubleshooting tips. Her style is both engaging and straightforward, making of this book an easy and digestible resource for all clinicians, novice or advanced, who are interested in making a difference in their DBT clinical work."

—Patricia E. Zurita Ona, PsyD, psychologist at East Bay Behavior Therapy Center and coauthor of *Mind and Emotions*

"Sheri Van Dijk has done it again! Her latest work teaches therapists how to use DBT with a wide variety of clients. She has accomplished an amazing feat—making DBT easy to understand without sacrificing its enormous depth. This is the book therapists have been waiting for."

—Paula Fuchs, PsyD, assistant clinical professor of psychology in the department of psychiatry at Harvard Medical School

"DBT Made Simple provides a well-organized, encouraging model to treat individuals with emotional dysregulation. This book is an excellent resource for therapists wishing to use DBT. It explains the theory of DBT and provides a clear, concise, user-friendly approach for therapists to learn, as well as teach, DBT skills."

—Linda Jeffery, RN, cognitive behavioral therapist with a private practice in Newmarket, ON, Canada

"What a wonderful guide to dialectical behavior therapy for therapists, both on a personal level, as well as on a client level. Sheri Van Dijk's book gives precise, clear direction for understanding and using DBT."

—Kathy Christie, BA, ADR, mental health case manager

"This book is a must-have for therapists interested in developing an understanding of DBT and how they can incorporate aspects of this treatment with a broader client population. Van Dijk provides a clear and concise foundation of DBT theory, complete with helpful strategies and handouts for each of the DBT skills. The book also provides practitioners with the flexibility to choose components of the DBT skills that would help meet their respective clients' needs."

—Diane Petrofski, MSW, RSW, Family Health Team

"As the demand for dialectical behavior therapy increases from our clients, practitioners need to be more informed about its dynamic process and targets. This book provides both the novice and the well-informed clinician with an uncomplicated review of DBT. A must-have for any therapist, whether they are practicing DBT, or referring to others for this type of therapy."

—Leanne Garfinkel, MA in clinical psychology and DBT-informed therapist

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I would like to dedicate this book, first and foremost, to my family and my friends, who have supported me in my writing career. Without your encouragement, I never would have had the courage or the belief in myself to accomplish the things I have.

Second, I would like to dedicate this book to my clients. You have taught me much about life, and about how to be a better therapist.

And finally, I would like to dedicate this book to all those who have difficulties regulating their emotions. Have hope! It can get better.

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Introduction: What to Expect

In 1980, Marsha Linehan, a psychologist in the United States, was working with her team to find more effective ways of treating suicidal behavior, a focus that she later narrowed to borderline personality disorder (BPD). BPD, an illness characterized by difficulties regulating emotions, often causes impulsivity, including suicide attempts and other self-harming behaviors. Traditional cognitive behavioral therapy (CBT) didn't seem very helpful in treating BPD, and because the consequences of the illness can be so severe, Dr. Linehan and her team continued to work on developing new strategies to help individuals with BPD. The result was dialectical behavior therapy (DBT).

THE PURPOSE OF THIS BOOK

Although DBT was originally designed to treat BPD, it has since been found to be helpful for all sorts of other disorders. In fact, we now know that it's quite helpful for anyone with problems regulating emotions, even if the cause isn't related to a psychiatric illness. Because of its success in helping people learn to manage their emotions more effectively, DBT has become a highly sought-after treatment. Unfortunately, there are still too few therapists sufficiently trained in DBT, given the number of people looking for this form of help for their problems. So the main purpose of this book is to provide therapists with a basic understanding of the theory underlying DBT, the strategies used in individual sessions that make it stand out from traditional CBT, and the DBT skills themselves.

This book is not meant in any way, shape, or form as an attempt to duplicate the extraordinary work of Marsha Linehan. Her work has been invaluable to the field of psychotherapy in many ways. Rather, my hope is to make DBT more accessible to therapists who may be intimidated by it, thus making DBT more available to clients who would benefit from this treatment.

WHO THIS BOOK IS WRITTEN FOR

If you are a therapist new to DBT, this book will provide you with everything you need to use the model to treat people with problems involving emotion dysregulation. For therapists whose goal is to learn how to provide DBT for individuals with BPD, this book will be a good start, but in the long run you'll need to read Linehan's seminal text, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993a). If you've already received training in DBT and use it in your practice, this book will be a good review and will also provide some helpful suggestions and handouts. In addition, this book will help you use DBT for mental illnesses other than BPD and will provide you with different ways of thinking about and teaching DBT skills to clients.

If you're new to DBT, I suggest that you read this book cover to cover before you start using the treatment with your clients. It's important that you have a good understanding of the DBT skills before you try to teach them. It's also important for you to have a good idea of how you wish to use DBT: Will you be using it only with BPD, only with other mental illnesses, or both? If you're just learning the model and your intention is to use it with both types of clients, I suggest that you practice with clients who don't have BPD first, as there are many more strategies and techniques you need to learn to use this treatment effectively with BPD clients. You'll probably want to do more training and reading before you start using the model with clients with BPD.

It is also extremely helpful for therapists to actually use the DBT skills themselves, in their own personal and professional lives. This will not only help with your own learning, but also allow you to say that you practice what you preach! It's difficult to teach others something if you're not doing it yourself. Can you imagine trying to teach someone how to ride a bike or drive a car if you only knew the theory behind it and didn't actually ride a bike or drive a car regularly yourself?

WHO DBT WORKS FOR

In my opinion, DBT can be effective for most clients. In my own practice, I've used DBT skills to help clients deal with bipolar disorder (see Van Dijk, 2009), depression, anxiety, bulimia and binge-eating disorder, chronic pain, grief, low self-esteem, relationship issues, and anger.

Of course, like any therapy, DBT won't work for everyone. But in my years of using this treatment modality, I've learned that, outside of treating borderline personality disorder, DBT can be a very flexible treatment modality. You can pick and choose which pieces of DBT you believe will be effective for different clients. For many clients with illnesses other than personality disorders, you may use only the DBT skills, and you may find that some of these clients only need some of the skills; for example, some clients won't actually need distress tolerance or interpersonal effectiveness skills because they are already well adapted in these ways, but they still need skills to help them be more mindful and to manage their emotions more effectively. For clients with traits associated with

personality disorders, you may decide to incorporate some of the learning theory DBT uses in individual sessions, as well as teaching some or all of the skills. The bottom line is that when you're not using DBT to treat BPD, the treatment is very flexible and can be used for any disorder. In chapter 1, we'll take a look at some of the research on using DBT for disorders other than BPD.

THE FORMAT OF THIS BOOK

This book is divided into two parts. In part 1, *The Foundation*, you'll learn about the theory that underlies the treatment model, how DBT differs from traditional CBT, and what the full DBT model entails. I'll also review some of the research on the use of DBT in the treatment of BPD and other disorders.

Part 1 will also focus on delivering the therapy in individual sessions. You'll learn about many of the techniques that are necessary in treating BPD due to the complexity of this illness and the problems therapists often encounter in developing and maintaining a good therapeutic alliance with these clients. These skills can also be useful, but aren't always necessary, in developing a good therapeutic relationship with clients without the same emotion dysregulation and interpersonal problems as clients with BPD.

In part 2, *The Skills*, you'll learn the actual DBT skills and how to teach them to your clients. Whereas part 1 focuses on the model more as it is applied to BPD, part 2 focuses on helping therapists use DBT skills with a broader client population.

Throughout this book, you'll find handouts to help you teach clients these skills, along with examples of therapist-client dialogues to help you put all of these strategies and skills into practice.

One of the points that Linehan (1993a) emphasizes in her textbook is that therapists are fallible. Keep this in mind as you read this book. Yes, you want to understand the strategies and skills as thoroughly as possible. Yes, you want to be as effective as you can be in your sessions. And yes, you are going to make mistakes and have problems implementing the strategies and teaching the skills. As therapists, we all need to learn to tolerate this thought, just as we teach our clients to tolerate their unpleasant and distressing thoughts. This book will help you become a more knowledgeable and confident DBT therapist. So keeping this thought in mind, welcome to *DBT Made Simple*.

PART I

The Foundation

CHAPTER I

The Basics of DBT

Since the middle of the twentieth century, psychotherapy has essentially gone through three evolutions: the development of behavior therapy in the 1950s, Aaron Beck's development of cognitive therapy in the 1970s, and a merging of these two therapies into the well-known and most-used contemporary treatment—cognitive behavioral therapy (Ost, 2008). The last ten to fifteen years have seen the rising of a "third wave" of cognitive and behavior therapy (Hayes, 2004), incorporating mindfulness and acceptance techniques. Dialectical behavior therapy is one of these third-wave therapies and has been proven highly effective in the treatment of patients with borderline personality disorder, who have difficulties regulating their emotions.

WHAT IS DBT?

DBT is a form of CBT. Palmer refers to it as "a strange hybrid" (2002, p. 12) of a number of different therapies and techniques. Many people have asked me how DBT and CBT differ. I usually respond that, in terms of the skills, DBT is really just CBT using a different language, with the addition of mindfulness and acceptance techniques. DBT takes the judgment out of CBT so that the way clients are thinking isn't "wrong," "erroneous," or "distorted," with the goal being to change their way of thinking. Instead, DBT acknowledges that there is a problem with the way clients think, but the therapist first encourages clients to accept this, rather than judge it, and *then* helps them look at how they can make changes so that their thinking is more balanced.

However, looking at the entire model of DBT rather than just the skills reveals that this treatment is quite different from CBT. The main distinction is that DBT is a principle-driven therapy, whereas CBT tends to be a protocol-based therapy (Swales & Heard, 2009). In CBT, the therapist follows specific procedures; for example, when a client presents with panic attacks, a certain set of rules or procedures are followed to treat the panic, such as providing psychoeducation, teaching abdominal breathing, and so on.

In DBT, the therapist is instead guided by principles, allowing the therapist to be more flexible. This is crucial in treating people who have difficulties managing their emotions—and specifically those with a diagnosis of BPD—since these clients often face a variety of problems, making it difficult to focus on just one issue in each session. When a client is experiencing a variety of problems, attempting to follow a highly structured treatment protocol that targets just one of these problems is almost impossible (Swales & Heard, 2009) and would probably be perceived by the client as invalidating.

A second major difference between DBT and CBT is in how treatment is delivered. CBT can be provided in either a group or individual format but rarely occurs in both simultaneously, whereas DBT consists of four different modes of therapy: individual therapy, skills group, telephone consultation, and the therapy team (each of which will be outlined later in this chapter).

Like CBT, DBT incorporates self-monitoring; however, it's taken to a different level in DBT with the use of Behavior Tracking Sheets (see chapter 2). DBT also differs from CBT in the way individual sessions are structured, addressing behaviors and stages of treatment in a hierarchy determined by the severity and threat of target behaviors. DBT is also distinguished by its use of a suicide risk and assessment protocol (see Linehan, 1993a, for detailed discussion).

Above and beyond the delivery of treatment, the use of the therapeutic relationship in DBT is based on learning theory and quite distinct from the approach in CBT. Because DBT is a behaviorally focused treatment, the therapist views BPD as a pattern of learned behaviors. To help clients unlearn these destructive behaviors, the DBT model emphasizes the importance of identifying the triggers for dysfunctional behaviors and the contingencies that are maintaining these behaviors.

To facilitate this, the DBT therapist makes every effort to develop a deep and genuine therapeutic alliance with the client, which can then be used in a variety of ways (discussed in depth in chapter 4) to help clients make the necessary changes. In CBT, clients learn many techniques to help change distorted thinking; in DBT, clients are taught to accept themselves as they are, and then they learn tools to help them change behaviors that are unhealthy or problematic in some way. The therapeutic relationship (including therapist self-disclosure) becomes another tool that the therapist uses to help clients make these difficult changes.

Having a relationship with a healthy, positive figure is especially important for clients who have problems regulating their emotions, as you'll see shortly when we look at the biosocial theory of BPD. Before we address the theory of how emotion dysregulation develops, however, we must first define emotion dysregulation itself.

WHAT IS EMOTION DYSREGULATION?

According to Linehan (1993a), *emotion dysregulation* results from a combination of high emotional sensitivity or vulnerability and an inability to regulate or modulate one's emotions.

Emotional Vulnerability

Emotional vulnerability refers to a biological predisposition or temperament where an individual is born more emotionally sensitive than most people. These individuals have a tendency to react emotionally to things that others wouldn't typically react to. Their emotional reaction is usually more intense than warranted by the situation, and it takes them longer than the average person to recover from that reaction and to return to their emotional baseline.

This idea of emotional vulnerability is similar to the concept of the highly sensitive person written about extensively by Elaine Aron (1996). Aron believes that having a sensitive nervous system is a relatively common neural trait, claiming that approximately 15 to 20 percent of the population experiences this high level of sensitivity. Aron postulates that highly sensitive people are more easily aroused (reacting emotionally to things that others wouldn't typically react to) and overaroused (experiencing a more intense reaction than is warranted by the situation).

Blakeslee and Blakeslee (2007) support the idea that this higher emotional awareness has a neural, physiological basis. Further, Koerner and Dimeff (2007) note that differences in the central nervous system have been found to play a role in making a person more emotionally vulnerable, and that these central nervous system differences could be related to a variety of factors, including genetics or trauma during fetal development or in early life.

Inability to Regulate Emotions

Emotion regulation refers to the processes we use (unconsciously, consciously, or even perhaps with a tremendous amount of effort) to decrease, maintain, or increase an emotion or aspects of an emotion (Werner & Gross, 2010). Most often we want to reduce the intensity of painful emotions or make them go away altogether if possible. But sometimes we actually want to increase an emotion (for example, someone who's feeling depressed may want to increase feelings of enjoyment). Both of these are considered emotion regulation.

It's important to note that emotion regulation doesn't mean suppressing emotions or trying to hide them from others; in those cases, the emotion is still there and *unregulated*, although it may be hidden. Instead, the goal of emotion regulation is to achieve a balanced state of consciously managing the experience and expression of the emotion (Greenberg & Paivio, 1997).

People who are unable to regulate their emotions usually find it difficult to identify or put a label on the emotion they're feeling, to understand why they feel that way, and to express the emotion in an effective way. As a result, they have a hard time tolerating the emotions they experience.

Unlike the emotional vulnerability component to this equation, it seems that the ability to regulate one's emotions is more influenced by the environment a person grows up in. For example, Miller, Rathus, and Linehan (2007) point to research that suggests that early abusive experiences have a direct effect on people's ability to regulate their emotions. On the positive side, this means that children develop healthier abilities to regulate their emotions when their parents respond to

their expression of painful emotions in an accepting and supportive way (Thompson & Goodman, 2010). Likewise, Koole (2009) reports that children's ability to regulate their emotions is greatly influenced by the quality of their social interactions with caregivers. Koole also notes that people's ability to regulate emotions changes across the life span, continuing to improve with age. So the good news is that we can teach adults the skills they need to regulate their emotions if they didn't learn them as children.

THE BIOSOCIAL THEORY OF BORDERLINE PERSONALITY DISORDER

Because Linehan originally developed her biosocial theory to aid in the understanding and treatment of borderline personality disorder (1993a), I will refer only to BPD in this discussion. However, at the end of this section I'll take a look at two examples of how researchers are beginning to apply this theory to other disorders.

According to Linehan's biosocial theory (1993a), emotion dysregulation (emotional vulnerability plus the inability to regulate one's emotions) stems from a biological predisposition and the individual's interaction with the environment (Miller et al., 2007). We've just looked at the biological predisposition—the emotional dysregulation component—and there is an abundance of research showing that some people are just born more emotionally sensitive than others. However, this doesn't mean that all people who are born emotionally sensitive will develop BPD or other mental health problems. This is only one part of the equation; the other part is the environment a person grows up in. Problems tend to arise when a biologically vulnerable person is faced with a pervasively invalidating environment (Linehan, 1993a).

The Invalidating Environment

Miller and colleagues (2007) define an *invalidating environment* as one in which there is a tendency to deny or respond unpredictably and inappropriately to the child's private experiences, and especially to private experiences such as emotions, physical sensations, and thoughts, which aren't accompanied by evidence to prove that this is, in fact, the child's experience. In other words, when a child expresses an emotion (a private experience), the people in her environment judge her for this experience (e.g., telling her that she shouldn't be feeling that way or that she's overreacting); tell her that her experience is incorrect or minimize her experience; punish her for talking about her experience; ignore her expression of the experience; and so on.

In invalidating environments, the expectation is usually that the child should be able to control the expression of her emotions (which, because of the emotional vulnerability of the child, is unrealistic) and should not express "negative" feelings (Miller et al., 2007). When she is unable to succeed in meeting these expectations, the environment punishes her for communicating these

negative experiences and responds to her emotional displays only when she escalates, essentially teaching her to alternate between stifling her emotions and communicating emotions in extreme ways in order to get help (Koerner & Dimeff, 2007).

The other important piece about invalidating environments is that often the message is conveyed that the individual should be able to easily solve the problem she's experiencing. However, in this type of environment, skills such as emotion regulation and problem solving are never properly taught to the emotionally sensitive child. So the message is that she should be able to help herself feel better, but she has never learned skills for doing so. This obviously sets her up for failure and leads to self-validation (for example, telling herself everyone says she should be able to do this, and judging herself when she can't).

There are many ways in which an environment can be invalidating. The next four sections discuss some examples.

THE POOR FIT

Sometimes children are born into families in which they just don't fit properly. An example would be a creative child born into a family in which her parents and siblings are practical and hardworking and see her creativity as a waste of time—something that will never earn her enough money to be independent and therefore not to be pursued. Such parents may have their child's best interests at heart; they want her to succeed and to be happy, but they discourage her from pursuing her creativity because they don't think it's in her best interests. The emotionally vulnerable child will grow up in this invalidating environment feeling that her desire to be creative is wrong, and that there is therefore something wrong with her for wanting to pursue it. She will also feel misunderstood by and different from the rest of her family.

THE CHAOTIC HOME

Some families have additional challenges that make it difficult for them to provide a validating environment. Perhaps the parents themselves were invalidated as children and therefore never learned how to provide validation for themselves or for others. Parents who have a mental health problem of their own or an addiction, or who are financially unstable and therefore have a hard time providing the necessities of life, will have a much more difficult time providing an emotionally safe and healthy environment for their children.

It's also important to note that highly emotionally sensitive children can be the cause of at least some of the chaos in the home. Miller and colleagues (2007) note that just having an emotionally vulnerable child in the family can be so challenging that the family system becomes overstressed, possibly resulting in an invalidating environment. In other words, when an emotionally vulnerable child is born into a family where others don't share this trait, it's difficult for the rest of the family to understand, and this in itself can cause invalidation as parents become frustrated with the child and don't know how to help. We've all heard a parent telling an anxious child, "Don't be silly;

there's nothing to be afraid of," telling a hurt child, "Stop crying," or telling an angry child, "You're not being very nice." These parents don't mean to invalidate the child; they're just feeling frustrated themselves and don't know how to effectively help their child in that moment. For an emotionally vulnerable child, however, over time these messages add up to the idea that there's something wrong with her.

THE ABUSIVE HOME

Abuse doesn't have to occur for BPD to develop, but it's certainly not uncommon. For example, one study (Stone, 1981) indicated that 75 percent of twelve hospitalized patients with a diagnosis of BPD had a history of incest. A chart review (Herman, 1986) found that 67 percent of twelve psychiatric outpatients with BPD had a history of abuse in childhood or adolescence. And a qualitative study (Bryer, Nelson, Miller, & Krol, 1987) found that 86 percent of fourteen hospitalized patients with BPD had experienced sexual abuse before the age of sixteen.

An abusive environment is, of course, the ultimate invalidating environment. It can take many forms, from physical abuse in response to the child's expression of negative emotions or for the child's "own good" to sexual abuse in which the abuser tells the child that it's okay but instructs her to not tell anyone, possibly threatening her or those she loves if she does tell. In addition to this invalidation by the abuser, many individuals experience further invalidation when they tell someone about the abuse and are disbelieved, accused of lying, and possibly even blamed for the abuse (Linehan, 1993a).

Although neglect is a passive form of abuse, it can be just as damaging. With neglect, the child learns that no matter what she does, her needs, wants, and emotions will be largely disregarded (invalidated)—unless, of course, she escalates her behaviors to the point that her caregivers can no longer ignore them.

OTHER INVALIDATING ENVIRONMENTS

While we generally look to the family and home environment to see where the problems lie, invalidation can also happen outside the home: at school, at church, at the babysitter's house, while spending time with other family members, while engaging in extracurricular activities such as sports or clubs, and so on. Of course, children spend a lot of time at school, and if the school is an unhealthy environment, it will have negative consequences for the emotionally vulnerable child. Examples of invalidation outside of the home include a child with attentional difficulties (such as ADD) whose teacher accuses her of not trying or of purposely being disruptive in class, a child who is bullied by peers (e.g., being teased for crying), a child who has difficulties making friends, or a child whose coach focuses on the negative and tells her she should be able to do more or do better.

A TRANSACTIONAL MODEL

It's important to emphasize that the biosocial theory is *dialectical* or *transactional*, meaning that interactions take place over time between the environment and the individual, gradually leading to

their adaptation to one another, and to the development of BPD. Therefore, therapists are encouraged to view client behaviors as natural reactions that occur in response to environmental reinforcers (Lynch, Trost, Salsman, & Linehan, 2007). The individual cannot be blamed for being "too sensitive," and the environment is also not completely at fault. Without the interaction between these two elements, the illness would be unlikely to develop.

Applying the Biosocial Theory to Other Disorders

As you can probably tell from your reading thus far, Linehan's biosocial theory can probably be applied to many clients, whether they have a diagnosis of BPD or not. In fact, difficulties regulating emotions are not uncommon, accounting for more than 75 percent of the mental illnesses described in the *Diagnostic and Statistical Manual of Mental Disorders* (Werner & Gross, 2010). This may also be an issue for people who have no specific mental illness.

Applying the biosocial theory to the development of other illnesses makes a lot of sense, given that emotion dysregulation is a component of so many different illnesses, and that this problem can lead to emotional avoidance through engaging in unhealthy behaviors such as substance use, disordered eating, self-harm, and so on. I'm sure that anyone who works with individuals with mental health problems regularly sees the impact that an invalidating environment can have on people.

While to date the biosocial theory has only been written about in regard to BPD, other personality disorders, and eating disorders, in my professional experience it would also apply to many clients with other diagnoses, and probably to individuals who might not have a diagnosable mental illness but do have difficulties regulating their emotions. For now, let's take a quick look at the thinking on the biosocial theory in relation to other personality disorders and eating disorders.

Other personality disorders. Lynch and Cheavens (2007) have proposed that the biosocial model can be applied to personality disorders other than BPD. They suggest that a biological predisposition toward increased negative affect interacts with an invalidating environment that reinforces unhealthy forms of avoidance in a transactional way to produce the cognitive, emotional, and behavioral patterns commonly seen in personality disorders, especially in the form of difficulties maintaining interpersonal relationships, regulating emotions, and controlling impulses.

Eating disorders. Some authors have looked at applying the biosocial theory to binge-eating disorder and bulimia, based on the idea that people engage in disordered eating behaviors due to an inability to regulate their emotions (Wisniewski, Safer, & Chen, 2007). Along these same lines, Safer, Telch, and Chen (2009) propose that the underlying problem in both binge-eating disorder and bulimia nervosa is an underdeveloped and insufficient emotion regulation system, leaving these individuals unable to adequately monitor, assess, accept, and change their emotional experience. Safer and colleagues theorize that these difficulties stem from the emotionally vulnerable child being given the message that she should be able to regulate her emotions and solve problems even though she hasn't been taught the skills for doing so.

THE DIALECTICAL THEORY OF DBT

In creating her treatment model, Linehan (1993a) was greatly influenced by the theory of *dialectics*, a complex philosophical and scientific concept with three main principles:

- Everything is interconnected or interrelated. This idea helps us understand the importance of taking a whole-systems approach to identifying and managing change. It also reminds us that the actions and reactions of the client will affect the therapist, who will in turn affect the client, and so on (Feigenbaum, 2007).
- Reality is not static, but is in a process of continuous change (Swales & Heard, 2009).
- The truth (which is always evolving) can be found by integrating or synthesizing differing (and possibly opposite) views (Feigenbaum, 2007). This idea, of course, is contrary to the black-and-white thinking typical of people with emotion dysregulation.

So what, exactly, does this mean for therapy? Miller and colleagues (2007) note that thinking dialectically means looking at both perspectives in a situation and then working toward synthesizing these possibly opposing perspectives. In other words, clients (and therapists!) need to learn to tolerate the idea that two seemingly opposite things can coexist. In thinking dialectically, therapist and client must remember that reality is not static and fixed, but is constantly changing and full of apparent contradictions; for example, the assertion that clients are doing the best they can and that, at the same time, they have to work harder and do more. Another common example, especially for a client with difficulties regulating emotions, is the idea of experiencing two seemingly opposite emotions at the same time; here it is the therapist's job to help the client learn that she can, for example, love her partner and be really angry at him at the same time.

Thinking dialectically means that we must practice acceptance while also continuing to work toward change. In DBT, this is the primary dialectic—both therapist and client need to accept the client as she is and also need to continue working toward changing the behaviors that are unhealthy or self-destructive. However, there are many other ways that dialectical thinking comes into play in therapy. For example, when disagreements arise in therapy or in the client's life, dialectical thinking helps both therapist and client remember to search for what's being left out of their reality so they can try to see the bigger picture or different perspectives (Basseches, 1984).

Lynch and colleagues (2007) point out that one of the most frequent dialectical tensions is the idea that an unhealthy or self-destructive behavior, such as cutting, can be both functional (in that it helps people reduce their emotional distress in the short term) and dysfunctional (since the self-injury results in a variety of negative consequences). In this dilemma, client and therapist need to find the synthesis of these two apparent opposites; for example, validating the need for the client to achieve some relief, while at the same time assisting her in learning and using skills that will reduce the distress in a nonharmful way (Lynch et al., 2007).

Thinking dialectically means recognizing that all points of view can have aspects that are both valid and incorrect. In therapy, it's important to know that polarizations are inevitable; taking a

dialectical perspective means acknowledging this inevitability, watching for the polarizations, and not allowing yourself to get caught up in them when they occur. Lynch and colleagues (2007) note that this dialectical idea of taking the middle path is an inherent feature of Zen, and that DBT incorporates these ideas to help clients act in more effective ways and live more balanced lives.

THE DBT MODEL

As mentioned earlier, the DBT model is made up of four components. Although my professional experience has been that DBT can be provided to clients in an effective way without including all of these components, the majority of the research on DBT for BPD looks at the full model, which includes skills training group, individual therapy, telephone consultation, and the consultation team.

Skills Training Group

The skills training group is a psychoeducational, structured group format designed to develop and enhance client capabilities. The group takes place once weekly and is divided into four modules: core mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills.

Core mindfulness skills. Linehan (1993b) breaks mindfulness down into smaller parts to make it easier for clients to understand and incorporate it into their lives. The aim of mindfulness in treating BPD is to reduce confusion about the self, but mindfulness is also helpful in many other ways. Increasing self-awareness helps clients become aware of their thoughts, emotions, and urges and gradually learn to manage them more effectively. Through mindfulness, clients also learn to tolerate the thoughts, emotions, and urges that they can't do anything about, coming to see that internal experiences don't have to be acted upon, but can simply be acknowledged, and that these experiences will gradually dissipate.

Interpersonal effectiveness skills. These skills aim to help clients reduce the interpersonal chaos that is often present in their lives and are primarily about how to be more assertive. Clients are taught to think about what they most want to get out of an interaction (for example, if they have a specific objective, if they wish to keep or even improve the relationship, or if they wish to keep or improve their self-respect) and then are taught skills that will make it more likely for them to reach this goal.

Emotion regulation skills. The goal of this module is to decrease mood lability. Clients are taught general information about emotions, such as why we need them and why we don't want to get rid of them even though they can be quite painful at times. Clients learn about the connection between their thoughts, feelings, and behaviors, and that by changing one of these they can have an impact on the others. Self-validation is emphasized in this module, along with other skills to help clients manage their emotions more effectively.

Distress tolerance skills. These skills are also known as *crisis survival skills*, and the goal is simply that: to help clients survive crises without making things worse by engaging in problem behaviors such as suicide attempts, self-harm, substance abuse, and so on. These skills help clients soothe and distract themselves from the problem, rather than dwelling on it and eventually acting on the urges that accompany the painful emotions.

Teaching skills in a group format as opposed to in individual therapy is done for a variety of reasons: First, clients with emotion regulation difficulties are often moving from one crisis to another, and it's extremely difficult to teach skills in an individual session when the client understandably wants help with the current crisis. In addition, an important aspect of any group setting is validation, as each client has the experience of being in a group with others who have similar problems. Another benefit of groups is that the learning experience can be much richer as each client learns from the experiences of fellow group members. Finally, because interpersonal issues often arise in groups, this can be an excellent arena for practicing the skills being taught and also allows clients to receive coaching from the group therapist on how to use the skills to act more effectively.

Individual Therapy

Clients usually attend individual sessions with a DBT therapist once weekly. The goal of individual sessions is to help clients use the skills learned in group to reduce target behaviors such as suicidality, self-harm, use of substances, and so on. As with group sessions, individual sessions have a very clear structure and format, which will be discussed in detail in chapter 2.

Telephone Consultation

Telephone consultation is used to coach clients to use skills. Telephone consultation is meant to be a brief interaction to help clients identify what skills might be most helpful in the situation they're facing, and to help them overcome obstacles to using these skills and acting effectively.

Consultation Team

According to Linehan, "There is no DBT without the team" (2011). The makeup of the DBT consultation team will vary depending on the therapist's environment. Typically, the team consists of all the therapists in a DBT clinic: social workers, psychologists, psychiatrists, and anyone else working in individual therapy and skills training groups with DBT clients. For therapists working in clinic settings, this is fairly straightforward. For those of us who work in private practice, however, it gets a little more complicated. Because the team is important in keeping therapists on track in their practice, private therapists may want to develop a team consisting of other private DBT therapists in their area or even online, provided that confidentiality is adhered to. As a DBT practitioner

in private practice, I have been fortunate enough to have a psychiatrist who works in a DBT clinic provide consultation for me on an ongoing basis. The team doesn't have to be large; what matters is that you receive objective feedback about your practice.

Whatever it consists of in your circumstances, the team is used in two ways: first, to provide support to therapists and help them continue to develop their skills in working with clients using the DBT model; and second, for case discussion. During case discussion, the team helps the therapist ensure that she is adhering to DBT strategies and techniques. The team also addresses any feelings of burnout and ineffectiveness. In consultation meetings, the team uses DBT techniques such as taking a dialectical stance and being nonjudgmental to prevent team members from getting caught up in power struggles and other dynamics that can disrupt the team and the therapeutic process.

BEING FLEXIBLE WITH DBT

Previously in my career, I've worked with a DBT team in both a hospital and a community setting. We tried many variations of DBT due to the problem of limited resources. We were a small team of about six therapists and case managers. We began by providing as much of the pure DBT model as we could. We provided a skills training group once weekly and individual therapy biweekly, and we had a consultation team meeting once a month, although the consultation meeting didn't strictly follow the DBT format. We were unable to provide twenty-four-hour telephone consultation, but clients had access to a twenty-four-hour crisis line. If they contacted the crisis line and identified themselves as DBT clients, they received coaching in distress tolerance skills to help them get through the current crisis.

Because we were such a small team with no extra resources, we experimented with variations on the pure DBT model in an attempt to reduce our workload, which was leading to feelings of burnout and ineffectiveness. Of course, while being able to provide the full model is ideal, those in the front lines know it's not always possible. My belief is that sometimes a little DBT is better than none. For instance, I find the DBT skills invaluable for many clients, especially the mindfulness and acceptance skills, which many clients have never learned in other treatment modalities. Validating clients and teaching them to validate themselves, given the environment they grew up in, is also invaluable. In addition, incorporating the biosocial model into your practice, thereby reducing the tendency to blame clients for their behaviors, will have a tremendous benefit both for your clients and for the therapeutic relationship, which will help reduce the likelihood that you'll burn out.

RESEARCH ON DBT FOR BPD AND OTHER DISORDERS

Since DBT originated in 1980, a lot of research has looked at its effectiveness as a treatment for BPD and, more recently, for other illnesses. In this section, I'll outline the research on DBT for BPD

as well as adaptations of the model, and then take a look at the emerging research on using DBT to treat other mental health problems.

DBT for Borderline Personality Disorder

DBT was the first psychotherapeutic treatment for BPD that was tested in a clinical trial. The original trial compared one year of DBT to treatment as usual and found that DBT was a superior treatment, especially in terms of reductions in self-harm, overdosing, and hospitalization rates (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Other studies completed since the original trial had similar findings (e.g., Koons et al., 2001; Verheul et al., 2003). In addition, in 2006, Linehan and colleagues completed another study, this time comparing DBT for BPD to treatment provided by community experts—therapists in the community who were selected because of their interest in treating BPD and because they used a treatment modality they described as nonbehavioral, or mostly psychodynamic. The results of this study also showed DBT to be a superior treatment, with reductions in suicide attempts and hospitalization rates (Linehan et al., 2006).

Adapting DBT

Several authors have modified the original DBT model in an attempt to shorten the length of Linehan's original twelve-month treatment model and lower costs. For example, Bohus and colleagues (2004) adapted the model to provide a shorter, three-month version of DBT for individuals with BPD on an inpatient unit. Similarly, Kleindienst and colleagues (2008) found three months of DBT provided to clients with BPD on an inpatient unit to be highly effective, and the improvements were maintained at a two-year follow-up. In addition, an outpatient study suggested that a six-month adapted version of DBT was effective in treating BPD (Stanley, Brodsky, Nelson, & Dulit, 2007).

Obviously, more research is needed to determine the efficacy of adapted models of DBT. However, my professional experience has been that you don't have to provide the "pure" or complete model of DBT for clients to benefit—especially clients without BPD. In fact, given that resources are often scarce these days, I believe we need to be more flexible so clients can still receive some sort of DBT treatment, even if it isn't possible to adhere to the complete model.

DBT for Other Psychiatric Disorders

More and more research is being done on using DBT to treat illnesses other than BPD. Because of the large body of research, I will provide only a brief summary here. In a 2008 paper, Harned and colleagues noted that several studies have found DBT to be effective in reducing behaviors associated with Axis I disorders, including substance use, bulimia, binge-eating disorder, depression, and anxiety. DBT has also been studied in the following contexts:

- Harley, Sprich, Safren, Jacobo, and Fauva (2008) found significant improvement in patients with treatment-resistant depression.
- Preliminary research has found DBT to be helpful in the treatment of bipolar disorder in adolescents (Goldstein, Axelson, Birmhaer, & Brent, 2007), and DBT skills to be helpful in the treatment of bipolar disorder in adults (Van Dijk, Jeffery, & Katz, in press).
- DBT skills training was determined to be feasible and promising in improving the behavior of adolescents with oppositional defiant disorder (Nelson-Gray et al., 2006).
- DBT-enhanced habit-reversal treatment was found to be a promising adaptation for trichotillomania, with improvements lasting at the six-month follow-up (Keuthen et al., 2011).
- DBT modified to intensively treat post-traumatic stress disorder (PTSD) related to childhood sexual abuse was found to be a promising approach (Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011).
- Perepeltchikova and colleagues (2011) adapted DBT to treat children who were engaging in nonsuicidal self-harming behaviors; the results were promising, with a significant increase in adaptive coping skills and significant reduction in depression and suicidal thoughts.
- Rajalin, Wickholm-Pethrus, Hursti, and Jokinen (2009) used DBT-based skills training for family members of people who had attempted suicide. Results indicated significant reductions in caregiver burden, improved emotional health, and increased satisfaction regarding the relationship with the patient.

Interestingly, clinicians are also using DBT to treat illnesses and problems not related to Axis I disorders. For example, Evershed and colleagues (2003) used DBT to treat anger in male forensic patients and found that, compared to patients who received treatment as usual, the DBT group made greater gains. More recently, Sakdalan, Shaw, and Collier (2010) found that DBT reduced level of risk in suicidal forensic patients with intellectual disability, and Drossel, Fisher, and Mercer (2011) found that DBT helped caregivers of loved ones with dementia increase appropriate help-seeking behavior, improved their psychosocial adjustment, increased their ability to cope, enhanced their emotional well-being, and reduced caregiver fatigue.

Again, in the spirit of reducing length and subsequent costs of treatment, some researchers have been working on adapted models of DBT treatment for disorders other than BPD. Lynch, Trost, Salsman, and Linehan (2007) note two studies that suggested that DBT skills training accompanied by only minimal individual therapy may be helpful for less severe psychiatric illnesses.

In spite of the length of this “brief” survey, it isn’t exhaustive. Many other studies have looked at the efficacy of DBT in treating BPD and other illnesses. Hopefully, though, this short review has illuminated the adaptability and flexibility of DBT.

WRAPPING UP

So far we've looked at what exactly DBT is as a treatment model: how it differs from CBT; its theoretical underpinnings; the different modes of treatment involved; that the model is flexible and can be adapted to reduce length of treatment or be applied to other populations; and that research supports the efficacy of both the pure DBT model and some adaptations of the model. In the next chapter, I'll discuss the DBT assumptions about clients with BPD (which can be applied to general difficulties with emotion regulation); some techniques used to help reduce therapist burnout; the stages of treatment; and how the individual sessions are structured.

CHAPTER 2

Preparing for the Individual Session: What You Need to Know

Over the years, many studies have demonstrated that a positive relationship between therapist and client has more of an effect on outcome than the actual treatment modality itself (e.g., Bordin, 1979; Martin, Garske, & Davis, 2000). Given the array of difficulties experienced by people with emotion dysregulation and how their chaotic lives lead to equally chaotic relationships, therapists often have an aversion to working with such clients. Fortunately, DBT helps therapists change their preconceived conceptions about these clients and assists them in developing the all-important therapeutic alliance.

