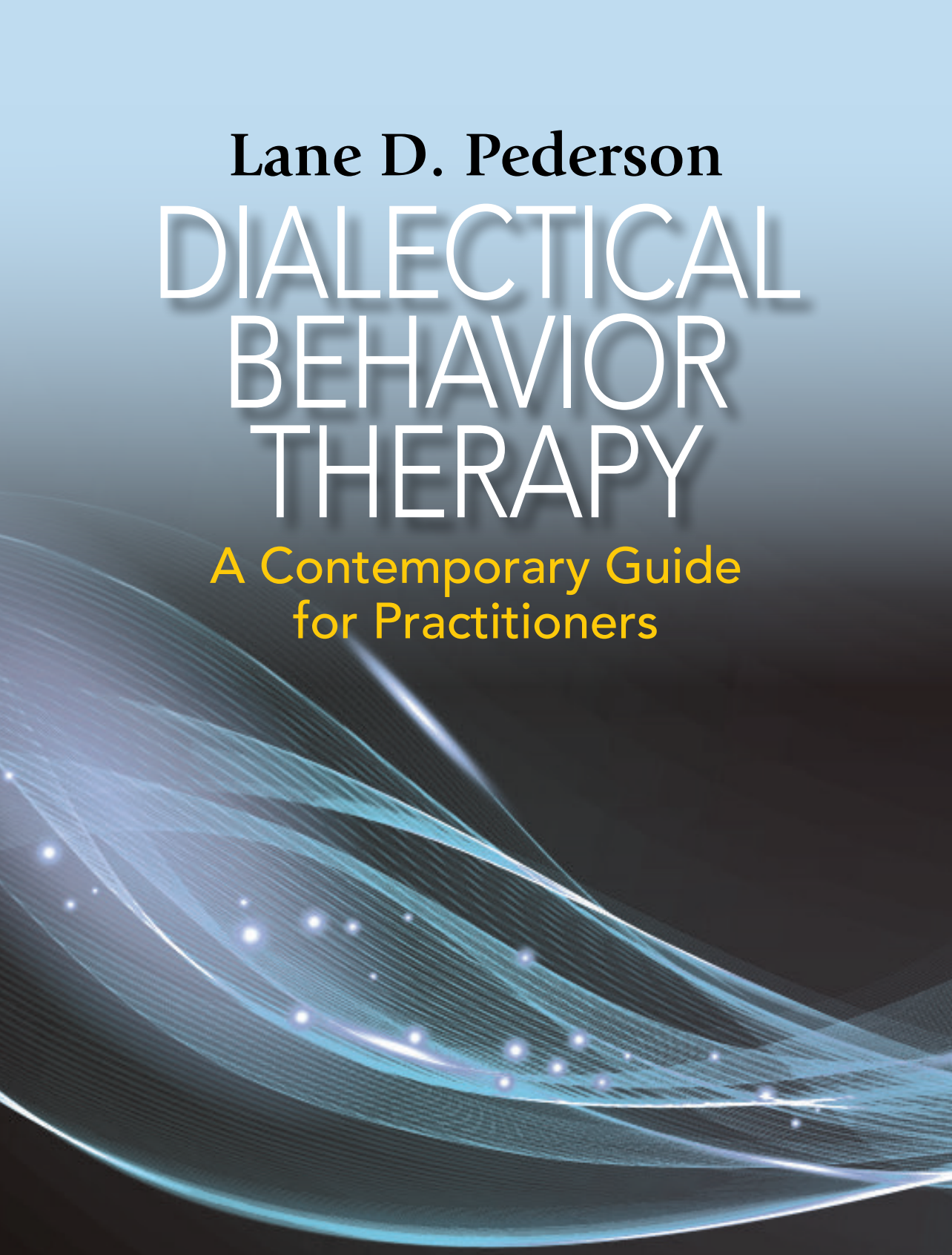
Lane D. Pederson

# DIALECTICAL BEHAVIOR THERAPY

## A Contemporary Guide for Practitioners



WILEY Blackwell

# Praise for *Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*

"Dr. Pederson's clinical expertise shines as he takes DBT out of the hands of researchers and translates it into a practical, flexible, and powerful approach to human problems. This is your all-in-one source for understanding and practicing DBT and, beyond that, for doing good clinical work in tough client situations."

**Barry L. Duncan, Psy.D., author of *On Becoming a Better Therapist: Evidence-Based Practice One Client at a Time***

"Bridging research and practice, with this straightforward, accessible guide, Pederson delivers on his promise to place DBT philosophies and techniques all-squarely into the hands of us *real-world clinicians* working with our *real-world clients* who so desperately need it!"

**Linda Curran, clinician, trainer, and author of *Trauma Competency: A Clinician's Guide* and *101 Trauma-Informed Interventions***

"*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners* is a valuable resource for all levels of clinicians. There are several highlighted evidence-based interventions throughout the chapters that are well crystallized and easy to apply and that Dr. Pederson supports with a wealth of research and relevant background information. New and experienced practitioners who include DBT interventions in their practice will find a treasure chest of skills and ideas. The vast array of psychoeducational strategies offers a great 'go to' resource and will quickly become a clinician's best friend!"

**Judith Belmont, MS, author of the *Tips and Tools For the Therapeutic Toolbox* series**

"Dr. Pederson's book is so timely. I am ever so grateful for a book that is practical in its tone and still grounded in the DBT worldview. It is so important to present DBT to our clients in such a way that they can internalize and generalize the skills and techniques. This book is honest in its appraisal and tone of how to adapt the DBT principles in the 'real world' with real clients. It gives a practitioner the confidence to teach and dialogue about dialectical dilemmas and the concepts of DBT that have previously felt vague while simultaneously pedantic in tone. Having implemented many of Dr. Pederson's approaches, I can verify that these techniques work to bring clients to a comprehensive understanding of how to live fully in a world that has judged them to be 'untreatable' and 'lost causes.' I recommend this book to any practitioner, be he or she a student or an extensively trained therapist tasked with working with individuals who suffer with a pervasive dysregulation of their emotions."

**Eboni Webb, Psy.D., HSP, owner, Kairos Mental Health Cooperative, LLC, and DBT trainer, PESI Mental Health**

"In *Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, Lane Pederson has written a very comprehensive, readable guide to DBT in which he is able to bring clarity and understanding to complex concepts. Following a cogent discussion about the dialectics inherent in the ongoing controversy of adherence to DBT versus adapting DBT, Dr. Pederson develops a synthesis by focusing on helping practitioners to provide DBT in a way that will be most effective for their clients. He clearly and succinctly presents very thorough practical guidance about providing DBT, with relevant and helpful examples of skills, treatment, client behaviors and dialogue with clients, while always focusing on the importance of the therapeutic relationship. For practitioners who have been using DBT in their practices for many years, this book provides new insights and ideas that will increase effectiveness. For new practitioners who want to understand more about how to use DBT with their clients, this book is a must read. For any practitioner, this is an incredibly useful book about a very effective form of treatment."

**Pat Harvey, LCSW-C, DBT coach, trainer, and consultant and coauthor of *Parenting a Child Who Has Intense Emotions* and *Dialectical Behavior Therapy for At-Risk Adolescents***

"This book promises to be the most influential DBT publication to date, not only in its superb description of the approach but also in the way it builds a bridge between research and practice with a focus on what is most effective for clients. The future of our field rests on outcome-based modifications and customizations to evidence-based treatments, and Dr. Pederson provides an in-depth analysis of research that empowers DBT therapists to embrace the future now. This is a must read for all DBT therapists."

**Dr. Mark Carlson, DBT trainer for PESI Healthcare and author of *CBT for Chronic Pain and Psychological Well-Being***

"In reading *Dialectical Behavior Therapy*, I am reminded of the story of Siddhartha Gatauma, a dutiful student of the contemporary spiritual masters, who searched for The Way but ultimately rejected the dogmatic teachings of his time and attained enlightenment by questioning 'truth' while sitting under a Bodhi tree. Dr. Marsha Linehan brought this same spirit of 'doing what works' to the field of psychotherapy with suicidal clients over 30 years ago. Like her, Dr. Pederson challenges the status quo, asks us to look again at the evidence, and reminds us to make sure we are asking the right questions."

**Dr. Stephanie Vaughn, national DBT consultant and trainer, and founder of Vanderbilt University's DBT Peer Consultation Team**

"*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners* is a clear, succinct, and readable guide for those who want to understand DBT. Dr. Pederson describes the components and techniques necessary to deliver the comprehensive treatment as well as some intriguing adaptations to standard DBT. Readers will find practical information that allows them to provide effective, evidence-based treatment with a sharp focus on the therapeutic relationship and, ultimately, outcomes. Anyone looking to improve his or her clinical skill and be a more effective clinician will find this book to be a useful resource."

**Britt H. Rathbone, co-author of *Dialectical Behavior Therapy for At-Risk Adolescents***

"New to DBT? Been using it for a while? Either way, this text will deepen your knowledge and strengthen your clinical skills. Dr. Pederson is an expert DBT clinician and trainer. He has created a comprehensive overview of DBT that has sufficient breadth and depth to empower readers to begin using DBT or improve their current practice. This text will be your go-to resource for all things DBT."