In the first part of this chapter, I'll discuss some assumptions in DBT about the client and therapist that help develop the therapeutic alliance, as well as two guiding principles that help maintain it. In the latter part of the chapter, I'll discuss the stages of therapy and how treatment is structured to help keep therapist and client on task.

DBT ASSUMPTIONS

In her book *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, Marsha Linehan (1993a) describes a set of assumptions about clients with BPD from the DBT perspective. These assumptions, which can be applied to clients with emotion dysregulation in general, help therapists change any preconceived notions about the "typical" client with these problems and also help them remember that

these clients, just like anyone else, want to reduce their suffering and increase their happiness. Of course, as Linehan (1993a) points out, these assumptions are not going to be accurate in every case. However, if we go into a session with these assumptions in mind, we're going to be much more successful in developing a positive relationship with the client and understanding her. The following sections are based on the assumptions set forth by Linehan (1993a).

Clients Are Doing Their Best

In therapy, clients (especially those who have problems regulating their emotions) are often perceived as simply not trying hard enough, or even as engaging in problematic or self-destructive behaviors as a way of getting attention or meeting another need. The assumption that clients are doing their best reminds the therapist that the client, whatever her diagnosis, is generally functioning as well as she can with what she has and what she knows. This assumption reminds the therapist that not everyone grows up learning what they need to know about how to manage their emotions and solve problems. If you can keep this assumption in mind, it will improve your ability to empathize with clients and teach them the skills they need to do better, rather than blaming them for the problems in their lives.

Clients Want to Get Better

In Buddhism, there is an assumption that one of the drives of all human beings is to reduce their suffering. I think it's safe to assume that if clients are coming for therapy, they want to make some positive changes in their lives. If you work in a setting where you see mandated clients, this obviously might not hold true; but even then, chances are you can find something that the client would truly like to change—such as not being involved with the criminal justice system. Regardless, if you go into a session believing the opposite—that the client doesn't want to get better—how motivated do you think you'll be to help? Remembering this assumption—that clients want to experience less suffering and more happiness in their lives—will help you reduce your judgments and be more willing to help.

Clients Need to Work Harder and Be More Motivated to Make Changes in Their Lives

One of the dialectical dilemmas in DBT is the acknowledgment that clients are doing the best they can with the resources they have and, at the same time, that we need to teach them skills that will help them try harder, be more effective, and be more motivated to change their lives. Placing the responsibility on clients in this way (with the therapist right beside them, teaching and

coaching them to use skills), helps keep therapists motivated to work with clients, as it reminds us that we aren't here to "fix" clients, but to help them create a life worth living (Linehan, 1993a).

Even If Clients Didn't Create Their Problems, They Still Have to Solve Them

Understanding that clients must be their own agents of change, rather than relying on others to make changes for them, takes a lot of pressure off therapists by reminding us (and clients) that we cannot "fix" them. Rather, clients need to solve their own problems, with the therapist as the coach or teacher, helping them learn the skills they need to do so. This is the case even if a client wasn't the cause of the problems she's currently facing. The invalidating environment is a perfect example of this: The client may have experienced pervasive invalidation when she was growing up, which, in combination with emotional vulnerability, led to her problems with emotion regulation. While obviously it's not the client's fault that she has these difficulties, if she doesn't work toward solving her problems, nothing will change and she'll continue to suffer. Keeping this assumption in mind will also help reduce therapist burnout by reminding you that your role as therapist is to teach clients to do the problem solving they never learned as children.

The Lives of Suicidal Clients Are Unbearable

We must take at face value the pain that clients express to us. When a client attempts suicide, rather than trying to figure out what her ulterior motives were, you need to assume that she tried to kill herself because she found her life unbearably painful. This assumption also helps you remember that the client is highly emotionally sensitive. You may have heard the analogy in which the client with BPD is compared to an individual who has experienced third-degree burns (Linehan, 1993a). How can life be bearable for someone walking around with this kind of emotional pain and no skills to help manage it? This assumption helps you to create or maintain a positive working alliance with such clients as you strengthen your ability to empathize with them, rather than blaming them for their behavior.

Clients Need to Learn How to Act Skillfully in All Areas of Their Lives

Many of us have encountered clients who have difficulties regulating their emotions but have nonetheless managed to succeed in their professions as teachers, lawyers, executives, and so on. What's easy to forget is that just because these clients can use skills in one area of life doesn't mean

they can transfer these skills to other areas. When you forget this, you're likely to give clients the same invalidating message they've received for years: that they should be able to solve the problem.

The second part of the assumption that clients need to learn how to act skillfully is that when they are learning new skills, this learning must occur in different situations, including stressful situations in which their emotions are intense. This is one reason why, in the DBT model, it is preferable not to hospitalize clients: the needed learning can only occur if clients remain in their environment.

Clients Cannot Fail in Psychotherapy

We don't blame cancer patients if chemo doesn't work. If someone breaks her leg and it doesn't heal after six weeks in a cast, we don't tell her she has failed. So why would we blame the client if psychotherapy doesn't work? If a client doesn't make progress or drops out of therapy, it's not the client's fault; rather, the fault lies with the therapy, the therapist, or both. In other words, either the mode of therapy just isn't right for the client or the therapist hasn't been effective in implementing the therapy with the client. This can also be helpful when you consider any past treatments that didn't work for the client. Remembering that it wasn't the client who failed the therapy, but the therapy that failed the client, can keep you motivated to work with the client to find something that *will* help.

Rest assured, however, that the emphasis isn't on blaming the therapist if the client doesn't get better or drops out of therapy. As therapists, of course we want to make sure that we're doing our best to implement the treatment, so use this assumption as a way of motivating yourself to do your best. If a client isn't showing improvement and you know the client can't fail in therapy, you'll examine your skills and look at how effective you are at implementing therapy, rather than simply attributing lack of progress to the client's "resistance."

Therapists Treating Clients with Emotion Dysregulation Need Support Themselves

BPD and emotion dysregulation in general are among the most difficult illnesses to work with in psychotherapy. Because of the high emotional sensitivity of these clients, it's easy for therapists to inadvertently invalidate or otherwise alienate them so that therapy comes to an end, sometimes quite abruptly. Even when the therapeutic alliance is strong, non-DBT therapists often don't engage in teaching these clients the skills they need or don't balance that skills training with acceptance. These are but a few of the reasons why therapists treating such clients need support, and why DBT therefore puts such an emphasis on the treatment team. According to Linehan (1993a), the team can be a consultant or supervisor, or it can be a full DBT treatment team. Whatever the format, the idea is therapy for the therapist to enhance the likelihood of success in treating clients with emotion dysregulation.

REDUCING THERAPIST BURNOUT WITH DBT

Keeping the DBT assumptions about clients in mind helps us as therapists bring empathy and compassion to our clients, rather than falling into the judgments that often take hold when working with clients with BPD or problems with emotion dysregulation. In addition to facilitating therapy, the ability to understand and empathize with these high-needs clients rather than judging or blaming them helps prevent therapist burnout. Two other components of DBT also play a role in preventing burnout: observing our limits, and what Linehan calls “consultation to the patient” (1993a, p. 406).

Observing Limits

Most therapists have been taught to set boundaries with clients. This emphasis on setting proper boundaries, especially with clients with BPD, reflects the commonly held belief that the illness prevents them from being able to act “appropriately” (or, even worse, makes them to want to act “inappropriately”) and results in clients crossing other people’s boundaries, including the therapist’s.

In DBT, neither the client nor the therapist is viewed as disordered; in other words, if a client calls her therapist daily, she isn’t too needy and isn’t trying to manipulate. Likewise, the therapist isn’t too tolerant for taking the client’s phone calls, nor is the therapist having countertransference issues. Rather than pathologizing the client or the therapist for having poor boundaries, in DBT the assumption is that there is simply a discrepancy, or poor fit, between what one individual wants and what the other is willing or able to give (Cardish, 2011).

Of course there are some hard-and-fast limits that, as therapists, we don’t cross: sexual relationships with clients or other relationships in which clients could possibly be exploited in some way. (See the guidelines of your profession’s regulating body if you’re not sure what I’m referring to.) But other than these, it’s important to realize that everyone’s limits are different and that they vary depending on a variety of factors. For therapists, those factors include your relationship with the client, other stressors in your life at a given time, the flexibility you have given your job and the setting you’re working in, and so on.

Let’s look at an example: In my practice, it’s fairly typical for me to get text messages, emails, or phone calls from clients outside of session. I generally find that clients don’t use this privilege very often or without good reason—for example, when needing assistance with skills because they are feeling highly anxious, having suicidal thoughts, or trying not to act on an unhealthy urge. But I do have certain limits: All of my clients are aware that I turn my cell phone off when I go to bed, so I’m not available in the overnight hours. Nor will I take phone calls or look at texts or emails while I’m with other clients, so I may not be able to respond immediately.

But some limits are more individual. For one client I’ve been working with for about two years, I have a limit that she isn’t to contact me about a problem until she’s used some skills to try to help herself. I wouldn’t have this limit for someone I’ve just begun working with, since that client wouldn’t

have learned the needed skills yet. On the other end of the spectrum, I have a client I've just started seeing who's been having difficulties completing homework outside of session. I send this client a text message every other day to remind her to do her homework. I wouldn't do this with the client I've been working with for two years, as she doesn't need that kind of support at this point in therapy.

Clearly, our limits as therapists should vary to reflect the client and the context. While you don't want to be arbitrary and unpredictable, it's important to recognize that limits shouldn't be static and unchanging. You might be willing to do something one week that you aren't willing to do the next week. You might be willing to do something that another therapist isn't willing to do, and vice versa. That doesn't make it right or wrong, or good or bad; it's simply a fact of life that everyone has different limits.

SETTING BOUNDARIES VS. OBSERVING LIMITS

If you think about the term "setting boundaries" versus "observing limits," it seems much less flexible. A boundary is more concrete and immovable than a limit. In addition, if you set a boundary, it then becomes the client's responsibility to not cross the boundary, and any behavior that crosses that boundary is pathologized and considered inappropriate. On the other hand, if you observe your limits, the responsibility falls on you to maintain your limits when client behaviors might exceed them. This recognizes that it's not about the inappropriateness of the client's behavior, but about your own personal and professional preferences. Observing our limits also calls for more communication with clients. Keeping in mind that everyone's limits are different and changeable (unlike a boundary, which is more of an immovable barrier), whether in therapy or in day-to-day life, how on earth can we expect our clients to know what our limits are?

HOW TO OBSERVE YOUR LIMITS

The first step in observing your limits, as with anything, is to become aware of them. This means monitoring your level of burnout with clients and checking in on your willingness in sessions. If you're judging or blaming the client, reflect on your limits: Is there something you need to change? If so, it's important that you be honest with the client about this. If you don't express this limit, you're going to burn out, reducing the likelihood that the client's therapy will progress effectively. Although expressing a limit to the client might be difficult, remember that it will reduce your feelings of burnout and make you more effective in the therapeutic relationship in the long run. Don't mistake this to mean that observing your limits is for the good of the client. It's for *your* good. Observing your limits is your responsibility, not the client's, so be sure to make this about you (Cardish, 2011).

While of course, you need to observe your limits and communicate them to clients, it's also important to extend your limits sometimes. For example, if you don't typically take telephone calls on weekends but you have a client who's struggling with a difficult situation and needs some extra skills coaching, you might tell her that she can call you on one particular weekend. However, don't extend your limits in response to behavioral escalation (Cardish, 2011). I'll explain this when I

discuss reinforcing behaviors in chapter 3, but for now just be aware that extending your limits because a client is threatening suicide, for example, is not helpful and will actually make it more likely that this will happen again in the future. Instead, if a behavior is escalating, continue to observe your limits while also validating the client's distress and helping her find other ways to cope with the problem (Cardish, 2011).

WHAT TO DO WITH YOUR LIMITS

First and foremost, it's important that you communicate to your clients what your limits are. That's not to say that you should give each client a list of your limits in the first session. For one thing, it's impossible to foresee what situations will arise with a given client that will cause you to set limits. Some limits might need to be expressed immediately. For example, it's a common practice that if a client doesn't show up for an appointment and doesn't give you twenty-four hours' notice, there will be a fee; that's a limit. Here are some other common examples. Think about what your limits are in these areas:

- **Frequency and number of sessions:** Do you see clients once weekly? Once every two weeks? As often as they would like to be seen? Do you have a maximum number of sessions, or can a client be seen indefinitely? In addition to being a matter of your preferences, these may also depend on your employer's policies.
- **Length of sessions:** How long are your sessions? Are you flexible with this? For example, if a client is in a crisis, will you extend the length of the session? Again, this may depend on your workplace.
- **Phone calls:** Do you take telephone calls from clients between sessions? If so, how often? Do you have a time frame for phone calls? For example, do you accept calls only during business hours, or at other times as well?

These are just a few examples, and the question of what your limits are will arise in an infinite number of ways. The key is to communicate to clients what your limits are as these situations arise. Allow yourself to be flexible, and give yourself permission to change. It can help if you think of situations in your day-to-day personal life: If a friend is twenty minutes late for dinner and doesn't call you, is that okay, or do you let her know you would have preferred a phone call? If you prefer a phone call, that's a limit. If a friend calls you in the middle of the night, will you answer the phone? If not, that's a limit for you. Maybe you have a rule that one weekend out of the month you stay at home with your partner to just spend time together and that nothing can interfere with that couple time. That's a limit.

Of course, maybe you typically don't like a phone call in the middle of the night, but when you find out that a friend's mother just died, you bend that rule. Maybe you usually don't let anything interfere with your couple time, but on a weekend when your best friend is moving and needs some help, you're more flexible. These kinds of things happen in therapy, as well.

Consultation to the Client

Like observing your limits, the DBT concept of consultation to the client can help minimize burnout and enhance your effectiveness in therapy. In essence, consultation to the client means that the role of the individual therapist is to teach the client how to interact with others, rather than telling others how they should interact with the client or intervening on the client's behalf. In other words, people should be consulting the client about her needs, rather than consulting with you. This could include anyone in the client's life: family, friends, other health professionals, and so on.

Let's look at an example to make this idea more clear: Julie is a twenty-seven-year-old woman with difficulties regulating her emotions who recently began attending a DBT skills training group at her local hospital. She's been seeing her individual therapist for about six months, and they both decided that the DBT skills would be helpful for her. However, after her second week of group, Julie told her individual therapist that she was considering dropping out of the group because she found it too difficult. A non-DBT therapist might contact the group facilitator to discuss this. In consultation to the client, however, the DBT therapist would discuss the problem with the client instead and coach her on using skills so that she could speak to the group facilitator herself.

At times this plays out a bit differently: The individual DBT therapist is expected to tell other professionals how to deal with the client. Sometimes this expectation is the client's; for example, wanting the therapist to contact the local emergency department to advocate for her to be admitted because she's feeling suicidal. Rather than doing this, the DBT therapist would coach the client to use skills to get her needs met. Other times the expectation is another professional's; for example, a nurse from the local emergency department calling to say that the client won't be admitted and asking what should be done with her. The guiding rule here, as Linehan (1993a) notes, is for professionals to follow their normal procedures. In other words, remember that the world isn't typically going to change just because the client has problems regulating her emotions; therefore, it's up to the client to learn how to deal with this in a skillful way.

I often run into this problem when working with teens whose parents are trying to be more effective in helping them with their problems. Quite often a parent will request to meet with me without the teen present, in which case I respond that this isn't part of my practice. Anything they wish to say must be said with the client present. If a parent contacts me through a telephone call, I explain that the content of the call will be disclosed to the client. Of course, it's important to be validating and empathetic when speaking with clients' family members or friends, but it is of utmost importance to remember who your client is and that she needs to learn how to assert herself and cope with these kinds of interactions on her own, with you providing skills training to enable her to do so.

Consultation to the client, then, is about helping clients learn the problem-solving skills they never learned as children so they can gradually rely less on others and more on themselves. It helps them take responsibility for their own lives, rather than depending on others to act on their behalf.

STAGES OF TREATMENT

Linehan (1993a) lays out a series of stages through which clients progress on their way to recovery: pretreatment, attaining basic capacities (stage 1), reducing post-traumatic stress (stage 2), and increasing self-respect and achieving goals (stage 3). In the remainder of this chapter, I'll outline each of Linehan's stages. However, the focus throughout the rest of this book is on stage 1 treatment, as this is the focus of the DBT model as it is currently. Treatment in the other stages of therapy would use a combination of other treatment models; for example, in stage 2, the therapist would utilize treatment models specific to treating PTSD, such as CBT or sensorimotor therapy.

Pretreatment Stage: Orientation and Commitment

Unfortunately, premature termination of therapy is not at all uncommon in clients with emotion dysregulation. Linehan (1993a) notes a study by Parloff, Waskow, and Wolfe (1978) that demonstrated a link between the use of pretreatment orientation strategies and a reduction in therapy dropout rates. Given that the dropout rate for these clients tends to be high, the first several individual sessions in DBT focus on having the client and therapist make a decision as to whether they are willing and able to work together. In these early sessions, the therapist also helps the client modify any beliefs or expectations about therapy that might lead to a negative outcome in treatment, such as premature termination (Linehan, 1993a). In addition, the therapist works on completing an assessment with the client, providing psychoeducation about the client's diagnosis, and obtaining a commitment to therapy in general as well as to specific goals.

Stage 1: Attaining Basic Capacities

Once therapist and client have committed to working together, therapy enters stage 1, which focuses on behaviors that pose a direct threat to the client's safety and stability (Swales & Heard, 2009). The goal in this stage is to reduce suicidal behaviors and thoughts, as well as other behaviors that are destabilizing, self-destructive, or otherwise unhealthy, and to address skills deficits (Linehan, 1993a).

As discussed in chapter 1, in traditional CBT a lot of time would be spent jumping from one crisis to the next, making it difficult for the therapist to find time to teach the skills the client needs for managing emotions. To address these issues in a productive way, DBT organizes the individual session in a methodical way that provides much-needed structure for clients with emotion dysregulation. This structure is provided by the client's Behavior Tracking Sheet, which is a short-form way of journaling. There are different types of tracking sheets, and you can personalize them for specific clients. I've included a copy of the one I use later in this section; feel free to photocopy it and use it in your practice. From this tracking sheet, behaviors are addressed in the following order (Linehan, 1993a):

1. Behaviors that interfere with life
2. Behaviors that interfere with therapy
3. Behaviors that interfere with quality of life

Linehan (1993a) notes that, with highly dysfunctional and suicidal clients, it may take over a year of therapy to reduce behaviors that interfere with life or interfere with therapy. However, she says that by the end of the first year of therapy, "patients should also have at least a working knowledge of and competence in the major behavioral skills taught in DBT" (p. 170). Keep in mind that having a working knowledge of the skills doesn't mean clients can apply them to all of their problems!

BEHAVIORS THAT INTERFERE WITH LIFE

In individual sessions, the first items to be addressed are behaviors that interfere with life, in the following order:

1. Any suicidal behaviors
2. Nonsuicidal self-harming behaviors, such as cutting or burning
3. Intrusive suicidal or homicidal urges or communications
4. Suicidal ideation

When these kinds of behaviors occur outside of session, they become a priority for discussion in the next individual session. In DBT, the tool most commonly used to address these kinds of behaviors is the behavior analysis (BA). The BA helps therapist and client take an in-depth look at the variables that lead to a target behavior and cause the client to continue engaging in the problem behavior. I'll discuss the BA in detail in chapter 3.

Linehan (1993a) notes that suicidal thoughts that are regularly or constantly present like background noise are not always directly addressed in the individual session, as this could prevent therapist and client from working on other problem behaviors. The DBT assumption is that this type of suicidal thinking is related to the low quality of life that results from emotion dysregulation, so the focus on enhancing quality of life (which is the third target on the agenda) will address this problem.

BEHAVIORS THAT INTERFERE WITH THERAPY

The second topic to be addressed is behaviors that directly interfere with the client's therapy in some way, in order from most destructive to least destructive. These behaviors can present in many different ways and may be engaged in by both client and therapist. Examples include the

client or therapist arriving late or canceling appointments, not being properly prepared for sessions (e.g., the client hasn't completed her tracking sheet or the therapist hasn't reviewed her notes to remind herself of what homework was assigned), taking phone calls during sessions, and so on.

These behaviors can also be more subtle, such as the therapist pushing the client too hard, invalidating the client, or reinforcing unhealthy behaviors in the client, or either the client or the therapist avoiding addressing difficult topics in session. Behaviors that interfere with therapy can also become more destructive (for example, the therapist not observing a limit with the client or the client threatening herself or the therapist in some way).

BEHAVIORS THAT INTERFERE WITH QUALITY OF LIFE

The final item on the agenda for individual sessions is addressing behaviors that interfere with the client's quality of life. This could include comorbid mood, anxiety, or substance abuse disorders; inappropriate housing or financial difficulties; or lack of social support.

Because clients with emotion dysregulation usually have many of these additional problems in their lives, it's important to decide which is the most important area to work on. Linehan's guidelines (1993a) are as follows: first, solve immediate problems, such as housing or getting into a rehabilitation program; second, address problems that are more solvable and tackle the harder stuff later; and third, prioritize behaviors that are related to the two higher-order targets (behaviors that interfere with life, and those that interfere with therapy).

PUTTING IT ALL TOGETHER

To summarize the previous three sections and make the priority of treatment targets explicit, here's a list of behaviors to address, from highest to lowest priority:

1. Suicidal behaviors and nonsuicidal self-harming behaviors
2. Behaviors that interfere with therapy
3. Suicidal ideation and "misery"
4. Maintaining treatment gains
5. Other goals the client identifies

As mentioned, I've included the Behavior Tracking Sheet I use. Take a look at this sheet, and then I'll discuss a client example to help you understand how the agenda for an individual session would be set in DBT. Note that the client instructions refer to a handout listing emotions that clients can refer to if need be. You'll find this handout in chapter 9. Feel free to photocopy the worksheet and handout for use in your practice.

BEHAVIOR TRACKING SHEET

Name:

Week of:

Thurs.	Emotions	How strong?	Urges	How strong?	Behaviors (number)
	<input type="checkbox"/>	-----5	<input type="checkbox"/> suicide	-----5	<input type="checkbox"/> suicide attempt
	<input type="checkbox"/>	-----5	<input type="checkbox"/> self-harm	-----5	<input type="checkbox"/> self-harm
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
Did you use a skill? Did it help?		Yes Yes	No No	If yes, which one(s)? If you didn't use one, why not?	
Fri.	Emotions	How strong?	Urges	How strong?	Behaviors (number)
	<input type="checkbox"/>	-----5	<input type="checkbox"/> suicide	-----5	<input type="checkbox"/> suicide attempt
	<input type="checkbox"/>	-----5	<input type="checkbox"/> self-harm	-----5	<input type="checkbox"/> self-harm
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
Did you use a skill? Did it help?		Yes Yes	No No	If yes, which one(s)? If you didn't use one, why not?	
Sat.	Emotions	How strong?	Urges	How strong?	Behaviors (number)
	<input type="checkbox"/>	-----5	<input type="checkbox"/> suicide	-----5	<input type="checkbox"/> suicide attempt
	<input type="checkbox"/>	-----5	<input type="checkbox"/> self-harm	-----5	<input type="checkbox"/> self-harm
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
Did you use a skill? Did it help?		Yes Yes	No No	If yes, which one(s)? If you didn't use one, why not?	
Sun.	Emotions	How strong?	Urges	How strong?	Behaviors (number)
	<input type="checkbox"/>	-----5	<input type="checkbox"/> suicide	-----5	<input type="checkbox"/> suicide attempt
	<input type="checkbox"/>	-----5	<input type="checkbox"/> self-harm	-----5	<input type="checkbox"/> self-harm
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
	<input type="checkbox"/>	-----5	<input type="checkbox"/>	-----5	<input type="checkbox"/>
Did you use a skill? Did it help?		Yes Yes	No No	If yes, which one(s)? If you didn't use one, why not?	

BEHAVIOR TRACKING SHEET

NOTES FOR THE WEEK

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

INSTRUCTIONS FOR COMPLETING THE BEHAVIOR TRACKING SHEET

1. **Emotions:** In this column, fill in the names of the emotions you felt today, whether they were positive or painful. If you're not sure of the name of the emotion you felt, you can refer to the separate handout listing emotions.
2. **How Strong?** In this column, rate each emotion you've written in the "Emotions" column. You can put an X or other symbol on the line to indicate how strong the emotion was, or you can write a number rating the emotion on a scale from 1 (minimal emotion) to 5 (really strong emotion).
3. **Urges:** In this column, keep track of all urges related to suicide or self-harm; there are also two blanks where you can fill in any other urges you had during the day (for example, to use drugs or alcohol, to vomit or use laxatives, or to lash out at someone). If you experience more than two urges, you can use a second tracking sheet, write it on another sheet of paper, or note it on the back of the tracking sheet, in the "Notes for the Week" section for the day.
4. **How Strong?** Rate how strong each urge in the "Urge" column was, again using a scale from 1 (minimal urge) to 5 (really strong urge).
5. **Behaviors:** Always keep track of any suicide attempts or self-harming behaviors. If you attempted suicide or if you hurt yourself in some way (for example, cut or burned yourself or banged your head against the wall), write down how many times you did this. There are two blanks for you to keep track of other target behaviors you engaged in.
6. **Did you use a skill?** Circle Yes or No to indicate if you used a skill. It doesn't matter if you feel it worked or not.
7. **If yes, which one(s)?** Note what skills you did use, if any.
8. **Did it help?** Circle Yes or No to show whether you feel the skill helped.
9. **If you didn't use one, why not?** Explain why you didn't use a skill if this was the case. For example, did you forget? Were you unable to think of a skill to use? Did you think of a skill but couldn't be bothered to try to use it?
10. **Notes for the Week:** In this space, you can make notes about any events that happened that you want to talk about in your therapy session. It's also a good idea to make notes about the emotions and urges you felt each day (for example, whether they were connected to a specific situation) and the skills you used. Keep in mind that I will often want to talk about what happened in great detail with you, so the Behavior Tracking Sheet is a good place to make notes to help jog your memory about what happened.

Case Example: Carmen

Carmen's case example will help demonstrate how to set the agenda for an individual session. Carmen, a twenty-year-old woman, was referred by her probation officer. She had a diagnosis of depression and general anxiety disorder with panic attacks and had been using illegal drugs over the last two years. She probably also had symptoms of PTSD from different events that had occurred since she started using drugs. Carmen had been living with her boyfriend, who was also a drug user, and a fight between them led to Carmen being charged with assault. She was sentenced to two years of probation and wasn't allowed to return to her boyfriend's apartment. When we began working together, Carmen was living in a women's shelter and was on social assistance.

Carmen regularly experienced thoughts of suicide but had never made an attempt and repeatedly told me that she didn't want to die. However, she had a history of self-harm. The first time she met with me, she informed me that it had been about eight months since she had cut herself. She had also reduced her drug use but was still using crack once or twice a month. This often led to having sexual relations with strangers, sometimes two or three different men in one night, without using protection. She regularly drank alcohol, at least three or four times weekly, and was aware that her drinking often led to urges to use crack, but she was ambivalent about stopping or even reducing her alcohol use.

Carmen had been seeing a psychiatrist since she was about fifteen and told me that she took her medication regularly but her anxiety continued to be a problem. She was having panic attacks regularly at the time of assessment and found that drinking often helped her feel calmer and also helped with her low self-esteem and feelings of worthlessness. Carmen reported that she didn't really have friends, although she did go to a bar with a group of guys about twice a week.

In our eighth session, Carmen arrived at my office almost ten minutes late and gave me her Behavior Tracking Sheet. The tracking sheet indicated that she hadn't made any suicide attempts, but her suicidal thoughts had increased from a 2 to a 4, and her self-harm urges had increased from a 3 to a 4 since our previous session. Her drinking had remained the same, and she had used crack once during the last week. Based on all of this information from the tracking sheet, here's how I structured this session with Carmen (note that this doesn't include an in-depth discussion of how these behaviors were addressed):

1. **Behaviors that interfere with life:** Because Carmen didn't record any suicidal behaviors, we first looked at her suicidal thoughts. Because those thoughts had increased recently, we needed to check this out, which we did with a behavior analysis. Next, we looked at the increase in self-harm urges. We didn't need to do a full BA here, as the reasons for the increase were the same as for the increase in suicidal thoughts.
2. **Behaviors that interfere with therapy:** Carmen was ten minutes late for her session, which interfered with her ability to get the most out of therapy, so we addressed this next.

3. Behaviors that interfere with quality of life: First, Carmen was still in temporary housing (an immediate problem), so we needed to work on getting her housing situation stabilized to ensure she could remain in therapy. Second, we had previously identified that her drug use almost always led to an increase in suicidal thoughts and also led to engaging in other self-destructive behaviors, such as having unsafe sex with strangers, which was a threat to her health, so we looked at her drug use next. If there had been more time in the session, we would probably have looked at Carmen's anxiety next, as it seemed to be at least one of the reasons she ended up drinking. Since Carmen hadn't identified reducing her alcohol use as a goal, this didn't go on the agenda. However, this came up in future sessions; I continued to point out how drinking was interfering with her quality of life and how it was connected to her drug use and other problems.

Of course, skills training is interwoven throughout this process, so we weren't simply analyzing the behavior without trying to do anything about it.

Once target behaviors are under control, clients are ready to move on to the second stage of therapy. As noted earlier, the focus of this book is on stage 1, so the discussion of the remaining stages will be brief.

Stage 2: Reducing Post-traumatic Stress

DBT doesn't focus on PTSD symptoms until clients have the necessary skills. When clients are regularly engaging in or experiencing urges to engage in suicide, self-harm, substance use, and other self-destructive behaviors, not only are they not ready, it's actually unsafe to do this kind of work. Of course, as Linehan (1993a) notes, that doesn't mean the client's trauma history is ignored during stage 1. If the client brings up these issues in session, the therapist validates the pain and suffering the client has experienced, but the focus remains on the present—how the trauma is probably contributing to problem behaviors and the skills the client can use to help reduce these behaviors.

In stage 2 this changes. The trauma becomes the focus and exposure therapy is used to emotionally process past traumas. Swales and Heard (2009) note that, because not all clients have a history of trauma, stage 2 may also focus on negative relationship experiences related to the client's emotion dysregulation and subsequent lack of interpersonal skills. While these might not be destabilizing experiences, they can nonetheless contribute to ongoing pain and problem behaviors if left unresolved.

Stage 3: Increasing Self-Respect and Achieving Individual Goals

In stage 3, the goal becomes helping clients work on trusting, valuing, and respecting themselves, as well as continuing to work on generalizing the skills they've learned in therapy to the rest of life. Linehan (1993a) points out that it's not unusual for clients to move between stages in a nonlinear way; for example, moving from stage 1 to stage 2, back to stage 1, then jumping to stage 3, and so on. She also emphasizes the importance of taking breaks when needed; for example, before moving from the relative stability of having completed stage 1 work to beginning the trauma work in stage 2.

WRAPPING UP

This chapter has covered what you need to know to get started using DBT in individual sessions: the DBT assumptions about clients, guidelines for observing limits, and consultation to the patient, all of which help reduce therapist burnout and increase motivation to work with the client. This chapter also examined the structure of therapy as embedded within the stages of treatment for borderline personality disorder. In the next chapter, you'll learn the basic concepts of behavior theory you need to know to effectively provide DBT to clients. I'll also provide a detailed discussion of the behavior analysis, which is used to do an in-depth analysis of a problem behavior.

CHAPTER 3

The “B” in DBT: What You Need to Know about Behavior Theory

In DBT there is a big emphasis on the “B”: the behavioral aspect of treatment. In this chapter, you’ll learn some of the basic concepts of behavior theory that you need to know in order to be a more effective DBT therapist. We’ll also take a close look at the behavior analysis, a structured way of analyzing a problem behavior in detail so you can learn more about it, and so that you can be more effective in helping clients to stop engaging in problem behaviors.

DEFINING BEHAVIORAL CONCEPTS

As you’ll see in chapter 4, communication is one way that we therapists affect our clients; however, it’s important to remember that *what* we say is only one way we influence them. In fact, everything we do, how we do it, and how we say what we say all have an influence on clients, just like in relationships in general. For this reason, it’s important to be familiar with some key concepts of behavior theory. (A more thorough discussion of behavior theory is beyond the scope of this book; if you want to do further reading on this topic, a good starting point is *The ABCs of Human Behavior*, Ramnerö & Törneke, 2008). Let’s start with a brief definition of some of the concepts that are important in the context of DBT, as well as a discussion of how these ideas are used in individual DBT sessions.

Reinforcement

Reinforcing a behavior is somehow making it more likely that the behavior will occur again. There are different ways to do this: primarily through positive reinforcement, negative reinforcement, and intermittent reinforcement.

POSITIVE REINFORCEMENT

With *positive reinforcement*, something the person sees as positive happens after he engages in a certain behavior. While rewards are an obvious and intuitive form of positive reinforcement, the dynamic can be much more subtle and complex. For example, say a client has recently asked you to see him for therapy sessions more frequently and you refused the request, stating that you only see clients once a week. The client then attempts suicide and is hospitalized for two weeks, and while in the hospital he contacts you and again asks you to see him twice per week for the time being to help him through this crisis. If you agree, you supply positive reinforcement for his suicide attempt by giving him something he wants as a result of suicidal behavior.

NEGATIVE REINFORCEMENT

Don't let the term *negative reinforcement* fool you. This isn't about punishment. It's still reinforcement, but in this case it occurs by taking away something that the person finds aversive. In other words, negatively reinforcing a behavior means that something the person finds unpleasant is removed after a certain behavior occurs, making it more likely that the person will engage in that same behavior in the future in order to have the unpleasant experience removed once again.

Consider a client who becomes anxious and ashamed when discussing his cutting behavior. When you try to analyze why he cut himself last week, he starts to yell at you and threatens to leave the session. If you relent and agree to change the subject, you've just negatively reinforced the client by taking away the aversive experience of having to discuss his self-harming behavior.

INTERMITTENT REINFORCEMENT

In *intermittent reinforcement*, the positive or negative reinforcement occurs only occasionally, rather than every time the behavior takes place. This is actually one of the most successful ways of reinforcing a behavior, since the person never knows when he'll be reinforced. The most potent example is in gambling. The slot machine intermittently reinforces the person for putting coins in the slot and pulling the handle, and every now and then the card player is dealt a winning hand.

Consider the client whose partner has recently broken up with him. Having difficulties accepting this, he calls her on a daily basis. Most often, she doesn't take his calls, but every now and then she gives in and speaks with him, even if only to reiterate that the relationship is over. This intermittent reinforcement of occasionally answering his calls keeps him calling her regularly in the hopes that she'll answer again.

SOME POINTERS ON REINFORCEMENT

There are a couple of important points to remember in regard to reinforcement. First, reinforcers are different for everyone. What one person finds aversive or rewarding may have different functions for the next person. For example, while one client may enjoy talking about his self-harm outside of sessions because he knows this triggers emotions in others such as surprise, interest, or even disgust, another client may be ashamed and go to extreme lengths to hide any signs of self-harm. It's important, therefore, to learn what is aversive and what is reinforcing for particular clients.

The second point to remember is that just because you recognize you may be reinforcing a behavior you don't want, that doesn't mean you shouldn't act as you would like to. It just provides you with more information to consider, and it may lead you to set firm limits before acting. For instance, in the example of the client who attempted suicide after being refused extra sessions, you may agree that the client needs some extra support after all, and you may decide to be flexible about your once-per-week limit for a short time. It's perfectly okay for you to do this, but you might want to explicitly tell the client that you changed your mind not because of the suicide attempt, but because you hadn't realized how much distress he was in. You might also want to establish new limits, such as being clear about for how long you're willing to see him more often and establishing whether there will be consequences of some sort (e.g., returning to once-weekly meetings) if there is another suicide attempt.

Consequences

The term *consequence* refers to the effect, result, or outcome of something that occurred earlier. When looking at the consequences of a person's behavior, we're asking what happened after the person acted. There are two primary types of consequences: *negative consequences* and *positive consequences*.

NEGATIVE CONSEQUENCES

Most often, we think of consequences in terms of negative outcomes: A client goes off his medications and then begins experiencing mood instability and suicidal thoughts and engages in reckless behavior, such as drinking and driving. A single mother attempts suicide and is put in the hospital against her will, and her children are taken into protective custody. While it's certainly important to look at the negative consequences of a person's behavior, it's just as important to remember that there are often also positive consequences.

POSITIVE CONSEQUENCES

If you keep in mind that a consequence is simply the result or outcome of something that happened earlier, it's easier to understand that consequences don't have to be negative, although it's common to think of them in this way. They can also be positive.

Let's look at this with the previous examples: The client who goes off his medications no longer has to tolerate the side effects of weight gain and feeling fatigued all the time. The client who attempted suicide receives the care and support she didn't have access to as a single mother on a limited income. Although therapists are usually quite adept at helping clients see the negative consequences of their behaviors, there's a tendency to forget that there are also positive consequences that work to maintain the problem behavior. (I'll discuss this in more detail later in the chapter.)

Of course, functional behavior also has consequences, and it's helpful if clients experience this, receiving positive reinforcement for acting in healthy ways. An example would be a client who tells his mother that he's feeling out of control with his emotions and, as a result, receives positive emotional support from his mother.

Shaping

By reinforcing behaviors that are close to the desired behavior, you can *shape* an individual's behavior. For instance, Jeremy, an eighteen-year-old young man, was on probation for assaulting his ex-girlfriend. He was living back at home with his parents and was struggling with anger, often punching holes in the walls and yelling and cursing at his parents. If he was to continue living with his parents, he needed to direct his anger elsewhere. Jeremy agreed that as soon as he started to feel angry, he would leave the situation and go to his bedroom in the basement, where he could yell and scream. (His parents were aware of this plan and agreed not to disturb him.) He set up a punching bag in the basement so he could take his anger out on it, and there was a concrete wall in the basement that he could throw pillows and other unbreakable items at to help alleviate his anger.

When Jeremy reported that he was no longer taking his anger out on his parents, I provided reinforcement in the form of positive feedback. Then we set up a system in which Jeremy would reward himself if he went one day without taking his anger out on his parents, and gradually expanded the time frame to one week. In this way, I helped shape Jeremy's behavior so it was closer to what we wanted. From there, I helped Jeremy reduce his need for these new avenues of expressing his anger and find healthier ways of expressing that emotion.

Modeling

Essentially, *modeling* is demonstrating a behavior for someone else to imitate. In DBT, it's important for therapists to model the use of skills in session. For example, when you're sitting with a client who is angry, speaking loudly, and gesticulating, you model by speaking softly and being still and calm. Of course it's natural for therapists to experience emotions in session, but if you become angry and react to the client by shouting back or asking him to leave, you're not setting a good example. How can we ask our clients to work on these difficult skills if we don't use them ourselves?

One excellent opportunity to model skills arises when the therapeutic relationship is in need of repair. As you may recall from the introduction, Linehan (1993a) asserts that therapists are fallible. If you've messed up, apologize to the client. Admit it when you've made a mistake. Acknowledge that your feelings are hurt or that you felt disappointed when the client blamed you for something or when he didn't complete his homework for the third week in a row. Remember that you're human too, and that this is therefore a human relationship. Keeping this in mind and acting as though you're human (albeit a skillful one!) will help you to model the behavior you would like the client to learn.

Of course, clients also learn behavior by modeling other people, and unfortunately this means that they won't always be modeling healthy behavior. When this is the case, it can help if clients see where they learned this behavior so they can choose whether they want to continue with the behavior or learn a new way of behaving.

Contingency Management

Contingency refers to a relationship between two events wherein if one event takes place, the other is more likely to occur. For example, if a therapist has learned from previous experiences that if he cancels an appointment with a client, that client is likely to experience emotional distress and engage in some kind of self-destructive behavior, this is a contingency.

In DBT, contingency procedures are based on the assumption that the consequences of a behavior will affect the probability of the person choosing to engage in that behavior again (Linehan, 1993a). *Contingency management*, then, is about utilizing therapeutic contingencies to benefit the client (Linehan, 1993a). In other words, therapists must be aware of how their behavior is likely to affect specific clients so they don't inadvertently reinforce unwanted behaviors or punish or neglect to reinforce desired behaviors. So if the aforementioned therapist knows his client is likely to act in a self-destructive way because he has to cancel their appointment, he can attempt to manage this contingency by establishing a limit that if the client engages in self-harm, he won't take extra telephone calls from the client for a set period of time (as doing so would provide positive reinforcement for the self-harming behavior). If extra telephone contact is positively reinforcing, the client would be less likely to engage in self-harming behavior.

Of course, there are other things the therapist can do ahead of time to help the client not engage in self-harming behavior, such as giving the client an appointment for the next day, coaching the client in using distress tolerance skills, and providing lots of validation by telling the client that he understands how difficult this is.

Ramnerö and Törneke (2008) note that sometimes people question the ethical value of deliberately attempting to influence a person's behavior through these kinds of procedures. However, they also point out that therapists' mere presence in the room with clients affects consequences, and that if we try to step outside of this context so we don't influence clients, we're simply creating

alternative circumstances, which will still influence clients. In other words, since our very presence is inevitably going to influence clients, why not use this to clients' advantage by purposely behaving in ways that increase the probability of a positive outcome?

Let's look at an example: Jennifer, a stay-at-home mom, was having difficulties functioning and had started going back to bed after sending her daughter off to school in the morning. She slept until noon and then became very anxious about getting the house tidied and dinner made before her family got home. To reduce this anxiety and help Jennifer feel more effective, we set a goal for her to not go back to bed after sending her daughter off to school. I know that Jennifer values our relationship and finds it positively reinforcing when I validate her, so the contingency here is that if I validate her, she'll be more likely to engage in the behavior I'm validating again in the future. Therefore, when she comes to our next session and tells me that she accomplished this goal three out of five days, I validate her, telling her I recognize how difficult this must have been for her given the extent of the depression she's currently experiencing, and congratulate her for her partial success. Then we turn to problem solving to see what else we can do to increase her success rate over the coming week.

However, if I know that Jennifer finds validation aversive (as some clients do), I won't provide validation to the same extent. It's important that I still validate her somewhat, since she needs to learn to accept validation and provide it for herself in the long run. But if I overdo it, my validation will become a negative consequence that might actually prevent her from acting effectively in the future. So I need to know how my behavior will influence her behavior and then manage the contingency by validating a little or a lot, depending on her preference. In this way, I can enhance the likelihood that she'll engage in the desired behavior again in the future.

PROBLEM-SOLVING STRATEGIES: THE BEHAVIOR ANALYSIS

Completing a thorough analysis of a target behavior is the first step in problem solving or stopping a target behavior. Before you can take steps toward eliminating the problem behavior, you must first understand it.

I've provided a Behavior Analysis Form that will help you and the client thoroughly analyze the problem behavior: What factors made him vulnerable to engaging in the behavior? What was the trigger, or prompting event, for the behavior? What were the events, however small, that took place between the occurrence of the trigger and when he actually engaged in the behavior? What were the consequences, positive or negative, of engaging in the behavior? When looking at the consequences, remember to extend the focus to positive consequences. Most clients know what the negative outcomes of their behavior are, but they have difficulty using this understanding to help them stop engaging in that behavior. Looking at the positive consequences—what clients are getting out of the behavior—can help them develop more insight and awareness into why they continue to engage in the behavior in spite of the harm it does.

You can then use the Solution Analysis section of the form to help you and the client look at possible ways to prevent the behavior from happening again in the future: What could he do to make himself less vulnerable to experiencing the urge to engage in the behavior? Are there things he can do to avoid the trigger? Where would he be able to intervene in the future by using skills instead, so that the end result is something other than the problem behavior? And are there things he needs to do now to correct any harm that was done?

You might tend to engage in a verbal analysis when a problem behavior has occurred, asking questions like “What triggered the urge?” “Did you do anything to try to stop it?” and “What happened between when you felt triggered and when you actually acted on the urge?” However, at the beginning of treatment or anytime a new problem behavior emerges, a BA should be written out to ensure that all factors are considered (Linehan, 1993a).

The BA should initially be completed by therapist and client together to ensure that the client understands how to complete it. The goal is for the client to learn how to do thorough and accurate BAs on his own when a problem behavior occurs, at least until you both have a good understanding of why and how these behaviors are occurring.

Linehan (1993a) notes that most therapeutic errors are based on faulty assessment, which leads to an inaccurate understanding of the behavior and why it’s happening. Therefore, she suggests that when completing the BA, therapists walk clients through the situation, creating an exhaustive description of the chain of events that led up to and followed the behavior.

Here are two sample Behavior Analysis Forms, followed by a blank version you can copy and use with clients.

SAMPLE BEHAVIOR ANALYSIS FORM

Date filled out: May 24, 2012

Date of problem behavior: May 23, 2012

CHAIN ANALYSIS OF PROBLEM BEHAVIOR

<p>What is the problem behavior that I'm analyzing? <i>Suicide attempt</i></p>
<p>What things in myself and in my environment made me vulnerable to engaging in the problem behavior? <i>Emotion mind was already high due to lack of sleep.</i></p>
<p>What prompting event in the environment started me on the chain to the problem behavior? <i>Had an argument with Rob, my partner.</i></p>
<p>What are the links in the chain between the prompting event and the problem behavior? (Be very specific and detailed about what happened between the prompting event and the behavior.) <i>I argued with Rob. I went into the bedroom, laid down on the bed, and started crying. I was thinking of how lousy life is and started remembering the last time we had a fight and how we didn't talk for three days. I didn't want to go through that again and decided to kill myself. I got off the bed and locked the bedroom door, then I yelled at Rob that he was going to be sorry. I started feeling happy because this was a way I could get back at him and also felt hopeful that he would come and apologize and make things better. I walked into the bathroom and got the razor out of the cabinet and started running water in the bathtub because I didn't want to make a mess. I undressed and got in the tub. I heard Rob coming down the hallway and asking me what I was doing. I listened to him at the door for a moment, then cut my left wrist. I noticed that the pain brought relief and helped me feel a bit better. Rob started banging on the door and calling to me, but I wouldn't answer him. He broke the door down after a few minutes, then came running into the bathroom. The scared look on his face made me feel regret and, at the same time, relief because I knew he was going to take care of me. He came to the tub and hugged me. He told me he was sorry, that he loved me, and that everything would be okay. He went into the bedroom and called 911, then he came back into the bathroom and helped me out of the tub, put towels around my wrist, and helped me get dressed. The ambulance came and he rode with me to the hospital.</i></p>
<p>Keeping in mind that consequences can be immediate or delayed, answer the following questions about your behavior:</p> <p>1. What were the negative consequences? <i>I ended up in the hospital for two weeks and was unable to work. I felt guilty and hopeless for engaging in my old behaviors</i></p> <p>2. What were the positive consequences? <i>The fight with Rob ended, and he apologized and took care of me. I got to stay in the hospital for two weeks and take a break, and I've been referred to a DBT therapist.</i></p>

SOLUTION ANALYSIS

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

Maintain healthier sleep habits.

Ways to prevent the **prompting event** from happening again. (You don't always have control over this, but see what ideas you can come up with.)

I know I can't prevent arguments with Rob, but maybe practicing my interpersonal effectiveness skills will result in fewer arguments. And hopefully by practicing these and other skills, I won't get so triggered in the future and will learn to cope more effectively.

Ways to work on **changing the links** in the chain from the **prompting event** to the **problem behavior**. (How can you interrupt the links in the chain so that you'll be less likely to engage in the problem behavior next time?)

1. Instead of running away from Rob, I need to stop isolating myself when I'm feeling really depressed and angry. I need to tell him how I'm feeling and ask for help.
2. When I noticed myself thinking about our last argument, I could have practiced mindfulness instead of allowing myself to dwell on the past and worry about the future.
3. I need to work on using my interpersonal effectiveness skills more to ask for what I want or need instead of trying to get my needs met by hurting myself.
4. When I first felt the urge to kill myself I could have used my distress tolerance skills instead of just letting myself act on the urge.

Are there things you need to do to **correct or repair the harm** caused by the problem behavior?

I need to apologize to Rob for trying to kill myself and for scaring him so badly.

SAMPLE BEHAVIOR ANALYSIS FORM

Date filled out: July 15, 2012

Date of problem behavior: July 15, 2012

CHAIN ANALYSIS OF PROBLEM BEHAVIOR

<p>What is the problem behavior that I'm analyzing? <i>Binge eating</i></p>
<p>What things in myself and in my environment made me vulnerable to engaging in the problem behavior? <i>I skipped breakfast and lunch.</i></p>
<p>What prompting event in the environment started me on the chain to the problem behavior? <i>I had a disagreement with my team leader at work. I was already feeling hungry because I hadn't eaten breakfast or lunch, and then I drove past a doughnut shop.</i></p>
<p>What are the links in the chain between the prompting event and the problem behavior? (Be very specific and detailed about what happened between the prompting event and the behavior.) <i>I did something that I thought would be helpful for my team leader, but when she found out she reprimanded me and told me I shouldn't have done it. I felt demoralized and frustrated, like I can never do anything right. I wasn't able to express this to her because my anxiety was too high. I left the situation feeling incompetent because I didn't assert myself. I returned to my office and packed up for the day. As I was leaving, I was thinking about other times I've felt this way with my team leader, dwelling on the fact that she doesn't like me and I'm sure she's trying to get me to quit. I started feeling more frustrated because sometimes I feel like I want to quit, but I can't afford to. I started worrying about my future and wondering if at some point she'll find a way to fire me. I was thinking about all of these things as I left work. On my usual route home I passed a doughnut shop and decided that I deserved some comfort food after the lousy day I'd had. I decided to use the drive-through in case anyone I know was inside. I ordered a dozen doughnuts and started eating them as I was driving home. Half the box was gone in the half hour it took to get home. I brought the rest into the house with me. I fed the dogs, then I turned on the television to watch the news and ate the remaining six doughnuts while watching TV.</i></p>
<p>Keeping in mind that consequences can be immediate or delayed, answer the following questions about your behavior:</p> <p>1. What were the negative consequences? <i>I felt physically unwell that night and the next morning. I felt guilty for bingeing again, and I weighed two pounds more the next day. Also, I spent almost \$10 on the doughnuts, which I really can't afford.</i></p> <p>2. What were the positive consequences? <i>I felt relief from my emotions for a little while. I didn't have to make dinner for myself, which I really didn't feel like doing, and the doughnuts tasted good!</i></p>

SOLUTION ANALYSIS

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

I know that skipping meals is a big trigger for me, so I need to make sure I eat breakfast and lunch. I also need to keep working on being more assertive so I can feel better about myself after these interactions.

Ways to prevent the **prompting event** from happening again. (You don't always have control over this, but see what ideas you can come up with.)

I can't foresee what my team leader is going to approve or disapprove of, so I'm not sure how I could prevent her from reprimanding me again. I do know that I need to work on asserting myself so that when she reprimands me, I'll be able to stick up for myself and at least feel better about how I handled the situation.

Ways to work on **changing the links** in the chain from the **prompting event** to the **problem behavior**. (How can you interrupt the links in the chain so that you'll be less likely to engage in the problem behavior next time?)

1. When my team leader reprimands me, I could stick up for myself more. In this case, I could have told her my side of the story, explaining that I thought I was being helpful.
2. Instead of letting myself dwell on the other times this has happened and starting to worry about the future, I could use mindfulness to help prevent my emotions from increasing.
3. I could take a different route home that doesn't go past the doughnut shop.
4. If I go into the shop, I might buy fewer doughnuts because I worry what others will think.
5. Instead of eating while driving, I could eat mindfully, either sitting in the parking lot to eat, or waiting until I got home. That way I wouldn't be eating mindlessly and might have more control.
6. When I got home and stopped eating to feed the dogs, I could have tried to access my wise self instead of just allowing myself to go back to eating without thinking about it.
7. Again, instead of watching TV while I eating, I could do just one thing at a time to get myself off automatic pilot. Then I might stop eating sooner.

Are there things you need to do to **correct or repair the harm** caused by the problem behavior?

No, it's just myself I let down when I binge.

BEHAVIOR ANALYSIS FORM

Date filled out:

Date of problem behavior:

CHAIN ANALYSIS OF PROBLEM BEHAVIOR

<p>What is the problem behavior that I'm analyzing?</p>
<p>What things in myself and in my environment made me vulnerable to engaging in the problem behavior?</p>
<p>What prompting event in the environment started me on the chain to the problem behavior?</p>
<p>What are the links in the chain between the prompting event and the problem behavior? (Be very specific and detailed about what happened between the prompting event and the behavior.)</p>
<p>Keeping in mind that consequences can be immediate or delayed, answer the following questions about your behavior:</p> <ol style="list-style-type: none">I. What were the negative consequences? 2. What were the positive consequences?

SOLUTION ANALYSIS

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

Ways to prevent the **prompting event** from happening again. (You don't always have control over this, but see what ideas you can come up with.)

Ways to work on **changing the links** in the chain from the **prompting event** to the **problem behavior**. (How can you interrupt the links in the chain so that you'll be less likely to engage in the problem behavior next time?)

Are there things you need to do to **correct or repair the harm** caused by the problem behavior?

It's important to make validation a part of the BA. I'll discuss validation in detail in the next chapter, so for now just bear in mind that completing a BA is often distressing for clients, especially at the beginning of treatment. We can make this a bit less aversive for them by letting them know that we understand their emotions and even the problem behavior; in this way, we can promote acceptance before pushing for change.

A lot of attention should be devoted to the solution analysis: helping clients come up with ways to reduce the likelihood that the behavior will occur again. Assist them in looking at each of the links in the chain. Once they have learned some of the DBT skills, you'll have more options in terms of what they could have done differently and where they might intervene with skills the next time this urge arises.

Interestingly, the BA itself can play a role in extinguishing the problem behavior. If clients find doing behavior analyses aversive, they may come to see that this will be an inevitable consequence of the behavior and therefore decide to not act on the urge in order to avoid the discomfort of having to complete a BA!

WRAPPING UP

Now that you have a basic understanding of the most important behavioral concepts pertaining to DBT, we'll start looking at some of the other strategies used in individual sessions. The next chapter outlines some of the specific DBT strategies and tools used in individual sessions. Although Dr. Linehan's (1993a) treatment was originally designed to be used with clients with BPD, these strategies can be applied to other clients, and you can pick and choose which will be most effective depending on the client you're working with.

CHAPTER 4

DBT Strategies for the Individual Session

In this chapter, I'll continue the discussion of what you need to know to conduct individual DBT sessions by examining different styles of communicating with clients, including the importance of validation. Next, I'll look at some dialectical strategies that will help you balance validation with pushing clients to change. Then I'll discuss the importance of goal setting and homework and address a few more considerations about the therapeutic relationship, including some ideas about preparing clients for the end of therapy.

COMMUNICATION STYLES

In DBT, there are so many strategies to choose from that it can be difficult to know where to start. However, whatever strategy we're using, the one thing we're constantly doing is communicating with clients, so let's start there. In DBT, Linehan (1993a) makes use of two specific styles of communication: reciprocal and irreverent.

Reciprocal Communication

Reciprocal communication, by definition, is about sharing with the client: giving *and* taking in the interaction, being warm and genuine, and treating the client as an equal. This includes the often-controversial strategy of therapist self-disclosure.

THERAPIST SELF-DISCLOSURE

Carew (2009) defines *self-disclosure* as making statements to the client that reveal personal information about the therapist and notes that this remains controversial. Depending on your previous training, the idea of self-disclosure may be counterintuitive and even scary. In more traditional therapies, therapists sharing personal information with clients is viewed as inappropriate; rather, it is thought that the therapist should be neutral, providing the blank slate clients need in order to sort out their problems.

However, the idea that therapist self-disclosure can be helpful isn't new. For example, Beck, Freeman, and associates (1990) suggested that there is a place for therapist self-disclosure in CBT—that by revealing personal reactions toward clients, therapists can help them understand the impact they have on other people within the safety of the therapeutic relationship. Along these lines, Carew (2009) notes that CBT clinicians regularly employ self-disclosure as a way of encouraging reciprocity in clients who are inexperienced in sharing their personal stories with others.

Therapist self-disclosure is also supported by humanistic therapies as a way of engaging the client in an authentic relationship. For example, Carl Rogers (1961) put forth the idea that the therapeutic relationship will be more genuine and real when therapists can simply be who they are, rather putting on a facade for the client.

Even more so than in other therapies, in DBT it's important that the therapist-client relationship be strong and positive. Linehan (1993a) notes that the effectiveness of many DBT strategies relies upon the strength and genuineness of the relationship. In addition, at times the relationship will be what helps the therapist maintain a working alliance with the client, especially when the therapist's reaction might otherwise be to lash out or abandon therapy with the client (Linehan, 1993a).

Linehan (1993a) notes that in DBT self-disclosure serves a variety of functions: It can be used to validate or normalize the client's experience (e.g., the therapist might share that she had a similar situation in which she felt the same way); to problem solve (e.g., the therapist might disclose solutions that she's tried to handle a similar problem); or to model how to engage in self-disclosure, teaching the client how to share her own experiences in an appropriate way.

Therapist self-disclosure is also used as exposure therapy and contingency management when the therapist uses *self-involving self-disclosure*—disclosing her reactions to the client's behavior (Linehan, 1993a). In this type of self-disclosure, the therapist identifies her own internal reactions to the client, communicating them directly to the client. A common example might be a client who isn't completing her Behavior Tracking Sheets regularly. In response, the therapist might say, "I understand that the tracking sheets can be a pain to fill out, but you say you understand how important they are. Each time you come to session without them completed, I feel less motivated to work with you."

GUIDELINES FOR SELF-DISCLOSURE

Of utmost importance to point out here is that you must use validation in conjunction with self-disclosure, especially when providing self-involving self-disclosure. Remember the dialectical

tension between these two: you can't *only* push for change; you have to accept clients as they are (validate) and push for change at the same time.

We also have to remember that while there are times when self-disclosure is helpful and even necessary, we must always be thinking about what will be most helpful—and what could be harmful—to the client and the therapeutic relationship. Linehan (1993a) reminds us that decisions about what we disclose to our clients must always be based on what will be most helpful and the relevance of the disclosure to the current topic of discussion. For example, one of my clients has a long history of binge-eating disorder, and we've been working on this behavior that interferes with her quality of life regularly in our individual sessions. Recently, the client asked me if I had ever struggled with eating problems. Understanding that she was looking for some reassurance and hope that she could successfully reduce her bingeing, I told her that I had had a period in my life when I struggled with my weight and was able to get it under control. I also let her know that I'm a chocoholic and therefore could relate to her urges to eat. I shared some techniques that had worked for me, and we then went on to look at more skills to help her with these issues.

My self-disclosure served a specific purpose: it was validating for the client to hear that someone she looks up to has had struggles similar to her own, and letting her know that I understand and have had similar experiences helped strengthen our relationship. Of course, there's a dialectical dilemma: as therapists, we need to balance self-disclosure with observing our limits. If, for example, I'd once had an eating disorder and it was too uncomfortable for me to acknowledge this even if it might have been helpful to the client, I would need to observe this limit and not engage in self-disclosure.

The key is to aim for balance. Many therapists come from a background that labels therapist self-disclosure as inappropriate. If this is you, keep in mind that just because it feels uncomfortable to disclose something, that doesn't mean you shouldn't do it; it just means you need to think about it carefully and weigh the possible benefits against the possible discomfort you might experience. You can also ask yourself why it's uncomfortable. Is it because you think you shouldn't disclose, or because this is something personal you'd rather not share with the client?

VALIDATION

The other major component of the reciprocal communication style is validation, which is the main acceptance strategy in DBT (Swales, Heard, & Williams, 2000). Linehan (1993a) defines *validation* as communicating that the client's responses make sense and are understandable given what's currently taking place in her life. Validation means taking the client's responses seriously, rather than discounting or minimizing them. Linehan (1993a) notes that effective validation requires that the therapist recognize and reflect back to clients the intrinsic validity in their reactions to situations and events.

Early in her research, Linehan (1993a) discovered that using CBT to treat BPD was ineffective. She attributed this to CBT's focus on change, a focus likely to be perceived as invalidating by clients with difficulties regulating their emotions. As Swales and Heard (2009) point out, being told that you must change is invalidating in and of itself, even when you are able to see the truth in it.

This is the main dialectic in DBT: balancing pushing clients to make changes in life while at the same time accepting the way they are and the life they're leading, as well as encouraging them to accept themselves. If the therapist pushes too hard for change and doesn't focus enough on acceptance, the client will feel invalidated and will be unable to work effectively in therapy. But too much acceptance and not enough push for change will create a sense of hopelessness, which will also result in an inability to work effectively in therapy (Swales et al., 2000).

Linehan (1997) outlines six different levels of validation:

1. **Listening and observing:** The therapist actively tries to understand what the client is saying, feeling, and doing, demonstrating genuine interest in her and actively working to get to know her. This entails paying close attention to both verbal and nonverbal communication and remaining fully present.
2. **Accurate reflection:** The therapist accurately and nonjudgmentally reflects back the feelings, thoughts, behaviors, and so on expressed by the client. At this level, the therapist is sufficiently in tune with the client to identify her perspective accurately.
3. **Articulating the unverbalized:** The therapist communicates to the client that she understands the client's experiences and responses that haven't been stated directly. In other words, the therapist interprets the client's behavior to determine what the client feels or thinks based on her knowledge of events. The therapist picks up on emotions and thoughts the client hasn't expressed through observation and speculation based on her knowledge of the client. This type of validation can be very powerful because, while clients often observe themselves accurately, they can also invalidate themselves and discount their own perceptions because of the mistrust fostered in them by their environment.
4. **Validating in terms of sufficient (but not necessarily valid) causes:** The therapist validates client behavior in relation to its causes, communicating to the client that her feelings, thoughts, and behaviors make sense in the context of her current and past life experience and her physiology (e.g., biological illness). This level of validation goes against the belief of many clients that they should be different in some way (for example, "I should be able to manage my emotions better").
5. **Validating as reasonable in the moment:** The therapist communicates that the client's behavior is understandable and effective given the current situation, typical biological functioning, and life goals. It's important for the therapist to find something in the response that's valid, even if it's only a small part of the response (for example, letting a client know that it's understandable she would resort to cutting herself because it provides temporary relief, even though it doesn't help her reach her long-term goals).
6. **Treating the person as valid—radical genuineness:** The therapist sees the client as she is, acknowledging her difficulties and challenges, as well as her strengths and inherent

wisdom. The therapist responds to her as an equal, deserving of respect, rather than seeing her as just a client or patient, or, worse, as a disorder. Linehan (1997) points out that level 6 validation involves acting in ways that assume the individual is capable, but that this must come from the therapist's genuine self, and that at this level, almost any response by the therapist can be validating: "The key is in what message the therapist's behavior communicates and how accurate the message is" (p. 379).

Swales and Heard (2009) note that, in addition to these different levels of validation, there are also two different types of validation: *explicit verbal validation*, which is the more direct validation that occurs in all six levels described by Linehan's (1997), and *implicit functional validation*, in which the therapist validates with actions rather than words. For example, say a client comes in distressed over the end of a common-law relationship and reports that she has to find a new place to live as soon as possible because she can no longer tolerate the abuse she's been experiencing from her partner. There are many ways of providing explicit verbal validation for the client in this moment, from a level 1 validation, staying in the present with the client and remaining interested and expressing concern, to a level 6 validation, such as "I'm so glad you've finally been able to make this tough decision. I've been so concerned for you."

In implicit functional validation, rather than validating with words, the therapist does so by means of her response to the client, moving directly to problem solving. As Swales and Heard note, "Sometimes the most validating response to a client's dilemma is to help them to solve it" (2009, p. 95).

Facial expressions and body language can also be implicitly validating. For example, if a client is telling you a very sad story, hopefully she will see in your facial expression that you feel sad as well. Or if a client comes in and shares a success story with you and you smile broadly and break into applause, that would be implicitly validating, as the message you are conveying isn't verbal but is clear nonetheless.

Irreverent Communication

Irreverent communication is the dialectical opposite of reciprocal communication. While reciprocal communication is about being warm, genuine, and giving, irreverence is blunt and confrontational and makes use of honesty and an offbeat sense of humor at the same time. It relies on a well-developed therapeutic alliance and on the therapist having a good understanding of how the client will respond to this type of communication. Most important, irreverence is not meant to be mean-spirited or invalidating, so this type of communication must be followed by validation, warmth, and support, or it can be construed as more of the invalidation the client has experienced her entire life.

The point of irreverence is to throw the client off balance, so one of the goals here is to say something the client doesn't expect. Linehan (1993a) describes a number of different kinds of irreverence, but here are some of the main qualities of an irreverent response:

- It entails calling something as you see it. Sometimes this means discussing dysfunctional behaviors such as self-harming in a matter-of-fact way. An example would be telling a client she shouldn't kill herself because it will interfere with therapy (Linehan, 1993a).
- Irreverence is a straightforward and direct way of communicating aimed at aspects of the client that aren't fragile.
- Irreverence is a way of helping both therapist and client get unstuck.

It's also important to remember that reciprocal and irreverent communication must be interwoven throughout the individual session, again, to work on that balance between acceptance and change. As Linehan says, "Reciprocity by itself is in danger of being too 'sweet'; irreverence used alone is in danger of being too 'mean'" (1993a, p. 397).

DIALECTICAL STRATEGIES

While how we talk to our clients is very important, obviously what we say is just as important! Linehan (1993a) describes a number of dialectical strategies that intrinsically include both acceptance and change; it is this synthesis of acceptance and change that promotes change in the client (Swales & Heard, 2009). Following is a brief description of three of these dialectical strategies.

Devil's Advocate

Playing the devil's advocate is a technique used in the beginning stages of therapy in an attempt to obtain commitment from the client to engage in DBT, but it's also a useful strategy at other points in therapy. The essence of this technique is that by arguing against something, the therapist can help the client argue for it, and through this process a synthesis can be achieved. Returning to my client who was struggling with binge eating, let's take a look at how I used this technique to help strengthen her commitment to change:

Therapist: You tell me that you want to stop bingeing, but at the same time you tell me that when you have the urge you don't want to use skills, you want to just eat. Do you think you're really committed to stopping the bingeing?

Client: Absolutely. I am committed. I know I have to stop.

Therapist: Knowing you have to stop and wanting to stop are two different things. Do you really feel committed to this goal?

Client: Yes. I do want to work on it. I'm gaining so much weight, and my cholesterol is high. I know this is causing health problems for me.

Therapist: Yes, but you've known for quite some time now that your cholesterol is high and that your weight is getting out of control. What's suddenly different now that makes you want to stop? Or what do you think you can do differently to help you stop?

Client: I've always wanted to stop. I just haven't seen a way to do it because it's so hard. I know we've talked about a lot of skills, and maybe I just haven't put as much effort into it as I could have. I think I need to go back and review the skills we've already talked about that will help me stop; for example, being mindful when the urge comes up and choosing to distract myself from the urge instead of just acting on it.

Therapist: Okay, that sounds like a great place to start.

You can see from this example that I wasn't telling the client that I thought she wasn't committed or that I thought she wouldn't be able to stop bingeing. The idea is not to be discouraging, but to question or argue with clients in a way that gets them thinking about and arguing for the other side. Sometimes, as in this instance, it helps them generate a solution that they'll be more likely to implement, since it was their idea.

Use of Metaphor

Linehan (1993a) notes that using metaphors provides an alternative, interesting way of teaching clients how to think dialectically, as well as opening up the possibility of behaving in a new way. Of course, using metaphors in therapy isn't unique to DBT; it has been stressed in many psychotherapies and is also frequently used informally in therapy. Its usefulness should not be underestimated. Lankton and Lankton (1989) note that therapeutic metaphors don't provoke the same kind of resistance to new ideas that direct suggestions often can; rather, they are experienced as a more gentle way of considering change.

According to Lyddon, Clay, and Sparks (2001), the use of metaphors in therapy can be helpful in numerous ways, including the following:

- Establishing rapport with clients
- Assisting clients in accessing their emotions
- Challenging client beliefs
- Working with client resistance (in DBT terms, helping therapist and client get unstuck from dialectical dilemmas)
- Introducing new ways of thinking

Linehan (1993a) points out some additional factors that make metaphors important in therapy, including the fact that stories are more interesting and therefore easier to recall; that metaphors are flexible, allowing clients to use them for different reasons and in their own way, which also provides them with a sense of autonomy; and that stories can be less threatening, as the point of the story is less direct.

The main purpose of using metaphors as a dialectical strategy is for the therapist to communicate acceptance and understanding of where clients are currently and, at the same time, to present an alternative that will assist clients in moving toward change. An example of this is the burn victim analogy in chapter 2. When the therapist describes emotion dysregulation to the client as the equivalent of having third-degree burns all over her body, the client both senses that the therapist understands the pain she's in and sees the necessity of doing something to help the burns heal. Here's a brief dialogue with another example of the use of metaphor:

Client: I'm just not sure how much longer I can cope with everything that's happening. I feel like I'm standing on the edge of a cliff, and I'm not so sure I don't want to jump.

Therapist: Jumping isn't the only option. You could also take the climbing equipment I'm holding and slowly climb down that cliff. That's what the DBT skills are for.

Wickman, Daniels, White, and Fesmire (1999) point out that metaphors will be more effective when they utilize the client's own language. In other words, whenever possible go with metaphors the client offers, as in the example above, since the client obviously relates to them.

Making Lemonade Out of Lemons

You've probably heard the saying "making lemonade out of lemons" or some version of it. In DBT, this requires therapists to take an apparent problem and turn it into something positive. As Linehan (1993a) points out, this is another skill that must be used with caution so it doesn't seem like invalidation of the client or minimizing the seriousness of the problem. To use her metaphor, "The skill of the therapist is in finding the silver lining without denying that the cloud is indeed black" (Linehan, 1993a, p. 217). Here's an example:

Client: I'm having a really hard time coming to group because I can't stand Michael. He's always talking and never gives anyone else a chance to speak up in group. He's driving me nuts.

Therapist: That's great news, since we've been looking for opportunities for you to practice being nonjudgmental!

The therapist would then discuss with the client ways she could practice being nonjudgmental in group, as well as other related skills if applicable.

GOAL SETTING IN DBT

The dialectical strategies outlined above are just a few such strategies used in DBT to help clients get unstuck. Of course, we also need to work with clients to forge an agreement on what we're working on. As with many therapies, in DBT it is extremely important to assist clients in setting concrete goals, or behavioral targets. In fact, Linehan (1993a) identifies this as a crucial step that must be taken before therapy even starts, which makes sense, as both therapist and client must be on the same page in terms of goals if therapy is to have any chance of success. If an agreement cannot be reached (for example, if the client won't agree to a goal of stopping self-harming behaviors), the therapist may suggest that DBT isn't for her, at least at this point in time.

We began looking at behavioral targets in chapter 2, with the outline for the individual DBT session and the order in which problems are discussed: behaviors that interfere with life first, then those that interfere with therapy, and, finally, those that interfere with quality of life. Goal setting is much more complicated and will progress as your alliance with the client develops. From the outset, it's important to remind clients of the overarching goal in DBT: to create a life worth living (Linehan, 1993a), which includes eliminating suicidal and self-harming behavior. There are usually many behaviors that therapist and client can agree need to stop in order to achieve this goal.

It's also important to remind clients that you're talking about goals or targets at this stage. Just because you're suggesting a goal of stopping self-harming behavior doesn't mean the client is expected to do this all at once; rather, this is something she's agreeing to work toward.

The Role of Validation in Setting Goals

Telling the client that she has to or should change a behavior is inherently invalidating, as it indicates that there is something wrong with the behavior (and, by extension, with the client for engaging in this behavior). So when discussing behavioral targets, it's important to surround the conversation with validation: first, find something about the behavior to validate. Repetitive behaviors always serve some sort of purpose, or we wouldn't continue to engage in them. (By the way, if you're not yet sure what purpose the behavior serves, it's okay to say just that; for example, "Even though we don't yet know what you get out of this behavior, it obviously does something for you, or you wouldn't still be doing it.") Here's an example with my client who was having difficulties with bingeing.

Client: I don't understand why I can't just stop myself from eating; I know it's bad for me, and I really do want to stop. What's wrong with me?

Therapist: If it were that easy, I'm sure you would have stopped a long time ago. You have to remind yourself that bingeing is a way you've developed to help yourself deal with intense anxiety. Even though you know it's not healthy for you, it's the way you've learned to deal with your emotions. So when things get tough, it makes

sense that bingeing is the way of coping you're most comfortable with and that you're still falling back into that old habit. That means we have to help you learn some new, healthier ways of coping, so that eventually you'll be able to turn to them instead.

You can see from this short dialogue that I already have a good understanding of why this client turns to bingeing to help her deal with emotions, so I am able to provide level 5 validation. Then I provide a rationale for why the behavior needs to change (which is brief because the client is already agreeable to working on this as a goal) and reassurance that we'll work on teaching her new skills that will help her change.

When Disagreements Arise about Goals

Of course, we're not always going to be able to agree with clients on what should be a goal in order to create a life worth living. For example, earlier I mentioned a client who wanted to stop using crack cocaine but didn't want to stop drinking, even though her drinking was excessive and often led to episodes of drug use. So what do you do when this reluctance arises? Two key DBT approaches are examining the costs and benefits, and acceptance.

EXAMINING THE COSTS AND BENEFITS

Looking at the costs, or negative consequences, of a behavior can help clients come to the conclusion that they want to make changing the behavior a goal. If you've identified a behavior that you think needs to change but the client disagrees, help her to look at the costs and benefits of the behavior. In chapter 8, I'll discuss a formal cost-benefit analysis. However, you can also explore this informally by asking the following kinds of questions:

- What are the negative consequences that occur when you engage in this behavior?
- How do you feel about yourself after you've behaved in this way?
- How do the people you care about respond to you when you behave this way?
- What are the benefits, or positive consequences, that occur when you engage in this behavior?
- What function does the behavior serve? What do you get out of behaving in this way?

This kind of analysis can help you and the client determine what needs the behavior is meeting and what is reinforcing the behavior. At the end of this discussion, hopefully the client will be able to see the costs of her behavior. That doesn't mean she'll be ready to give it up, but it does mean she's one step closer to considering setting it as a goal to be worked on.

ACCEPTANCE

In my experience, clients are often reluctant to look at making something a goal because of fear. When this is the case, remember that you probably have enough goals to keep you busy for a while anyway, and as you work on preexisting goals, you'll probably be building the client's trust (and teaching her skills). With time, she might be more comfortable revisiting the potential goal. It can be more productive to accept that the client isn't willing to work on this behavior yet, rather than pushing. Even if pushing results in an agreement to set a goal, the chances that she will actually working on it are slim, since it's really your goal, not hers. Also keep in mind that just because you're accepting her refusal in the moment doesn't mean you can't continue to gently point out those times when you see the behavior directly impacting her life in a negative way.

Homework

A discussion of goal setting wouldn't be complete without looking at one of the most important aspects of treatment: homework. If you keep in mind that you'll only see each client about one hour per week or less, you can see why homework is essential. Nothing is going to change if clients aren't working on goals outside of session.

If homework is to be helpful, it must be collaborative: the client must understand the rationale and buy into it, or she probably won't do it. If I give more than one task for homework, I ask clients to write them down so they don't forget. I also write the homework down myself so I remember to ask about each task in the next session to ensure clients follow up and that the homework is therefore meaningful. Reviewing this list at the end of session is also a good idea, ensuring that clients understand the homework and providing an opportunity to troubleshoot any problems that might get in the way of completing the tasks assigned.

Reviewing homework should be one of the first thing that happens in the next session. This can often be incorporated with looking at the client's Behavior Tracking Sheet. For example, you might say, "There was an episode of cutting on Thursday; did you complete a BA?" or "I see that you practiced mindfulness every day this week as we discussed last session for homework. Nice job!"