**Cathy Moonshine, author of *Acquiring Competency and Achieving Proficiency with Dialectical Behavior Therapy, Volumes I and II***

"In *Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, Lane Pederson takes DBT to the next level by demonstrating its efficacy with psychiatric illnesses other than borderline personality disorder (BPD), as well as the efficacy of adapted models versus the original model. In this book, Pederson helps clinicians learn how to provide the traditional DBT model for BPD as it was originally designed, while also encouraging us to take a more dialectical approach than has traditionally been taken with DBT: while it is innovative, it is also a therapy that derives many of its techniques from other tried and true therapies. In this respect, Pederson helps us continue to move in the direction of making DBT more accessible to therapists, and therefore also to individuals in need of a client-centered, nonjudgmental, skills-based model. This is a wonderful, thorough book that is a great introduction to DBT for newcomers and that will help seasoned therapists develop a more thorough understanding of the model and how to make it best suit their practice and, more importantly, their clients' needs!"

**Sheri Van Dijk, MSW, RSW, psychotherapist, international speaker, and author of *The Dialectical Behavior Therapy Skills Workbook for Bipolar Disorder*, *Calming the Emotional Storm*, and *DBT Made Simple***

# Dialectical Behavior Therapy

## *A Contemporary Guide for Practitioners*

Lane D. Pederson

WILEY Blackwell

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# Contents

# Acknowledgments

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I would like to thank Cathy Moonshine, an author and friend who is responsible for opening the door to my work as a speaker and trainer. Along with Thomas Marra, whom I also thank, she has contributed much to opening up the field of dialectical behavior therapy (DBT). Both Cathy and Tom have influenced my work with their innovations.

I acknowledge and I am grateful for the immense contributions of Marsha Linehan to the field of psychology. Her work is the genesis of mine, and my work is certainly a dialectical response to the rigidity promoted by some of her followers. Without them, I would only be me.

I owe debts of gratitude to my wife, Cortney, and my children, Sophie and Sawyer, who generously gave their support and tolerated my absences as I completed this book. I especially thank Cortney, who I am sure grew weary of hearing that "tomorrow I'm going to work on the book!"

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Last, my appreciation to Darren Reed and the team at Wiley Blackwell for giving me the opportunity to bring my DBT message to a larger audience, and special thanks to Hazel Harris for her excellent judgment, suggestions, and editing skill, which immeasurably improved this project.

# To the Reader

My background is that of a practitioner, consultant, speaker, and trainer, not a researcher. That said, my education was grounded in the local clinical scientist model, and as such I am trained to bridge research and practice.

This book, consistent with evidence-based practice, considers broad-based research that informs clinical practice. Contemporary therapies such as DBT should not be learned and practiced in a vacuum but should instead be conceptualized and applied within a larger understanding of what is effective beyond a research laboratory, with actual clients in real-world settings.

This book is for real-world providers. Having trained over 7,000 professionals at the time of writing, I can say with confidence that the vast majority of therapists want to learn approaches that work in a manner that allows them to adapt, customize, and integrate those approaches rather than simply following a manual. Thankfully, the science supports that preference. Nonetheless, the politics of adopting Marsha Linehan's original DBT model versus adapting it to clinical practice sometimes creates heated, and occasionally unprofessional, debate. This book outlines the research that supports thoughtful DBT adaptations in order to educate readers on adopting versus adapting issues and to ground DBT in evidence-based practice. At times, that means critiquing and criticizing Linehan's and others' DBT research, which may seem counterintuitive or confusing in a text on DBT. However, challenging establishment thinking is a part of science and is what pushes innovation. Paradoxically, discussing the limitations of DBT research alongside emphasizing broad-based psychological research is what brings balance and practicality to its applications.

With any approach, I recommend that therapists seek out a variety of resources, and in the case of DBT I recommend reading and studying Marsha Linehan's (1993a, 1993b) source practitioner book and skills manual. Astute readers will notice, and hopefully appreciate, variations from and additions to her original DBT approach. Changes and expansions from Linehan's work stem from my 14 years of DBT practice, from my five years as a speaker and trainer, and from following research and practice in DBT and psychotherapy in general.

Dialectics are about synthesis, movement, and change. In this spirit I present a contemporary guide to DBT, and I hope readers find it understandable, accessible, and applicable.

# Definitions

**dialectics** The art of investigating the relative truth of opinions, principles, and guidelines.

**dogma** Opinions, principles, and guidelines presented by authorities as incontrovertibly true.

**evidence-based practice (EBP)** The process by which evidence is applied, evaluated, and adjusted in the context of the therapist's judgment and expertise in combination with a client's culture, characteristics, and preferences.

**evidence-based treatment (EBT)** A treatment that meets a minimum standard of research evidence. Synonyms: empirically supported treatment (EST); empirically validated treatment (EVT).

# 1

# Why Learn DBT?

When therapy models are compared, the consistent finding is that no one approach is superior to others, dialectical behavior therapy (DBT) included (Clarkin et al., 2007; McMain et al., 2009; Wampold, 2001). The virtual ties from hundreds of horserace therapy studies beg the question: Why learn DBT when you probably already know effective approaches?

The research is clear that therapy is contextual, not prescriptive, and as such successful therapists need to learn and become competent in a variety of treatments to find a goodness of fit between clients, therapists, and approaches. To paraphrase an amalgamation of experts who advocate a contextual approach to therapies and evidence-based practices (EBPs), to be effective, therapists ought to learn contemporary treatments sought by clients and payers, so long as therapists can coherently deliver them with belief, expectancy, and sufficient adaptation to clients' needs and preferences. And DBT fits the bill, as it is a highly sought contemporary approach for a number of reasons.

First, DBT's privileged status generates tremendous interest in its applications across settings and populations. Therapists gravitate to the approach, and they find that its philosophies and interventions fit nicely with their personalities and beliefs about what works with clients. Many therapists develop a natural allegiance to DBT, and DBT marketing has reached clients who tend to have significant buy-in with DBT therapists and programs. Therapists' and clients' belief and expectancy in DBT

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

will enhance outcomes in many cases, as this therapeutic factor affects outcomes as much as or more than actual therapy models or techniques (Lambert, 1992; Wampold, 2001). As an example, DBT enhances the belief that difficult-to-treat populations such as those with chronic and severe suicidality and borderline personality disorder can be successfully treated, positively impacting the field and treatment results. Positive perceptions and successful outcomes contribute to DBT's credibility and popularity, increasing demand for the approach.

Second, there is a tremendous variety of interventions that comprise DBT, to the point that it can be argued that it approximates an eclectic therapy in practice. DBT interventions include mindfulness practice, skills training, relationship strategies, cognitive and behavioral techniques, and environmental interventions among others. Heard and Linehan (1994) point out that DBT has commonalities with client-centered, psychodynamic, gestalt, paradoxical, and strategic therapies. Marra (2005) also makes convincing comparisons between DBT and other approaches. Further, in a study of common therapeutic factors in empirically supported treatments for borderline personality disorder, 12 categories of interventions were rated from extremely important to proscribed, as indicated by each respective treatment manual. Of these categories, 11 of the 12 were rated extremely important in DBT with only one of the 12 being proscribed (making an interpretation) (Weinberg et al., 2010). This variety of interventions assists therapists in customizing the approach to clients, a hallmark of EBP.

Among its interventions, DBT places strong emphasis on acceptance and validation. Validation is perhaps the most fundamental method of building the therapeutic alliance and "represents a logical application of common factors research" (Duncan & Moynihan, 1994, p. 297). DBT also emphasizes active commitment to therapy and early agreement on goals, treatment targets, and methods of therapy, enhancing important elements that underlie the therapeutic alliance (DeFife & Hilsenroth, 2011; Linehan, 1993a).

Third, DBT is a teachable and practical treatment, making it accessible to therapists of all levels. Hawkins and Sinha (1998) evaluated the conceptual mastery of over 100 therapists following DBT training and found that therapists from diverse backgrounds were able to demonstrate understanding of the approach. Comtois et al. (2007) emphasize that DBT programs can be staffed with graduate therapy students who are often eager to learn the approach. This recommendation highlights that properly supervised therapists new to the field can effectively use DBT with clients. In my clinics, talented master- and doctoral-level students and interns

successfully lead skills groups and conduct individual and group DBT after a few months of intensive training and mentoring by our team.

Last, DBT's dialectical philosophies fit with integrating research and practice, applying DBT with a formal consistency while customizing it to individuals, and balancing allegiance to *a* therapy, DBT, with allegiance to the therapeutic factors that transcend *all therapies*.

# 2

# Introduction to DBT

## *Brief Background and Current Controversies*

DBT was developed by Marsha Linehan in the late 1980s and early 1990s at the University of Washington. Interested in helping those with chronic suicidality and self-injury, Linehan specialized in the treatment of women diagnosed with borderline personality disorder.

Linehan's (1993a) initial work with this population used cognitive-behavioral therapy (CBT). However, she found that traditional CBT administered with too much problem and solution focus was ineffective and left her clients feeling misunderstood and invalidated. To compensate, Linehan began to incorporate acceptance strategies, but she found that too much acceptance focus was also ineffective, leaving her clients demoralized and thinking nothing would change. Linehan observed that her clients responded best to fluid combinations of acceptance and change strategies rather than the emphasis of one over the other. The balanced movement and flow between acceptance and change is a fundamental dialectic in DBT.