Other times, however, the homework may be quite separate. For example, I asked my client with binge-eating disorder to complete a food journal in addition to her Behavior Tracking Sheet. Another example would be doing exposure therapy to help reduce social anxiety. Regardless, make sure that homework is addressed at some point so you can reinforce the client for completing it and provide validation and feedback. Of course, it's also important to know if the homework wasn't completed, in which case this is addressed as a behavior that interferes with therapy.

ENDING THERAPY

Linehan (1993a) notes the importance of preparing clients with BPD for the eventual termination of therapy from the very outset. For other client populations, the timing of the discussion of termination depends on the limits of the environment in which you work. In my private practice, I can see clients as long as they wish to be seen—as long as therapy remains helpful. In my work in a hospital clinic, however, in the very first session I tell patients that we have twelve sessions, or approximately six months of therapy, in which to work on their goals. I find that this helps clients remain focused on goals and helps them work harder at practicing skills and doing homework tasks that might help them reach those goals. I also provide periodic reminders. At session six, I advise them that we're halfway through treatment and ask for feedback about how they feel we're progressing. I ask whether we're working on what they want to work on, whether there are things they'd like to talk about that we haven't looked at yet, and so on. From session eight on, I remind them what session we're at. We also discuss whether they need referrals to other agencies to carry on with work that remains unfinished or that we haven't been able to get to in our brief time together.

Whenever possible, I find it useful to taper sessions with clients rather than stopping treatment suddenly. Tapering gives people the opportunity to have more accountability to themselves to continue using skills while still knowing that in, say, a month, they have to come back and report on their progress. As some clients have put it, this allows them the freedom to do the work themselves but still hang onto me as a "security blanket" for a little while.

Linehan (1993a) discusses the possibility of continued contact between therapist and client when therapy is over. Rather than making the assumption that there will be no further contact, she says that therapist and client should discuss whether or not they wish to have ongoing contact, and if so, what the limits surrounding this will be. I certainly agree that if it's possible to have some sort of ongoing contact, this is extremely helpful in assisting clients in gradually transitioning out of therapy, especially with BPD clients. Seeing someone weekly or biweekly for such a long period of time and then no longer being able to have contact with that person is much more difficult to accept than a gradual reduction of contact, especially for clients with BPD, who have probably had lifelong difficulties with relationships.

WRAPPING UP

In this chapter you've learned a lot about how to conduct an individual session using DBT. I discussed different communication styles, some of the dialectical strategies, goal setting, and ending therapy. Now that you have more of an understanding of the foundation of DBT, in part 2 I'll present the building blocks: the specific skills you'll be teaching clients in individual sessions or in skills training groups, depending on your resources and the format you've chosen.

PART 2

The Skills

CHAPTER 5

Introducing Clients to Mindfulness

Just as we tell clients to have patience, that their understanding of skills will increase with practice, I'd like to remind you of this as well. There's a lot to learn in order to be able to provide DBT effectively, but as you practice the skills, things will start to fall into place.

This brings me to one of the key factors in DBT: therapists must practice the skills they are teaching. If you try to teach them without practicing them, you won't have the complete understanding needed to relate to the problems clients will experience as they work on integrating the skills into their lives. Imagine trying to explain a rock climbing technique to someone when you've never climbed anything more than a ladder! It's difficult to teach something you don't fully understand, and the only way to fully understand is to practice what you're preaching. Therefore, in part 2 of the book, I'll more often address you, the reader, directly, since the fundamental qualities of human experience and the benefits of the skills apply equally to therapists and clients alike.

So, with that said, let's turn to the first skill, the *core* skill in DBT: mindfulness. As with any skill, the first step in teaching mindfulness to clients is getting them to buy into it. So your initial task is to convince clients that mindfulness will be helpful. Because mindfulness isn't a component of traditional therapy, I find a little more convincing is needed than for many of the other skills. People often question it and are skeptical of it. Therefore, it's especially important to relate it to the client's needs and to use language that is not only understandable, but acceptable to the client.

WHAT IS MINDFULNESS?

There are many ways of defining mindfulness, and it's important to find the definition that works best for you. My favorite is this: doing one thing at a time, in the present moment, with your full

attention, and with acceptance. I then break this down into two parts for clients. The first is awareness: focusing on the present moment, concentrating on whatever you happen to be doing in that moment—walking, driving, having a conversation, playing with a pet, and so on.

The second part—and the part people tend to overlook—is acceptance: simply being aware of your experience without judging it. So if you notice that you’re feeling anxious, just accept it. If you notice that you’re bored or you’re thinking, *This exercise is pointless*, just acknowledge it. If you have pain in your body, just allow yourself to sense it, rather than judging your experience. Mindfulness is about experiencing things as they are without trying to change them.

I also have some advice about what *not* to say. When talking to clients about mindfulness, especially when they’re first learning about it, I avoid using the word “meditation.” Although mindfulness is a form of meditation, many people have stereotypical ideas about what meditation is (for example, sitting on the floor in the lotus position and chanting “Om”) that can cloud their understanding of mindfulness and perhaps make them less likely to practice.

And while mindfulness has its roots in Zen Buddhism, I also avoid even the slightest reference to this because I find that some people become convinced that mindfulness is a religious practice. That may be either positive or negative for the individual, and until you know, it’s best to not bring it up. Unless clients bring these issues up, I tend to stay away from them, at least until they have a good understanding of mindfulness and are practicing regularly.

SELLING MINDFULNESS TO CLIENTS

After explaining what mindfulness is, it’s important to personalize the skill for clients. Remember, it’s your job to convince them that mindfulness will be helpful, so think about the problems they’ve identified that they would like to work on, and then explain how mindfulness will help with these target behaviors. Let’s take a look at some of the typical problems mindfulness can help with.

Taking Control of Your Mind

Most clients will easily acknowledge that they spend too much time in the past, reliving negative things that have happened, or in the future, worrying, catastrophizing, and “what-iffling.” Ask clients if they do one or the other or both. Next, ask them what emotions come up when they’re living in the past (depression, sadness, anger, regret, shame, and so on) or in the future (anxiety, worry, sadness, etc.). Typically, they can readily identify which emotions they experience. Then present them with the alternative of living in the present moment more often. Of course, the present moment often has pain in it as well. But when they are living in the present moment and it’s painful, at least they’re only dealing with the pain of the present, rather than the pain of the present, the past, and the future simultaneously. In other words, when they’re being mindful, they only have pain multiplied by one, rather than pain multiplied by three.

I explain to clients that previously their mind has been controlling them, taking them wherever it wants to go. Mindfulness is about taking that control back, so that when they see their mind going to the past or the future, they have a choice whether they want to go there. It's also important to mention that, like any skill, mindfulness takes practice and can be strengthened through training, and that research indicates that strengthening this ability can reduce symptoms of depression and anxiety, including rumination (Masicampo & Baumeister, 2007).

Next, I explain the second part of mindfulness: acceptance. We humans tend to fight the things that cause us pain (something I'll discuss further in chapter 10). Unfortunately, this tendency actually causes more pain. If you can work on accepting whatever you find in the present moment, you'll actually experience less pain in life. Some things in life can't be changed, but you can change your relationship to them.

Improving Emotion Regulation

Because living in the present moment reduces the amount of emotional pain clients experience, it makes emotions easier to manage. I tell clients to think of their emotions as being contained in a bucket inside of them. If they're walking around with their bucket full to the brim with emotions—in part due to living in the past and the future—it only takes one small event to make the bucket overflow. This results in problem behaviors such as lashing out, substance use, and suicidal behaviors. If clients are practicing mindfulness, the level of emotions in the bucket is automatically lowered because they aren't generating extra pain by living in the past or the future. And again, the less emotional pain they have, the easier it will be to manage.

In addition, when we live more in the present moment, we're more aware of what's happening within ourselves: thoughts, physical sensations, and emotions. This increased awareness helps us tune in to any emotions that might be present more quickly, providing an opportunity to choose how to act, rather than just reacting and allowing emotions to control us. As Bennett-Goleman (2001) puts it, "Instead of being swept away and captured by a thought or feeling, mindfulness steadily observes those thoughts and feelings as they come and go" (p. 9).

Looking at mindfulness in this way, it's reasonable to expect that, in the long run, it will be helpful with problems such as mood and anxiety disorders, anger problems, eating disorders, and substance abuse problems, as well as just generally helping people live healthier, happier lives.

Increasing Behavioral Control

I often hear people talking about their behavior as though they have no control over it: "I just couldn't help myself" or "I didn't even think about it; I just did it." Although clients might often feel as though they have no control over their behavior, it's important to emphasize that this isn't the case.

Again, the key to not acting on urges and to increasing control over our actions is awareness. Mindfulness helps us become more aware of what we're thinking and feeling so that when an unwanted urge does arise, we become aware of it more quickly and can take action to help prevent engaging in the behavior. As I'll discuss further in chapter 8 when I cover how to manage urges, increasing the time between when the urge arises and when we act on it gradually helps break the habit of engaging in that behavior. As Masicampo and Baumeister note, "Systematic practice gradually erodes patterns of habitual responding" (as quoted in Chambers, Lo, & Allen, 2008, p. 304). Developing self-control is similar to building muscle: we have to exercise it to improve our control over ourselves. Mindfulness is one way of developing this self-control. It also helps improve our understanding of why we respond in particular ways, which helps us stop habitual or reactive behaviors (Wilkinson-Tough, Bocci, Thorne, & Herlihy, 2010).

Improving Concentration and Memory

If you think of your mind similar to a muscle, you can understand that it needs to be exercised. Mindfulness is an exercise that helps strengthen the mind in many ways, including enhancing the ability to concentrate. Because a key aspect of mindfulness is noticing when your attention wanders and intentionally bringing it back to whatever you're doing in the present, over time this improves your ability to concentrate.

This has another benefit, as well: when you're focusing on the present and whatever you're doing in that moment, you'll have a better memory of it later. How many times have you washed your hair twice in the shower or driven home from work and suddenly realized you have no recollection of the last ten minutes of the drive? When you're not fully engaged in the present moment, you'll have little or no memory of it later on.

I recently discussed this with a client who realized she had little memory of her three-year-old son's life because an anxiety disorder kept her constantly living in the future. She was so focused on thinking and worrying about what might happen that she was hardly ever fully in the present moment and therefore had little memory of daily life with her son.

Engaging in Life

When you're in the present moment more often, you're more able to engage in life. This not only means that you'll remember things better, but that you'll also really be there to enjoy any positive emotions and experiences. Quite often people miss out on positive events, especially the smaller ones, because they're so busy thinking about something else. When you're in the present moment, you're just more *there* in your life, whatever may be happening.

Relaxation

While it's important to emphasize to clients that mindfulness isn't intended as a relaxation technique, it should be pointed out that relaxation is often a beneficial side effect. When you do only one thing at a time and focus your full attention on that one thing, life becomes less overwhelming and chaotic, which helps you feel more relaxed. In addition, many of the activities people choose to do mindfully are inherently relaxing: taking a hot bath, sitting outside and watching the wildlife, listening to music, and so on. When you actually pay attention to these activities, rather than doing them while thinking about the past or the future, you'll feel more relaxed.

The Research

Once I've given clients my spiel about how mindfulness will help them, I find it useful to back this up with research findings. This is another way of convincing clients that mindfulness will be helpful, and isn't just some abstract, "airy-fairy" concept. It's been studied extensively, and knowing this helps clients buy into and practice this skill.

When discussing the research, you obviously don't want to bore clients to tears, and again, think about ways to personalize this information. There is more and more research being done on mindfulness for different mental health problems and physical conditions. Keep yourself up-to-date so you can give clients the most current information.

Some of the current evidence indicates that living life more mindfully can improve immune function and the ability to cope with physical illness. It can also reduce stress, anxiety, depression, and sleep problems and generally increase the ability to enjoy life (Harvard Health Publications, 2004). In addition, mindfulness improves the capacity to be self-aware and tolerate upsetting thoughts, and by activating a specific part of the brain that's connected to experiencing happiness and optimism, it triggers positive feelings (Harvard Health Publications, 2004).

Regular practice of formal mindfulness meditation is proving to have even more positive effects, actually changing the physiological makeup of the brain. Hanson and Mendius (2009) note that regular practice improves psychological functions in certain areas of the brain, which has a positive effect on mood; improves attention, compassion, and empathy; decreases stress-related cortisol levels; improves overall immune system functioning; and specifically helps a variety of medical conditions, including heart problems, asthma, type 2 diabetes, premenstrual syndrome, and chronic pain.

HOW TO PRACTICE MINDFULNESS

Once clients buy into mindfulness and can see how it will be helpful for them, I turn to teaching them how to practice mindfulness. I find it easiest to break mindfulness down into four steps:

1. **Choose an activity.** Although you can practice mindfulness in an infinite number of ways, it's important to personalize this for clients. Give them some examples of how they can practice mindfulness based on what you know about them. For example, if a client has spoken with you about her children or pets, mention that she can spend time with them mindfully. If she plays a sport or has a hobby, suggest engaging in it mindfully.
2. **Focus on the activity.** The second step to practicing mindfulness is to start to focus on being in the present moment with whatever activity has been chosen.
3. **Notice when your attention wanders.** Remind clients that it's natural for attention to wander. Our brains generate thousands of thoughts daily, so it's inevitable that this will happen; the important thing is to notice it when it happens. So the third step is just being aware that attention has wandered from the present moment.
4. **Gently bring your attention back.** The final step is accepting that attention has wandered—being gentle rather than judging oneself—and bringing attention back to the present moment. In other words, we just notice that we're no longer focusing on the activity and bring our attention back to it without judging ourselves for wandering, and without judging anything about our experience.

The trick is to continue to do steps 3 and 4 over and over again: noticing that attention has wandered and bringing it back to the present moment. I find it helpful to emphasize to clients that they might have to bring their attention back continuously when they first start practicing mindfulness, and that this is okay—that it is, in fact, what mindfulness is all about. Mindfulness isn't so much about *staying* in the present moment; it's about noticing when your attention has wandered and *returning* to the present. Of course, it's important to find the dialectical balance between ensuring that clients understand that mindfulness is difficult and helping them believe that they will be able to do it.

Monkey Mind and Puppies

There are two analogies I find helpful when teaching mindfulness. The first is the Buddhist metaphor (which I don't introduce as being a Buddhist metaphor!) for the typical state of the human mind: monkey mind. The mind is often like a monkey: jumping around, constantly distracted and wandering, chattering about different things, and nearly impossible to quiet. This helps clients understand that their experience of being distracted while practicing mindfulness isn't unusual and is, in fact, pretty typical.

The second analogy helps clients have a little more patience with themselves while practicing mindfulness. Most people either have had a puppy at some point or have known someone who did

and can relate to what it's like to train a puppy. When you first start to train the puppy to sit and stay, what happens? You turn around and slowly take a few steps in another direction, and the puppy is up and following you right away. You don't get angry with the puppy, calling it stupid or an idiot for not staying; you understand that the puppy isn't yet trained and doesn't know how to sit and stay. The client's mind is the puppy, and mindfulness is how she will train her mind to sit and stay. When she first begins, of course her mind isn't going to listen—it has never been trained and doesn't know how. She needs to have patience with her mind rather than judging it. (This is also a useful metaphor later on, in that even well-trained puppies have a hard time sitting and staying when they're excited or distressed in some way, just as intense emotions of any sort make it harder to practice mindfulness, even for experienced practitioners.)

Even with these helpful metaphors, most clients still become frustrated and have difficulties with mindfulness, and this calls for validation. Reassure clients that their difficulties are typical, that mindfulness is hard, and that, over time, it will get easier—the puppy will gradually learn to sit and stay.

Informal and Formal Mindfulness Practice

The next thing I teach clients is the difference between formal and informal practices: Informal mindfulness is simply bringing mindfulness to whatever you happen to be doing: reading these pages, having a conversation, riding a bike, and so on. Formal mindfulness is when you actually set aside time to do a practice, such as a breathing exercise or observing thoughts or emotions. This is a good time to remind clients that mindfulness is about doing *one thing at a time*. So if you're practicing mindfulness, you can't do a breathing exercise while driving, because that's two things. You either drive mindfully (an informal exercise, bringing mindfulness to something you're doing anyway), or you set aside five minutes to do a breathing exercise (a formal exercise, where you set aside time to do a mindfulness practice).

I find that having clients start with informal mindfulness exercises between sessions makes it more likely that they'll practice. I introduce formal exercises in session, starting off with short, simple exercises (e.g., counting breaths for one minute) and working up to the practices that people tend to find more difficult (e.g., observing thoughts or emotions). I also gradually increase the amount of time of the formal practice.

Of course, everyone learns and practices at a different pace. Some clients latch right on to mindfulness, quickly grasping the concepts and becoming adept at incorporating it into their lives. You'll be able to get these individuals to practice formal exercises on their own very quickly. Others struggle with the concept and have trouble remembering to practice or don't see the point of practicing. With these clients, you might need to repeatedly review the purpose of mindfulness and why you're asking them to do these exercises. In addition, the pacing will be slower, focusing on informal exercises for longer before progressing to formal practices. Either way, validate and continue pushing for change.

Occasionally I encounter a client who just can't grasp mindfulness or how helpful it can be, or who is opposed to practicing it for some reason. If this happens, trying to push the client will only result in a power struggle, so start with some of the other skills instead. You might find that once you build more of a relationship and the client develops more trust in you, she'll be more willing to work on mindfulness.

In my experience, clients have a tendency to focus on informal practices and don't engage in formal mindfulness as often as would be helpful. Be sure to explain that informal and formal mindfulness practices, while both helpful and important, serve different functions. Informal exercises help them live their lives more mindfully and be in the present moment on a regular basis, whereas formal exercises help them become more aware of their internal experiences, increasing self-awareness and the ability to manage themselves more effectively. Therefore, both types of exercises are extremely important. I've included a handout describing various formal mindfulness exercises. Feel free to give this to clients to aid them in their practice.

FORMAL MINDFULNESS PRACTICES

- **Counting breaths.** Sitting quietly, count “one” as you draw a deep breath in, and “two” as you slowly breathe out, “three” on the inhalation, “four” on the exhalation, and so on. Count up to ten, then start over at one. When you find that your mind is wandering and you’ve stopped counting, simply notice this without judgment and return your focus to breathing and counting.
- **Observing sounds.** Sitting quietly, focus your attention on any sounds that you hear: the sound of your breathing, the sound of people talking in the next room, the sound of air coming through the vents, the sound of the television in the next room, and so on. When you notice your mind wandering, notice it without judgment, then return your attention to whatever sounds enter into your awareness.
- **Observing an object.** Pick up an object, such as a framed photo, a knickknack that sits on the mantle, a piece of jewelry, or a child’s toy, and observe it mindfully. Examine the object with all of your senses, focusing all of your attention on the item. Experience the sensation of touching it. Notice any smell it might have or any sound it might make as you move it around in your hands. When you notice your mind wandering to other things, bring your attention back to observing the object without judging yourself.
- **Observing your thoughts in clouds.** Pretend you’re lying in a field of grass, looking up at the clouds. In each cloud is a thought. Observe the thought as it slowly floats by and label it in terms of what kind of thought it is. For example, when the thought *Am I going to be able to pay my credit card bill this month?* floats by, label it “worrying thought” or “anxiety thought.” When you see the thought *This is a stupid exercise* in a cloud, label it “anger thought” or “judgmental thought,” and so on. As best as you can, don’t judge yourself for the thoughts you’re having or for how you’re labeling them; there’s no right or wrong answer. When you notice you’ve gotten caught up thinking about a thought, simply let it go and notice the next thought.
- **Focusing on a thought.** Choose a meaningful word or a short sentence to focus on, then repeat it to yourself as you focus on your breathing. For example, while breathing in, think “wise,” and while breathing out think “mind.” When you notice that your mind has wandered, don’t judge yourself; simply bring your attention back to the exercise.
- **Being the gatekeeper to your mind.** Pretend that you’re standing at the “gate” of your mind watching thoughts and feelings that are coming through the gate. As best as you can, don’t judge these thoughts and feelings; simply observe what they are so you can become aware of what’s in your mind, just as a gatekeeper must be aware of who’s coming through the gate. Welcome thoughts and emotions as they come through the door, rather than trying to block them. When your mind wanders or you feel yourself trying to stop thoughts or feelings from entering, try to relax and simply observe these things, then go back to watching thoughts and feelings enter. If you find that thoughts and feelings are coming through the gate too quickly, try to slow them down by having each one knock before entering so that you can open the gate, acknowledge it, and then let it through.
- **Being in your body.** Sitting quietly, focus on the different sensations you experience in your body. Notice, for example, the feel of your bottom on the chair or the feel of your arms against the armrests. Observe any tension you may have in your muscles. Notice that you feel cool or that your face feels hot. Acknowledge any emotions you may be experiencing, such as anger about a situation that happened earlier or frustration because you’re finding it difficult to do this exercise. When your mind takes you away from observing physical sensations, simply bring your attention back to the exercise and let the other thoughts go. Another way of focusing on your body is to run a fingernail sharply across your face just between your lip and your nose. Then sit quietly and focus on that sensation for as long as possible; see how long you can feel it. When your mind wanders to other things, tell yourself it’s okay, then bring your attention back to the sensation.

It's important to point out to clients that it's okay to change mindfulness practices to better suit their needs. In the counting breaths exercise, for example, some people like to include both the inhalation and exhalation in each count. Some people have trouble seeing their thoughts in clouds and find that they hear their thoughts rather than see them. For these clients, I direct them to simply let themselves hear the thought, and then label it: *There's a thought about work... There's anxiety... There's a thought about the weather...* and so on. As long as clients are getting the main point of the exercise—counting breaths, observing thoughts, and so on—it doesn't matter if they change it a bit to suit their needs. Plus, giving them this flexibility makes it more likely that they'll practice.

I find it helpful to have clients keep a log when they first start practicing, and I have designed the Mindfulness Tracking Sheet for this purpose. You're welcome to photocopy it for use in your own practice. This is a good learning tool that serves a few different functions: First, it helps clients remember to practice mindfulness because of the accountability factor; they know this is homework and that I'll be looking at the tracking sheet in our next session. Second, it helps them think about how they're practicing mindfulness and what their experience of mindfulness is like. And third, it allows me to see if they truly understand the idea of mindfulness and how they're practicing, giving me an opportunity to provide feedback about their practice. I write comments on these tracking sheets; for example, suggesting that clients increase their practice time or the variety of activities they're using for mindfulness, pointing out when they're judging aspects of their experience, and so on. In this way, clients get regular feedback about their practice that helps them continue learning.

MINDFULNESS TRACKING SHEET

Date	What I did mindfully	Length of practice	What I noticed about my experience (thoughts, emotions, and so on)

Make It Easy

If you're already practicing mindfulness, you know how difficult it can be, and if you're about to start practicing, you'll soon find out! You can do clients a favor—and make it more likely that they'll practice—by making mindfulness as easy as possible. Because both the focusing and accepting aspects of mindfulness are difficult for most people, see if you can make one of these a bit more doable. If you can get clients to come up with an activity they are already able to focus on and deeply engage in, this will be an ideal way for them to begin practicing.

I once worked with a client who was having tremendous difficulties with mindfulness. He had such a hard time concentrating on practicing and got so frustrated that he would just stop. He felt like he wasn't getting anywhere. I asked him if he could think of an activity that he was already able to deeply engage in, and he immediately said playing guitar. Since he was able to focus when playing guitar, the only difficulty he would face was the acceptance piece. Of course, acceptance isn't easy either, but having clients start practicing mindfulness with something they're easily able to focus on frees up more energy for accepting their experience.

PRACTICE WHAT YOU PREACH

At the beginning of this chapter, I mentioned the importance of therapists practicing the DBT skills themselves. I find that clients usually ask me at some point if I use these skills myself, if I had problems when I started learning them, if they've helped me over the years, and so on. Because I *have* been practicing these skills for a number of years, I can answer these questions honestly and provide validation that I understand how difficult the skills can be and some of the problems they're facing in practicing the skills.

But having your own practice is also important from a more practical perspective. After all, how can you effectively teach someone how to do something that you're not doing on a regular basis yourself? If you don't have the thorough understanding that can come only from practice, you can't be a truly effective teacher. That's not to say that you're going to experience the same problems with these skills as your clients or to the same degree, but it will give you a better understanding of their experience and also allow you to model the skills.

Some mindfulness teachers believe that therapists and clients should be practicing formal exercises for at least thirty minutes each day. I think we each have to find our own way in this, and that what works best for one person might not work for another. However, if you're going to teach clients that both formal and informal practices are important, you should be practicing both types of exercises yourself. Likewise, if you're going to ask clients to practice thirty-minute exercises for homework, you should be doing thirty-minute exercises yourself. The bottom line, in my opinion, is that we shouldn't ask our clients to do what we aren't willing to do ourselves.

PROBLEMS CLIENTS FREQUENTLY ENCOUNTER

As with any new skill, and maybe even more so, most clients find mindfulness difficult to practice and implement in their lives. So let's take a look at some of the common problems clients have expressed to me over the years I've been teaching mindfulness, and some suggestions to help people overcome these problems.

"It makes me more anxious."

Sometimes clients find that practicing mindfulness makes them more anxious, particularly when anxiety is already a problem. When clients tell you they can't practice mindfulness because it makes them too anxious, the first thing to do is validate. It's understandable. We're not used to taking such a close look at ourselves, and we're often afraid of what we might find or don't like what we do find.

Recently, I worked with a woman who was experiencing anxiety during mindfulness. Over time, she realized that she was so unaccustomed to being in the present moment that this was causing the anxiety. She continued practicing mindfulness, essentially doing exposure therapy, and practiced accepting her anxiety. Gradually, her anxiety came down and the mindfulness practices became less anxiety provoking for her.

After validating clients' anxiety, push for change, reminding them that mindfulness is an important tool that will help with their specific problems. Encourage them to work on acceptance of whatever they notice, as nonacceptance might be increasing their anxiety. For example, if an anxious client notices that her breathing is shallow, she might tend to judge this, which causes her to worry about it: *I'm breathing too quickly. Something's wrong.* Help her try to identify what thoughts might be increasing her anxiety; then you'll have more material to work with to problem solve.

Be aware that focusing on breathing often increases anxiety in clients with anxiety disorders. In such cases, encourage clients to focus on mindfulness exercises other than breathing for the time being, until their anxiety starts to come down. Just make sure that, once they're feeling a bit more comfortable with mindfulness in general, they come back to the breathing exercises even if they find it challenging.

"I just can't do it."

Clients often say that they just can't do it. When this happens, it's important to explore exactly what they mean. Does a particular client mean it's really hard or that she's having difficulties concentrating? Is the problem that her kids keep interrupting her? Does she remain under the misimpression that "successful" mindfulness means thoughts and emotions never intrude? Once you've

sorted this out, you can help clients problem solve. Many people say they can't do it, but what they actually mean is they find it incredibly hard. Validate this. It is really hard! Most people find mindfulness difficult when they first start practicing. The key is to keep practicing in spite of this.

"I don't have time."

This is one of my favorite "problems" because it's one of the easiest to fix: simply remind clients that they don't have to make time to practice mindfulness; they can do it with any activity, anytime and anywhere. You may have to review the definition of informal mindfulness practice here. Give clients some examples based on what you know about them. Perhaps a client can do two minutes of her drive to work mindfully, help her kids with homework mindfully, watch her favorite TV show mindfully, or do deep breathing mindfully every time she stops at a red light. That's one of the things I love most about mindfulness: you don't have to make time for it.

Of course, if clients want to reap the full benefit of mindfulness, they have to practice formal exercises as well. Although this requires setting aside some time, explain that some of the formal practices can be done for just a couple of minutes at a time. For example, you can observe your thoughts for two minutes, count ten breaths, or notice the sounds around you for just a few minutes. Encourage them not to think in black-and-white terms; just because a person can't do a thirty-minute body scan doesn't mean she can't do a formal exercise.

"I can't stay focused."

I find it amazing that no matter how many times I remind clients that the only goal with mindfulness is to be in the present moment with acceptance, they still come back and say, "I can't stay focused" or some variation on this, such as "I can't do it right" or "It's not working." Repeatedly remind clients to throw their expectations out the window. Even though we humans are used to doing things with a certain end in mind, with mindfulness we have to get used to the idea of the means being the end itself.

It's a paradox, and one that can be difficult to wrap your mind around: Our clients practice mindfulness because they want to feel better, but we're asking them to throw that goal away and just be in the present moment with acceptance. Yet by doing this—by putting aside their goals of feeling better, having better focus, or being able to relax—they open the door to actually achieving the goals they had in the first place. Paradoxically, holding on to such goals and expectations is often what gets in the way of people being able to just be in the moment with acceptance. If a person's goal is to feel better, instead of just being in the moment with acceptance when she's practicing mindfulness, she'll be judging the experience in terms of whether it's "helping" or "working." This then becomes the focus, rather than just present-moment awareness and acceptance.

"I already focus on the task at hand."

Quite often I hear clients say they already practice mindfulness: "I'm always focused on what I'm doing" or "It just comes naturally for me to concentrate on the present moment." As you practice mindfulness day in and day out, it will start to come more naturally, but this usually takes quite a while; mindfulness just isn't something that most people do naturally or learn and become adept at overnight. So when I hear clients insisting that they're already practicing mindfulness all the time, I validate this. Maybe they are very focused and in the present moment. But then I gently suggest that they might not be accepting whatever they happen to find in the present moment. We are judgmental creatures, so it's very unlikely that this part of mindfulness is coming naturally. Most of us have to really work at it. In fact, I think being accepting is so difficult for us that we tend to forget that part of mindfulness.

"I fall asleep."

Sometimes people find that they drift off when they're practicing mindfulness. For people with sleep problems, this can be a good thing; they can practice mindfulness at bedtime to help them sleep. But mindfulness is about being *aware*, and how can you be aware if you're asleep? Of course, it's important to validate the client's experience first. For many people, it makes sense that the moment the brain has a chance to rest it wants to sleep, since it's constantly kept busy. Indeed, some people are so accustomed to being busy that the moment they stop to practice mindfulness they get bored and feel the urge to sleep. The key here is to treat this like any other urge during mindfulness: just notice it.

When the urge becomes strong, however, sometimes people drift off during mindfulness practice. If this happens regularly, obviously it will interfere with mindfulness. Here are some considerations that can help you and the client problem solve the situation:

- Does the client simply need more sleep? If she's sleep deprived, her body will want to take advantage of this quiet time to rest. In this case, you'll need to work with the client to improve her sleep. (See chapter 7 for more tips on this.)
- If this isn't the case, is there a better time of the day for the client to practice? If she knows she's always exhausted by the end of the day, can she make time to practice earlier in the day?
- Is she eating a big meal shortly before practicing mindfulness? Food coma can be a culprit!
- Is there a different position she can try? If she's lying down, she could try sitting up. If she's already sitting up, she could try a less comfortable chair or even try standing.

- If she's closing her eyes, keeping them open might help.

If you've done all of this with a client and falling asleep remains a problem, here are two techniques that help people stay awake during mindfulness practice:

- Really focus on breathing. Consciously breathing can help bring focus to the energy entering the body. This can help people feel more alert and less sleepy.
- Put pressure on the fingertips by pressing them on a table, on the legs, on the arms of the chair, and so on, or by pressing the fingertips together, then focus on this sensation.

"I have to multitask!"

Some people are convinced that they have to multitask in order to accomplish everything they need to do. When people hold this belief, I first tell them about the research that has been done on multitasking. According to Linehan (2003d), a study was done in which two groups of people were given the same tasks to complete and told to do them as quickly as possible; one group was told to accomplish this by multitasking, and the other was instructed to do only one thing at a time, with full attention. The group that did only one thing at a time and with full attention completed the tasks more quickly and accurately.

After providing this information, I remind clients that mindfulness doesn't mean you have to *finish* one task before moving on to the next. For example, if I'm sitting at my desk typing an email and the telephone rings, it's not effective for me to answer the telephone and speak to the person while I continue typing my email. I'll either make mistakes in the email or won't be able to fully concentrate on what the person is trying to talk with me about—or both. Instead of multitasking in this way, it's more effective for me to stop typing the email and turn my full attention to answering the telephone (if that's what I choose to do). Once I'm done on the telephone, I hang up and turn my full attention back to the email.

It's also important to explain that this doesn't mean clients can never again multitask. Although the ideal is to live our lives more mindfully, we do have to choose when we're going to practice mindfulness and when we're not. It isn't realistic to expect that we can practice mindfulness through all of our waking hours. Hopefully, with continued practice, we will all choose to practice more and more often. But when clients are just beginning, the less intimidating you can make mindfulness, the more likely they'll be to practice.

"Isn't mindfulness just avoiding or repressing?"

Sometimes people have the mistaken impression that continuously bringing their attention back to the present moment from wherever they've wandered means they're just avoiding or

repressing their emotions. This is absolutely untrue. The intent isn't to avoid or repress. It's actually the opposite: practicing acceptance of whatever happens to come up, rather than judging it and pushing it away.

However, if, for example, you're practicing mindfulness of sounds and a sound reminds you of a recent loss, it won't be helpful to just allow your mind to take you where it wants to go—back to that loss—and dwell on it. Part of mindfulness is training your mind so that you're in charge. So instead, you notice your experience, accept the emotions that arise, and turn your attention back to the current exercise. Once you've completed the exercise, you're free to go back to explore the feelings that arose.

"But you have to plan for the future!"

Sometimes clients think that practicing mindfulness means never thinking about the past or the future. When this problem arises, I remind clients that they have a choice about when to practice mindfulness. I also emphasize that you can plan for the future mindfully. Quite often, though, "planning" for the future isn't actually planning but a form of worrying.

I remember when I bought my first house. It was an older home, built originally as a cottage, and the main source of heat was baseboard heaters. Unfortunately, the previous owners of the house had left the heaters in the crawl space turned up quite high and I didn't know it, so my first electricity bill was almost five hundred dollars for one month. I freaked! I cried and convinced myself that I was going to have to sell the house and move back in with my family because I obviously couldn't afford to live in the house on a single income. This is a perfect example of *worrying* about the future. I wasn't planning at all; I was living in an imaginary future where I was moving back in with my family, completely disappointed that I couldn't afford to live on my own. And not only was I not planning for the future, I wasn't figuring out what was going on in the present.

I once had a client who pointed out that he probably *did* know the outcome of the situation he was worrying about. His mother had told him she was leaving his father, and she was making preparations to move out. In the meantime, he was imagining what it was going to be like for his father to hear the news, the pain both of his parents would go through, the pain he would go through, and so on. So I asked him: If this was actually the case—that there was going to be a lot of pain their lives that they'd have to deal with—did he really want to live through it twice? Wouldn't it be bad enough when he actually did have to go through it? Why would he want to imagine going through it and imagine how painful it would be, when soon enough he would be experiencing it? This is another way to help clients see the pitfalls of living in the past or the future: Do they really want to live it twice?

So yes, you do have to plan for the future, and no, mindfulness doesn't prevent you from doing so; in fact, mindfulness helps you to plan for the future by keeping you grounded in the present—in reality—while you're making your future plans.

WRAPPING UP

Mindfulness is a simple skill, but it's far from easy. It goes against how most people are accustomed to living their lives. In this chapter, you've learned about the importance of convincing clients that mindfulness will be helpful for them, and I've given you a lot of tips on how to do this, as well as on how to teach clients (and yourself, if you're new to it) how to practice mindfulness. I've also reviewed many of the problems clients encounter when they start practicing mindfulness and how you can help clients deal with these issues and continue with their practice. In the next chapter, we'll look at additional skills to help clients in their mindfulness practice.

As you read through this book, remember that you don't necessarily have to use every DBT skill with every client; you can pick and choose the skills that are most relevant to each client. Also remember that if you are to provide effective DBT, it's of utmost importance that you practice these skills yourself.

CHAPTER 6

Additional Skills for Mindfulness

In the previous chapter we began looking at how to teach clients about mindfulness. As I noted in that chapter, while mindfulness seems easy and like common sense, it's actually quite difficult to practice. Because of this, I find it helpful to break mindfulness down into smaller steps. So in this chapter I'll outline how to do this with the skills of mental noting and being nonjudgmental.

MENTAL NOTING

To assist clients when they first start practicing mindfulness, it's helpful to break the skill into smaller steps, mentally noting events as they occur. *Mental noting*, also known as *witnessing*, is the DBT skill Linehan (1993b) calls *observing and describing*. The idea behind this skill is to first look at your experience, moment by moment, in a nonjudgmental way, simply sensing or noticing what's happening, and then describe the experience, putting a nonjudgmental label on it.

For example, instead of saying to yourself, *The weather is lousy today*, you mentally note it: *It's gray and rainy today and it has me feeling blah*. Or instead of getting caught up in the emotion of sadness and saying to yourself, *I'm depressed and hopeless. Things are never going to get better, and I don't know how I'm going to manage*, you mentally note your experience: *I'm feeling extremely depressed and hopeless right now. I feel like I want to cry and scream. My thoughts keep going to the future, and I'm having a hard time not acting on the urge to hurt myself*.

Simply Observing

Mentally noting emotions can help clients not get caught up in them. A good example of this is anxiety, which escalates easily because the very feeling of anxiety is often scary, making people feel more anxious, perhaps saying to themselves, *Oh no! Here comes that feeling again. What if I have a panic attack and do something that makes me look stupid in front of all of these people? Is this never going to end? I feel like I'm losing my mind. What if I go crazy?* Quite often, the thoughts people have about their anxiety make them more anxious. Mentally noting the anxiety can prevent or at least reduce this; for example, *I'm starting to feel anxious. There's a knot in my stomach and I'm starting to have worry thoughts. My heart is starting to race, and I'm worrying about having a panic attack.*

You can probably see why this skill is also referred to as witnessing, since it basically involves narrating whatever your experience is in the moment. When you teach this skill to clients, remind them to let go of judgments; when they are mentally noting, they are objective observers, just describing events as they experience them. Things aren't good or bad, or right or wrong; they just are.

Mentally Noting Internal vs. External Experiences

There are two types of events that we can bring awareness to: *Internal events* take place inside ourselves and include memories, thoughts, images that enter the mind, urges, emotions, and physical sensations. *External events*, on the other hand, occur outside the body.

While mental noting can be applied to any experience, it's important to recognize that some people have more of an internal focus, already being very aware of their internal experience—sometimes so much so that they can be oblivious to what's happening externally. Conversely, some people have more of an external focus, being very aware of what's happening in their environment but not having much awareness of what's happening internally.

For people who have difficulties regulating their emotions, this focus can go either way. A client may be so in tune with her internal experience that it's difficult for her to be aware of anything else, which amplifies her emotional experience and makes it more difficult to tolerate. Or she may be so in tune with her environment that she's completely unaware of what's going on inside of her. For both types of clients—those who are overly aware of emotional pain and those who ignore or avoid it—it's more difficult to manage their emotions and the behavior that results from their emotional pain.

When you're first teaching mental noting to clients, it's important to assess with them whether they fall more into one category or the other. If they do, have them focus on the opposite: Ask those who are very in tune with their internal experience to focus on mentally noting external experiences, and vice versa. Practice in mentally noting the experiences they aren't as in touch with will help them become more balanced, increasing their awareness of both internal and external experiences. This will enhance their ability to manage their emotions.

LEAVING THE JUDGMENTS OUT

If you're teaching the skill of being nonjudgmental to clients, you probably already have a good idea that it will be a useful skill for them. I usually introduce this skill by asking a client to consider her judgments: Does she think she has a tendency to judge others, herself, or both? I don't think I've ever encountered a client who does neither, but if you encounter such a client, obviously this is one skill you don't have to teach—remember, DBT is flexible! That said, people are often unaware of their judgments, so it's important to help clients carefully consider any tendency to judge and what role this plays in their lives.

Like mindfulness, being nonjudgmental is a skill that clients tend to resist not because it doesn't make sense, but because it's hard. So your job is to make this skill as approachable and unintimidating as possible. Sharing the following information about judgments with clients can help them buy into the skill.

What Is a Judgment?

The word "judgment" refers to the act of assessing or evaluating someone or something as either positive or negative in some way. For example, if your daughter comes home with an A on a test, she's a "good" girl, or if the neighbors next door keep to themselves, they're "weird." When you stop and notice, you'll see that you're probably judging regularly: Your friend's boyfriend is a "loser" for treating her that way, or the steak you had for dinner was "great." In fact, if you try not to judge, you'll probably find that it's quite difficult to just experience something without labeling it in this way.

One reason it's so difficult not to judge is because judgments abound in our society. Most of us hear them from the time we can understand language, so it only makes sense that we grow up to be judgmental. Because we form this habit at such a young age, our brains become judgment machines. For many of us, judgments are so automatic that we often don't even recognize them. For instance, when I'm teaching this skill to clients, they often say something like, "Yeah, I'm really bad for judging." Here we are, talking about judgments, and they have no awareness that they're judging themselves in that moment!

The Problem with Judgments

Because judging is such an automatic behavior, it's usually quite a challenge to change it. Before you can start helping clients do this, you need to convince them that it's important to work on reducing this behavior. So let's take a look at what's so "bad" about judging.

JUDGMENTS ADD FUEL TO THE FIRE

As mentioned, judgments can be positive or negative. We typically don't concern ourselves with positive judgments, since they usually don't trigger emotional pain. However, Linehan (1993b) points out that positive judgments aren't ideal either, since they create assumptions about or a context for negative judgments; for example, if you think of a friend as "good," she can do something that will make her "bad." For the most part, I think it's important for us to be aware of both positive and negative judgments so we can choose whether or not to judge, but my focus here will be on reducing negative judgments because of the emotional pain they cause.

More often than not, negative judgments come from painful emotions: People feel hurt, anger, disgust, or another painful emotion, and this emotion causes them to judge. But one effect of that judgment is to increase emotions, which causes more judgment, which triggers more emotional pain, and so on. In other words, judging usually increases the intensity of emotions, trapping people in a vicious cycle.

Some clients disagree with this, saying that they vent, and this helps them feel better. In this case, ask them to closely consider whether they really do feel better. Research indicates that venting anger (which involves judging) actually increases feelings of anger and aggression, most likely by adding fuel to the fire and increasing angry thoughts and urges, leading to more angry emotions and behaviors (Koole, 2009). If a client doesn't buy into this, help her by having her mentally note her experience in session. Here's an example of how you might work through this with a client:

Therapist: I understand that you don't see a connection for yourself between judging and experiencing more intense emotions. We don't usually pay that much attention to how our thoughts affect us. But would you be willing to do an experiment with me to check this out?

Client: I guess so.

Therapist: Great! Here's what I want you to do: I want you to think about a judgment you made recently. Maybe it happened during an argument you had with someone, maybe someone cut you off in traffic, or maybe you judged yourself for something. Just take a moment to think of a judgment you made.

Client: Okay. When I was leaving the house I saw my son's lunch bag sitting on the kitchen counter and realized I had forgotten to put it in his backpack.

Therapist: Great example. Can you recall what judgments you made in that situation?

Client: I couldn't believe how stupid I was for forgetting his lunch, and I probably called myself a bad mother.

Therapist: Okay, good. Now I want you to really focus on those two thoughts: *I'm stupid* and *I'm a bad mother*. Say them to yourself a couple of times, really focusing on the fact that you forgot to give your son his lunch. As you do this, I want you to mentally note what you're experiencing. Do that out loud: just observe and describe to me what you're experiencing.

Client: Okay. I feel bad. I have that thought again: *I can't believe I could be so stupid*, and that's reminding me of when I first got pregnant and my mother told me she didn't think I'd be able to manage raising a child. That's making me feel sad, and now I feel like crying (*becoming tearful*). I'm telling myself my mom was right: I'm a bad mother. I feel guilty.

After doing this type of exercise with clients, validation is crucial. Support them and express appreciation to them for going through this exercise, and then ask for feedback. Did they notice, once they were paying attention, any connection between their judgments and an increase in their emotions? Hopefully they did (clients usually do, once they're paying attention). If they didn't, don't get discouraged; sometimes it just takes some practice at being mindful of an experience before clients can see the connection.

I've included a Judgmental Thoughts Tracking Sheet that I use with clients who need extra convincing. As clients complete the tracking sheet—noticing negative judgments, the situation that triggered them, the extra emotions that arise because of them, and then assessing the outcome—they'll become more aware of the fact that they're judging and the consequences those judgments often have, as the sample worksheet shows. Feel free to copy the blank form and use it with clients if you like.

SAMPLE JUDGMENTAL THOUGHTS TRACKING SHEET

Situation	Emotions about the situation	Judgments that resulted from these emotions	Extra emotions triggered by the judgments	Outcome (Was it positive or negative? Did it help you work toward your goals?)
I was driving and got stuck behind a truck going really slow.	Frustrated	This guy doesn't know how to drive. What an idiot.	Anger	I just got more angry.
A coworker said something unkind.	Hurt	She shouldn't be treating me this way. She's such a witch.	Anger	I lost my temper and yelled at her. Then I felt bad about myself for yelling.
I did some extra work; then my team leader told me that I shouldn't have done it.	Hurt, shocked, confused, frustrated	What's wrong with her? She's unbelievable! She's an awful team leader.	Rage	I sat and dwelled on this for a long time and got myself really worked up in anger. This didn't help at all. It didn't change anything, and it made me more emotional.
My best friend hardly ever calls me anymore. When we talk or get together, it's because of my efforts.	Hurt, annoyed	She's thoughtless. She should be putting more effort into our friendship.	Anger	I got more and more angry and decided to call her and give her a piece of my mind. I told her what I thought and said some hurtful things, and she hung up on me.

JUDGMENTAL THOUGHTS TRACKING SHEET

Situation	Emotions about the situation	Judgments that resulted from these emotions	Extra emotions triggered by the judgments	Outcome (Was it positive or negative? Did it help you work toward your goals?)

Of course, negative judgments don't always trigger more emotions. For example, imagine you go to the fridge to grab some cheese and see that your cheddar is a terrific shade of green. You might say, "Oh no! The cheese is bad." Yes, "bad" is a judgment, but this judgment probably hasn't triggered any emotional pain for you, because it wasn't emotional pain that caused you to judge in the first place. In this instance, "bad" is just a shorthand way of saying that the cheese is moldy and won't taste good.

JUDGMENTS DON'T PROVIDE USEFUL INFORMATION

Other than triggering more pain, judgments are also unhelpful because they don't provide useful information. Most of us probably understand what is meant by "The cheese is bad," but if you tell a friend you think her boyfriend is a loser, she might not know exactly what you mean. You might mean that you don't like the way he treats her, that you don't appreciate him flirting with you, that you don't approve of the fact that he doesn't have a job, and the list goes on. Judgments are a shorthand way of saying something—a quick label we stick on things instead of saying what we really mean.

SELF-JUDGMENTS ARE HURTFUL

Regardless of what is meant by the judgment, one thing is certain: negative judgments are hurtful. This is true whether people direct judgments at someone else or at themselves. When I first suggest this, people often don't believe it. I find the most powerful way to explain this to clients is by comparing it to verbal abuse, as in the following dialogue, again with the client who forgot to send her son's lunch to school with him:

Therapist: Think about a person in a verbally abusive situation. (*You may be able to use the example of the client herself if she's been in a verbally abusive relationship.*) Her partner regularly tells her that she's stupid, worthless, and unlovable, that she'll never find anyone else to put up with her, and so on. You've probably heard that when you're constantly being told these kinds of things, over time you come to believe them. When you judge yourself, you're essentially verbally abusing yourself. For example, was this the first time you called yourself a bad mother?

Client: No. It's kind of a theme for me when I feel I haven't done something right with my son.

Therapist: Exactly. And the more often you tell yourself you're a bad mother, the more you actually come to believe it.

It's important to point out that most people are hard on themselves; as the saying goes, we're our own worst critic. But self-judgments tend to be especially problematic for emotionally dysregulated clients, in part because an invalidating environment has taught them to respond harshly to

any perceived failure (Swales & Heard, 2009). When a person is regularly given the message that she's wrong in some way—for example that her thoughts, feelings, or beliefs are incorrect, invalid, stupid, ridiculous, silly, crazy, and so on—she begins to automatically assume that this is true and starts judging herself in the same way. This is *learned behavior* and it's understandable that she's judging herself, but it's also not helpful and something that she needs to work on.

Negative judgments are also hurtful to others. We'll be looking at skills that help with relationships in chapter 12; for now, just keep in mind that judging others obviously has a negative impact on clients' relationships.

It's Not Just about the Words

It's important to point out to clients that sometimes we judge without words. Judgments can come in the form of facial expression or tone of voice. For example, imagine yourself having a telephone conversation with your boss. You might be saying, "Of course I understand the importance of this," while also rolling your eyes. Although you aren't judging your boss out loud, rolling your eyes would let any observer know that you're being judgmental in that moment.

Likewise, your tone of voice can also give you away. To continue with the previous example, let's say you hang up the phone and summarize the conversation for your coworker: "Jackie says she wants me to drop the packages off at the courier instead of having them pick the packages up. That makes sense." While tone of voice is difficult to convey in these pages, you can imagine the last sentence, "That makes sense," being stated nonjudgmentally—simply a factual statement, probably indicating that you agree with the decision and it makes sense to you. However, given a different tone of voice or emphasis (for example, "*That makes sense!*"), it could be a judgment, indicating that you actually think the decision is stupid or doesn't make sense.

Sometimes Judgments Are Necessary

There's one last piece of information clients need to learn before you start teaching them how to be nonjudgmental: that the skill of being nonjudgmental isn't about eradicating judgments. As in the earlier example, it's okay to say the cheese is bad. Throughout life, there are times when we need to judge. Doing performance evaluations at work, grading assignments at school, evaluating whether or not a situation is safe, assessing your actions in order to learn from your mistakes—these are all examples of judgments, and you can see how they are necessary.

Point out to clients that the judgments to let go of are those that increase their emotional pain. Given that they have difficulty managing their emotions, anything they can do to reduce the amount of pain they experience will help them improve their ability to regulate their emotions. Again, you want to make this skill as doable as possible for clients, so make sure you emphasize that the expectation isn't that they be nonjudgmental 100 percent of the time. Rather, the times to let go of judgments are when they notice that they're feeling pain that seems disproportionate to the

situation they're in or if they suddenly experience a painful emotion, especially anger or some variation of anger.

What to Do about Judgments

Paying attention to a behavior often has the effect of changing that behavior in some way (Ramnerö & Törneke, 2008), so the first thing to do is have clients increase their awareness of their judgments. Several techniques are useful here: filling out the Judgmental Thoughts Tracking Sheet; practicing mindfulness exercises that help them observe their thoughts so they'll notice their judgmental thoughts more often; or simply counting their judgments throughout the day (or if they judge a lot, for a certain period of time during the day). Once they become aware of their judgments, the next step is to have clients change them to nonjudgmental or neutral statements, which we'll look at next. It will also be very useful if you point out their judgments in individual sessions. When they say something judgmental, draw their attention to this in a gentle way and invite them to change it to a neutral statement.

Once clients can identify a judgment, the next step is to change it to a nonjudgmental statement: a neutral statement that addresses the same situation in a nonjudgmental way. In other words, this means saying the same thing—expressing opinions and emotions about something—but without judgment. Emphasize to clients that being nonjudgmental isn't about being passive; rather, it's about being assertive. It's about saying what you really mean and talking about your emotions, rather than just slapping shorthand, judgmental labels on things.

Experience has taught me that this is a difficult skill for people to grasp because judgments come so easily to most of us. I've found that the most effective way of teaching clients how to turn judgments into neutral statements is through examples. Ask clients to think of times when they've judged. Most of us tend to be hard on certain people in our lives (including ourselves) or to have disagreements with certain people regularly enough that we can think of times we've judged them. Similarly, we can usually think of situations we deal with regularly, such as rush-hour traffic, that elicit judgments. Given these suggestions, most people can think of examples of judgments if they put their mind to it.

Once clients have an example, provide them with this formula for turning a judgment into a nonjudgment: first, describe the facts of the situation; and second, express their emotions about the situation: What are the feelings that caused them to make the judgment? Here are some examples, taken from the sample Judgmental Thoughts Tracking Sheet earlier in the chapter.

Judgment: This guy doesn't know how to drive. What an idiot.

Nonjudgment: The guy in front of me is driving twenty miles per hour under the limit, and I'm feeling really frustrated with him.

Judgment: She shouldn't be treating me this way. She's such a witch.

Nonjudgment: My coworker said something unkind to me, and I'm feeling hurt and angry with her.

Judgment: What's wrong with her? She's unbelievable. She's an awful team leader.

Nonjudgment: I did some extra work, and now my team leader tells me I was wrong for doing this. I feel shocked, hurt, and angered by her reaction. I don't understand her reaction, and I don't think she handled the situation very effectively.

Judgment: She's thoughtless. She should be putting more effort into our friendship.

Nonjudgment: We hardly ever speak anymore unless I make the effort to call her. It doesn't seem like our friendship matters to her anymore, and I'm feeling hurt and resentful toward her.

Validate!

As you're teaching the skill of nonjudgment, be sure to provide a lot of validation, as people often get down on themselves for judging. Be sure to point out to clients that it makes sense that they are having difficulties with this skill, because it's really hard! If they judge themselves a lot, explain that this makes sense too, especially if they heard a lot of judgments from their parents as they were growing up. In this case, I like to point out that it doesn't place blame on their parents, since they learned how to communicate from *their* parents, and so on. It can also be very validating for clients to hear about some of your experiences with judging, so don't be afraid to provide some examples of your own. Remember, this kind of self-disclosure can go a long way toward establishing trust, as you're displaying that you're human too. This also helps clients see that you practice this skill yourself and therefore can relate to difficulties they might be having.

WRAPPING UP

In this chapter we've looked at additional skills to help clients with their mindfulness practice: mental noting and being nonjudgmental. Many of the other skills in this book build on these, so they form a good foundation or starting point for helping clients manage their emotions more effectively. In the next chapter, I'll continue to build on this by looking at three different thinking styles and how understanding them can build self-awareness and help clients reduce the extent to which their emotions control them, allowing them to be more effective in life.

CHAPTER 7

Helping Clients Reduce Emotional Reactivity

Up to this point in part 2 of the book, we've looked at skills to help clients become more mindful so they can manage their emotions more effectively. This chapter continues in the same vein by exploring the three different thinking styles we all have and how they influence whether clients continue to react from their emotions or learn how to manage their emotions more effectively. I'll also discuss some lifestyle changes that can help clients reduce their vulnerability to their emotions.

THREE STYLES OF THINKING

Linehan (1993b) outlines three states of mind, or ways we have of thinking about things: the reasoning self, the emotional self, and the wise self. I usually find it most effective to teach clients about these styles of thinking right after the mindfulness skills, as this furthers the process of increasing clients' self-awareness.

The Reasoning Self

When teaching clients about the three styles of thinking, I first describe the *reasoning self*: the part of ourselves that we use when we're thinking logically or reasoning something out. When we use this part of ourselves, there are few or no emotions involved. If there are emotions present, they don't significantly influence how we behave. Rather, the focus is on thinking logically about something: organizing your day at work, leaving instructions for the babysitter, deciding whether you should drive or take the subway to work, taking minutes at a meeting, and so on.

Give clients some examples and then ask them to think of some times when they acted from their reasoning self. This may take a while and you may need to help, but clients can usually come up with at least one example.

The Emotional Self

Most clients don't have difficulties coming up with examples of times when they've acted from their *emotional self*—the part that often gets us into trouble, as our behaviors are controlled by the emotion we're feeling in the moment. I give clients some general examples, such as feeling angry and lashing out at someone, feeling anxious and avoiding whatever is causing the anxiety, or feeling depressed and withdrawing and isolating. Then I ask clients to think of some examples of their own: When have they acted from their emotional self? Usually clients can relate to this thinking style and examples come to them easily. If not, you've probably learned enough about a given client and why he's coming for treatment to prompt him with some examples.

The Wise Self

The difficulty often lies in getting clients to see that they have a *wise self*, which is the combination of the reasoning self, the emotional self, and intuition (Linehan, 1993b). In other words, we feel our emotions and are still able to think straight, and we weigh the consequences of our actions and choose to act in a way that's in our best interests in the long run, even if that means behaving in a way that's quite difficult. Again, provide some examples: You're having an argument with your partner, and instead of saying something hurtful that comes to mind, you bite your tongue because you know you'll regret it later. You have an urge to drink, but part of you recognizes this as an ineffective way of coping, so you call your mother or go to an AA meeting instead.

It's also important to point out to clients that acting from your wise self doesn't necessarily entail a humongous achievement. Give smaller examples as well. You wake up in the morning and feel down; it's cold, it's still dark outside, and your first impulse is to call in sick. But instead you roll over, turn off the alarm, and get out of bed. This is your wise self. Or say it's 5:00 p.m., your partner's going to be home from work soon, and you promised you would cook dinner, but you're exhausted and don't feel like it. Yet you do it anyway. This is your wise self.

Sometimes clients say something like, "But I have to go to work because I have to pay the bills; that's not acting wisely." But the truth is, no one *has* to go to work, we *choose* to go to work. We could choose to not go and the bills wouldn't get paid. When you make a choice to get out of bed and go to work, that choice comes from your wise self. You weighed the consequences and decided what would be more effective in the long run, even though it wasn't necessarily the easy thing to do.

HOW TO ACCESS YOUR WISE SELF

Often, just having an awareness of the different ways we think about things can help clients access their wise self more often. But there are also skills you can teach clients to help expedite this process, described in the following sections.

Mental Noting with Emotions

Using the mindfulness skill mental noting (discussed in chapter 6) with emotions can help clients access their wise self. I find the following analogy helpful in explaining this concept to clients and illustrating how it can help them access their wise self:

Therapist: Think of your emotions as a tornado. Because of your difficulties in regulating your emotions, right now when you experience an emotion you tend to get sucked up into it. The emotion takes over and sends you out of control, just like a tornado does with anything in its path. Mentally noting your experience of the emotion helps you put a little distance between you and the emotion so you can watch the tornado from a safe distance, rather than getting sucked up into it. You're still in touch with the emotion, still experiencing how it feels, but not at its mercy—just like if you were standing at a safe distance from a tornado, you'd still be able to feel the rain and wind and observe the thunder and lightning, but without getting caught up in the whirlwind.

Improving Self-Talk

Another way you can help the client access the wise self is through his self-talk. We often hear clients judging themselves, putting themselves down, and just generally being quite hard on themselves. (And, let's admit it, we also do this ourselves at times.) The more a client beats up on himself this way, the more he'll be hijacked by his emotional self, and the harder it will be for him to access his wise self. Help clients work on changing this using the skill of being nonjudgmental toward themselves. Remind them that how they talk to themselves influences how they think and feel about things. Encourage them to think of someone they really care about and to speak to themselves the way they would to that person. This will help them be kinder to themselves, which will help them access their wise self.

Just This Moment

A third DBT skill that will help clients access their wise self is focusing on the present moment and whatever they happen to find in the moment (Linehan, 1993b). By practicing mindfulness with whatever activity they are doing in the moment, they can distract themselves from painful emotions. Once again, help clients with this skill by personalizing it for them. Here's an example using the client from the previous chapter, who thinks of herself as a bad mother:

Therapist: Next time something happens that brings up those old self-defeating messages of what a bad mother you are, mindfully focus on what you need to do instead. If you notice your son's lunch sitting on the counter, say to yourself, *I'm picking up the lunch bag off the counter. I'm getting my coat and car keys. I'm putting on my shoes and taking my purse out of the closet. I'm walking down the walkway to the car... and so on.*

By focusing on just the present moment, clients can remain in the moment more often, rather than thinking about some mistake they've made and judging themselves for it, dwelling on hurtful comments others made in the past, and so on. Instead, they can take things one step at a time and focus on what they need to do in the moment.

While focusing on just this moment is mindfulness, it's only one part of mindfulness. As discussed, the other part is nonjudgment, or acceptance. (I'll discuss the skill of acceptance in depth in chapter 10.) Whatever clients notice while focusing on just this moment, they should also work on accepting, because nonacceptance is judging, and judging increases emotional pain. When emotions are intense, it's much more difficult to access the wise self, so by practicing the skill of focusing on just this moment, clients will develop a greater ability to access their wise self.

Encourage clients to work on this skill whenever they notice painful emotions arising, mindfully focusing on whatever they happen to be doing in that moment. If a client is doing the dishes, he should focus on just that: cleaning each dish, the sensation of the soap on his hands, the warmth of the water, and so on. If he's at work, he should be focusing on just work-related tasks: doing his job, checking emails, returning phone calls, meeting with clients, speaking with his boss, and so on. At the same time, he should work on accepting whatever happens to come into his awareness as best as he can, whether it's an emotion, a thought, a physical sensation, or whatever. As with mindfulness, the focus is on direct experience in the moment, and when attention wanders from just this moment, he should gently bring his attention back, without judgment.

ADDRESSING LIFESTYLE ISSUES THAT AFFECT EMOTION REGULATION

Most effective psychotherapies examine lifestyle factors that affect clients' emotional state. In DBT, the skills that address these issues are referred to as *skills that help reduce emotional vulnerability*

(Linehan, 1993b). Essentially, this is about assessing different aspects of clients' lifestyles and helping them make changes in some of these areas to reduce their emotional reactivity and increase their ability to act from their wise self.

Balancing Sleep

It's difficult to function without enough sleep, yet the average person is sleep deprived, getting about one hour less of sleep each night than what the body requires (Hanson & Mendius, 2009). Given the busy world we live in, when I broach this subject with clients I tend to get all sorts of excuses for why it's not possible for them to sleep more: the commute, the kids' swimming lessons, the housework, and so on. In any case, it always comes back to the fundamental reality that you can't force clients to do what you know will be helpful for them. You can point out that making sleep (and self-care in general) more of a priority is acting from their wise self, and that just as going to work isn't really negotiable, self-care shouldn't be either, but in the end you must give clients room to make the decision for themselves.

Still, you may be able to exert some influence by explaining that sleep deprivation impairs memory, is associated with reduced attention and alertness, and increases irritability and emotional instability. Further, according to Van der Helm and Walker (2010), "sleep loss appears to differentially disrupt the learning of affective experiences, potentially creating a dominance of negative emotional memory" (p. 258). In other words, sleep deprivation causes people to remember emotional situations as being more negative than they actually were.

Of course, not all clients are sleep deprived by choice. I've been working with a young man who has insomnia. He's tried all of my suggestions for improving sleep to no avail and finally agreed to a trial of medications with his psychiatrist to see if this might improve his sleep. He's also attending a sleep clinic to assess the problem. For most of our clients, however, there are things they can do to improve sleep. Here are some examples:

- Going to bed earlier or getting up later
- Cutting down or eliminating caffeine, nicotine, and other stimulants
- Taking sleeping medications (and other medications) as prescribed, or using herbal remedies approved by a doctor or pharmacist, such as valerian, melatonin, or chamomile tea
- Eating earlier in the evening and not going to bed on an empty stomach
- Ensuring the bedroom is a comfortable temperature with reduced light and noise, and that the bed is used only for sleep (and sex), rather than for watching television, working on the computer, and so on

- Establishing an end-of-day routine that allows time for activities that get the body ready for sleep; for example, watching nonstressful television programs, light reading, taking a hot bath, listening to a relaxation CD, saying prayers or meditating, and so on

While for some of our clients the problem is getting enough sleep, for others it's sleeping too much. Some people use sleep as an escape when emotions are intense and they don't know how else to cope. For others, sleep alleviates boredom. Often, however, people don't realize that sleeping too much can reduce their ability to regulate emotions, not to mention making them feel more tired and lethargic, less energetic, and even irritable.

Help your clients balance their amount of sleep: not too much and not too little. If a client is sleeping too much, encourage him to reduce his amount of sleep gradually, starting by going to bed fifteen minutes later than he usually would or waking up fifteen minutes earlier. Every few days, he can reduce his amount of sleep by another fifteen minutes.

I believe we all have an ideal number of hours of sleep for optimal functioning. Try to help clients find this number. In my experience, people usually require somewhere between seven and ten hours. However, this is a very individual requirement and everyone is different, so ask clients about this: Do they know what their ideal amount of sleep is? If not, can they recall a time when they regularly felt rested and functioned well? If so, how many hours of sleep were they typically getting then?

If a client can't recall a time like that, then it's about experimenting. Have him begin to reduce his sleep slowly if he seems to be sleeping too much or increase it slowly if he seems to be sleeping too little. It's helpful to have the client keep a journal as he's doing this, recording how many hours he slept the night before, what his mood was like during the day, and whether he felt irritable, fatigued, and so on. Hopefully, this process will help him determine the amount of sleep that's optimal for him. If not, have him explore other possible contributing factors with his medical doctor. Sometimes people are over- or undermedicated, resulting in poor sleep or a "hungover," sedated feeling. Sometimes thyroid problems, sleep apnea, or other medical conditions can cause fatigue or insomnia, and a doctor can also assess for these problems.

Treating Physical Illness

Physical illnesses often make it more difficult for people to manage their emotions. When people have a medical condition such as diabetes, high or low blood pressure, or a heart condition, it's obviously important for them to take their medications as prescribed in order to limit the physiological effects of the illness. But it's also important from a psychological perspective. When conditions go untreated, they can create sensations in the body that mimic feelings of anxiety or depression, for example, or that simply make people more vulnerable to their emotions.

Think about how lousy you feel when you have the flu, a cold, or strep throat, and how being sick affects you. It's likely that you feel more irritable and lethargic and have less patience and

energy. Whether clients are dealing with the flu or a heart condition, it's important for them to take medications prescribed for the condition and to follow any other doctor recommendations for treatment. When dealing with temporary illnesses such as the flu or a cold, they need to reduce their responsibilities wherever possible so they can get more rest and take good care of themselves.

Chronic pain conditions are also important to consider. We've all had pain of some sort, so you can imagine how this would affect someone experiencing it constantly. Pain makes people more irritable and less patient, making it more difficult to manage feelings if something triggers emotional pain. If a client has a chronic pain condition, this is an additional challenge, and it's important that he be aware of that. While he can follow treatment recommendations and take medications as prescribed, chronic pain often means the client is stuck with the pain and has to learn to live with it and not let it limit his ability to manage his emotions more effectively. If chronic pain is an issue, consider referring the client to a mindfulness group for this problem; such interventions can be very helpful.

Reducing Use of Mood-Altering Substances

Drugs and alcohol are called mood-altering substances for a reason: They alter a person's mood, and the person has no control over how his mood is altered. People commonly report that they use alcohol to help them relax, but the disinhibiting effects of alcohol often turn into physical aggression, yelling and screaming, tears, and so on. If a person already has difficulties managing his emotions, is it wise to add the unpredictable effects of drugs or alcohol?

Some clients use alcohol to help them sleep. It's important to inform such clients that alcohol actually has a negative effect on sleep due to a rebound effect. Four to five hours after consuming alcohol, the rebound effect kicks in and people usually find themselves awake (Roehrs & Roth, 2001). In addition, researchers have found that consuming alcohol within an hour of bedtime seems to disrupt the second half of the sleep period, so people don't get the same deep sleep they otherwise would (Landolt, Roth, Dijk, & Borbely, 1996).

Then there are clients who use drugs or alcohol to help numb their emotions so they don't have to deal with them. This makes sense, and we therefore need to validate it, indicating that we understand it, and at the same time encourage them to see this as a goal to work on, as it's unhealthy and possibly even self-destructive.

Your first challenge may be to just get a client to see that drugs and alcohol are a problem. Doing behavior analyses (discussed in chapter 3) will help with this. But even when people can see that a behavior is problematic, they still might not want to change it. In this case, your next challenge is getting them to set small goals around reducing their use—keeping in mind that if a client isn't willing to set something as a goal yet, you need to accept this and gently continue to push for change over time.

Improving Nutrition

Amazingly, people often don't seem to understand the connection between nutrition and mental health. Time and again I'm assessing clients and they tell me they don't eat breakfast, skip lunch, or don't bother to eat until later in the day. Sometimes people simply forget to eat because they're busy. Some people lose their appetite because of emotional distress, and others just can't be bothered to eat properly. Whatever the reason, it's imperative to teach clients about the connection between poor eating habits and mood and anxiety, as this will underscore the importance of eating properly.

Everybody has heard the cliché you are what you eat, but for some reason many people don't connect that adage with how they feel mentally and emotionally. What you eat doesn't affect just physical health; it can also affect general mood on a day-to-day basis. In order for the brain to communicate with the rest of the body, it needs neurotransmitters, such as serotonin, which are made from the nutrients in the foods we eat. Explain to clients that not eating enough, or not eating a well-balanced, nutritious diet, prevents the body from being able to create enough of these chemicals, and depression and anxiety can result.

Also explain that skipping meals can make blood sugar levels fall too low, and that eating starchy, sugary foods or simple carbohydrates can cause blood sugar levels to increase too much. These fluctuations in blood sugar levels can make a person irritable, forgetful, or sad. In addition, not eating enough can lead to emotional reactivity, higher stress levels, and an overall sense of reduced well-being. Research in children has shown that skipping breakfast has negative consequences on problem solving, short-term memory, and concentration, and that eating breakfast increases positive mood, contentment, and alertness (Logan, 2006).

Of course, if a client has anorexia or bulimia, this must be addressed in therapy, either by you or by someone who has experience with eating disorders—and sooner rather than later due to the health risks these disorders present. If you treat the eating disorder yourself, make sure the client has been seen by a medical doctor and declared physically healthy enough to do this kind of work.

Increasing Exercise

Exercise is, of course, a natural antidepressant. It leads to the release of endorphins, those chemicals in the brain that help us relax and feel happy. Exercise also simply helps people feel good about themselves because they know they're acting effectively and doing something that's good for them. Some studies (e.g., Brenes et al., 2007) suggest that exercise is as effective as antidepressant medications at reducing symptoms of depression among adults diagnosed with major depression. Both the biological effects and the psychological effects (increasing self-efficacy and self-esteem and reducing negative thinking) of exercise are thought to be responsible for its positive influence on mood.

In addition, there is abundant evidence that exercise has positive effects on blood pressure and cardiovascular disorders, improves learning and memory, delays age-related cognitive decline, reduces risk for dementia, and improves medical conditions such as diabetes, osteoporosis, and Alzheimer's disease (Barbour, Edenfield, & Blumenthal, 2007).

While there are guidelines about how much exercise people should get, I usually tell clients that anything more than what they're currently doing is a great start. This helps take the pressure off and makes it more likely that they'll actually increase their exercise, whereas telling them that they need to exercise for twenty minutes three times a week could overwhelm them and result in not exercising at all. On the other hand, if you're working with a client with an eating disorder, you may need do the opposite and encourage reducing compulsive or excessive exercise.

WRAPPING UP

In this chapter you learned about the three different styles of thinking: the reasoning self, the emotional self, and the wise self. It's important to get clients thinking about these states of mind, so ask them to start paying close attention to what thinking style they're using in the moment. They don't have to write anything down; this is just about increasing awareness. It will also be helpful to have clients consider whether they can make some lifestyle changes that will reduce their vulnerability to being controlled by the emotional self. If so, help them set small, realistic, and achievable goals in these areas. While some of the lifestyle changes discussed in this chapter might seem like simple changes for clients to make, such changes aren't always easy. Assess each of these areas with clients, provide them with information, and make suggestions. Help them set realistic goals, and hopefully they'll see the importance of working hard to make these changes, even if it takes some time. In the next chapter, we'll look at the skills clients need to help them survive crisis situations without making things worse.

CHAPTER 8

Helping Clients Survive a Crisis: Distress Tolerance Skills

So far we've looked at skills to help clients manage their emotions more effectively in the long run. But sometimes things get so out of control that the focus must become simply helping the client stay alive, or at least just get through a crisis without engaging in behaviors that make the situation worse. This is where DBT distress tolerance skills come in.

In this chapter, we'll first look at how a cost-benefit analysis can help clients decide that a behavior isn't helpful and may in fact be harmful. Then we'll look at different ways clients can distract themselves from distressing thoughts and emotions when they're in a crisis situation, which can help them not act on urges to engage in old, problematic behaviors. We'll also look at the skill of coping ahead, which can help clients be more effective in their lives.

IDENTIFYING PROBLEM BEHAVIORS

As always, the first step in using skills is to help clients increase their awareness. What behaviors do they engage in that are unhealthy or even self-destructive? The long list of possibilities includes drinking or using drugs, gambling, self-harming behaviors, threatening or attempting suicide, lashing out at people who care about them, shoplifting, driving dangerously, under- or overeating, or sleeping to avoid or escape life.

Of course, your idea of what qualifies as an unhealthy behavior might differ from a client's. If you believe a client is using an unhealthy behavior to cope in times of crisis and she disagrees, it may be helpful to complete a cost-benefit analysis of the behavior with the client. (I've provided a worksheet for this, along with a sample.)

EXAMINING THE COSTS AND BENEFITS OF PROBLEM BEHAVIORS

The DBT skill of looking at the pros and cons (Linehan, 1993b) is used when clients are ambivalent about giving up a behavior and need help seeing that the behavior has costs or negative consequences. Doing a cost-benefit analysis helps them come to terms with this so they can make a more conscious decision to either engage in the behavior or choose to act in another way. In the event that they choose to continue with the problem behavior, the analysis has at least had the effect of helping them recognize that they're making a choice, rather than just reverting back to a habit.

I've included the Cost-Benefit Analysis Worksheet to help with the process, along with a sample that examines the behavior of lashing out at someone in anger. Initially, it's most helpful if you work together with clients to fill out the worksheet and generate ideas about benefits and costs of both engaging and not engaging in a behavior. First have them think of the benefits and costs of the behavior. Clients usually don't have difficulty with this: they know how they find the behavior helpful, and they can often see at least some of the negatives. Then have them consider the flip side: What are the benefits and costs of *not* engaging in the behavior? What happens when they don't resort to engaging in the behavior?

Once clients have identified some costs and benefits in each area, have them rate each on a scale from 1 (very little importance) to 5 (high importance). The idea is to have them assign a numerical value to each cost and benefit, so that rather than just looking at how many items they have in each column, as in a traditional pros and cons chart, they can assign a numerical value to each category of benefits and costs. This provides a better assessment of whether the behavior is truly helpful or harmful.

I like to start the worksheet in my office with clients and then have them take it home to continue working on it. I ask them to bring it back to our next session for review.

SAMPLE COST-BENEFIT ANALYSIS WORKSHEET

Problem Behavior: *Lashing out in anger*

Benefits of self-destructive coping behavior: *Lashing out*

- | | |
|--|---|
| <p><u>2</u> <i>It provides immediate relief.</i></p> <p><u>3</u> <i>It helps me protect myself.</i></p> <p><u>2</u> <i>People are careful around me afterward.</i></p> | <p><u>2</u> <i>It sometimes helps me get what I want.</i></p> <p><u>1</u> <i>It's satisfying.</i></p> <p><u>3</u> <i>It helps me feel in control.</i></p> |
|--|---|

Total: 13

Costs of self-destructive coping behavior: *Lashing out*

- | | |
|--|---|
| <p><u>5</u> <i>People don't respect me.</i></p> <p><u>3</u> <i>I don't get to practice coping skills.</i></p> <p><u>5</u> <i>Sometimes I end up hurting people I care about.</i></p> | <p><u>5</u> <i>I don't respect myself.</i></p> <p><u>5</u> <i>Sometimes I lose relationships.</i></p> |
|--|---|

Total: 23

Benefits of healthy coping behavior: *Not lashing out*

- | | |
|---|---|
| <p><u>5</u> <i>It makes me feel good about myself.</i></p> <p><u>3</u> <i>I often get what I want in a healthy way.</i></p> | <p><u>5</u> <i>It improves my relationships.</i></p> <p><u>3</u> <i>It allows me to work on DBT skills.</i></p> |
|---|---|

Total: 16

Costs of healthy coping behavior: *Not lashing out*

- | | |
|--|---|
| <p><u>4</u> <i>I don't get to speak my mind.</i></p> <p><u>3</u> <i>It feels like giving up control.</i></p> | <p><u>3</u> <i>It's harder to use skills.</i></p> <p><u>2</u> <i>I don't get instant gratification.</i></p> |
|--|---|

Total: 9

Total of benefits of self-destructive coping behavior + costs of healthy coping behavior = 22

Total of costs of self-destructive coping behavior + benefits of healthy coping behavior = 39

COST-BENEFIT ANALYSIS WORKSHEET

Problem behavior: _____

Benefits of self-destructive coping behavior: _____

Total: _____

Costs of self-destructive coping behavior: _____

Total: _____

Benefits of healthy coping behavior: Not _____

Total: _____

Costs of healthy coping behavior: Not _____

Total: _____

Total of benefits of self-destructive coping behavior + costs of healthy coping behavior = _____

Total of costs of self-destructive coping behavior + benefits of healthy coping behavior = _____

Tell clients not to limit themselves and to write down anything that comes to mind in any of the four categories. It doesn't matter if the items repeat or overlap; what matters is that clients see the bigger picture, and that they see the behavior they're analyzing from a different perspective, with an awareness that it has both costs and benefits attached to it.