As DBT evolved, Linehan (1993a) searched for and integrated philosophies, relationship practices, and interventions that distinguished DBT from traditional CBT. *Dialectical philosophies* were used to bring balance and save clients and therapists from all-or-nothing concepts and behaviors. *Treatment assumptions* were drafted to orient clients and therapists to effective treatment. *Mindfulness* practices, taught from a secular perspective, emphasized nonjudgmental experiencing in the moment and effective

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

rather than reactive behavioral responses in life. Systematic *skills training* bridged the gap between behavioral deficits and desired behavioral change. *Treatment stages* and a *hierarchy* to prioritize treatment targets decreased chaos and increased therapeutic focus. *Functional behavioral analysis* structured sessions with systematic pattern recognition aided by problem-solving with skills. And *validation* underpinned a strong relationship focus that included *communication styles* ranging from reciprocal to irreverent. Last, Linehan created a multimodal treatment-delivery framework to structure and administer DBT. Called the "standard model," the treatment-delivery modes of standard DBT include weekly individual therapy, weekly group skills training, weekly therapist consultation, and individual therapists providing 24/7 telephone-coaching availability to their clients.

The prodigious changes from CBT seemed to better fit the needs and preferences of clients with borderline personality disorder, and therapists were inspired by this radically new yet highly derivative theoretical orientation. The therapy became in high demand, and Linehan with her associates founded a training company dedicated to teaching teams of therapists how to implement and deliver standard DBT as it was researched in Linehan's clinical trials.

The dedicated focus on one delivery of DBT, the standard model, makes historical sense given that DBT's initial development happened during the empirically supported treatment (EST) zeitgeist,[1] when a major emphasis was placed on diagnosis-specific treatments, forever pairing DBT with borderline personality disorder. During this time period, therapists were compelled to adopt evidence-based treatments (EBTs) with fidelity to how the models were researched, with adherence[2] to the specific ingredients prescribed by treatment manuals. In the case of DBT, treatment fidelity meant also following the researched treatment-delivery framework, the standard model.

With a paucity of evidence, the EBT movement created and perpetuated a myth that stubbornly persists today: that specific models of therapy and their interventions should be applied prescriptively to diagnoses vis-à-vis a

[1] Empirically supported treatments (ESTs), once called empirically validated treatments (EVTs), are now commonly called evidence-based treatments (EBTs). The most current term, evidence-based treatment, or EBT, will be used in the remainder of this text.

[2] Adherence refers to the extent to which therapists apply the prescribed interventions (i.e., the specific ingredients) of a treatment manual or model, with interventions of different models being avoided or proscribed. DBT purists also expect adherence to the treatment framework, standard DBT.

medical model of treatment, as if clients, therapists, and other important mediating factors are irrelevant in psychological treatment.[3]

Despite the EBT movement and Linehan's efforts to promote fidelity to the standard model, DBT has been widely disseminated as a theoretical orientation for a broad variety of diagnoses in many adapted treatment frameworks (Andion et al., 2012; Apsche et al., 2006; Christensen et al., 2013; Chugani et al., 2013; Engle et al., 2013; Erb et al., 2013; Evershed et al., 2003; Federici et al., 2012; Goldstein et al., 2007; Harley et al., 2007; Hashim et al., 2013; Iverson et al., 2009; Keuthen et al., 2010; Klein et al., 2013; Kroger et al., 2005; Linehan et al., 1999; Low et al., 2001; Lynch & Cheavens, 2008; Rakfeldt, 2005; Ritschel et al., 2012; Roosen et al., 2012; Rosenfeld et al., 2007; Simpson et al., 1998; Sneed et al., 2003; Soler et al., 2009; Steil, 2011; Sunseri, 2004; Vitacco & Van Rybroek, 2006; Ward-Ciesielski, 2013; Wasser et al., 2008; Wolpow et al., 2000). In fact, research articles on adapting DBT to differing diagnoses and settings, frequently with changes from the standard model in service delivery, outnumber articles on standard DBT. As therapists continue to customize DBT to diverse populations in new settings, levels of adherence to the standard model differ, and, while DBT's reputation as a go-to treatment for borderline personality disorder and other difficult-to-treat issues has been enhanced by successful treatment adaptors, this has not happened without controversy.

A segment of self-described adherent therapists assert that only the standard model is "real" DBT, claiming a specious empirical high ground[4] while ignoring a large body of research evidence and current guidelines on evidence-based practice (EBP). With varying applications and treatment frameworks, the natural question is: "Who is following the evidence?"

Standard DBT is an EBT for borderline personality disorder, but it may surprise many that adherence to an EBT is not necessarily EBP. Whereas adherence to an EBT meets a "minimum standard of empirical support," EBP "is a process of applying research that involves clinical expertise and judgment in the context of client needs and preferences" (Duncan and

[3] Ironically, the factors shown to most affect change, such as the therapeutic alliance, are commonly referred to in clinical trials as "nonspecific factors," with the assumption that they simply support the application of therapy ingredients, assumed to be the real drivers of change. The science shows quite the opposite.

[4] Adherent DBT therapists rest primarily on Linehan's randomized clinical trials that compare DBT to treatment as usual. As discussed in Chapter 3, broader research and evidence-based practice would support adaptations. Ironically, when Linehan published her best-selling textbook (1993a) and skills manual (1993b), DBT was not classified as an EBT, and only one small randomized clinical trial had been conducted; in other words, DBT was popularized with extremely limited specific empirical support.

Reese, 2012, p. 1009). EBP supersedes prescriptive therapy applications because it recognizes the important contextual roles played by therapists and clients in determining therapeutic outcomes, roles that have significantly greater impact than models and their techniques.

Movement to EBP is based on a larger view of the evidence, illuminating a cogent answer to the "who is following the evidence" question. We know therapy works, and its effect size is robust (Smith et al., 1980; Wampold, 2007), but the reasons why therapy is effective differ from those therapists and researchers often promote. The jury has been in for some time, and empirical evidence overwhelmingly supports the thesis that therapy works due to pan-theoretical therapeutic factors[5] that operate within a contextual model. As noted in Chapter 1 and further explained in Chapter 3, this thesis rests on the fact that no therapy model, including DBT, has reliably demonstrated efficacy superior to that of other therapy models (Clarkin et al., 2007; Duncan et al., 2010; McMain et al., 2009; Wampold, 2001). The competing thesis—that the "specific ingredients" that comprise particular therapies such as DBT applied vis-à-vis a medical model account for change—has comparatively little empirical support (Wampold, 2001).

To compel therapists to attend to specific ingredients through high adherence to particular therapies is empirically misguided and narrows the scope and practice of therapy, both generally and with specific models such as DBT. Moreover, to adopt only certain therapies, in certain applications, with certain diagnoses, has moral and ethical implications when clients end up with limited and restricted options that neglect their needs and preferences.

Regardless, many adherent DBT providers continue to lobby that providers adopt only standard DBT, and they at times openly denigrate therapists who deliver DBT in differing treatment frameworks. The unfortunate result is that presumably well-intentioned policy-makers, payers, and providers end up "privileging"[6] a narrow application of a robust theoretical orientation derived from other established orientations

[5] It was suggested in *The Heart and Soul of Change* (Duncan et al., 2010) that "therapeutic factors" could replace "common factors" to refer to the change agents that are shared across theoretical orientations and therapy models. This book adopts this suggested change for the remainder of the text.

[6] A privileged therapy is one that is strongly advocated and is viewed as superior and therefore more legitimate than other approaches, even in the absence of any evidence for its superiority. These therapies are frequently encouraged or even mandated by policy-makers and those who pay for mental-health services. Cognitive-behavioral therapy is a prime example of a privileged approach. When was the last time a health maintenance organization recommended object relations or an existential approach?

that have broad empirical bases. Even Linehan has acknowledged that the evidence may ultimately show that the effectiveness of DBT is due to its "standard cognitive-behavioral components" with differences being "not as sharp" as she suggested (Linehan, 1993a, p. 22).[7]

The split between those who adhere to the standard model and those who adapt from it begs for an appraisal of research evidence beyond DBT's important yet limited empirical base as well as a thorough understanding of current trends in EBP. In the foreword to *Dialectical Behavior Therapy in Clinical Practice*, Linehan offered a "word of wisdom" that DBT change in response to emerging DBT and CBT research to be "in sync with the empirical literature" (Dimeff & Koerner, 2007, p. xiii). I go further to recommend that DBT change to be in sync with decades of established yet often neglected research to bridge the dialectical split and to demonstrate that changes to standard DBT are legitimate, oftentimes necessary, and, importantly, also based in the empirical literature.

Constant change and responsiveness to it are fundamental to dialectics and should be for its namesake therapy. For Linehan to have the first and last word about DBT makes as much sense as saying psychodynamic therapy began and ended with Freud. A sea change is happening in psychology as the field wakes up to what the research has been telling us all along: that structured and credible treatment approaches will be effective when applied flexibly within the context of therapeutic factors.

To this end, a review of the contextual model of therapy, therapeutic factors, and EBP precedes an in-depth explanation of DBT. A broad-based analysis of this research and a true synthesis of research and practice will guide contemporary DBT practitioners.

[7] Linehan's hypothesis is likely partially correct. The outcome variance accounted for by DBT ingredients would likely not differ significantly from the outcome variance accounted for by CBT ingredients. What she fails to acknowledge is that therapeutic factors account for significantly more variance in outcomes than do specific ingredients.

# 3

# The Contextual Model and DBT

Every therapy approach is a contextual model therapy, and DBT is no exception. Nonetheless, proponents of treatments such as DBT often believe that high adherence to the techniques (i.e., the "specific ingredients") that comprise approaches are of paramount importance to successful clinical results. Grounded in research evidence, this chapter explains the contextual model, comparisons of DBT with other therapies, the therapeutic factors that most affect outcomes, the relative importance of adherence to specific ingredients, and how DBT therapists can better align to the therapeutic factors that will improve positive outcomes.