What I like about this cost-benefit analysis versus a pros and cons chart is that clients aren't just comparing how many answers they come up with for each category; they're looking at the *weight* of each answer in each category. In other words, by assigning each answer a numerical value, clients can come up with a total for each category and see that (hopefully) the benefits of acting in a healthy way and consequences of acting in an unhealthy way outnumber the benefits of acting in an unhealthy way and the costs of acting in a healthy way. (By the way, it might take a while for you to wrap your own head around this, so you might want to do a worksheet or two on your own.)

In addition to helping clients make the decision to set a goal of stopping an unhealthy behavior, the cost-benefit analysis can provide support along the way. Consider having clients write out the benefits of acting in a healthy way and the consequences of acting in an unhealthy way on a separate sheet of paper or on an index card they can carry with them. When they start to experience the urge to engage in the problem behavior, they can read the benefits and consequences to remind themselves why they don't want to act on the urge.

RESISTTING THE URGE

Although it's often very difficult for clients to change habitual problem behaviors, there are lots of things they can do to help themselves not act on the urge. In DBT, these are known as *crisis survival skills* (Linehan, 1993b). Let's take a look at these now, using the acronym RESISTT:

R: Reframe.

E: Mindfully Engage in an activity.

S: Do something for Someone else.

I: Intense sensations.

S: Shut it out.

T: Think neutral Thoughts.

T: Take a break.

R: Reframe

Reframing refers to changing one's perspective about something—in other words, helping clients make lemons out of lemonade (Linehan, 1993a) or helping them see the silver lining. Of course, you have to be careful that in doing so you don't invalidate clients or minimize their worries. Here's an example:

Client: I can't believe that I've been in therapy and doing all of this work for almost two years, and I've started bingeing again. What's wrong with me that I can't stop? I know how unhealthy it is, and I don't want to gain weight again!

Therapist: Yes, you're struggling, Anna, but it makes sense given all of the stressors in your life right now (*validation*). If this was two years ago, how do you think you'd be coping with everything that's going on?

Client: Well I'd probably be in the hospital already. At the very least, I'd be feeling suicidal and wouldn't be functioning very well.

Therapist: Right. So even though you've gone back to an unhealthy behavior, you're not where you were two years ago. In fact, you're coping quite a bit better than you were back then, right?

Client: Yeah, I guess you're right.

There are many different ways to reframe. The above dialogue is an example of helping a client compare herself now to how she was in the past, at a time when she wasn't coping as well. This can often help clients acknowledge the changes they've made, even though they may still be struggling.

You can also help clients compare themselves to someone who isn't coping as well. With this approach, it's important to realize, and to point out to the client, that this isn't about putting the other person down, but about changing the client's perspective or getting her to see that although things might be difficult, they could be worse. Some people have a hard time comparing themselves to others in this way, so be careful when using this technique and monitor how the client is responding. Using the same situation as above, here's an example of how you might use this approach:

Client: I can't believe that I've been in therapy and doing all of this work for almost two years, and I've started bingeing again. What's wrong with me that I can't stop? I know how unhealthy it is, and I don't want to gain weight again!

Therapist: I know you're struggling right now Anna, and it makes sense, given all of the stressors you're dealing with (*validation*). But look at how far you've come. You're

using skills, and for the most part, they're helping you not engage in those old unhealthy behaviors, right? Remember how you recently told me you had run into Matthew from group? You said he wasn't doing very well and had just been discharged from the hospital. Even though things are hard right now, it could be worse, Anna. You have to give yourself credit for all of the work you've done and the progress you've made.

Of course, over time you want clients to be able to reframe on their own, but like any skill, it takes practice. If a client struggles with this at first, you can also have her compare her personal situation to more global situations, rather than comparing herself to individuals. I once worked with a client who told me that she'd been feeling suicidal and was trying to distract herself from those thoughts. In practicing her distracting skills, she turned on the television and was looking for something to take her mind off her problems. She came across a news broadcast on the war in Iraq, and she started thinking about how unfortunate the people there were—how they never knew when the next attack would come or who it would come from. She said, "Here I was thinking of killing myself, and every day these people are faced with the threat of suicide bombers. I thought of how strong they are, and I knew that I had to be strong too." By acknowledging that others were suffering just as much or even more than she was, this client was able to see that things could be worse.

The way clients talk to themselves about what's happening in their lives can also change the way they think and feel about things. Often, especially when depression and anxiety are a problem, people tend to get fixated on the negatives. They focus on how bad the situation is and catastrophize or think about the worst possible thing that could happen. If you can help them change how they think about the situation, they'll find that it's more bearable than they imagined and will be more likely to get through it without engaging in behaviors that could make it worse.

To help with self-talk, have clients write out coping statements to use when they get into situations that they're struggling with and that trigger intense emotions. That way they won't make it worse with self-talk and can actually help themselves cope more effectively. Here are some examples:

- *I can get through this.*
- *The emotions are intense and uncomfortable, but I know they won't hurt me.*
- *This pain won't last forever.*

E: Mindfully Engage in an Activity

Getting one's mind off a painful situation and the emotions it's evoking is often helpful. Researchers (Koole, 2009) have found that telling people to not think about an unwanted emotion

actually increases the activation of that emotion, whereas providing them with something to think about in place of the emotion greatly increases their ability to not think about it. The important lesson for clients is that if they don't want to think about something or feel something, efforts to not have the experience are, paradoxically, the most effective way to ensure that the experience persists. If they say to themselves, *I don't want to feel this way*, the feeling will hang around longer because of trying to push it away. Rather than trying not to think or feel certain things, they need to learn to distract themselves.

There's a subtle but critical difference between trying to push an experience away and turning your mind to something else. When you try to push an experience away, you're judging it and trying to avoid it. Christopher Germer (2009) notes that when you try to push something away, it goes into the basement and lifts weights! Not only does it not go away, it actually gets stronger. In contrast, when we turn our minds to something else, we're acknowledging the experience and then moving our attention elsewhere, without judgment. Therefore, this is also about mindfulness. Rather than judging our experience, we just notice it and then bring our attention to whatever we're doing in the present.

When clients are in a crisis, you want them to be able to distract with activities that will hold their attention. So have them make a list of activities they can do that might distract them when they're feeling distressed. There are an infinite number of activities they could turn their attention to: going for a walk, calling a friend, baking cookies, playing with a pet, reading to their children, going to the gym, and so on. Again, I usually help clients start their list during a session and then ask them to work on it for homework. It's also important to add to the list regularly. The goal is for it to be as long as possible so that when clients are in a crisis, they have many options for activities that might take their mind off the situation.

S: Do Something for Someone Else

Sometimes, an effective way for clients to get their minds off their own problems is to do something for someone else. When clients are in a crisis, they might find it helpful to distract themselves by turning their attention to someone else, perhaps visiting a friend who's in the hospital or who can't get out of the house, spending a couple of hours baking a special treat for a family member or friend, planning a surprise for someone they care about, and so on. Such activities can distract them from their pain. Of course, in difficult times, clients might not be able to think of something they can do for someone else. Therefore, have them come up with some ideas in session and add them to their list of activities that can help them get through the crisis without making it worse.

Some activities will be more doable than others in a crisis; for example, if a client is feeling suicidal, it probably wouldn't be safe for her to ask her sister if she can help out by taking the kids for a few hours. So make sure you discuss with clients ahead of time a variety of ideas for how they can use this skill in a safe, appropriate, and helpful way.

I: Experience Intense Sensations

Sometimes generating intense physical sensations can distract the mind from painful emotions. This helps explain why many clients resort to cutting or hurting themselves in other ways: because it can actually help them feel better temporarily. Obviously, the key here is to help clients identify intense sensations that aren't harmful. Have them think about physical sensations they can generate that might take their mind off a crisis. For people who engage in self-harm, Linehan (1993b) suggests holding an ice cube in one hand. This can cause physical pain if held long enough, and the sensation is intense. For some people, this can take the place of self-harming behaviors. Here are some examples of other things clients might do to get their mind off a crisis:

- Take a hot or cold bath or shower.
- Keep a rubber band on one wrist and snap it—not so hard that it causes a lot of physical pain, but hard enough to generate a sensation that will temporarily occupy the mind.
- Chew on crushed ice or frozen fruit.
- Go for a walk in cold or hot weather.
- Lie in the hot sun (with sunscreen on!).

Again, have clients add whatever intense sensations they can think of to their list of activities to help them survive a crisis.

S: Shut It Out

Quite often, clients' surroundings and the people around them can contribute to the overwhelming emotions they experience. When this is the case, physically leaving the situation and going somewhere calm and quiet will make it more likely that they can use their skills, access their wise self, and manage their emotions more effectively.

Sometimes, however, this isn't enough. Clients may continue to dwell on the problem even though they've left the situation physically. This is when the DBT skill known as *pushing away* (Linehan, 1993b) is helpful. With this skill, clients use their imagination to convince the mind that the problem isn't something that can be worked on in the present moment.

To help clients develop this skill, first have them write down all of the problems that are triggering the painful emotions. Even if there's only one, still have them write it down. Next, have them ask themselves whether this is a problem they can solve *right now*: Do they have the skills to solve the problem? Is there a solution to the problem that they can start working on in this very moment? And is now a good time to work on the problem?

If a client sees that she can solve the problem, then she needs to work on doing just that, rather than shutting it out or pushing it away. If solving the problem will reduce her emotional distress, this is the most effective thing to do. The skill of pushing away is only effective if the client can convince her mind that the problem at hand isn't one that can be solved in the moment. Of course, we can't solve all of the problems in our lives, so for those that can't be solved, at least in the short term, have the client shut them out. Ask the client to close her eyes and mentally picture an image that represents the problem she's struggling with. For example, if the problem centers on an argument she had, she might call up an image of the person or visualize the person's name. Next, have her picture putting her problem in a box, putting a lid on the box, and tying the lid on with string. I tell clients to go all out with this visualization to convince the mind that the problem must be put away for the time being. For example, the client can go on to picture herself putting the box on a high shelf in a closet, shutting the closet door, and putting a padlock on the door or chaining it shut. Ask clients to imagine whatever works to send the message to the brain that this problem is off-limits for the time being (Linehan, 2003a).

This skill, and any other approach that involves trying to avoid thinking certain thoughts or feeling certain emotions, can be helpful for some people. As mentioned earlier, though, sometimes trying to push thoughts and emotions away just makes them stronger, so this skill should be used sparingly, almost as a last resort. And of course, as with all of the RESISTT skills, even if it does help, it should only be used temporarily. Regular use of these skills turns into avoidance, which will make the situation worse in the long run.

T: Think Neutral Thoughts

Focusing attention on neutral thoughts can provide distraction from emotions and urges, thereby reducing their intensity. Neutral thoughts can be anything that won't add to the distressing emotions. A common example is counting to ten to help you remain in control when you're feeling angry. Here are some other examples of using neutral thoughts for distraction:

- Saying a prayer
- Singing a favorite song or reciting a nursery rhyme or poem
- Saying the names of objects observed in the environment (e.g.: desk, bed, dresser)
- Repeating a mantra, such as "It is what it is" or "Peace and calm"

Again, personalize this skill for clients. If you're already aware of something a client does that fits into this category, point out that she's already using this skill sometimes—and that now that she knows it's skillful behavior, she can make a point of using it even more frequently and in a conscious

way. Sometimes when I teach clients other DBT skills, they really connect with a saying I give them (such as “It is what it is,” the mantra of acceptance), or they’ll tell me about a saying they’ve come up with on their own. Use these as examples of how they can practice focusing on neutral thoughts to help them get through a crisis without making things worse.

T: Take a Break

Taking a break in some way when emotions are high can also help clients get through a crisis without making it worse (Linehan, 2003b). Help them get creative with this. Taking a break might mean doing so literally—taking a “mental health day” from work as long as this won’t have negative consequences. And even if they can’t take a whole day off from work, they can still go out for lunch or at least a fifteen-minute walk to get some fresh air and clear their head.

Help each client figure out what taking a break might look like for her. She might need to ask someone to come babysit the kids for an hour so she can go out for a drive or walk and relax for a bit. Maybe she needs to skip the errands she had planned for the day and order a pizza for dinner instead of cooking. Taking a break might also involve practicing mindfulness, relaxation exercises, or imagery techniques that help her relax, such as imagining herself in a safe place, like a room in her mind where she feels safe or a favorite vacation spot. This kind of visualization can induce relaxation, promote calm, and, overall, help clients not make the situation worse. There are many different ways of taking a break from your problems.

Again, when teaching clients this skill, make sure they understand that it shouldn’t be used too often, and that the breaks shouldn’t last so long that they interfere with their responsibilities or goals, which would cause more harm than good (Linehan, 2003b). Taking a break can be very helpful in reducing stress, but only when it’s used appropriately and in a limited way; otherwise it can turn into avoidance and make the situation worse.

MANAGING URGES

Often, once therapist and client have agreed on some goals, the client still has a hard time not acting on problematic urges when they arise. I find it’s usually best to help clients create a plan about what they’ll do when they begin to experience an urge. The handout Steps to Managing Your Urges outlines an approach that most people find helpful. Feel free to photocopy the handout and use it in your practice. Also, note that it will be most effective if you go through the handout with clients and personalize the approach to each client’s situation.

STEPS TO MANAGING YOUR URGES

1. Rate the urge from 1 (minimal urge) to 10 (highly intense urge).
2. Set an alarm (for example, on your cell phone, an alarm clock, or a kitchen timer) for fifteen minutes and commit to not acting on the urge for those fifteen minutes. By putting some time between when the urge arises and when you act on it, you may find that the urge decreases and you're able to not act on it. Don't set a time longer than fifteen minutes, or resisting for that long may seem overwhelming and unachievable.
3. During the next fifteen minutes, use your distress tolerance skills to get yourself through the crisis. Having the urge is a crisis; acting on the urge will make the situation worse. So pull out your list of reasons to not act on the urge from your Cost-Benefit Analysis Worksheet and read them to remind yourself why you don't want to act on the urge. Then use your RESISTT skills to help you not act on the urge.

It's also helpful if you do activities that make it harder for you to act on the urge. For example, if your urge is to go to the casino, take a shower. Once you've showered, you have to dry off, dry your hair, and get dressed again before you can go anywhere, so it puts more time between you and the action. If your urge is to eat junk food, go for a walk. It's harder to eat while you're walking down the sidewalk. Better yet, if you have a dog, take him for a walk; that way you'll only have one hand available.

4. When your alarm goes off after fifteen minutes, rate your urge again. If it's come down to a manageable level and you're confident you won't act on it, pat yourself on the back and go about your day. If not, set your alarm for another fifteen minutes and continue practicing the skills. If you end up acting on the urge anyway, at least you've shown yourself that you can use skills instead of acting on the urge for fifteen minutes. As you practice, hopefully this will increase to thirty minutes, then forty-five minutes, and so on.

Of course, there are other things you can do to help prevent yourself from acting on urges: give your debit card to your partner so you can't easily withdraw money to gamble, don't keep junk food in the house, and so on.

COPING AHEAD

The final distress tolerance skill I'll cover is the DBT skill called *coping ahead* (Dimeff & Koerner, 2005). When clients know that an upcoming situation will be emotionally difficult, it can be very helpful for them to rehearse their plan ahead of time so they're prepared to cope in a more skillful way. The following dialogue provides an example:

Client: So Christmas is coming, and my sister is having it at her house again this year. Nothing's changed with her. She still doesn't like my boyfriend, and because it's at her house, I know she's going to tell me again that I can't bring Michael.

Therapist: Well Melanie, I know we've talked a lot about trying not to go into the future. But sometimes we can predict how someone is going to behave based on their previous behavior. And when we're pretty sure we know we'll be facing a difficult situation, it can really help to plan ahead for it. Have you thought about what you'll do if your sister invites you for Christmas dinner but tells you Michael can't come?

Client: No, I don't know what I'll do. I get so triggered by her, and nothing ever changes.

Therapist: Maybe now is a good time for us to plan ahead what you can do to help you feel more effective with your sister. Do you want to go to her house for dinner without Michael? Is it worth it to you to make that sacrifice to see your family?

Client: I think I've sacrificed enough over the years. For so long, I've done everything they've asked me to. But I'm sick of being the only one to give, give, give. I want my sister to start respecting me more.

Therapist: Okay, so you aren't willing to go to Christmas dinner without Michael. If your sister tells you he can't come, what do you want to say to her?

Client: I want to tell her that she can't keep excluding him—that he's part of my life and she has to accept that as my decision. I want to tell her that if he can't come for dinner, then I won't be coming either.

Therapist: Okay. That's a good start, Melanie. Are you willing to not see your family on Christmas, though?

Client: Well, that would be disappointing, especially because my parents are getting older and I don't know how much longer they'll be around.

Therapist: That's understandable. So is there a compromise? Remember, it doesn't have to be all or nothing. You could tell her you'll come for an hour before dinner if you have to come alone, or you could refuse to go to her house without Michael and instead spend time with your parents on Christmas Eve.

Client: Yeah, that's a good idea. I'd like to see everyone, and I'd have to bring the presents over for my sister's kids anyway, so I could go for a little while before dinner, without Michael. Then Michael and I could have Christmas dinner together at my house.

Therapist: Okay, great. So let's talk about how you'll express this decision to your sister if you need to. Think about your assertiveness skills, and talk to me like I'm Anna.

Client: Okay. Anna, I know you don't like that I've chosen to be with Michael. You've made that clear in the way you continue to exclude him from family gatherings. But excluding him from the family is disrespectful to Michael and to me. I would like for you to start working on accepting that he's part of my life, and if you want me to be a part of your life, you have to accept Michael as well. If you insist that he can't come with me to Christmas dinner, then I'll come to your house earlier on Christmas day, but I won't be staying for dinner. He's my partner, and I want to spend Christmas with him as well.

Therapist: Great job, Melanie! Now I want you to picture in your mind how you want this conversation to go with Anna. Imagine it in as much detail as you can. Maybe you're feeling anxious and hurt, but you're expressing yourself confidently; your voice is firm, but you're not yelling; and you're treating your sister with the same respect you want from her.

In this way, clients can cope ahead, preparing themselves for upcoming situations so they can deal with those situations more effectively and skillfully.

WRAPPING UP

In this chapter, you've learned about skills that can help clients get through a crisis situation without making it worse. We looked at the cost-benefit analysis, which assists clients in making decisions about harmful or self-destructive behaviors. Then we looked at the various ways clients can prevent themselves from acting on the urge to engage in those self-destructive behaviors using the RESISTT skills: reframing; distracting by mindfully engaging in an activity, doing something for someone else, or generating intense sensations; shutting it out; thinking neutral thoughts; and taking a break. Finally, we looked at coping ahead, in which clients rehearse acting skillfully in difficult situations before they encounter them. In the next chapter, we'll look at some information clients need to know about emotions in order to use specific skills that will be introduced in chapters 10 and 11 to help them manage their emotions more effectively.

CHAPTER 9

What Clients Need to Know about Emotions

Before you can begin teaching clients the specific skills that will help them manage their emotions, it's usually helpful to provide some general education about emotions. In this chapter we'll take a look at what clients need to know about emotions, including what an emotion is and the functions emotions serve; the connections between emotions, thoughts, and behaviors; that emotions and thoughts sometimes happen so quickly and automatically that it can be difficult to be aware of them; and how being able to name an emotion can be helpful in more effectively managing it.

WHAT IS AN EMOTION?

When I'm working with clients, I try to stay away from the word "feeling" because it implies that an emotion consists solely of how we *feel*, when it's really much more than that. Marsha Linehan (1993b) refers to an emotion as a *full-system response*, because it includes not only the way we feel, but the way we think, which could include images, memories, or urges. In addition, emotions trigger physiological reactions that cause changes in body chemistry and body language.

Help clients relate to this from their own experience. For example, if a client has problems with anxiety, say something like "When you experience the emotion of anxiety, what do you notice other than the *feeling*?" Most people notice an increase in heart rate or feel their heart beating harder. They might experience shortness of breath, tightness or pain in the chest, nausea, dizziness, and so forth. These are the physiological changes. Be sure to help clients identify thoughts that accompany the experience of anxiety. Perhaps they have thoughts about needing to escape and feel the need to flee, fear going crazy or making a fool of themselves, and so on. They might also experience memories of other times when they felt this way. Be sure to help them identify urges; for

example, with anxiety, the urge is often to run, escape the situation, or avoid going into the situation in the first place.

It's also important for clients to understand that emotions can manifest differently depending on the person and situation. Some expressions of emotion are hardwired into us and look the same no matter where you are on the planet; for example, we cry when we feel sad and frown when we're angry. But because each emotion can be accompanied by so many different physiological sensations, thoughts, and urges, everyone's experience of any given emotion is somewhat unique. In fact, the same emotion can even feel different for one person depending on a variety of factors: the circumstances she's facing, the people involved, the environment, and so on. For example, imagine sitting at home watching television and hearing about the earthquake and tsunami in Japan. Most people would feel grief, sadness, fear, and shock for what the people in Japan were going through. But if your partner, parent, sibling, friend, or another loved one was in Japan at the time, your grief, sadness, fear, and shock would manifest at a completely different level because the situation is more personal. The same emotions would feel different because the circumstances are different.

THE ROLE OF EMOTIONS

Clients often want to get rid of emotions altogether. Their goal in therapy might be to stop feeling anxious or get rid of anger. It's important to explain right off the bat that this isn't a realistic goal—that all of our emotions are necessary and serve important functions. Even though they can be incredibly painful at times, they play specific roles and are there for a reason, such as providing motivation or information and aiding communication. Helping clients understand a bit more about why we need emotions and don't want to just toss them out the window brings you one step closer to teaching them skills to help them manage their emotions.

Motivation

Sometimes the role of an emotion is to prompt us to act (Linehan, 1993b). Anger and fear are prime examples here: We feel angry when something happens that we don't like, motivating us to act to change the situation. Fear motivates us to flee, fight, freeze, or faint in order to survive when we're being threatened (Beck, Emery, & Greenberg, 1985). In these situations, emotions not only motivate us, they also prepare us to act by causing physiological changes in the body; for example, the adrenaline rush of fear causes blood pressure to increase and muscles to tense up, readying the body to flee the situation or to stay and fight.

It can be helpful to emphasize to clients that, although anxiety, for example, is uncomfortable, it's an emotion that has helped our species survive. What would have happened if our ancestors never felt fear? They wouldn't have fled even when a saber-toothed tiger was approaching—a quality that surely would have led to the extinction of the human race. Even in modern times, fear serves a purpose. For example, when you're walking alone in an unfamiliar area, anxiety causes you

to be more alert and aware of what's happening around you so you can move more quickly if a threat arises.

Information

Emotions can also provide information about situations that we want to change in some way to make them better suit our needs (Campos, Campos, & Barrett, 1989). For example, you might feel angry because you think there's something unjust about a situation. Another example is guilt, which arises to let you know you've done something that goes against your morals and values.

It's important to help clients think of their emotions as a sense, providing important information, just like vision, hearing, touch, taste, and smell. Sometimes emotions arise to provide us with information before the brain has time to process the information it's receiving from the other senses (Linehan, 1993b). For example, if you're walking in the woods and you see something that looks like a snake, your brain automatically activates fear, starting the fight-or-flight response and getting you to move away from the danger before your eyes have time to process that what they're actually seeing lying in the path ahead of you is a piece of coiled rope. Of course, sometimes this emotional process kicks into overdrive. An example would be someone with PTSD who is more sensitive to certain stimuli and responds to them more often than warranted, in which case the response can become problematic. Overall, though, providing information is an important role of emotions, and one that has helped our species survive.

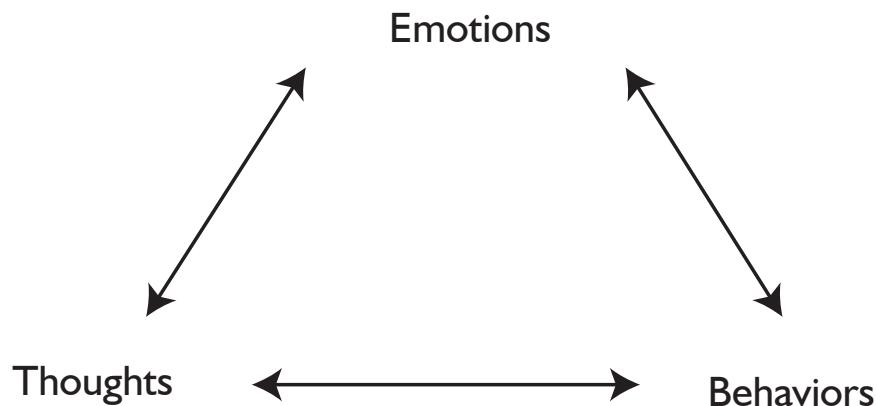
Communication

Emotions help people communicate more effectively (Linehan, 1993b), particularly because, as mentioned, some emotions are hardwired into us and evoke universal facial expressions and body language. Therefore, we are able to instinctively recognize these emotions in others. For example, if you're crying, others would be able to guess that you're probably feeling sad, or if you're frowning, others would be able to guess that you're probably feeling angry. When we recognize how others feel, we can empathize with them and act in an emotionally appropriate way, such as consoling them when they're sad. Simply having our emotions recognized is often helpful in and of itself, as we feel understood and "felt" by another.

THE CONNECTIONS BETWEEN EMOTIONS, THOUGHTS, AND BEHAVIORS

The following diagram illustrates the connections between emotions, thoughts, and behaviors as typically described in cognitive behavioral therapy. The idea here is that emotions affect how we

think and behave in a situation; thoughts influence how we feel and behave in the situation; and actions have an effect on how we think and feel about that situation.



Because emotions, thoughts, and behaviors are so intimately connected, it can be easy to confuse them. For example, when you ask clients how they feel about something, they'll often respond by giving you thoughts about it. Some clients find it extremely difficult to move beyond that thinking part to get to what they're actually feeling. Another example of this confusion is clients referring to anger as a bad emotion; generally, this evaluation applies not to the emotion itself, but to the behaviors that result from feeling angry.

It's especially easy to get confused about what we think versus what we feel, in part because emotions and thoughts happen so quickly and automatically that we usually don't stop to think about them before we act. However, separating emotions, thoughts, and behaviors is an important step in managing emotions more effectively, so make sure clients understand the difference between them.

When clients are trying to determine how they feel about something, encourage them to begin by thinking about the six main emotions: anger, fear, sadness, shame or guilt, love, and happiness. If the emotion doesn't seem to be described by one of these words, suggest that clients think in degrees; for example, they might not be afraid, but perhaps they feel anxious, worried, or nervous.

Behavior, of course, is simply how we act—not what we think about doing or what we feel like doing, but how we actually behave in the situation.

Thoughts are what we think about the situation—but of course it's not quite that simple. Make sure clients understand that they usually aren't having an emotional response to the situation that's occurring, but to their interpretation of that event. Sometimes emotions happen in direct response to an event. The previous example of the coiled rope that you mistook for a snake

is an example of a situation in which the emotional response is immediate, requiring no interpretation. But for the most part, the emotions we experience arise in response to our interpretations. When an event takes place, the mind forms an interpretation of that event, and an emotion arises in response to that interpretation:



The good news is that practicing skills will help clients become more aware of their emotional responses and the interpretations that trigger them. Then they can decide whether those interpretations are valid. I've provided the worksheet Getting to Know Your Emotions, which can help clients start working on differentiating between emotions, thoughts, and behaviors. This worksheet also helps them get to know how they experience the full-system response of emotions. Feel free to photocopy the worksheet and use it in your practice.

The worksheet includes the six main emotions, along with two blank spaces in case clients have other emotions that they'd like to get to know. For each, have the client note how her body responds physically: Does her heart rate increase? Does she start to tremble or shake? Does she tense up? What about her body language? Does she clench her fists? What is the expression on her face? Next, have the client focus on the thoughts that accompany that emotion; for example, does she tend to get judgmental or to recall other times she's felt that emotion? Then ask her to think about what urges come up when she's experiencing this emotion: whether she wants to lash out, isolate herself, hurt herself or someone else in some way, and so on. Next, have her describe her behavior—what she actually does. For example, does she lash out, physically or verbally hurting herself or others? Finally, help her look at the consequences of the behavior; this can further help her distinguish between just having the emotion and what she does about it, so it's important that she consider the consequences of the way she acted (Linehan, 1993a).

Be sure to explain to the client that she may not be able to fully complete the worksheet at first; she might need to experience these emotions again while being mindful of her experience to develop a well-rounded understanding of her experience. Point out that this is fine. There's no rush; the goal is to get to know her emotions and how she tends to experience them, and this usually takes some time and practice.

GETTING TO KNOW YOUR EMOTIONS

Emotion	Body responses (physical sensations, body language, facial expressions)	Thoughts (including memories, images, and judgments)	Urges (what you feel like doing when you experience the emotion)	Behaviors (what you actually do when feeling the emotion)	Consequences (impact or effect of the behavior, such as self-judgments)
Anger					
Happiness					
Sadness					
Fear					

Emotion	Body Responses (physical sensations, body language, facial expressions)	Thoughts (including memories, images, and judgments)	Urges (what you feel like doing when you experience the emotion)	Behaviors (what you actually do when feeling the emotion)	Consequences (impact or effect of the behavior, such as self-judgments)
Love					
Shame or guilt					
Other:					
Other:					

EMOTIONS AND AUTOMATIC THOUGHTS

Another concept that's relevant here, and one that can also help clients see why they might have a hard time differentiating between thoughts and emotions, is the concept of automatic thoughts (Beck, 1976). CBT theorist Aaron Beck noted that we have a constant dialogue running through our minds about whatever we're experiencing: what our senses are telling us, how we feel physically and emotionally, and so on. According to Beck (1976), these automatic thoughts largely determine how we feel about a situation, and both the thoughts and the feelings they evoke influence how we behave.

The biggest problem with automatic thoughts is that they happen so automatically that they are almost unconscious; often we aren't even aware that they're occurring. Because they arise so quickly and almost reflexively, and yet are so realistic and believable (Beck, 1976), we usually don't stop to question them and instead act as though they're facts.

However, if clients are to manage their emotions more effectively, they must understand that thoughts, and the emotions they evoke, are not facts; rather, they're just a reflection of a person's experience of a situation. Just because a client thinks something doesn't mean it's a fact; for example, just because a client thinks it's impossible to change a behavior doesn't mean it really is impossible. Likewise, just because something feels a certain way doesn't mean it's the truth. For example, just because a client feels hopeless doesn't mean the situation is hopeless.

Here's an example of how this might be conveyed in session:

Therapist: So you were having an argument with your boyfriend. Can you tell me more about what happened?

Client: We had talked about getting together after I finished work at 10:00 p.m. I texted him at about nine thirty to let him know we were busy and I was going to be finished a bit late, and he didn't text me back.

Therapist: Okay. What happened next?

Client: I got really angry with him. We haven't seen much of each other since I started working. He knew how important it was to me to get together, and he didn't even bother messaging me back.

Therapist: Were you able to think about the reasons why he may not have been able to get back to you?

Client: No. He's always got his cell phone with him. All I could think was *He knew how much I wanted to spend time together, and he can't be bothered; I obviously don't mean that much to him.*

Therapist: I can understand, Jessica, how that might be one place your mind goes given the problems you've had with relationships in the past. But sitting here right now, can you see that there might be other explanations for why he didn't get back to you?

Client: No! Like I said, he always has his cell phone, so he obviously just decided not to bother.

Therapist: Okay. Let's pause here for a second and put this in a different context. Let's pretend you were trying to contact me, not Scott. Say you send me a text about our appointment this week, and I don't get back to you right away. What would you think?

Client: Well, I know you're often busy and can't get back to me right away.

Therapist: Good. What else might you think? Let's say a day or two passes and you still don't hear from me.

Client: Well, I would probably try again because I know it's not like you to not get back to me. I might think that you didn't get the message. Maybe you were having problems with your phone or something.

Therapist: Okay, great. Can you think of anything else that might prevent me from getting back to you?

Client: Um, I'm not sure. Maybe that you were dealing with some kind of emergency?

Therapist: Okay, great! So maybe I didn't get the message, maybe I was having problems with my phone, maybe I was dealing with an emergency. Do you think that any of these reasons could apply to Scott?

Client: (Pauses to think.) I suppose so.

Therapist: Okay, so why do you think you have such a hard time believing Scott had a problem with his phone or some kind of emergency?

Client: I guess because I don't feel like he cares about me the way I care about him.

Therapist: Okay Jessica, this is great. Do you see how this automatic thought triggered the anger in you and prevented you from really seeing the situation? Scott didn't return your text, and for you that turned into *He doesn't care about me*. I'm not

saying you're wrong; I don't know how he feels about you. But you jumped to conclusions. And again, we can see where this comes from, but do you understand how harmful this can be to your relationship in the long run? Making these kinds of assumptions regularly could lead to the end of the relationship. They could become a self-fulfilling prophecy.

Client: Yeah. He was trying to talk to me about what happened, and I was so angry I wouldn't even let him tell me what happened. I guess I'd better call him and apologize for making assumptions.

You can see from this dialogue that validation is important. The goal isn't simply to point out to clients that their thinking is incorrect; it's also important to assist them in understanding where their thinking comes from, that there are patterns that can be identified and even understood, although they may no longer be helpful. While you don't want clients to judge their emotions (something I'll discuss in chapter 10), they do need to be able to evaluate their behavior to determine whether it's helping them move toward their goals.

NAMING EMOTIONS

Some people are more adept at labeling their emotions than others. I'm sure you've had a client at some point who just couldn't seem to name what she was feeling. She might have said she felt bad or upset, but pinning her down as to what that really meant was challenging. Many people walk around in this kind of emotional fog. Unfortunately, if you don't know what you're feeling, you can't do much to change it. People who can name their emotions are more capable of managing them, so it's important for clients to become more familiar with their emotions and learn to identify them.

Start by encouraging clients to stop using words like "bad" or "upset" to describe how they're feeling. These are very generic words that don't describe a specific emotion. When a client says she's "upset," what does she really mean? It could mean she's sad, anxious, angry, or a variety of other things. So when clients use such vague language, ask them to be more specific. For some clients, it's easier if you outline the six general categories mentioned previously: anger, fear, sadness, shame or guilt, love, and happiness. Start with these six general emotions, and again, if none seem to fit, help clients think about levels of each emotion. A client might not be angry, but maybe she's irritated or frustrated.

I've provided a handout that lists the names of emotions. Give it to clients and go through it with them to make sure they understand what each word means. Then, anytime a client is unable to identify an emotion she's experiencing, have her refer to the list. Reading through it, she should be able to find a word that closely describes the emotion she's feeling.

EMOTIONS LIST

ANGER

Aggravated
Aggressive
Agitated
Annoyed
Betrayed
Bitter
Bothered
Combative
Cross
Distrustful
Disapproving
Disgusted
Displeased
Dissatisfied
Disturbed
Enraged
Exasperated
Frustrated
Fuming
Furious
Hateful
Hostile
Hurt
Ignored
Impatient
Incensed
Indignant
Infuriated
Irate
Irritated
Jealous
Livid
Mad
Obstinate
Offended
Outraged
Rejected
Resentful
Vicious

HAPPINESS

Amused
Blissful
Calm
Charmed
Cheerful
Comfortable
Confident
Content
Delighted
Eager
Ecstatic
Elated
Euphoric
Excited
Exhilarated
Exuberant
Fulfilled
Glad
Grateful
Honored
Hopeful
Inspired
Jovial
Joyful
Jubilant
Overjoyed
Pleasant
Pleased
Proud
Relaxed
Relieved
Satisfied
Serene
Thankful
Thrilled
Tranquil
Triumphant

SADNESS

Abandoned
Anguished
Cheerless
Defeated
Dejected
Depressed
Despairing
Despondent
Disheartened
Distressed
Disturbed
Dreary
Dull
Forlorn
Gloomy
Glum
Grieving
Heartbroken
Helpless
Hopeless
Inadequate
Lonely
Low
Melancholy
Miserable
Mournful
Negative
Pained
Pessimistic
Powerless
Regretful
Remorseful
Sad
Somber
Sorrowful
Troubled
Unhappy
Woeful
Worthless

FEAR

Afraid
Alarmed
Anxious
Apprehensive
Bothered
Concerned
Disconcerted
Distraught
Distressed
Disturbed
Edgy
Fearful
Frantic
Frazzled
Fretful
Frightened
Jittery
Jumping
Nervous
Overwhelmed
Overwrought
Panicked
Perturbed
Petrified
Restless
Scared
Startled
Stressed
Tense
Terrified
Threatened
Troubled
Uncertain
Uncomfortable
Uneasy
Unsettled
Unsure
Uptight
Worried

LOVE

Accepted
Adoring
Affectionate
Alive
Amorous
Appreciative
Ardent
Aroused
Attracted
Besotted
Caring
Cherishing
Committed
Complete
Connected
Desirous
Devoted
Entranced
Fond
Infatuated
Intimate
Kind
Liking
Longing
Lovable
Love-struck
Loving
Lust
Passionate
Romantic
Sensual
Smitten
Tender
Worshipful
Yearning

SHAME OR GUILT

Apologetic
Ashamed
Awkward
Blamed
Contrite
Degraded
Disgraced
Dishonored
Embarrassed
Foolish
Forlorn
Guilty
Humiliated
Inferior
Mortified
Penitent
Pitiful
Regretful
Rejected
Remorseful
Repentant
Rueful
Self-conscious
Sorry
Uncomfortable
Vulnerable
Wretched

In the list above, shame and guilt are included under the same heading because the experience of these emotions is usually the same. The difference is that we experience shame when we feel other people are judging us for what we have done, whereas we feel guilt when we judge ourselves for what we've done. Quite often, we may feel these emotions together.