The contextual model "emphasizes the contextual factors of the psychotherapy endeavor" (Wampold, 2001, p. 23). In other words, it acknowledges the significant overlap between therapy models and the therapeutic factors they share, knowing that therapists cannot apply the "specific ingredients" (Wampold, 2001, p. 23) of any therapy in the absence of these contextual factors. The contextual model also recognizes the ongoing and ever-changing dynamics that characterize the therapeutic alliance, going far beyond the medical-model perspective of applying specific manualized interventions believed to remedy specific disorders.

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Early last century, an article titled "Some Implicit Common Factors in Diverse Methods of Psychotherapy"[1] marked the birth of therapeutic factors (Rosenweig, 1936). Since then, the evidence that therapy works through shared therapeutic factors has accumulated to the point where it is not hyperbole but empirical fact. Perhaps the most compelling evidence that supports therapeutic factors is the Dodo Bird Verdict (DBV).[2]

The DBV refers to the fact that no therapy model has reliably shown superior efficacy to other therapy models, with the number of studies showing significant differences being less than what would be attributed to chance when examining the overall body of research (Duncan et al., 2010; Wampold, 2001). Extensive meta-analysis of the body of outcome research has shown that real therapies intended to be beneficial are so when applied coherently with belief and expectancy; CBT, interpersonal therapy, Rogerian therapy, psychodynamic therapy, and on and on all work, and equally well. DBT is no exception to the DBV. So what accounts for DBT's reputation as a superior treatment?

## Comparisons of DBT with Other Therapies

Many therapists do not know that DBT has never been shown to be more efficacious than other treatment models, only to comparison conditions that are not representative of bona fide therapy models. Linehan's and others' randomized clinical trials (Koons et al., 2001; Linehan et al., 1991, 1993, 1994, 1999; van den Bosch, 2002; Verheul et al., 2003) have primarily compared DBT to a control condition called "treatment as usual" (TAU),[3] which can be thought of as unknown therapies by unknown

[1] Rosenzweig's article is reprinted in its entirety in *The Heart and Soul of Change* (Duncan et al., 2010).

[2] The phrase "Dodo Bird Verdict" was coined by Lester Luborsky but originated with Saul Rosenzweig. Rosenzweig noticed that vastly different therapies all demonstrate success and determined that there must be implicit common factors that transcend therapy models. The quote associated with the Dodo Bird Verdict comes from *Alice's Adventures in Wonderland* by Lewis Carroll. When the Dodo Bird must judge the winner of a race and cannot decide, he proclaims, "Everybody has won, and all must have prizes!" This proclamation holds true for therapy approaches too.

[3] Claims of superiority should always bring the inquiry "compared to what?" In addition to the six DBT versus TAU studies cited, three more of the 10 randomized clinical trials on DBT have weak comparison conditions. Safer et al. (2001) and Telch et al. (2001) compared DBT to a wait-list control and Lynch et al. (2003) compared DBT plus medication to a medication-only condition. Are the findings that DBT outperformed the competition surprising?

therapists. TAU is not a bona fide therapy model, and virtually any structured therapy that is intended to be beneficial will outperform TAU. Indeed, it has been noted that one would almost have to create an iatrogenic "treatment" to fare worse than TAU. The results of TAU comparisons tend to be overvalued for several reasons.

First, large differences in therapist training and support between DBT and TAU can be expected to affect outcomes. Most of the therapists in Linehan's studies were highly trained and received intensive, ongoing consultation and support. As stated by Scheel (2000), "the comparison is not as simple as 'DBT versus treatment as usual' It is also 'highly trained and supervised therapists versus therapists as usual'" (p. 77). In reference to the training and support that DBT research therapists received, Scheel stated, "it would be hard to beat this level of training and supervision in the field" (p. 77).

Second, allegiance effects significantly alter therapy outcomes (Wampold, 2001). Unlike double-blind medication studies, therapists and clients in randomized clinical trials are cognizant of what therapy condition is supposed to be more beneficial than the other, especially since informed consent requires that participants be told what treatment options they might be randomly assigned to. Allegiant therapists[4] tend to be motivated to achieve desired outcomes, and their belief and expectancy in the approach are undoubtedly communicated to clients, who benefit from "enhanced" placebo (Luborsky et al., 1999; Wampold, 2001).

By comparison, TAU therapists, who typically work with greater caseloads and less training and support, may have had less belief and expectancy with the high-need and sometimes underfunded clients typical of studies like Linehan's. Moreover, clients referred to TAU conditions may have less enthusiasm to be in the "same old" therapy and not assigned to the "new and innovative" therapy, again affecting belief and expectancy and therefore outcomes. A person does not sign up for a medication trial if his or her current medications work, and he or she would not do so to get the placebo. Similarly, a client would not sign up for a therapy trial if "usual therapy" gets the desired results, and he or she would not do so with the hopes of being reassigned to what has already fallen short.

Third, TAU comparisons tend to be significantly different from manualized therapy models in terms of structure and oftentimes treatment dose, and they commonly do not have the formal consistency and stability that

[4] It is noteworthy that therapist allegiance is a critical component of the contextual model (Wampold, 2001). If a therapist does not believe a therapy will be helpful, it probably will not be. Thus, therapists should probably not be mandated to do therapies to which they lack allegiance.

come with DBT or other structured therapies. Compared to one year of stable treatment in DBT, TAU clients are less likely to receive and continue therapy, and they can be involved in more intermittent and disjointed treatment efforts (Scheel, 2000). Structure and focus are central to therapeutic success with the lack of these qualities predicting negative outcomes (Mohl, 1995; Sachs, 1983). Further, Baskin et al. (2003) found through meta-analysis that, when control conditions approximated the treatment conditions in terms of structural equivalency, the differences between treatment and control conditions became nonsignificant. Considering treatment structure to be another therapeutic factor, Weinberg et al. (2011) found that a clear treatment framework was shared by EBTs for borderline personality disorder.

Recognizing the limitations that come with TAU comparisons, Linehan et al. (2006) compared DBT to treatment by community experts, finding that DBT resulted in fewer suicide attempts, ER visits, and hospitalizations (although it did not fare better than community experts in other measured outcomes such as suicidal thinking and depression). While the comparison condition of community experts seemed more credible than a typical TAU comparison, thereby lending more credence to the findings, a close look at the tables revealed questionable methods in calculating treatment dose, which likely influenced the results in favor of DBT. Duncan and Reese (2012) noted that 38 two-and-a-half-hour skills-training groups were tabulated as only 20 minutes of therapy each, "a somewhat curious way to record 95 hours of additional treatment" (p. 1009). Duncan and Reese also noted disparate levels of training, consultation, and support between the DBT therapists and community experts, mirroring concerns noted in the DBT versus TAU comparisons. These issues again highlight threats to validity.

When DBT has been compared to other bona fide treatments the results were consistent with the DBV. In 2007, Clarkin et al. compared DBT to transference-focused psychotherapy and supportive treatment. This study found no statistical differences in outcomes between the manualized approaches.[5] The overall conclusion of this study was that "structured treatment works for clients with borderline personality disorder" (p. 922).

[5] Linehan publicly downplayed the finding of this study, saying that the results could not be trusted as no adherence measures had been used. In her opinion, the research subjects might not have received real DBT. It can be noted that adherence measures have not been used in the majority of comparative studies conducted. The relative importance of adherence is discussed later in this chapter.

In 2009, McMain et al. conducted another randomized clinical trial that compared DBT to another bona fide therapy: general psychiatric management.[6] This well-designed study had a large sample size and included adherence checks with DBT adherence comparable to standards established by Linehan. In spite of the hypothesis that DBT would outperform general psychiatric management, McMain et al. found no statistical differences between the approaches, again consistent with the DBV.

Practitioners should not be disheartened by this less-than-glowing summation of DBT research. The noted issues apply to virtually all randomized clinical trials that use TAU (and lesser, e.g., no-treatment) comparisons. In fact, the system for classifying EBTs that allows for unsatisfactory comparisons (especially no-treatment comparisons) has drawn criticism and calls for reform (Herbert, 2003). Since unfair comparisons provide expected results and comparisons between bona fide approaches most often result in no significant differences (Wampold, 2001), why continue these comparisons at all? Switching the focus from therapy comparisons to research on client and especially therapist effects would yield more useful information for practitioners, as will applying practice-based evidence as discussed in Chapter 28 and focusing on the therapeutic factors discussed next.[7]

## Therapeutic Factors that Most Affect Outcomes

Frank and Frank (1991)[8] set the stage for therapeutic factors by describing commonalities between psychotherapies and other types of healing endeavors. They illuminated the importance of belief and expectation (i.e., placebo), the idea of common active components, and the importance of the larger healing context. In particular, Frank and Frank outlined the shared therapeutic factors of successful therapies. These factors include a confiding and emotional healing relationship (i.e., a therapy alliance), a healing setting, an acceptable explanation for the problems or symptoms with convincing methods and procedures to address those issues (i.e., a

[6] General psychiatric management includes a structured therapy component in addition to medication management.