Once clients are more capable of naming their emotions, they'll have more choices in terms of what to do about an emotion if it's uncomfortable and they would prefer to at least reduce its intensity. Keep in mind that many clients with emotion dysregulation grow up without learning this important information, so for some people it takes a lot of time to get the hang of naming their emotions. Be patient. If you start to get frustrated, or if a client does, reframe this process as helping the client learn a new language. In fact, that's exactly what's happening: you're helping the client learn the language of emotion.

WRAPPING UP

In this chapter you've learned key information that clients need to know in order to learn and utilize the specific skills that will help them regulate their emotions. In the next two chapters, we get to the meat of the matter: teaching clients skills to help them regulate their emotions. As you read on, remember that everyone is different and that DBT is flexible, so you won't necessarily have to teach every client all of the skills. Once you get more comfortable with this approach, you'll be able to pick and choose the skills that you think will be most helpful for a given client.

CHAPTER 10

Skills to Help Clients Regulate Emotions: Reducing Painful Emotions

Up to this point, part 2 of this book has looked at skills that, in one way or another, are related to emotion regulation. When clients are practicing mindfulness, for example, they'll have more awareness of their emotions, increasing their ability to manage them. Noticing what thinking style they're using will help them see when they're acting from their emotions and allow them to choose how to act rather than simply reacting. Practicing distress tolerance skills when they're in a crisis situation will help them refrain from engaging in behaviors that will make their situation worse, which again will give them a greater ability to manage their emotions and keep them at a more tolerable level.

In this and the next chapter, we'll be looking at skills more specific to managing emotions more effectively. In this chapter, we'll look at skills to help clients reduce their painful emotions and make them more bearable. Then, in chapter 11, we'll look at skills that will help them generate more positive emotions. Throughout both chapters (and chapter 12 as well), continue to keep in mind that these skills will be much easier for you to teach if you practice them yourself, so think about how you can implement these skills in your own life to increase your effectiveness.

USING MINDFULNESS TO REDUCE EMOTIONAL PAIN

In chapter 5, we took an in-depth look at mindfulness and how it can be helpful in a variety of ways. One benefit, of course, is increasing awareness of emotions, which results in an increased

ability to choose how to act rather than simply reacting. Let's take a closer look at some specific targets of mindfulness of emotions and how they can help clients regulate their emotions. Specifically, let's focus on what the skill of being mindful of an emotion means, for both painful and positive emotions.

Being Mindful of Painful Emotions

With painful emotions, mindfulness entails accepting them as they are and not trying to get rid of them or push them away. Being mindful of painful emotions means seeing them for what they are—a part of life—without judging them or judging yourself for having them. (I'll discuss such judgments further in the section on self-validation.) This doesn't preclude trying to do something to change an emotion or reduce its intensity; it simply means doing so in an accepting, rather than judgmental, way.

A number of studies have found that, although it is sometimes possible to successfully suppress emotionally expressive behavior, doing so also has the effect of reducing the subjective experience of positive emotions (Fairholme, Boisseau, Ellard, Ehrenreich, & Barlow, 2010). Therefore, clients who regularly work to not feel their painful emotions may indeed be able to somewhat reduce the amount of pain they experience, but this comes at the cost of not feeling positive emotions as strongly either. Similarly, Bloch, Moran, and Kring (2010) reported that people who regularly use suppression as a means of trying to cope with painful emotions experience fewer positive emotions, more depressive symptoms, and less satisfaction with life in general.

Being Mindful of Positive Emotions

With positive emotions, mindfulness also entails accepting them as they are and, in this case, not trying to cling to them. Being mindful of positive emotions means enjoying them while they last, rather than worrying about whether you deserve to feel this way. Instead of being mindful of positive emotions, many people worry about when the feeling will end. An example would be a person who thinks, *Sure, I feel good now, while my family is visiting, but as soon as they leave I'm going to be miserable again.* Rather than enjoying positive feelings, this person creates an imaginary future in which he's feeling miserable.

Practicing Mindfulness of Emotions

Being mindful of emotions involves focusing your attention on whatever emotion happens to be present at the time, not judging it, and bringing your attention back to the present moment when you notice you've wandered. Again, this means not trying to suppress or avoid emotional

pain and not trying to hang on to pleasant emotions; rather, you simply accept whatever is there in each moment.

To help clients with this skill, have them think of an emotion as a wave: It will build and peak, but then it subsides and fades away again. It might build and peak again, but an emotion, just like a wave, always subsides; it's not possible for it to endure indefinitely. However, many clients don't understand this because they do so much to try to get rid of painful emotions that they never give them a chance to subside. Mindfulness will help them learn this as they simply sit with emotions without judging them or trying to push them away. As they allow emotions to simply be, they'll experience how emotions naturally subside.

SELF-VALIDATION

Let's take a closer look at accepting emotions. This is the DBT skill known as *self-validation* (Linehan, 1993b).

How often do you hear clients judging their emotions or judging themselves for experiencing those emotions? One of the major consequences of growing up in a pervasively invalidating environment is that it makes people think they can't trust their own experience, that they are incapable of solving the problems life presents, and that they are defective or flawed in some way. In other words, they regularly invalidate themselves, judging themselves for their emotions and thinking of themselves as incapable and worthless. Therefore, as I've mentioned throughout this book, in therapy a lot of time and effort must be devoted to validating clients and gradually helping them learn to validate themselves.

Because of their history, many clients with emotion dysregulation find the skill of self-validation especially difficult; however, it is especially important for them. One of the principal ways of teaching clients this skill is modeling it: providing lots of validation in session, especially at the beginning of therapy, until clients are more proficient at doing this for themselves. But before I get into the specifics of how to practice self-validation—and before clients can learn this skill—there's some important information about emotions that both you and your clients need to know: how we learn about emotions, and the difference between primary and secondary emotions.

Messages about Emotions

The first thing both therapist and client need to understand is that everyone receives messages about emotions: from the family they grew up in and the peers who surrounded them as they developed, in the important relationships they have as adults, and from society in general. For example, as they are growing up, many people learn that anger is a bad emotion. Maybe they had a father who was prone to explosive rage, so they learned anger was bad because of his behavior. Perhaps no one in their family expressed anger, sending the message that it isn't appropriate to feel

angry. Alternatively, they might have received quite straightforward verbal communication about emotions, such as, "What's wrong with you? You shouldn't be angry. It's not nice!"

It can be very helpful for clients if you take some time to help them think about the messages they've received about emotions throughout life. What emotions are okay to have? Which ones shouldn't be felt? In the course of this discussion, remember to point out that you're talking about *emotions*, not behaviors; as mentioned, people often have difficulty distinguishing between these two.

It's also important to point out to clients that this isn't about blaming others for their emotional problems. Explain that their parents also received messages about emotions that influenced their ability to validate their own emotions, and so on. That said, once clients can identify where their patterns came from, it often makes it easier for them to change.

Primary and Secondary Emotions

The other key point relevant to the skill of self-validation is that there are two types of emotions: primary emotions and secondary emotions.

Primary emotions are those we experience in response to our interpretations of events. As mentioned in chapter 9, more often than not we don't experience emotions in direct relation to a situation; they arise in response to our interpretation of the situation. Say a friend calls you to cancel a dinner date for that night. You get annoyed not in response to the situation itself, but as a result of your interpretation: *She should have given me more notice so I could have made other plans*. Although it's based on an interpretation, annoyance is your primary emotion.

Secondary emotions are essentially the way you feel about your feelings. In other words, when you get annoyed at your friend for canceling dinner, if you judge yourself for that, you might end up feeling guilty and angry at yourself for feeling annoyed at your friend. The guilt and anger at yourself are your secondary emotions, which arise in response to judgments about your primary emotion. If you've grown up thinking that it's not right to be angry (annoyance being a form of anger), when you feel annoyed you're likely to judge yourself, triggering guilt and anger at yourself.

Practicing Self-Validation

With that background established, let's look at how to practice the skill of self-validation. At bare minimum, validating an emotion means not judging the emotion and not judging oneself for feeling the emotion. Edith Weisskopf-Jelson, a professor of psychology at the University of Georgia, wrote that society puts so much stress on the fact that people should be happy that unhappiness has come to be seen as a symptom of maladjustment. She said, "Such a value system might be responsible for the fact that the burden of unavoidable unhappiness is increased by

unhappiness about being unhappy" (1955, p. 702). In other words, when we judge ourselves by thinking we should be feeling happy, this exacerbates our unhappiness. This is self-invalidation.

Self-validation, on the other hand, is about acceptance. When you can, at the very least, not judge your emotional experience—for example, just acknowledging that you feel unhappy rather than judging yourself for feeling that way—you don't trigger extra emotional pain for yourself. That leaves room to access your wise self and see if there's something you can do to reduce the primary emotion, assuming it's an emotion you don't want to continue having. For instance, in the above scenario, maybe you need to ask your friend why she didn't give you more notice when she canceled dinner. If she tells you that her grandmother is in the hospital, your annoyance will probably subside. If she tells you that someone asked her out on a date, you might want to tell her that you would have preferred more notice so you could have made other plans. This will help you validate your annoyance. Plus, when you assert yourself and feel heard, painful emotions will often diminish.

Levels of Self-Validation

To make the concept of self-validating a little easier for clients, I break it down into three levels:

1. **Acknowledging:** The most basic level of self-validation is simply acknowledging the presence of the emotion rather than judging it; for example, telling yourself, *I feel unhappy*. Just acknowledging or naming the emotion and putting a period on the end of the sentence rather than going down the road of judging it validates the emotion.
2. **Allowing:** The second level of self-validation is allowing, which is essentially giving yourself permission to feel the feeling; for example, telling yourself, *It's okay that I feel unhappy*. This takes not judging the feeling one step further, affirming that it's okay to feel this way. This doesn't mean liking the feeling or wanting it to hang around; it just means acknowledging that you're allowed to feel the emotion.
3. **Understanding:** The highest (and hardest) level of self-validation is understanding. This level, which goes beyond not judging the emotion and saying it's okay to feel it, involves having an understanding of it; for example, *It makes sense that I feel unhappy, given the difficulties I have managing my emotions and the chaos this causes in my relationships and my life*.

Most clients with emotion dysregulation have a lifelong pattern of invalidating themselves, so, again, it makes sense that this is typically a very challenging skill for them. It's likely that they'll start out self-validating most emotions at the first level—acknowledging the emotion—and that even this will be difficult for many of them. But over time, they'll be able to move on to the next level, and then the next. It's also natural for people to move at a different pace with different emotions. Some emotions will be easier to validate than others.

It's often helpful to have clients write a list of validating statements that they can read when they notice that they're invalidating themselves. Recently, I was working with a client who has BPD and regularly thinks I'm going to abandon her. When these fears of abandonment come up, she regularly invalidates herself with self-talk like, *It's ridiculous, I should be able to manage this better by now* or *I'm a grown woman. I shouldn't still be feeling this way. Why can't I get over this?* I helped her start a list of self-validating statements to use when these feelings arose. Here are some examples of what we came up with:

- *I'm feeling anxious about Sheri leaving me.* (level 1)
- *It's okay that I'm feeling this way.* (level 2)
- *I'm worrying that Sheri will leave me. It's uncomfortable, but it is what it is.* (level 2)
- *It makes sense that I get anxious about Sheri leaving me because of the relationships I've lost throughout my life.* (level 3)
- *It makes sense that I get anxious about people leaving me because of the abuse and neglect I experienced as a child.* (level 3)

Start working on a list of self-validating statements with clients in session and then have them continue working on it for homework. At the next session, review the list to see what they've been able to add, if anything. Many clients find this difficult to do on their own, but hopefully they're able to come up with one or two additional statements. Have clients carry this list with them so they can read the statements whenever they notice that they're invalidating their emotions. In this way, over time they'll be able to change the way they speak to themselves about how they're feeling, rather than just falling back into old, familiar patterns of negative self-talk and judgments.

ACCEPTING REALITY

I've discussed acceptance as part of mindfulness and the importance of accepting emotions. In DBT, we also emphasize the need to work on accepting reality in general (Linehan, 1993b). It's natural that we try to fight things or push them away when they're painful. While this is understandable, it's not very effective; in fact, it actually works against us most of the time. When we try to suppress painful experiences or fight reality by saying things like *It's not fair* or *It shouldn't be this way*, the same thing happens as when we try to suppress painful emotions: we end up generating more pain for ourselves (Linehan, 1993b).

Fighting reality causes suffering. This isn't to say that we shouldn't have emotions about difficult situations. But when we fight reality, this *increases* the amount of unnecessary emotional pain we experience, which creates suffering. Pain is unavoidable in life; suffering isn't. By accepting the pain in life, we actually decrease the amount of suffering we experience.

What Acceptance Is Not

A lot of people have a hard time with the skill of acceptance simply because of the word “acceptance.” It’s important to clarify with clients right off the bat that, in this context, acceptance has nothing to do with approval or being okay with something. Rather, in DBT acceptance is nonjudgmental. Therefore, accepting something doesn’t mean you’re saying it’s good or bad; it means you’re simply acknowledging reality as it is. Tara Brach (2003, p. 4) describes acceptance as “the willingness to experience ourselves and our life as it is.”

Usually, clients need an example here. Keep it concrete and simple. I often reference the carpet in the group room that I use, which is an unpleasant shade of beige. I tell clients that I don’t like the color of the carpet, but that I have to *acknowledge the reality* that the carpet is that color; in other words, I have to accept it. After all, how can I do otherwise? This is what we mean by acceptance in DBT.

In fact, accepting reality is the shift that must take place to open the door to genuine and permanent change (Brach, 2003). You can’t change something unless you have first accepted it. Think about it: If clients are constantly fighting the reality of a situation (for example, the reality that they have difficulties managing their emotions), they won’t be doing the things that will help them with this problem, such as learning DBT skills. Instead, they’ll be spending a lot of time and energy fighting the reality and essentially trying to pretend it doesn’t exist. Once they arrive at acceptance, they can spend that time and energy doing something to improve their situation.

It’s also usually helpful to emphasize to clients that, just as with other DBT skills, they don’t practice acceptance for others. Many clients confuse the idea of acceptance with forgiveness, but the point isn’t to accept a reality in order to put someone else’s mind at ease. Acceptance is simply about whether or not they want to continue spending so much energy and having so many painful emotions about things that are out of their control. They can’t control what’s happened in the past. If the reality they’re trying to accept is something in the present that they do have some control over, then they need to first accept the situation, and then exercise some control to try to change the situation. Continuing to fight reality, on the other hand, is just exhausting and doesn’t actually accomplish anything.

Like many other DBT skills, accepting reality isn’t easy, but there are a few things you can teach clients to help them with this. First, the more painful a situation is, the more difficult it will be to accept, and the longer it will usually take. Acceptance isn’t a skill that can be mastered overnight, even at the best of times. In addition, they may find that they get to the point of acceptance with a situation and then something triggers them to start fighting reality again. For example, I worked with a woman whose husband had an affair a number of years ago. She told me that they had gotten through it—that she had accepted it and things had improved tremendously in their marriage. But then a young woman moved in next door, and she reminded my client of the person her husband had the affair with. My client started feeling angry more often, but she quickly realized that seeing this young woman was triggering her to not accept her husband’s past infidelities,

and that this was what was causing her anger. So once again she started working on accepting the reality of her husband's affair.

Because it can take a lot of time and energy to get to acceptance, you might find that you and your clients get frustrated with it. When this happens, think of it in this way: When you're working on accepting a painful reality, you may find that you can only accept it for about thirty seconds each day. But even when this is the case, you've just had thirty seconds less suffering, and gradually that time will increase to thirty minutes, then three hours, and so on.

It can also be helpful to ask clients to recall a previous painful situation that they were eventually able to accept (for example, the death of a loved one or not getting a desirable job). Most people have experienced difficult situations that they later naturally came to accept. Once clients bring to mind a situation that was painful but they were eventually able to accept, have them recall what it felt like once they could accept it versus when they were still fighting it. Most people say that they felt a sense of relief or felt "lighter," or that the situation had less power over them, so they spent less time thinking about it—and when they did think about it, it didn't have the same degree of emotional pain attached to it anymore. Remembering how their pain diminished once they achieved acceptance can help motivate clients to continue working on acceptance even when it's extremely hard.

How to Practice Accepting Reality

The old saying "Time heals all wounds" is often true. But with acceptance, there's no need to endure for an indeterminate amount of time. Acceptance is something clients can consciously do to help expedite the healing process. So how, exactly, can a client get to acceptance? Here are the four basic steps:

1. First, the client needs to decide if this is a situation he wants to accept. Remember, just because you think or know a skill will be helpful for a client, he won't get anywhere if he doesn't buy into it.
2. If the client decides to work on acceptance, the second step is to help him make a commitment to himself to accept whatever reality he's fighting. Basically, he needs to promise himself that, starting now, he's going to do his best to accept the situation. Of course, it's likely that he will soon find himself fighting reality again, thinking about how unfair it is, judging the situation, and so on.
3. The third step is for the client to notice when he starts fighting reality again.
4. The final step is for the client to turn his mind back to acceptance (Linehan, 1993b). I think of the practice of accepting reality as one of those internal arguments we often have with ourselves and explain it like this: "You make the decision to accept a reality,

and you make the commitment to yourself that, as of that moment, you're working on accepting this situation. A few seconds later, though, you may be saying to yourself, *Why on earth should I accept it? It's not fair!* As soon as you notice that you've gone back to fighting reality, turn your mind back to acceptance and remind yourself of your commitment. You may need to turn your mind back to acceptance over and over again in the course of just a few minutes."

I find that clients often have a lot of difficulties with this skill. Here are some of their most common questions or concerns about acceptance, along with suggestions for how to respond.

"DOESN'T ACCEPTING REALITY MEAN I'M GIVING UP OR BEING PASSIVE?"

In regard to current situations, clients often think that accepting the situation means not trying to do anything to change it (Linehan, 1993b). This is not the case. Acceptance simply means giving up the suffering they have been experiencing because of fighting the reality of the situation. Stopping the fight doesn't mean stopping efforts to try to solve the problem. Accepting reality is the shift that has to happen to make way for change. Encourage clients to remember that they can't change something until they first accept the reality of what is. Once they are no longer fighting reality, this frees up energy that they can put into solving the problem.

"HOW CAN I ACCEPT THAT I WILL BE ALONE FOR THE REST OF MY LIFE?"

Sometimes clients try to accept things that haven't happened yet. For instance, one client I worked with had been in a few long-term relationships since her divorce, but none that lasted. At the age of forty-nine, she was frustrated and lonely. One day she told me that she was trying to accept that she would be alone for the rest of her life. My response was that you can't accept things that haven't happened yet! This skill is about accepting *reality*, and the future isn't reality yet. We can't possibly know what the future holds. Besides, most people have enough things in the past and the present to work on accepting. Why on earth would anyone want to spend energy trying to accept possible realities that might arise in the future?

With this client, I suggested that if being alone was a reality she was fighting, she needed to accept that *at the present time* she was without a partner. I pointed out that working on accepting this would probably be difficult enough and recommended that she not add the pressure and pain of trying to accept that she was fated to feel so sad and lonely for the rest of her life. The bottom line is this: clients who are regularly worrying about the future need to focus on practicing not acceptance, but mindfulness, since mindfulness is about living in the present moment, not the future.

"HOW CAN I ACCEPT THAT I'M A BAD PERSON?"

One day in a group session, a client asked how he could accept that he was a bad person. I pointed out that just as we can't accept the future, we also can't accept judgments because they aren't facts. Judgments aren't reality, they are perceptions of reality. Then I asked this client to describe why he thought he was a bad person. He had a list of things he was doing and had done in the past that in his mind were bad, such as being addicted to drugs and alcohol and lashing out at people who were trying to help him. I explained that *these* were the realities he needed to work on accepting.

"SOME THINGS IN LIFE ARE JUST TOO AWFUL TO ACCEPT."

Often people have difficulties with accepting reality because the situation is so painful that they don't want to accept it. For clients in this situation, help them see what's stopping them from trying to accept the reality. I find this is often a problem with people who have experienced some kind of abuse. They tell me they can't even think about accepting something so awful. The first thing I look at when this is a problem is forgiveness: Remind such clients that they are practicing acceptance for themselves, not for anyone else. This isn't about forgiveness and has nothing to do with anyone else. If clients are working on this skill because they feel obligated to (for example, because a family member tells them they need to let something go), it's not going to work.

That said, some clients who are trying to accept reality for themselves will still run into this obstacle, thinking the reality is just too awful to accept. In this case, take a closer look at the thoughts they have about what it means to accept the situation. Sometimes it goes back to a confusion of language. They might still be thinking acceptance means they approve of the situation or are okay with what happened.

Other times, people feel as though the situation was just so painful that they can't go there. Unfortunately, they're going there whether they want to or not. When we can't accept something, the mind has an unfortunate tendency to bring us back there over and over again. Remind such clients that, over time, acceptance will actually help them think about the situation less often, and that when they do think about it, the situation will have less power over them, triggering fewer emotions and with less intensity.

ACTING OPPOSITE TO URGES

The last skill we'll look at for reducing painful emotions is acting opposite to urges. As discussed, emotions often have urges attached to them; for example, anger often leads to an urge to attack, whether verbally or physically. Quite often, people make no effort to not act on these urges because the behavior simply feels like the right thing to do. From the perspective of the wise self, however, people can see that it isn't in their best interests to act on these urges, such as avoiding social

situations because of anxiety, isolating themselves when they're feeling depressed, or yelling at their boss when they feel they've been treated unfairly.

Interestingly, researchers have found that acting on urges related to an emotion actually strengthens that emotion (Niedenthal, 2007). So if you act on the urge to verbally or physically attack someone you're angry with, for example, you actually strengthen your anger. In addition, because acting in this way probably isn't consistent with your morals and values, doing so can trigger additional emotions, such as guilt and regret when you later judge yourself for the way you behaved. It makes sense, therefore, that not acting on the urges that accompany an emotion will, at the very least, not make the emotion stronger. In fact, according to Linehan (1993b), acting opposite to those urges can help reduce the intensity of the emotion.

The following table outlines the urges that are usually attached to four painful emotions, along with potential actions that would be opposite those urges. I haven't included positive emotions because, for the most part, acting on urges associated with positive emotions, such as happiness, doesn't usually cause problems.

Emotion	Urge	Opposite action
Anger	To attack verbally or physically	To leave the situation if possible or act civilly or politely, rather than making things worse
Sadness	To withdraw from people and isolate yourself	To approach people and ask for support
Anxiety	To avoid the anxiety-provoking situation by leaving it and avoiding similar situations in the future	To remain in the anxiety-provoking situation and place yourself in that situation again in the future
Shame or guilt	To withdraw and hide from others	To approach others, and when shame or guilt isn't justified, to continue the activity that triggers those feelings

Once an emotion has done its job, it often gets in the way of being able to act effectively. If we can act opposite to the urge elicited by the emotion and thereby reduce its intensity, we can probably respond more effectively. Let's look at this with an example of anxiety. Vicki was attacked by a dog when she was a child. Understandably, after the attack she was terrified of dogs, and this fear continued into adulthood. When she moved into a new neighborhood at the age of thirty-three, Vicki was unhappy to discover that there was a dog park just down the street and people often walked past her house with their dogs to get there. Her anxiety remained high, and not only did she stop going for walks, which she had enjoyed, she also stopped going out of the house by herself, fearing that she would be attacked.

Vicki's anxiety has served its purpose: it protected her when she was a child, and it continues to motivate her to protect herself. But her anxiety is now getting in the way. It has alerted her to the possible threat, but because she continues to avoid the situation, she isn't learning that the threat is minimal or nonexistent; rather, the anxiety remains at such a high level that Vicki is having difficulties functioning. However, if she can act opposite the urge to avoid, she can reduce the anxiety as her brain learns there's nothing to be anxious about. This will allow her to function more effectively.

Help clients identify the urges attached to the emotions they're experiencing, and then offer guidance in doing the opposite. Clients often find it helpful to write down some details about their experience to help them analyze it from their wise self. I've provided an Acting Opposite to Urges Worksheet, which can help clients assess their use of this skill, along with an example. Feel free to photocopy the blank form and use it in your practice. Have clients start by describing the situation in the left-hand column. The rest of the columns guide them through noting what emotion they experienced, what urge was attached to the emotion, what behavior they actually engaged in, and what the aftereffects were (the consequences of the behavior). This worksheet is a great way for you and your clients to monitor their use of this skill and will allow them to see how helpful it is in reaching their goals.

SAMPLE ACTING OPPOSITE TO URGES WORKSHEET

Situation (event that prompted the emotion)	Emotion (emotion experienced)	Action urges (urges attached to the emotion)	Action taken (what you actually did)	Aftereffects (consequences of the behavior, such as intensity of emotions, regrets, or whether your needs were met)
<i>I decided to practice self-soothing by taking a hot bath.</i>	Guilt	<i>Get out of the bath and do something productive.</i>	<i>Made myself stay in the bath for the full twenty minutes I had given myself.</i>	<i>My guilt gradually went down. I met my goal of practicing self-soothing, which I know is in my best interests in the long run. I have no regrets.</i>
<i>Someone cut me off while I was driving.</i>	Rage	<i>Follow the car until it stops, get out, and give the driver a piece of my mind.</i>	<i>Followed the car to a gas station, got out, and yelled at the driver.</i>	<i>Got even more enraged because he denied cutting me off. The worker at the gas station came out and threatened to call the police. Later I was embarrassed and realized I could have gotten into big trouble. I also realized my behavior didn't actually help in any way. I ended up feeling worse.</i>

ACTING OPPOSITE TO URGES WORKSHEET

Situation (event that prompted the emotion)	Emotion (emotion experienced)	Action urges (urges attached to the emotion)	Action taken (what you actually did)	Aftereffects (consequences of the behavior, such as intensity of emotions, regrets, or whether your needs were met)

WATCH YOUR EMOTIONS

Clients often try to avoid their emotions because they find them too painful. Remember the analogy of the third-degree burn victim: clients who haven't learned how to regulate their emotions are in a lot of pain, and they don't have the skills to manage and tolerate their emotions. You can use the acronym WATCH to help such clients summarize the skills in this chapter—skills that will help them reduce their avoidance of emotions and improve their ability to manage emotions:

Watch: Watch your emotions. Mentally note your experience of an emotion, acknowledging how it feels physically, the thoughts, memories, or images that accompany it, and so on.

Avoid acting: Don't act immediately. Remember that it's just an emotion, not a fact, and that you don't necessarily need to do anything about it.

Think: Think of your emotion as a wave. Remember that it will recede naturally if you don't try to push it away.

Choose: Choose to let yourself experience the emotion. Remind yourself that not avoiding the emotion is in your best interests and will help you work toward your long-term goals.

Helpers: Remember that emotions are helpers. They all serve a purpose and arise to tell you something important. Let them do their job!

WRAPPING UP

This chapter covered a lot of skills to help clients reduce the amount of emotional pain they experience. As you continue working with clients to help them learn these skills, remember to use a lot of validation and encouragement. It makes sense that they didn't learn these skills, given that they probably grew up in a chaotic environment, that their parents didn't know these skills themselves or had a mental illness or addiction, and so on. Also remember that your clients are constantly looking to you for guidance. Model these skills for them as much as you can by using the skills in session and in your life. The next chapter will continue to look at skills that help clients regulate their emotions, shifting the focus to increasing positive emotions.

CHAPTER 11

Skills to Help Clients Regulate Emotions: Increasing Positive Emotions

The previous chapter looked at emotion regulation skills focused on reducing painful emotions. This chapter is about something equally important: increasing positive emotions. This isn't just beneficial because it improves mood and it's nice to feel happy; positive emotions also strengthen the immune system (Frederickson, 2000) and heart (Frederickson & Levenson, 1998) and help minimize the impact of painful experiences, including trauma (Frederickson, 2001). In addition, as Hanson and Mendius aptly note, "It's a positive cycle: good feelings today increase the likelihood of good feelings tomorrow" (2009, p. 75).

Many people don't seem to understand that sometimes we have to actively work to generate positive emotions; for example, when an inability to regulate emotions causes chaos in relationships and makes it difficult to function, positive feelings don't often arise spontaneously. In this chapter, we'll look at some skills that can help clients consciously work toward increasing positive experiences—and with them, positive emotions.

BEING EFFECTIVE IN LIFE

In DBT, the skill of *being effective* refers to doing what you need to do to get your needs met or move closer to your long-term goals (Linehan, 1993b). The more effective clients are, the more positive emotions they'll experience as they increase their self-respect and improve their quality of life. While being effective might sound logical and even a little bit simple, for many of our clients (and,

let's face it, even for ourselves at times), it can be a real challenge, often because emotions get in the way. When clients are acting from their emotional self, it's usually difficult for them to figure out what their long-term goals are, much less sort out what they need to do to get there.

When you first teach clients this skill, you might encounter resistance. Remember to provide a lot of validation, underscoring that being effective is difficult, and then push for change. Explain to clients that you'll help them practice this skill, which will improve their quality of life. It's also important to point out from the start that acting effectively doesn't guarantee they'll get their needs met. It can increase the chances, but other obstacles may still get in the way of reaching their goals.

I find the best way to introduce this skill is by asking clients to think of times in the past when they haven't acted effectively: When have they done something they later regretted? When have they acted in a way they later recognized as not being helpful—or even being harmful—to them in the long run? Explain that when they do something that might feel good in the moment (most often acting from the emotional self) but that isn't in their best interests in the long run, they are acting ineffectively. Linehan (1993b) uses the expression "cutting off your nose to spite your face" to describe ineffective behavior. An example would be acting out of anger in a way that, in the long run, is more hurtful to yourself than it is to the person you're angry with.

Acting effectively, therefore, is acting from your wise self—taking into consideration your emotions and thoughts, as well as what your gut instinct or intuition tells you is in your best interests. Acting effectively means thinking about what's going to help you reach your goals in the long run, even though it might not be what you want to do or what's easiest in the situation. The following dialogue gives an example of how to convey this:

Therapist: So you got laid off from work at the day care center. I'm so sorry to hear it, Rebecca. I know how much you've enjoyed the job, and you've been doing so well there.

Client: Yeah, it sucks. They told me it's because they've had a reduction in enrollment, so there are too many workers now and not enough hours to go around. And, of course, I'm one of the newest employees even though I've been there a year. They told me they might call me back for occasional shifts, but if they do, I don't think I'll go.

Therapist: Why wouldn't you go? Obviously if you find another job quickly and you're not available, you can't go, but if that's not the case, wouldn't the extra hours come in handy?

Client: Yes, but I don't think it's fair that they laid me off and now expect me be at their beck and call if they decide they need me.

Therapist: Do you really think that's what's going on here, Rebecca? You've told me what a good relationship you've had with your employers up until now, and it's always sounded like they've valued you.

Client: Well, they obviously didn't value me enough to keep me on.

Therapist: So is that what this is really about? You're angry with them, and to punish them, you're not going to go back to work even though it would help you out as well as helping them?

Client: Why should I help them after what they've done?

Therapist: Can you try to think about what would be effective for *you* in this situation, instead of focusing on how to get back at them? What could you do here that might help you get your needs met?

Client: (Pauses.) I know you're thinking that I could use the money, and you're right. But I still don't see why I should help them out.

Therapist: I understand that you're angry and disappointed about losing your job. I know that this was the longest you'd held a job, and that it was very important to you. You've formed relationships not only with your coworkers, but with the children you've been working with. You've even gone back to school to get your diploma so you can continue working in the field, so obviously this job meant a lot to you. But yes, you're right: you do need the money. It will also do you good to get out of the house now and then, because without your job you're pretty isolated. I'm also wondering if there's any chance that you might get your job back later if enrollment increases again or if other staff members leave because of the shortage of hours.

Client: Yeah, I guess you're right. I'm just so disappointed, and I'm taking it personally. They did tell me more than once that the only reason I was the first to be let go is because of my lack of seniority. And yes, they did say that, if they can, they'll take me back, even if it's only part-time. So you're right. I guess I should be focusing more on what I can do to make it more likely that I'll get my job back, or at least that they'll give me a good reference for my next job.

What Gets in the Way of Effectiveness?

One of the biggest problems that can get in the way of clients' ability to be effective is not knowing what their long-term goals are (Linehan, 1993b). It will be hard for them to figure out what they need to do to get their needs met if they aren't even sure what their needs are! Encourage them to practice mindfulness so they can slow down and really think about what will be most effective for them in a given situation. Also, they might have more than one goal in a situation, so it's important to help them figure out what's most important in case they aren't able to achieve all of their goals.

Thoughts about the situation can also get in the way of doing what works. For example, Rebecca's thought that her employer was treating her unfairly got in the way of being effective. All she was focusing on was her thoughts about how the situation should have been, so she was responding not to the reality of the situation, but to the way she wished the situation was.

Another common obstacle to effectiveness is focusing on short-term goals rather than considering what will be most helpful in the long run. So while Rebecca might get some satisfaction out of not helping her employer if they need her, in the long run this would be cutting off her nose to spite her face: hurting herself by not earning the money she needs, not demonstrating to her employer that she'd like to come back if there's an opportunity, and not acting in a way that would get her a good reference letter for future jobs. All of this hurts her more than it hurts her employer, who would probably be able to get someone else to work those shifts.

A Caveat about Being Effective

Be sure to emphasize to clients that, although the focus of being effective is doing what it takes to reach their goals, this doesn't give them permission to do so at the expense of others. Being effective means acting from their wise self, which includes acting in alignment with their morals and values. If they act in ways that go against their principles, they'll lose respect for themselves, and this obviously isn't in their best interests in the long run.

INCREASING POSITIVE EXPERIENCES

When clients' lives are chaotic, their relationships are in constant turmoil, and feelings of anger, sadness, and anxiety are constantly overwhelming them, it's understandable that they wouldn't think about doing fun things. It's also understandable that when you suggest they do more fun things, they'll think you're nuts! You have to get them to see that positive emotions aren't going to miraculously appear out of thin air, especially if they are regularly in a lot of emotional pain. Explain that it's up to them to work on generating good feelings. Hansen and Mendius (2009) point out that the remedy for painful experiences is to accept them rather than try to suppress them, and then to work on fostering positive experiences, taking them in so they become a part of who you are.

Increase Pleasurable Activities

For clients who are regularly experiencing emotional pain, increasing pleasurable activities can be extremely difficult, but it's also really important (Linehan, 1993b). If they don't work on increasing the pleasurable activities, the emotional pain they're currently experiencing is unlikely to dissipate.

Help clients think about what they can do that might bring more positive emotions into their lives. This is especially difficult for clients who are depressed because, in that state, it seems like nothing will bring them pleasure or change the way they feel. If this kind of thinking feels like too big a task for a depressed client, start by helping her try to think of things that may calm or soothe her or that might bring her some peace or contentment. Explain that the idea isn't that these activities will necessarily make her emotional pain disappear; rather, they are a way of taking small steps to feel just a bit better for even just a short period of time. This skill isn't necessarily about feeling good, but about feeling any kind of positive emotion, even to a small degree.

A good starting point is to ask clients to think of things they've done in the past that have helped improve their mood. If they draw a blank, try to offer some suggestions based on your knowledge of them. For example, if you know that a client likes animals but can't have a pet in her apartment building, suggest she go to the pet store to play with the kittens for a while or even sign up to do some volunteer work at a local animal shelter. Or if you know that she likes spending time with children, suggest that she ask her brother if she can take his children to the park or a movie. Whatever you suggest, make sure to choose things that she can do immediately, in the short term (Linehan, 1993b). Once you get the ball rolling, help clients create a list of enjoyable activities, and then have them pick one to start with for homework.

Addressing Motivation

People often say they don't have the motivation, just don't feel like it, or don't have the energy to do things. For clients whose emotions are out of control, this is likely to be true. The problem is, their mood isn't going to improve until they start to engage in some of enjoyable activities. Until then, they are essentially stuck in a vicious cycle.

Many people seem to believe that they should feel a drive or desire to do something—that if they don't feel like doing it, then they can't. With clients who express this belief, remind them of all the things they do on a regular basis that they probably don't really feel like doing: housework, helping their children with homework, or even just getting up in the morning. It's likely that most clients make themselves do many things they don't enjoy or feel like doing.

Explain that they can't wait for feelings of motivation or enthusiasm to arise, because that might not happen, especially if their mood is low or they have problems regulating their emotions and life is chaotic as a result. They'll probably find that they usually don't feel like doing an activity until after they've started doing it. Try to get them to think of times this has happened in the past: when they felt unmotivated or as though they didn't have the energy to do something, but once they started the activity it wasn't so bad, and maybe they even enjoyed it. Remind them that doing enjoyable activities—even if they have to push themselves to get started—will help reduce their painful emotions by increasing their activity level and positive experiences.

Goal Setting

Doing pleasant activities in the present is obviously going to help improve clients' mood and reduce their level of emotional pain, but it's just as important for them to make changes in their lifestyle so that pleasurable events occur regularly (Linehan, 1993b). One way of promoting this is to help clients examine their goals. Hopefully you've already discussed their short-term goals for therapy, but it's also important to encourage them to think about what positive changes they might like to make in the long run. They might be able to identify some fairly major changes they'd like to make, like ending an unhealthy relationship, getting a job, or finishing school. However, smaller goals can be just as effective and rewarding; what's important is that they have goals.

You might find that the idea of long-term goals is foreign to some clients. They may have been so focused on trying to cope with their emotions and just survive on a daily basis that thoughts about the future haven't been a priority. If they haven't considered this before, they may have no idea what their goals are. In this case, help them develop some goals. I often start the process by asking clients to brainstorm: if they could do absolutely anything they wanted, what would it be? I've provided a Goal Setting Worksheet, which you can use to help clients identify long-term goals.

GOAL SETTING WORKSHEET

- I. Start by brainstorming: List any interests you've ever had, even activities you've never actually engaged in. Don't limit yourself. If it pops into your head and seems like it might be a fun, enjoyable, calming, peaceful, or positive experience in some way, write it down. You can use another sheet of paper if you run out of room.

2. Choose one of the above activities that most appeals to you, and then do some research on the topic. Is this an activity you can just do? If there are costs involved, can you afford it? Do you have transportation, if needed? If it's not so straightforward, see if you can make it more realistic for yourself. Perhaps, as is often the case, money is a limiting factor. Even if, for example, you can't quit your job to go back to school, maybe you can take night classes, correspondence classes, or online courses, or perhaps you can go to school part-time while you work. Jot down some ideas here:

3. Now that you have a goal and some ideas about how to reach that goal, what are some first steps you can take toward accomplishing it? For example, maybe you would research the program you'd like to enroll in and see where it's available, find out if there are prerequisites you need for the program, and look into what financial assistance might be available to you.

4. Now identify the first step you'll take toward your goal:

Once you've taken this first step, you'll know more about what you need to do to move closer to your goal. Take it step by step. Make sure the goals you set are small enough that they are realistic and achievable. For example, if you can't afford to return to school full-time, don't set a goal to be finished in two years; if you do, you'll be disappointed when you don't achieve this, making it less likely that you'll continue to work hard to reach your goal. In other words, don't set yourself up for failure!

Building Mastery

Making sure we have positive events and activities in life on a regular basis in the short term and thinking about what our long-term goals are so we can work toward them are both important aspects of increasing positive emotions. But it's also important to have activities that we do, not necessarily because they're fun, but because they give us a sense of accomplishment and pride. They make us feel fulfilled and give our lives purpose. This is the DBT skill known as *building mastery* (Linehan, 1993b).

Emphasize to clients that building mastery isn't about the activities they do, but about the feeling those activities create. It's about challenging themselves and feeling good about themselves for doing so, regardless of the outcome. When building mastery, they'll feel proud of themselves for what they've accomplished and for being productive, and they'll feel a sense of fulfillment, regardless of how big or small the accomplishment might seem.

The activities that build a sense of mastery vary from person to person, so, again, personalize this skill for each client. Most people already have some things they do fairly regularly that build mastery. This is the place to start, but it may take some digging to help clients identify these pre-existing activities. Ask what they already do that gives them a sense of pride, fulfillment, or accomplishment. If they can't think of anything, you may know them well enough to make some suggestions. Perhaps a client makes her son's lunch every morning and walks him to school. Maybe she works out regularly, does volunteer work, or takes pride in her job. Just remember: this is a very individual skill, so don't make assumptions—use your knowledge of the client to offer suggestions.

Once you've identified some of the things a client already does that build mastery, explain the importance of doing these kinds of activities at least once a day to generate positive emotions. To make this seem less overwhelming, give the client some relatively simple examples of how she might build mastery daily; for example, getting out of bed or showering in the morning even though she feels awful, taking a five-minute walk, or going outside to get the mail.

WILLINGNESS: ADOPTING AN ATTITUDE OF OPENNESS

Sometimes clients seem to understand how skills will be helpful and that, if they are to make any kind of change they need to practice these skills, but they still find themselves unable to make a commitment to do so. When this is the case, it can be helpful to introduce the ideas of willfulness and willingness.

In this context, *willfulness* is removing oneself from the fundamental essence of life, refusing to do what's effective, and shutting oneself off from the abundance of possibilities that always exist (May, 1987). Willfulness is throwing up one's hands and saying, "I don't care." It's giving up, refusing to try or to even consider what may be possible. In a slightly different way of looking at this,

willfulness is trying to impose one's will on reality—trying to "fix" everything, rather than doing what is needed.

Often, the harder something is, the more likely people are to be willful about it. It's easier to throw up their hands and say it doesn't matter anymore. But, obviously, that isn't effective. Help clients think of times when they've been willful so they'll be familiar with the feeling. See if they can identify how willfulness feels for them and what behaviors they engage in when they're feeling willful: Do they turn to any of their problem behaviors when willfulness arises? Do they throw a temper tantrum? Do they just withdraw?

The antidote is *willingness*, which is the opposite of willfulness. Willingness is about acceptance and taking an attitude of openness toward life or choosing to enter into life fully (May, 1987), regardless of the challenges this entails. Willingness is doing one's best to access the wise self and be effective. It's trying to solve problems even when they seem unsolvable. It means using skills even when a situation is acutely painful and it seems like acting effectively is impossible in that moment. Willingness is trying to be more flexible (Hayes, 2005), taking an attitude of openness, and allowing oneself to see possibilities.

Moving from Willfulness to Willingness

After helping clients identify what they do when they feel willful, encourage them to see these behaviors as signals of willfulness and to accept that they're feeling willful. It is what it is, and judging it will only increase their emotions, making it more difficult for them to manage their emotions and access their wise self.

Next, ask them to think of willingness as opening themselves to their experience, to learning, and to possibilities. Thinking about this openness can help them change their attitude, and expressing this attitude physically can help them move from willfulness to willingness. Ask clients to express openness with their body language, turning an unwilling posture into a willing one. I recommend doing this with them to help them feel more comfortable and increase the likelihood that they do it. Uncross your arms and unclench your fists. Open your hands, palms facing upward. Smooth out your facial expression and relax your jaw.

Using the language of willingness can also help clients move from willfulness to willingness. Given that willfulness is about nonacceptance, refusal, and denial—about saying no to the universe—encourage clients to act opposite to this urge, saying yes to the universe instead. This can help them move toward willingness (Linehan, 2003c). Have clients close their eyes, take some deep breaths, and talk to themselves in a way that expresses willingness; for example, *I can do this, I'm all right, or I'm going to try*.

The Half Smile

There is a wise saying that goes "Sometimes your joy is the source of your smile, but sometimes your smile can be the source of your joy." In fact, researchers have found that making the facial expression of an emotion actually increases the intensity of that emotion (Niedenthal, 2007). The DBT skill of *putting on a half smile* (Linehan, 1993b) is simply slightly turning up the corners of your mouth so you're smiling just a bit. I like to have clients practice this skill with me, although it's generally best not to look directly at each other while practicing the half smile, as this usually results in laughter and a full smile (which is actually good evidence for the value of this skill!).

Be sure to point out to clients that the half smile isn't about grinning to cover up painful emotions; rather, it's about using their facial muscles to send messages to the brain that will increase their feelings of well-being. The half smile can help increase positive emotions and also help people move toward willingness.

WRAPPING UP

In this chapter, we looked at skills that help clients regulate their emotions more effectively by increasing their positive feelings: being effective, increasing enjoyable activities, setting goals, building self-respect and self-esteem through activities that provide a sense of mastery, and learning how to move from willfulness toward willingness and the sense of openness it brings. As clients practice these skills, they will enjoy more positive experiences, which will increase their positive emotions. And when they have more positives in their lives, their pain will be a little easier to deal with.

The next chapter will look at how clients' relationships can contribute to their emotional pain and how communication skills can help them improve their relationships. The chaos that can be caused by relationships adds to people's difficulties with emotion regulation, so these skills are crucial.

CHAPTER 12

Helping Clients Become More Effective in Relationships

Relationships can have a huge impact on mood, especially for those who have difficulties regulating their emotions. People with BPD typically experience more emotional stability when they have secure, loving relationships. Conversely, when a relationship isn't stable, this can create more turmoil in their lives, and this turbulence often leads to self-destructive behaviors that can cause further problems in relationships. Lack of relationships can also be an issue for these clients. If they don't have enough relationships, they may feel lonely and depressed.

This chapter looks at how you can help clients improve their relationships and initiate new ones through assertiveness skills. I'll also discuss DBT skills to help clients develop and maintain more of a balance in life—balancing the things that they want to do or that are enjoyable with their responsibilities, and also balancing the inherent give-and-take in relationships.

ASSESSING SOCIAL SUPPORTS

As social beings, we humans need other people in our lives in order to be happy. So it's important to look at social support with clients early on in therapy: Do they have friends and acquaintances? Are they close to any family members? Do they belong to a church, where they might have relationships with other parishioners or obtain support from a minister? Sometimes people report that they have close, supportive online friends whom they've never actually met. Also help clients examine the quality of these relationships and how satisfied they are with them: Are these relationships healthy? Do they lead to feelings of satisfaction and enjoyment, or do they cause a lot of pain, anger, and resentment?

As with many of the other decisions clients make, you might disagree with them about their assessments. You may believe a client needs more relationships in her life or think some of her current relationships aren't healthy. Keep in mind that we all have different needs when it comes to relationships. Some people describe themselves as loners, not needing many people in their lives, whereas others are social butterflies and need more relationships to feel fulfilled. So the issue isn't so much number of relationships as how satisfied or fulfilled a client is by whatever relationships she has. In other words, once you and a client have done this assessment, it's important to ask, "Are you happy with your social life, or do you feel something is lacking there?" As you consider her answer, keep in mind any challenges that might interfere with her ability to assess this accurately, such as social anxiety.

If your opinion does differ from a client's, remember that getting stuck in a power struggle over this issue won't be helpful. It's completely okay, and even important, to express your opinion to her, but if she disagrees, don't try to force it. Over time, as your therapeutic relationship develops and you gain her trust, you can work toward helping her see things from a different perspective, and hopefully at some point improving her social support will become a goal.

Once clients acknowledge that their relationships aren't satisfying or that they don't have many (or any) people to turn for support and say they'd like to work on this as a goal, help them sort out their options. First, help them consider what they can do to improve their relationships. Do they need to work on improving any current relationships that aren't healthy? Could they develop deeper relationships with people they already know? Do they need to work on developing new relationships altogether?

IMPROVING CURRENT RELATIONSHIPS

It's usually easiest to start with existing relationships. If clients aren't satisfied with their current relationships, they'll need to work on improving them, but they may struggle to identify what the problems are. To this end, it's useful to help them understand their communication style. I've provided a Communication Styles Quiz, and I recommend having clients complete it to help them see what style they use most often and possibly identify the communication styles others tend to use.

COMMUNICATION STYLES QUIZ

The following questions will help you get an idea of what your communication style is. Check off any for which your answer is yes. However, you'll probably be able to see that you do many of these things sometimes, so only check off those that seem to describe you best. The style for which you have the most checks is your dominant communication style.

I. PASSIVE

- Do you try to push your feelings away rather than express them to others?
- Do you fear that expressing yourself will cause others to be angry with you or not like you?
- Do you often say things like "I don't care" or "It doesn't matter to me" when you do care or it actually does matter?
- Do you keep quiet or try not to rock the boat because you don't want to upset others?
- Do you often go along with others' opinions because you don't want to be different?

Total: _____

2. AGGRESSIVE

- Are you most concerned with getting your own way, regardless of how it impacts others?
- Do you yell, swear, or use other aggressive means of communicating regularly?
- Do your friends fear you?
- Are you disrespectful toward others when communicating with them, not really caring if they get what they need as long as your needs are met?
- Do you have an attitude of "my way or the highway"? Have you ever heard anyone describe you this way?

Total: _____

3. PASSIVE-AGGRESSIVE

- Do you have a tendency to be sarcastic when you feel angry?
- Do you tend to give people the silent treatment when you're angry with them?
- Do you often find yourself saying one thing but thinking another, such as going along with another person's wishes even though you want to do something else?
- Are you generally reluctant to express your emotions but find that how you feel gets expressed in other ways, like slamming doors or other aggressive behaviors?
- Do you fear that expressing yourself will cause others to be angry with you or stop liking you, so you try to get your message across in more subtle ways?

Total: _____

4. ASSERTIVE

- Do you believe that you have a right to express your opinions and emotions?
- When you're having a disagreement with someone, are you able to express your opinions and emotions clearly and honestly?
- When communicating with others, do you treat them with respect while also respecting yourself?
- Do you listen closely to what others are saying, sending them the message that you're trying to understand their perspective?
- Do you try to negotiate with others if you have different goals, rather than being focused on getting your own needs met?

Total: _____

When a client has completed the quiz, explain the four different communication styles. (I've outlined them below, in case you need any pointers on how to describe them to clients.) Then discuss how her communication style may be having a negative effect on her relationships. Be sure to point out that it's not uncommon for people to use different styles depending on the situation and the person they're communicating with. Also emphasize that the point isn't to diagnose how she communicates, but to increase her awareness of her patterns of communicating so she can choose to communicate in a different way if she wishes. Since so many people have a hard time communicating their wishes, thoughts, and feelings, especially with the people they care about most, it's often worthwhile for clients to develop more assertiveness. Validation will come in handy here, as most people find it difficult to be assertive, especially in certain situations and with certain people.

COMMUNICATION STYLES

Describe each of the four communication styles to clients to help them understand how communication styles—their own or others'—might be causing problems in their relationships. As you discuss this, ask clients for examples of times when they've used each communication style, who they tend to use it with, and whether they think it's effective.

Passive Communication

Passive people often don't communicate verbally. They tend to bottle up their emotions instead of expressing them, perhaps out of fear of hurting others or making them uncomfortable, or maybe because they don't believe their feelings or opinions matter as much as those of others. People with a passive communication style usually fear confrontation and believe that voicing their opinions, beliefs, or emotions will cause conflict. Their goal is usually to keep the peace and not rock the boat, so they sit back and say little.

The passive client often allows others to violate her rights and shows a lack of respect for her own needs. Her passivity communicates a message of inadequacy or inferiority. This style of communication may not negatively impact the other person in a relationship, or others may become uncomfortable with her difficulties in speaking up and lack of respect for herself. Regardless of the impact on others, this form of communicating definitely has a negative impact on the client over time, as she resents not having her needs met.

Aggressive Communication

Aggressive communicators attempt to control others. They're concerned with getting their own way, regardless of the cost to others. Aggressive people are direct, but in a forceful, demanding, and perhaps even vicious way. They tend to leave others feeling resentful, hurt, and afraid. They might get what they want, but it's usually at the expense of others, and sometimes at their own expense, as they may later feel guilty, regretful, or ashamed because of how they behaved.

An aggressive client doesn't care how she gets her needs met, even if it means disrespecting and violating the rights of others. This communication style obviously has negative impacts on relationships, as people usually won't tolerate being abused and disrespected for very long.

Passive-Aggressive Communication

Like passive communicators, those who have a passive-aggressive style fear confrontation and don't express themselves directly. However, because of their aggressive tendencies, their goal is to get their way, but they tend to use indirect techniques that more subtly express their emotions, such as sarcasm, the silent treatment, or saying they'll do something for others but then "forgetting."

A passive-aggressive client gets her message across without actually saying the words. This can be very confusing to others, as she says one thing but then sends a contradictory message. Many passive-aggressive techniques are characterized as manipulative; they are usually unhealthy ways of trying to get one's needs met, and they often have negative consequences.

Assertive Communication

Assertive people express their wishes, thoughts, feelings, and beliefs in a direct and honest way that's respectful both of themselves and of others. They attempt to get their own needs met but also try to meet the needs of others as much as possible. They listen and negotiate, so others often choose to cooperate with them because they're also getting something out of the interaction. Others tend to respect and value assertive communicators because this communication style makes them feel respected and valued.

Assertive communication is the way people with good self-esteem tend to express themselves. They feel good about themselves, and they recognize that they have a right to express their opinions and feelings. However, do point out to clients that this doesn't mean those with low self-esteem can't be assertive, and that being more assertive in their communication will actually improve how they feel about themselves. It will also improve their relationships and interactions with others, and this too will also increase their self-esteem.

THE SKILL OF ASSERTIVENESS

Since so many of us have a hard time communicating—especially with the people we care about the most—most clients can benefit from developing assertiveness skills. Explain that, as with any new behavior, becoming more assertive will take time and effort. Like any skill, it takes practice. Some people, especially those who have been more passive, find that communicating and acting assertively feels like acting aggressively, simply because they're not used to asking for what they want. For many clients, learning to be assertive will be uncomfortable and possibly even scary at times, but gradually they'll learn that this is the healthiest way of communicating and begin to see positive changes in their relationships.

As discussed in chapter 10, the messages we received about emotions as we were growing up shaped our thoughts and feelings about them. The same thing happens with communication: we learn how to communicate by observing how others around us communicate. It can be challenging to be assertive if you grew up surrounded by people who communicated in passive, aggressive, or passive-aggressive ways.

Explain this to clients and help them see where some of their communication patterns came from. Remind them that this isn't about placing blame, but about helping them understand the reasons for their current difficulties. This often makes it easier to change. Once clients have a good understanding of the four basic communication styles and the role their communication style plays in their relationships, you can work with them on developing assertiveness using the following skills (Linehan, 1993b):

- Deciding on priorities, such as reaching a goal, improving a relationship, or feeling good about one's choices
- Making requests in a way that doesn't damage relationships, by describing the situation and related thoughts and feelings
- Negotiating
- Obtaining information
- Saying no in a way that doesn't damage relationships
- Acting in accordance with personal values and morals

I've provided some guidelines that may be helpful in explaining these skills to clients. Feel free to photocopy them and give them to clients as a handout.

GUIDELINES FOR ASSERTIVE COMMUNICATION

The following interpersonal skills can help you become more assertive in relationships.

I. DECIDE ON YOUR PRIORITIES.

First you need to decide what your priority is in the current situation: Do you have a goal that the other person could help you with, or that the person might prevent you from reaching? Do you want to improve the relationship? Do you want to feel good about how you handle yourself in the interaction, regardless of the other outcomes? Do you want to be able to say no to a request that has been made of you?

This can be a difficult decision if you have priorities in more than one of these areas. It's possible that you might be able to reach multiple goals, but sometimes you'll have to choose which is the most important. Whatever your decision, it's important to be very clear about what your top priority is so that you can clearly communicate it. It's hard to get what you want if you're not sure what that is! Once you've decided on your priority, you can choose which skills will be most helpful in reaching that goal.

2. ASK FOR WHAT YOU WANT IN A WAY THAT DOESN'T DAMAGE THE RELATIONSHIP.

Here are the steps for making an assertive request:

- a. **Nonjudgmentally describe the situation.** Once you've decided what your priority is, start by clearly and factually describing the situation to the other person. Judgments and blaming will reduce the likelihood that you'll achieve your goals, so be sure to stick to the facts. Also remember that, at this point, the problem you're addressing is neither a conflict nor a confrontation; it's simply a problem that needs solving.
- b. **Describe what you think and feel about the situation.** The second step in asserting yourself is telling the other person what you think and feel about the situation.
- c. **Assert yourself.** The final step is to assert yourself by clearly asking for what you want.

3. NEGOTIATE.

An inherent part of assertiveness is showing respect for the other person and demonstrating a desire that everyone get something out of the interaction if at all possible. Negotiating—being willing to give something in order to get something—usually goes a long way in encouraging others to help you reach

your goal. Rather than focusing on how to get your needs met, work on reaching a mutually agreeable solution where both you and the other person get some needs met.

4. OBTAIN INFORMATION.

Understanding what the other person wants, thinks, and feels will help you to communicate assertively. Being assertive means being just as concerned about the other person as you are about yourself. Obtaining information that increases your understanding of others will help you treat them fairly and respectfully and assist them in meeting their needs.

People tend to make assumptions about others rather than asking them about their goals, thoughts, and feelings. These assumptions can damage relationships and stand in the way of successful interactions. Having accurate information will help you to be more successful in communicating with others and reaching your goals.

5. SAY NO IN A WAY THAT DOESN'T DAMAGE THE RELATIONSHIP.

Many people have a hard time saying no to others' requests. They may feel guilty for saying no or they may judge themselves in some way, such as thinking, *I'm a bad friend if I say no.* Sometimes people worry that others will be angry if they say no. But setting limits for yourself and sticking to them—even if it means denying others' requests at times—simply shows that you respect and value yourself. Assertively saying no rather than giving in and doing something you don't want to do also protects relationships from the resentment that tends to build up over time if you regularly say yes when you really don't want to.

6. ACT ACCORDING TO YOUR VALUES AND MORALS.

Be clear about what your values and morals are and stick to them. You won't feel good about yourself if you agree to do things that go against your principles. So be truthful with yourself and others rather than making excuses when you don't want to do something. It's perfectly okay to say no and to be honest about the reason—even if it's just because you don't want to do something. If you can be truthful and assertively tell others you don't want to do what they're asking of you, your self-respect will increase.

Of course, sometimes a little white lie is appropriate. For example, if you don't want to have dinner at a friend's house because you don't like her cooking, you don't necessarily have to come out and tell her that; in fact, you'll probably feel worse about yourself for hurting her feelings if you do. So use your discretion, but make sure you don't resort to little white lies too frequently, as this can also reduce your self-respect.

Additional Techniques for Assertiveness

Depending on a client's goal in a situation, other assertiveness techniques may come in handy. Here are some additional tips you can share with clients to make it more likely that they'll reach their goals without damaging relationships. Indeed, these techniques might even help improve relationships, and that will probably help increase clients' self-respect:

- **Listen mindfully.** Listening mindfully will help the client gain a better understanding of what others are saying. Plus, others often notice and appreciate that she's really paying attention. They feel as though she's truly listening and interested in what they have to say.
- **Validate.** Validating others is a great way for the client to let them know she cares, and is listening and trying to understand. If she resists the idea of validating others, remind her that, just as with validating her emotions, it doesn't mean she likes what's happening; it simply means that she acknowledges or understands it. This is an especially helpful skill for the client to use when someone is angry with her, as it's hard to stay angry with someone when she's telling you she understands why you're angry. De-escalating anger in this way can lead to a productive discussion of the problem, which can improve the relationship.
- **Think dialectically about the situation.** Remind the client that the idea of dialectical thinking means trying to see the bigger picture. In an interpersonal situation, thinking dialectically would mean trying to see something from the other person's perspective. Thinking about interactions this way will help the client validate others, as she'll have a better understanding of why they think or feel the way they do. Thinking dialectically can also help her get unstuck from power struggles, allowing her to feel better about herself after the interaction.
- **Adopt an attitude of openness.** Being willing in interpersonal situations makes it easier to be more open-minded, to hear the other person's perspective, and to work together. Taking an open attitude also makes it easier to be lighthearted. If the client's goal is to improve a relationship, she should be gentle and try to make the other person feel more comfortable, perhaps by smiling or using humor.
- **Only apologize when an apology is genuinely called for.** Some people have an inexplicable need to apologize for things they aren't responsible for. If an apology is truly warranted, the client should take responsibility and apologize. But apologizing excessively will reduce her self-respect and can be a sign that her self-esteem is suffering.

How Assertiveness Is Like Getting the Oil Changed

People often have difficulties asserting themselves with those they really care about, possibly because they fear they might damage the relationship by expressing their true needs and emotions. But relationships usually suffer because of a *lack* of assertiveness by one or both of the people in the relationship. Ask the client to think of a time when assertiveness helped her resolve a problem, could have helped her be more effective, or might have salvaged a relationship that ended prematurely. Did she have a relationship in which she let the problems pile up, not speaking to the other person about the issues until she finally got to the point where she'd had enough and just ended the relationship? Or did she perhaps talk to a friend or partner about how she was feeling so they could try to work it out before it got to that point? Of course, the latter approach is preferable: addressing problems as they arise in a relationship rather than letting them pile up until they become unmanageable. However, one of the most common reasons why people lose relationships is because they take their relationships for granted and don't work to keep them healthy (Linehan, 1993b).

When I'm teaching clients assertiveness skills, I like to use the metaphor of maintenance on a car: When you own a car, you want to take good care of it. When something starts to rattle under the hood or the car just doesn't feel like it's driving right, you take it in to get it checked out, but you also regularly take it in for a tune-up, an oil change, to have the tires rotated, and so on. In other words, you take good care of your car because you know that if you don't, it could develop more problems, maybe even unmanageable problems.

Explain to clients that a relationship needs to be treated the same way. It needs to be taken care of on a regular basis, not just when the squeaks and rattles become noticeable. So what would regular relationship maintenance look like? Calling a friend on a regular basis, asking about her day or a recent trip, taking her out for her birthday, supporting her when her grandmother is dying, and so on. To take care of relationships and prevent them from deteriorating, we show others that they're important to us. Of course, we also have to take care of major problems as they arise. For example, I often hear the complaint, "I'm the one who always has to call." If clients feel they're putting more energy into a relationship than the other person is, this is a squeak that needs to be discussed. If they need something from a friend that she currently isn't giving, they need to ask for it. They shouldn't assume others are mind readers or automatically know what their needs are.

Of course, being assertive and asking for what we want or talking about problems when they arise in a relationship is often easier said than done. Many people avoid speaking up when they're unhappy in a relationship because they're afraid of the consequences; for example, the other person might get angry or end the relationship altogether. Remind clients that the worst thing that might happen is that the relationship ends, and that if they don't discuss the problems and their feelings, chances are the relationship will end anyway as resentment builds. However, the more likely outcome is that discussing the problem using assertiveness skills will allow them to work cooperatively with others to make their relationships healthier.

THE ROLE OF ASSERTIVENESS IN BALANCING ENJOYABLE ACTIVITIES AND RESPONSIBILITIES

Another important part of taking care of relationships is developing more balance. In chapter 11, I discussed the importance of helping clients make sure they regularly experience events that generate positive emotions: events that are fun, interesting, fulfilling, relaxing, peaceful, calming, and so on. It's important that clients continue to do these activities in spite of the demands that others will inevitably place on them. Therefore, you need to teach clients to work on balancing the activities they do for themselves with their responsibilities (Linehan, 1993b).

Everyone has responsibilities—going to work, paying the bills, taking care of children, pets, or parents—and these are just as important as activities that generate positive feelings. But when enjoyable activities conflict with the demands of others, assertiveness skills will be necessary to resolve the discord that can result.

Ask clients to consider a time when this happened to them: Perhaps someone pressured them to do something they didn't want to do, maybe when they already had plans to do something else. For example, maybe a client's friend asked her to help him move, but she already had plans to go away for the weekend. What did the client do in this situation? What was the outcome?

It's important to help clients think about what their patterns are: Do they have a tendency to always give in and do what their partner, friends, or family members want them to do? Do they usually disregard others' wishes and pursue their own interests? Or are they able to find more of a balance, sometimes putting their own needs first and other times putting the needs of others first? To live balanced lives, we all need to give, share, and sometimes make sacrifices in relationships, but we must also sometimes put our own needs first or even ask others to make sacrifices for us. Always giving in to another person's wishes won't be healthy for the relationship. If a client does this, in the long run she'll feel resentful because her needs aren't being met and because the other person is always getting his way—even though the client is allowing this to happen.

If clients feel guilty about putting their own needs first at times, review the skill of acting opposite to urges with them. Putting their needs first isn't contrary to their morals and values as long as they aren't doing this consistently or at the expense of others. Rather, putting their own needs first is actually good self-care and will benefit their relationships as their needs are met. Encourage them to persist, and assure them that the guilt will gradually dissipate.

Encourage clients to practice assertiveness often. Do role-plays in session with them, and encourage them to find opportunities to practice in day-to-day life. For some clients, these opportunities don't present themselves naturally. When this is the case, encourage them to create opportunities to practice (Linehan, 1993b). Brainstorm about situations they can put themselves in where they are forcing themselves to be assertive, such as calling a customer service line and asking for assistance, or ordering something at a restaurant that's different from what's on the menu. Think of assertiveness as a new language for clients: unless they have opportunities to speak this new language, they're going to lose it fast.

DEEPENING CURRENT RELATIONSHIPS AND DEVELOPING NEW ONES

Up to this point in the chapter, I've focused on how clients can improve their existing relationships, primarily through assertiveness. But for those who simply don't have many meaningful relationships, it will be important to help them find ways to change this situation.

With these clients, the first thing I do is look at how their life is currently structured and how they spend their time: Do they work? Do they engage in activities or hobbies that might be conducive to developing new relationships? Meeting new people can be quite stressful, so it will be easier for clients to forge deeper relationships with people they already know.

I've recently been working with a client named Mathew on trying to increase his social network. Unfortunately, he has the additional challenge of social anxiety. He's been attending a series of writing classes to help him develop his talent for creative writing, and in these classes he's met a couple of people he feels more comfortable talking with. Mathew was able to set a goal for himself of working toward deepening these two relationships by making an effort to talk to them and perhaps at some point asking them to go out for coffee or another minor social activity. For clients with social anxiety, it's especially important to help them find ways of deepening relationships that will make this goal more achievable, and that often means taking small steps.

Sometimes, however, deepening existing relationships isn't possible. Clients either don't know anyone they'd be interested in having more of a relationship with or are so isolated that they seldom have opportunities to meet people they might want to develop relationships with. Helping such clients meet new people who might become friends can be a challenge. It often means trying new things, so help these clients consider what their interests are and encourage them to look into joining a club or group devoted to that interest, like Mathew's creative writing class. Have them do research on courses or workshops they might attend, sports they might start playing, volunteer activities, or any other situations where they might meet new people. Another option is websites dedicated to social networking that facilitate people in getting together to share a specific activity. It's usually more comfortable for clients if they can find something they enjoy doing and then turn this into a social event. Encourage them to do something like join a knitting or crafts class or sign up for yoga and then do their best to be open to developing friendships during this activity.

That last point is important: emphasize to clients that they need to go into the situation with an open mind. You might ask them what they have to lose. After all, the worst-case scenario is probably just not enjoying the experience and therefore leaving early or not going back, whereas the best-case scenario is that they meet someone and develop a new relationship. We can never have too many people in our lives.

WRAPPING UP

This chapter tackled the issue of relationships: how clients can be more effective in them, how to make relationships healthier, and how to develop more relationships. Remember that this is a difficult realm for many people, particularly those with emotion dysregulation, sometimes because of past experiences, and sometimes because of what-ifs that trigger anxiety. Remember to validate clients' fears and encourage them to continue practicing the other skills they've learned to help increase their chances of being more effective in both current and new relationships.

Conclusion: Putting It All Together

Dialectical behavior therapy is a complex treatment, but it's effective for a wide variety of illnesses and a helpful tool in treating more challenging illnesses, such as BPD, that involve emotion dysregulation. In this book, you've learned a lot about how to use DBT with emotionally dysregulated clients. We've looked at the theoretical underpinnings of DBT; you've learned some of the basic concepts of behavior theory that are pertinent to putting DBT into practice; I've explained some of the techniques and strategies used in individual DBT sessions; and you've learned the DBT skills in each of the four modules: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. You've got a lot of information to absorb and put into practice, and the next steps you take to help you with this are up to you. However, I do have some suggestions.

START WITH THE SKILLS

When I began using DBT in my own practice, I found it helpful to begin by focusing on the skills. Start by practicing the DBT skills yourself and teaching them to clients. In the process, you'll develop a more thorough understanding of the skills and greater effectiveness in teaching them.

I've provided a DBT Skills Use Diary (see pages 179-181), which lists all of the DBT skills you've learned in this book. You can use the list as a cheat sheet for yourself, as it gives a brief description of each of the skills. I also recommend that you photocopy it and give it to clients so they can use it to remind themselves of the skills they've learned and keep track of how often they use them.

SAVE THE COMPLICATED STUFF FOR LATER

Save the more complicated stuff for later, once you're more comfortable with the basics. This probably means that, at first, it will be best to focus on using DBT to treat illnesses other than BPD, since it's such a complex illness and requires fluency with the treatment and a thorough understanding of the theories underlying the model. You will get there, but I suggest you proceed slowly, giving yourself time to get familiar and comfortable with the model.

Once you're more comfortable with the skills, you will, of course, want to focus more on the rest of the DBT model: incorporating aspects of behavior theory into your practice (for example, thinking about how to manage contingencies with clients); starting to use some of the dialectical strategies in sessions; incorporating the Behavior Tracking Sheet to structure sessions and the Behavior Analysis Form to learn more about clients' problem behaviors; and so on.

DEVELOP A TEAM

Remember that there is no DBT without the team. Ideally, you'd find an experienced DBT practitioner to help you learn. But whether or not this is possible, and whether or not you're utilizing the full DBT model, working as a team with a group of practitioners, even if they don't have much experience with DBT, will provide all team members with much-needed support. It also offers additional opportunities for learning, since you can bounce ideas off each other and help one another learn the skills and the model.

UTILIZE ADDITIONAL RESOURCES

To increase your comfort level in teaching these skills, you'll probably need to read this book more than once. Also make use of other resources that will help you learn the skills. My book *Calming the Emotional Storm* (2012), for example, is a good resource that will help enhance your understanding of the skills covered in this book. Marsha Linehan's website, behavioraltech.org, is also an excellent resource; there you'll find training videos and other valuable tools to help you learn about DBT.

REMAIN FLEXIBLE!

Wherever you decide to go from here, remember that DBT is flexible, and that some DBT is better than no DBT. If at times it seems too difficult and you feel like giving up, remember that this is how many of your clients probably feel on a daily basis. So do what you'd ask of them: Practice your DBT skills. Do some deep breathing, bring yourself back to the present moment, validate the difficulties you're having, and offer yourself encouragement. You can do it!

DBT SKILLS USE DIARY

Fill in a number for the degree to which you used each skill each day:

1. Realized afterward that I could have used the skill.
2. Thought about the skill but chose not to use it.
3. Realized afterward that I did use the skill, and that I did so effectively.
4. Mindfully tried to use the skill but it wasn't effective.
5. Mindfully used the skill and it was effective.

	Emotion Regulation			Distress Tolerance			Core Mindfulness		
	M	T	W	T	F	S	S		
Accepting reality: Reduce your emotional pain by accepting reality. It is what it is. (Then consider whether there's something you can do to change the situation.)									
Practicing self-validation: Be aware of the messages you received about emotions that shape the way you think and feel about them now. Don't judge your emotions; just accept them.									
Being mindful of emotions: Bring your awareness and acceptance to whatever emotions are present; don't try to fight painful emotions, and don't try to hang on to pleasant emotions. Remember that emotions are like waves, coming and going.									
Coping ahead: Plan and rehearse for difficult situations that are likely to arise. Imagine the outcome as you want it to be. Think positively.									
RESISTing urges: To help yourself not act on urges, reframe, engage in an activity, do something for someone else, generate intense sensations, shut it out, think neutral thoughts, or take a break.									
Doing a cost-benefit analysis: Consider the costs and benefits of problem behaviors.									
Finding balance: Reduce vulnerability to emotions by balancing sleep, treating physical illness, reducing substance use, eating properly, and exercising.									
Accessing wise self: Be centered and calm. Balance the emotional self and the reasoning self. Be mindful. To get to your wise self, mentally note emotions, improve self-talk, and focus on just this moment.									
Being nonjudgmental: Reduce your emotional pain by being nonjudgmental. Stick to the facts and your emotions rather than judgments.									
Practicing mental noting: Observe and describe whatever you experience without judgment. Simply experience what's happening.									
Practicing mindfulness: Do one thing at a time, in the present moment, with your full attention, and with acceptance.									

Interpersonal Effectiveness				Emotion Regulation			
Looking for new relationships: If you don't have enough healthy relationships in your life, make sure you look for and create opportunities to meet new people and develop new relationships.							
Balancing enjoyable activities and responsibilities: Make sure you do things for yourself because you enjoy them, as well as taking care of your responsibilities and the demands of others. Put your own needs first at times, and at other times make sacrifices for the people you care about.							
Communicating assertively: Notice the communication style you're using. Practice assertive communication. Don't let problems pile up in your relationships; address them as they occur.							
Maintaining relationships: Take care of your relationships. Reach out to the people you care about and show them that they're important to you.							
Practicing willingness: Open yourself up to possibilities. Do your best with what you've got, even if you don't like the cards you've been dealt in life.							
Building mastery: Increase feelings of fulfillment by doing things that make you feel productive, as though you've accomplished something. Build your self-respect and self-esteem.							
Increasing pleasurable activities: Engage in activities that are fun, enjoyable, calming, or peaceful for you. Set goals for yourself so you have things to look forward to in both the short term and the long term.							
Being effective: Don't cut off your nose to spite your face. Consider what your long-term goals are, then do what you need to do in order to meet your goal. Act from your wise self.							
Acting opposite to urges: Notice the emotion you're experiencing and the urge attached to it, then act opposite to the urge.							

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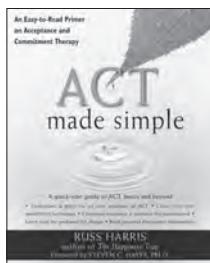
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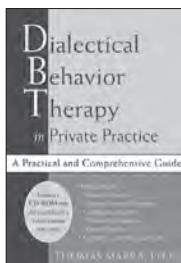


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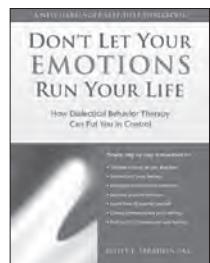


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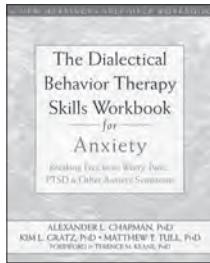


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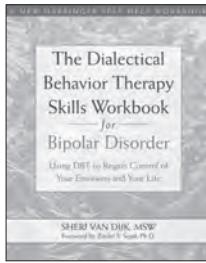


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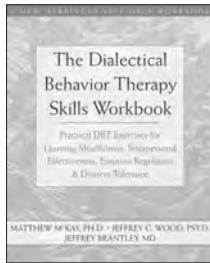


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The Borderline Personality Disorder Survival Guide

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