[7] Miller et al. (2010) have suggested that knowledge about how "supershrinks" conduct treatment promises to improve the field. Indeed, through a synthesis of research on therapist effects, Wampold (2001) characterized therapist effects as "an ignored but critical factor" (p. 184). Research on the therapeutic behaviors of the highly skilled DBT therapists used in Linehan's randomized clinical trials would likely produce more fruitful knowledge for DBT (and other) practice than simply knowing that DBT outperforms TAU.

[8] Frank and Frank's *Persuasion and Healing* was first published in 1961.

myth and ritual), and active participation by both client and healer in the competent delivery of those methods and procedures.

Frank and Frank further described theoretical commonalties shared by therapeutic interventions. They noted that effective therapists decrease alienation and demoralization as they cultivate hope and expectancy, that they attend to emotions, that they create learning experiences, and that they help clients develop mastery through engaging them in practicing this new learning. Taken together, these theoretical factors summarized the effective practice of virtually any therapy, including DBT, and set the foundation for future investigation. In time, studies that examined the relative importance of factors that impact clinical outcomes would validate the centrality of shared therapeutic factors.

Lambert (1986) extended Frank and Frank's work with the identification of four therapeutic factors along with an estimation of their respective percentages of outcome variance. Derived from analysis of outcome research, the estimated percentages of Lambert's factors are as follows: model/techniques 15%; placebo, hope, and expectancy 15%; relationship 30%; and extratherapeutic (client) variables 40%. As research on therapeutic factors evolved past Lambert's four factors, Hubble et al. (2010) noted that emerging research on therapist effects pointed to therapist variables being a fifth factor, and the research of Baskin et al. (2003), Weinberg et al. (2011), and others points to treatment structure as a sixth factor. Of note is the modest estimation of the impact of the model/technique on outcome in relation to the other factors, as validated by research on the DBV.

Duncan (2014) further extended therapeutic factors by thinking beyond static descriptions of them and instead emphasizing their interplay. According to Duncan, therapeutic factors are "interdependent, fluid, dynamic, and dependent on who the players are and what their interactions are like" (Duncan, 2014, pp. 19–20). This fluid interplay mirrors the application of dialectic philosophy to the therapy process and this book's emphasis on filtering DBT through therapeutic factors.

Based on recent research and meta-analysis, Duncan (2014) updated the contributions of therapeutic factors to include client-feedback effects. To start, 86% of outcome can be attributed to extratherapeutic, or client, factors (i.e., unique and specific client and circumstantial variables that have nothing to do with therapy), with the remaining 13% attributed to actual treatment effects. Of that 13%, the relative proportion of change attributed to what makes up treatment is characterized by substantial overlap, interdependence, and dialectical interplay. Duncan lists the relative importance of these highly interrelated treatment components in ascending

order: model/technique 7%; feedback effects 21–42%; model/technique *delivered*,[9] which includes the general effects of expectancy/allegiance and rationale/ritual, 28–?% alliance effects 36–50%; and therapist effects 36–57%. In reporting the relative importance of these treatment components, Duncan (2014) suggests that we take a "big-picture" view of therapy and "spend our time in therapy commensurate to each element's differential impact on outcome" (p. 19).

As examples, since the unique qualities of clients and their situations account for so much of the outcome, it makes sense to continuously rally their resources and enlist their engagement. Similarly, since the therapy alliance and the elements that underlie it are five to seven times more powerful than specific therapy models and their techniques (Martin et al., 2000; Wampold, 2001), therapists ought to continuously evaluate whether the therapy is serving the alliance or detracting from it. Of course, one of the surest methods of following these suggestions requires obtaining and integrating client feedback (Duncan, 2014), discussed further in Chapter 28.

The conceptualization, practice, and customization of DBT with the dialectic balance of therapeutic factors is called for by the evidence, and thoughtful adaptations and customizations in treatment manuals, models, and frameworks are acceptable and even necessary from a contextual perspective. As cited above, a large body of published research supports adapted DBT, and the success of these adaptations makes perfect sense as the science places primacy on the client, the therapist, and their shared participation in therapeutic factors, not on specific models or their interventions. Nonetheless, the ongoing prominence of the DBT adherence movement calls for further response to the questions regarding fidelity to standard DBT.

## Adopting versus Adapting Standard DBT: The Question of Treatment Fidelity

The dissemination of DBT from Linehan's clinical trials conducted in a university setting to community practice has created debate on best practices. DBT experts connected to Linehan (Dimeff & Koerner, 2007) have written on the dissemination of DBT into clinical practice with a strong focus

[9] Duncan acknowledges that the term "model/technique delivered" was coined by Wampold. This term captures the idea that belief and expectancy in the deploying model and interventions significantly impact outcome.

on treatment fidelity. Fidelity to treatment refers to the extent that components theorized to impact the success of EBTs are transferred to community settings. The belief is that faithful implementations that have high therapist skill and adherence (i.e., therapists that are competent in the approach and closely administer the specific ingredients of it) and use a structure that is highly similar to the researched model will be more successful. Dimeff and Koerner's position will be summarized before the evidence on fidelity is presented.

Dimeff and Koerner (2007) argue that adoption of the standard model should be considered over adapting the standard model because a modification "may or may not retain the active ingredients required to get good clinical outcomes" (p. 19). While they admit that "little is known about the specific active ingredients of DBT (or, for that matter, about any psychosocial interactions)" (pp. 19–20), they caution that applying some DBT instead of all of the ingredients of standard DBT could lead to harm, citing a single study by Springer et al. (1996).[10] They emphasize their argument with this statement:

> To the extent that an intervention's benefits are caused by its active ingredients, omitting the active ingredients (or enough of the active ingredients) results in a treatment that fails to produce the intended benefits. A watered-down version of a psychosocial intervention is like a sugar pill: all form, no function. The first consideration, therefore, before undertaking adaptation of DBT is that good clinical outcomes may require adopting and implementing the standard model, the form and functions of DBT, so that "enough" of the effective elements are active in your setting. (p. 20)

This advice, especially when offered from Linehan's inner circle, seems prudent and has face validity. However, *therapy is not equivalent to a pill*,

[10] In this study, the authors taught some of the DBT skills along with other skills in a "creative coping" group held in a short-term hospital setting. In the results, the authors noted that there was some increase in self-injury among some participants, and Dimeff and Koerner cite this finding as evidence that adaptation of DBT can lead to harm. What they do not mention is that the participants in the creative coping group felt better able to handle stressors when leaving the hospital. Dimeff and Koerner also do not present Springer et al.'s study with enough context: the creative coping group taught DBT skills (minus mindfulness) in a group that met for *a period of days*; the adaptation was so far from standard DBT in terms of philosophy, structure, content, and length of treatment that almost no one could reasonably characterize it as DBT. To use this article to state that adaptation could lead to harm seems to be a stretch.

and empirical evidence does not support that high fidelity and adherence to specific ingredients are needed for successful outcomes.[11] Areas of research that shed light on the issues of fidelity and adherence include comparisons between treatments in controlled trials versus those in real-world settings, research examining the subtraction and addition of specific ingredients, research examining the effect of adherence on outcome, and research focusing on training and implementation methods of EBTs.

First, if research fidelity is vital then there should be clear differences in comparisons between treatments in controlled clinical trials versus treatments in clinically representative practice settings, with outcomes in clinical trials beating out those in clinical practice. The idea is that therapists in research settings follow manuals adherently (high fidelity/adherence) whereas therapists in clinical settings do not (lower fidelity/adherence). Wampold (2001) reports and explains the relevance of two meta-analyses[12] (Shadish et al., 1997, 2000) that speak directly to this question. He states that

> it appears that treatments administered in clinically representative contexts are not inferior to treatments administered in strictly controlled clinical trials, where adherence to treatment protocols is expected. These findings suggest that adherence to a treatment protocol is not related to the outcomes produced by the treatment, a phenomenon that indicates that specific ingredients are not crucial to the success of psychotherapy. (Wampold, 2001, p. 175)

More recent research continues to show that, when benchmarking strategies are applied, psychotherapy in community settings is generally as effective as psychotherapy in clinical trials (Minami & Wampold, 2008; Minami et al., 2008, 2009; Nadort et al., 2009; Wales et al. 2009).

[11] Dimeff and Koerner would have a salient point if they addressed treatment dose (i.e., the frequency, intensity, and duration of treatment). Matching clients to appropriate levels of treatment intensity is discussed in Chapter 10.

[12] One of the inherent problems with the examination of single research studies is that individual studies can be found to support varying hypotheses (i.e., one can usually find studies to support a particular position). For example, Koerner et al. cite four sources that support the fidelity (Drake et al., 2001; Jerral and Ridgely, 1999; McDonnell et al., 1989; McHugo et al., 1999). It is therefore difficult to reach a consensus on a body of individual studies that sometimes show conflicting results. The solution is meta-analysis, a statistical method to synthesize research in a given area to show true effect size.

Second, research that subtracts or adds specific ingredients, often called component designs, highlights the relative importance of these ingredients on outcomes. If an ingredient hypothesized to be important is removed from the treatment protocol, the outcomes should suffer. Conversely, if a theoretically important active ingredient is added to a treatment, the outcomes should be improved. Ahn and Wampold (2001) conducted a meta-analysis of adult psychotherapy component studies and found that subtracting and adding specific ingredients had no statistically significant effect on outcomes. This finding is consistent with the contextual model and with the DBV and leads to the conclusion that strict adherence to specific ingredients does not appreciably increase the limited power of methods and techniques.[13]

The third area of research directly examines adherence and its effect on outcomes, and it shows that valuing adherence over therapeutic factors is not the ticket to improved results. Studies on adherence to treatment models tend to indicate that it has little to no effect on outcome (Imel & Wampold, 2008; Wampold, 2001) and may even have detrimental outcomes at times (Castonguay et al., 1996; Henry et al., 1993). In particular, high adherence may be iatrogenic when clients lack investment in therapy and disagree on treatment goals (Wampold, 2010).[14] Meta-analysis also does not support positive effects of adherence. Webb et al. (2010) conducted a meta-analytic study on the relationship of adherence and competence on outcomes and noted:

> In this systematic review, we analyzed findings from 36 studies in which therapist adherence or competence was examined in relation to outcome. The most striking result is that variability in neither adherence nor competence was found to be related to patient outcome and indeed that the aggregate estimates of their effects were very close to zero. One explanation for these results is that adherence and competence are relatively inert therapeutic ingredients that play at most a small role in determining the extent of

[13] The finding that specific ingredients contribute to only a small amount of the variance in change does not mean that DBT ingredients (or ingredients of other therapies) are unimportant or irrelevant or that "anything goes" in therapy. On the contrary, remember that these ingredients are necessary as part of the healing context, and, dialectically, they constitute counterparts to therapeutic factors that complement one another in a fluid, interrelated dance. Therapists must be skilled in the techniques of DBT and any other approaches used to deploy credible and effective therapy.

[14] Treatment adherence is presumably easier with cooperative clients who go along with the protocols and procedures.

> symptom change. It is possible that the constituent studies in which significant positive adherence–outcome and competence–outcome effect sizes were reported were simply chance findings from a population in which variability in adherence and competence accounts for little, if any, variability in outcome. (p. 207)

These results demonstrate that adherence related to outcomes does not even have a small effect size. However, this study has an interesting caveat related to how the data were analyzed. Webb et al. indicated that "the current meta-analysis was restricted to a quantitative synthesis of linear adherence–outcome and competence–outcome relations. To the extent that the relation between adherence or competence and outcome is in fact nonlinear, this meta-analysis would represent an inappropriate modeling of actual curvilinear effects" (p. 208).

Curvilinear adherence effects have been found in a couple of studies. Hogue et al. (2008) found curvilinear effects in a study of adherence, competence, and outcome in individual CBT and multidimensional family therapy (MDFT) for adolescent behavior problems. The curvilinear effects in this study indicated that intermediate levels of adherence had the best outcomes for internalizing symptoms whereas high and low adherence showed less improvement.[15] This finding replicated the work of Barber et al. (2006), who also demonstrated curvilinear effects in their study of therapist adherence, competence, and alliance in individual drug counseling. Future research may validate curvilinear adherence effects and, interestingly, these effects would support a contextual model prediction: that high adherence could interfere with therapeutic factors and that low adherence may lack enough formal consistency to activate belief in the application of the interventions proposed to remedy the presenting problems. Within the ever-changing fabric of therapy, the formal consistency from moderate adherence balanced with flexible deviations from the treatment manual when therapeutically indicated may be the optimum way of applying DBT, sometimes using a "proscribed" intervention if it may be beneficial to a particular client in a particular session or is indicated by therapeutic factors. Hogue et al. (2008) state: "Like Barber et al. (2006), we interpret curvilinear effects to be a caution against being too lax or too strict in adhering to treatment protocols" (p. 553).

[15] In this study, stronger adherence did predict greater declines in drug use in CBT only, and greater declines in externalizing behaviors per parent report for both CBT and MDFT. Effect sizes were small to medium.

In sum, the evidence suggests that the coherent application of the DBT model and techniques is important insomuch as they are a necessary (but not sufficient) part of how therapy works, as explained by the contextual model. However, an overemphasis on high adherence to DBT ingredients should heed Wampold's (2001) statement that "manuals focus attention toward a wasteland and away from the fertile ground" (p. 212). Maximized benefits will be derived by DBT therapists who synthesize the manual with attention to therapeutic factors, *placing clients and therapists, not the manual, at the center of treatment*.

Another important note about treatment fidelity: Research regarding how to most effectively train therapists in EBTs is in its infancy, without any established evidence-based models for dissemination and implementation, and without data to demonstrate any positive outcomes for clients in community settings (Herschell et al., 2010). The creation of movements to mandate treatment fidelity when the evidence for specific ingredients is so sparse and when dissemination methods are unproven puts the cart before the horse. Most importantly, based on what we already know, emphasis on training relative to treatment fidelity to EBTs is likely to be academic, without significant positive impact on client outcomes in clinical settings. Fortunately, rather than chasing the belief that EBTs need to be applied with fidelity to improve outcomes, energy can be put into evaluating outcomes with real-world clients in real-world settings with practice-based evidence, as discussed in Chapter 28.

Further, contextual rather than prescriptive approaches to therapy, DBT included, fit better with how practitioners tend to apply models and techniques. It seems that few general practitioners, even those allegiant with particular approaches, follow treatment manuals closely. Thoma and Cecero (2009) conducted a survey consisting of 127 techniques from eight major theories of psychotherapy that was administered to a random sample of US doctoral therapists. They found that "participants endorsed substantial numbers of techniques from outside their respective orientations, many of which were quite different from those of the core theories of the therapists' respective orientations" (p. 405). Moreover, in my extensive experience training therapists in DBT, I find ideas around adaptation of DBT (and other therapies) to be widely accepted. While treatment fidelity has its champions, it is not a practice that is well established by research nor does it seem normative or popular among practicing therapists, many of whom presumably want to learn DBT to integrate it with techniques and methods of other therapy models. The desire to integrate DBT with other models fits an overall predicted trend that integrative therapeutic approaches will be among the fastest growing theoretical orientations by

**Table 3.1** Comparisons between Adherent DBT and DBT Practiced from a Contextual, Adaptive Stance

| *Adherent DBT* | *Contextual DBT* |
|---|---|
| • Emphasis on specific ingredients of DBT over therapeutic factors<br>• Overpromotion of Linehan's standard model and of randomized clinical trials creates an ossification of the approach<br>• Not supported by the broad-based research and unlikely to be broadly supported in the future | • Emphasis on therapeutic factors and outcomes balanced with DBT<br>• Promotion of DBT adaptations monitored by practice-based evidence creates a robust practice of the approach<br>• Supported by the broad-based research and likely to be supported in the future |

2022 (Norcross et al. 2013). Table 3.1 details comparisons between adherent and contextual DBT.

## The Answer to Fidelity: EBP

In 2005, the American Psychological Association (APA) formed a presidential task force to examine the empirical evidence and determine a policy on EBP to guide practitioners. The impetus behind the new policy arose from recognition that the strict adoption of EBTs had a too narrow scope for the practice of therapy and did not fit the existing body of research. While EBTs are beacons that guide practice, they do not shine brightly enough to inform treatment across diverse settings and populations. Importantly, EBTs lack external validity, the extent to which findings from randomized clinical trials can be generalized to other populations and settings.

At a DBT seminar, an adherent trainer was asked about the evidence for adherence to the manual. Her answer was that it was "standard research protocol." While her answer was correct (i.e., research protocols by necessity call for adherence to manuals for the sake of internal validity), it sidestepped two major issues. The first was the lack of empirical evidence supporting high adherence, as discussed above, and the second was that what is researched may not be representative of community practice. Research trials tend to require homogeneous participants who are carefully and narrowly selected (excluding large numbers), and services tend to be delivered adherent to a manual in a specified level of care and delivery system (Wampold, 2001). There is danger in treating real-world people

as if they are indistinguishable from research subjects and in pretending that community settings are facsimiles of research settings. To sharpen the point, is the delivery of standard DBT in a university setting, paid for with a government grant, on a population of Caucasian woman aged 18 to 45 with a singular diagnosis of borderline personality disorder representative of broader clinical practice? It can be staggering how issues of external validity are conveniently ignored by those who value adherence to a model above all else. When a cookie cutter is brought down on a general population, who gets left outside the cutter and who gets cut in half?

Enter the APA policy on EBP that seeks the integration of research with clinical expertise and judgment informed by clients' culture, characteristics, and preferences (American Psychological Association, 2005). The APA policy states that "the treating psychologist determines the applicability of research conclusions to a particular patient" as "individual patients may require decisions and interventions not directly addressed by the available research" (p. 2). The APA policy acknowledges the "gaps and limitations in the existing literature and [the existing literature's] applicability to the specific case at hand," and it states that "it is important not to assume that interventions that have not yet been studied in controlled trials are ineffective" (p. 1). Dialectically, the policy seeks to bridge research and practice, valuing both without one superseding the other.

Crucially, the policy also calls for the ongoing assessment of clinical outcomes and adjusting therapy as needed based on that data (American Psychological Association, 2005). The use of clinical outcome data in real-world settings is referred to as "practice-based evidence," which is the topic covered in Chapter 28, on clinical outcome evaluation. EBP, not treatment fidelity, is the foundation for contemporary DBT applications.

# 4

# DBT: An Eclectic yet Distinctive Approach

DBT is an eclectic mix of concepts and techniques from a wide variety of psychological and philosophical approaches. DBT has obvious behavioral and cognitive roots, but astute therapists will see commonalities with client-centered, gestalt, psychodynamic, strategic, and systems approaches, among others (Marra, 2005). DBT also blends Eastern mindfulness and dialectical philosophies into the orientation.

To orient to DBT, this chapter briefly details parallels and distinctions between DBT and the well-known therapies from which it borrows, all of which have extensive theoretical and empirical bases. Throughout this chapter, other chapters that relate to the main ideas will be identified for those who wish to read in a nonsequential manner. While this chapter spotlights the eclectic[1] nature of DBT, it is important to remember that DBT is more than the simple repackaging of techniques already proven efficacious in the literature. DBT is a stand-alone theoretical orientation because it has its own guiding theory that delineates why clients suffer along with procedures for addressing those difficulties. Notably, DBT's biosocial theory places a predominant emphasis on emotions and their interplay with environments, providing the theoretical core that guides treatment (Chapter 7). This guiding theory is a major distinction that separates DBT from its contributing therapies.

[1] Eclecticism refers to the mostly atheoretical selection and use of treatment methods.

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

Among DBT's contributing approaches, the most central are behavioral and cognitive-behavioral therapies. Much of what happens in DBT rests on traditional behavioral principles and techniques, especially functional behavioral analysis, which determines the antecedents and consequences of target behaviors (Chapter 20 and Chapter 21). In behavioral analysis, identified antecedents include vulnerabilities, events that lead up to behaviors, and triggers or prompting events for behaviors. The consequences that follow behaviors include both immediate reinforcers and the other repercussions that keep people susceptible to maladaptive patterns. This behavioral analysis goes beyond assessment of these patterns and what motivates particular behaviors to include active problem-solving.

Solutions in DBT come from two primary behavioral sources. The first is contingency management. Contingency management is based on the straightforward principle that people do more of what is rewarded and less of what lacks a reward or is punished. DBT actively works with clients and people in their environment to support functional behavior and remove reinforcement from behavior that is ineffective. As contingencies are adjusted, clients learn what works.

The second source of solutions comes from systematic skills training (Chapter 19). Once behavioral analysis has established the chain of events that precedes and follows certain behaviors, learned skills can be plugged in at every link, breaking these maladaptive chains through the systematic application of more functional behaviors. Throughout DBT, as in traditional behaviorism, skillful behavior is not just taught but also modeled, practiced, shaped, and refined until effective behaviors become part of clients' repertoires.

While DBT is behavioral, it is not as extreme as applied behavioral analysis, where internal events such as thoughts and feelings are not considered. On a continuum of applied behavioral analysis to CBT, DBT overlaps more with CBT in that DBT's behavioral analysis includes internal events. However, in regard to those internal events and consistent with its theory, DBT is decidedly more focused on emotions compared to CBT's emphasis on thoughts and interpretations (Marra, 2005).

Placing value on internal events is only one similarity DBT shares with CBT. Both approaches emphasize educating clients about the treatments and socializing them to the respective approaches (Chapter 16). For example, DBT therapists explain DBT theories and philosophies and discuss the rationale behind the tasks and interventions of the treatment to build a collaborative alliance regarding goals and methodologies. DBT also borrows the concept of self-monitoring from CBT. In DBT, the self-monitoring tool is the diary card, which is used to track treatment targets and craft session

agendas (Chapter 13). Last, DBT does incorporate cognitive modification, albeit with considerable adaptations from traditional CBT (Marra, 2005) (Chapter 23).

Building on the behavioral and CBT foundation, DBT incorporates important concepts from client-centered therapy. Foremost, DBT pays explicit attention to the therapy alliance with an acceptance-based, nonjudgmental position (Chapter 14). Further, both approaches advocate that the therapist be authentic and willing to be in a real relationship with the client. Like client-centered therapy, DBT leads with attempts to understand the phenomenological world of clients with empathic, validating responses. However, a difference is that validation and a Rogerian style of interacting with clients, called "reciprocal communication," is counterbalanced with irreverent communication, a decidedly un-Rogerian manner of speaking to clients (Chapter 17). Other shared concepts are that clients do the best they can with what they have and that they have the ability to grow and change. The difference is that client-centered therapists believe that people have an internal tendency toward growth when the conditions of acceptance exist whereas DBT therapists believe that acceptance is a precursor to change that happens through the acquisition of skills and behavioral interventions. Another difference is that client-centered therapy is nondirective whereas DBT counterbalances acceptance strategies with directive change strategies.

DBT borrows philosophical, acceptance, and experiential strategies from gestalt therapy. First, dialectical philosophy (Chapter 6) is congruent with the gestalt theory that polemic tensions occur (e.g., internally or between self and others) and that their resolution comes through synthesis. Second, like DBT, gestalt places a premium on awareness, especially without bias, as gained through repeated observation and through connecting and relating to experience and reality rather than attempting to control it. In DBT, these ideas are promoted through mindfulness and acceptance practices (Chapter 18). Next, DBT and gestalt (and client-centered therapy) accept clients as doing the best they can given their circumstances. Fourth, DBT and gestalt are action oriented, having clients try new behaviors. The difference is that behavioral activation in gestalt is more experimental whereas DBT features organized behaviorism. And last, the cognitive modifications in DBT parallel the gestalt philosophy that there are no ultimate truths as to what is rational versus irrational and that it is more useful to observe thoughts and explore alternative perspectives that are more functional rather than "correct" (Yontef & Jacobs, 2014).

Finally, and perhaps surprisingly, DBT shares commonalities with contemporary psychodynamic therapy. The first is an explicit interest in the

quality of the therapy alliance along with attention to affect and encouraging its regulated expression as an alternative to avoiding it. Next, DBT and psychodynamic therapy (with gestalt) have in common the examination of dynamic (dialectical) tensions and conflicts with an emphasis on successful resolution. And, with quite different theories, semantics, and techniques, DBT and psychodynamic therapy assist clients in gaining awareness of what has been out of awareness, including identification of themes and patterns. Whether awareness comes from tapping the unconscious, practicing mindfulness, or completing a behavioral analysis, the end goals remain the same: choice and behavior change.

Linehan (1993a) observed that therapists commonly exclaim in DBT training that they already follow many DBT philosophies and use many of its techniques. In my DBT training, participants often tell me that their therapy approach has been similar to DBT and that one of the benefits of the training was putting that knowledge into a structure and framework of treatment (Chapter 10). As you go throughout the text, consider how DBT overlaps with and differs from your existing approach(es) for added understanding.

# 5

# Is It DBT?

## *A Guide for DBT-Identified Therapists and Programs*

The adaptation of DBT begs the question: What essential features must remain to keep an adaptation true enough to the original to consider it representative of its namesake? While this determination is subject to expert opinion and debate, the guidelines that follow offer a checklist to answer the question, "Is it DBT?" These guidelines are discussed in more depth in subsequent chapters noted here.

The first guideline is that the therapy flows from the *biosocial theory* that emotional dysregulation transacts with invalidating environments (Chapter 7). Notably, Lynch et al. (2003, 2007, 2013) have expanded the biosocial theory to include populations characterized by emotional overregulation, and I make the case in Chapter 7 that guiding theories of models must sometimes take a backseat to clients' theories when clinically relevant. Nonetheless, not starting with the biosocial theory means the approach may be similar to DBT but that it is not DBT.

The next guideline is that the therapy must be *structured* and have clear client and therapist expectations and protocols (Chapter 10). Clear, predictable, and consistent protocols establish the contingencies that develop responsible therapy attitudes and behaviors on the part of both clients and therapists. Moreover, the service delivery method—be it individual, group, another modality, or a combination of modalities—must follow an established structure with clear agendas, treatment targets, and a schedule for

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Lane D. Pederson.

accomplishing therapy tasks. Treatment targets and the therapy agenda are determined in part by the client's overall treatment stage, by the treatment hierarchy (Chapter 11), and by structured tools such as the diary card (Chapter 13). Used together, the stages, hierarchy, and diary card provide the structural filter that defines the content of sessions. There is no one way to structure treatment, but as a therapeutic factor it must be done.

The third guideline is that DBT must meet the *five functions* of DBT (Chapter 9): motivating clients through a DBT therapy process, teaching skills, generalizing what is learned in therapy and skills training, motivating therapists and improving their effectiveness through consultation, and again, establishing a therapeutic structure.

The fourth guideline is that DBT requires *skills training* (Chapter 19) and a DBT *therapy process* component. Skills training and therapy components can happen individually or in groups, but both skills and therapy need to be present for it to be DBT. Conducting only psychoeducational DBT skills training as a stand-alone service may or may not be of benefit to clients (which is why outcome assessment is vital), but presenting this one component as DBT falls short of meeting the functions of DBT. In this situation, the clear, informed consent would include a statement that the group is a skills-only service and not full DBT.

The fifth guideline requires that DBT therapists have ongoing *consultation* (Chapter 27). Clients referred to DBT commonly have multiple and severe problems. For therapists to meet the function of staying motivated and effective, they cannot practice in isolation and must have the support of other professionals.

The next guideline is that DBT case conceptualization and interventions be centered in *behaviorism*. If therapists or programs present themselves as DBT, they must be allegiant to the approach and lead with it as their primary orientation. At the same time, this does not and should not mean that high adherence is a prerequisite to being DBT-identified. As the research attests and this book promotes, consistency of approach with a degree of adaptive flexibility is desirable. Linehan (1993a) wrote that the reader "can and should add any techniques you believe are effective change procedures or that have been shown in research to be effective" (p. 370). As an example, Linehan suggested that gestalt therapists could add gestalt techniques such as the open-chair dialogue to treatment. The idea behind adaptive flexibility for DBT-identified therapists and programs is that non-DBT interventions and additions must supplement the approach and the other guidelines, not take over. In other words, if your approach ends up more eclectic or integrative than allegiant to DBT, it is not DBT in name

or content. Many readers will be looking to be eclectic or integrative with their DBT knowledge and techniques, and in these cases their services can be presented as such.[1] Dimeff and Koerner (2007) recommend that providers who do not provide full, standard DBT refer to themselves as "DBT-informed." I believe that the labels "DBT" and "DBT-informed" set up a dichotomy that does not improve the descriptiveness of services and that incorrectly excludes comprehensive DBT programs offered in varying treatment frameworks. The real issue is making sure through informed consent that clients understand the services offered and their options to make informed and self-determined choices. I leave it to readers to do that with accuracy.

The seventh guideline is that therapists and programs follow DBT *philosophies and assumptions* in their approach to clients. These assumptions, detailed in Chapter 8, promote attitudes that facilitate the application of DBT.

The eighth guideline is that DBT promotes *mindfulness* practice through skills training, in therapy sessions, in consultation, and in life (Chapter 18).

The last guideline is that DBT follows a *dialectical philosophy*, described in Chapter 6.

Box 5.1 summarizes these guidelines, which allow for greater DBT breadth compared to the "standard DBT-only" definition promoted by some DBT providers. If your therapy or program meets these guidelines, *it is DBT*. Nonetheless, name alone should not be a stamp of quality, and any virtue comes from the effectiveness of your services, as covered in Chapter 28.

**Box 5.1** Is it DBT? A Summary of Guidelines

1. It follows the biosocial theory.
2. It has clear, predictable, and consistent expectations, protocols, and treatment structures.
3. It meets the five functions.
4. It has skills training.
5. It has ongoing consultation.

[1] From informal polling, the majority of practitioners I have trained to use DBT planned to do it as part of an eclectic therapy style.

6 Its case conceptualizations and interventions stay centered in behaviorism.
7 It follows DBT philosophies and assumptions.
8 It promotes mindfulness.
9 It is guided by dialectic philosophy.

If it does the above, it is DBT!

# 6

# Dialectical Philosophy

Dialectical philosophy originates from ancient Greek philosophers such as Plato and Socrates, who used dialectical persuasion to resolve disparate viewpoints. They understood the relativity of truth and that a more complete truth emerged through synthesis. Although dialectics can certainly involve logic, the use of dialectical philosophy in DBT also recognizes *personal truths* that may not withstand a purely logical analysis but can be understood given the context of one's internal frame of reference. The value of a dialectical stance is obvious when the goal is to understand and validate clients to create movement.

Dialectical philosophy rests on assumptions that guide its application. First, dialectics recognize inherent contradictions and tensions that arise within us, between us, in situations, and in the world. Rather than allowing these oppositions to negate each other, the philosophy seeks synthesis, balance, and flow, transforming the crystallization of opposites into fluid movement. This movement represents the second assumption, that change is continual and will lead to new contradictions and crises. What is effective in this moment both affects and has no bearing on what is effective in the next. Thus, dialectics require constant attention to and (re)orientation toward context as each moment evolves into the next. The goal of dialectics is responsive synthesis to meet demands and be effective. Often, responsive dialectics involve seeing new and different perspectives and engaging in middle-ground behaviors.

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Lane D. Pederson.

For instance, anyone attempting change notices the dialectical tension between doing the same behaviors and trying something new. Valid reasons exist for both sides, and these explain the waxing and waning that come with the most significant changes; however, understanding the reasons for staying the same often gives rise to what is needed to change and vice versa. Further, dialectics recognize that successful change is preceded by unsuccessful, yet ultimately necessary, attempts, and it tends to comprise behaviors that incrementally approximate the goal. Other dialectical examples can be seen in relationships in which tensions between people, their wants and needs, and their perspectives are common. Using dialectics, people keep relationships and themselves in balance.

In DBT, therapists and clients apply dialectical philosophy to bring balance and guidance to the therapeutic alliance, the treatment, and life. Dialectics are apparent in all aspects of the treatment.

## Dialectics in Practice

Therapy is a balancing act in which the participants navigate the pushing and pulling tensions between where clients are and where they want to be. Dialectics recognize the relativity of thoughts and perceptions, and the shades of gray between black-and-white propositions. Because competing experiences tend to hold just one piece of the puzzle, dialectics search for and synthesize what is missing to approximate a more complete picture that in turn creates greater understanding and opportunity for movement. The mutual search for synthesis by therapist and client keeps treatment responsive to what works in each moment as time moves forward and the context of treatment evolves and changes. Nuanced dialectics guide virtually every DBT assumption, practice, and intervention. The following highlights some of the most useful dialectics in clinical work.

## Validation versus Change

The most fundamental dialectic in DBT is validation versus change (Linehan, 1993a). Validation is acceptance-based, meeting clients where they are without the expectation that they or their reality be different. Validation and acceptance are powerful and healing, but they are only one side of the equation. At some point, movement toward change is needed, counterbalancing acceptance of what currently "is." DBT recognizes

that acceptance of the person, in the moment, is what opens the door to change. Rogers purportedly said, "The curious paradox is that, when I accept myself just as I am, then I can change." DBT embraces such a statement, but, in contrast to client-centered therapy, it pushes toward change when the conditions of acceptance are sufficient to allow it.

The tension between acceptance and change highlights the dialectical philosophy of holding two opposites at the same time, embracing the wisdom of both and seeking the synthesis of the two. In practice, therapists rarely do just one versus the other but instead intermingle and fluidly move between the two to be maximally effective, being awake to the contextual nature of what is happening in the alliance and therapy. When clients feel validated, movement toward change can be made, and, as the client struggles to change, movement back to validation and acceptance are indicated.

Acceptance is difficult for many reasons. For some, the word itself conjures up the idea that an unwanted reality is approved of or is something to be resigned to, being static and unworkable. For painful emotions, physical sensations, and events, the natural inclination is to reject the reality, as if fighting what is will somehow lead to escape and avoidance of the pain. *This reaction is human and should be treated nonpathologically*. Acceptance requires validation that communicates the inherent sense in emotions and behaviors that are otherwise misunderstood, rejected, and pathologized. Acceptance of the "unacceptable" requires a shift that comprehends reality given the circumstances that construct it. Similar to Kübler-Ross's (2006) stages of acceptance of dying and death, acceptance is best understood as a process that commonly involves denial, anger, bargaining, and depression. As therapists meet clients where they are with validation, clients gradually learn to self-validate and meet themselves and situations with an attitude of acceptance, freeing their resources for the process of change.

As clients practice acceptance, change becomes a given. Chapter 14, on validation, and Chapter 18, on mindfulness, further describe the role of acceptance in DBT, and Chapter 19, Chapter 20, Chapter 21, Chapter 22, and Chapter 23 cover DBT change strategies.

## Acceptance of Experience versus Distraction from or Changing Experience

DBT is grounded in the here-and-now acceptance of experience. With the knowledge that escape and avoidance behaviors ultimately increase the intensity of painful emotions, DBT uses mindfulness principles to

enable clients to connect with experience to reduce and gain freedom from suffering. Mindfulness practice in and out of session is exposure, and gradually clients learn that experience, when met with an attitude of acceptance, is tolerable.

At the same time, sometimes emotions are too intense in the moment to fully experience or sometimes people need a healthy break from them. In these cases, clients can use distress-tolerance skills until the intensity can be successfully experienced, leading to desensitization.

Further, accepting what is painful is not incompatible with working toward change. Engaging in behaviors that mitigate vulnerabilities to intense emotions as well as behaviors to create different emotions works well in concert with acceptance.

Chapter 18, on mindfulness, further describes this balance between experiencing what is and distraction from or actively working to change one's experience.

## Doing One's Best versus Needing to Do Better

DBT holds that clients and therapists are doing the best they can and that they need to do better (Linehan, 1993a). These two ideas seem to be opposites at first glance, but a closer examination reveals truth in both. No one wants to live a miserable life, making the same mistakes again and again, continually sabotaging relationships and life. We all do our best, though what constitutes our best changes from day to day, minute by minute, as affected by countless factors. Yet, change happens when we transcend our best to learn new skills and behaviors to increase our overall effectiveness.

The belief that we are doing our best steps us out of judgments to find our compassion for others and ourselves. It is fundamentally true that we all are trying to get our wants and needs met in the best way possible. Not acknowledging this truth tends to imply criticism and blame that keep people stuck, whereas acknowledging it tends to open people to the other truth that there can be more effective ways of fulfilling our wants and needs. Through holding both concepts inherent in this assumption, we are able to pursue both acceptance and change.

## Noting the Adaptive in What Seems Maladaptive

A dialectical stance finds what is adaptive in even the most (seemingly) maladaptive behaviors. Duncan (2005) and others have written about the

"killer Ds": deficits, disability, disease, disorder, and dysfunction. Viewing clients through the "Ds" is incomplete and discounts their strengths, their resiliencies, and the adaptations they make to survive difficult situations.

When possible, a strength-based, nonpathological view creates a more effective basis for the therapeutic alliance as well as hope and expectancy. While much of our training is disorder-based (as is our primary means of procuring payment for services), our approach to working with clients should validate how their behaviors make sense given their frame of reference.

Searching for the positive intent is a variation of finding what is adaptive. Elium and Elium (2003) discussed positive intent in the context of raising children. Positive intent looks behind behavior perceived to be frustrating to discover the true and positive motivation for it. I once found myself in an escalating power struggle with my then four-year-old daughter over her refusal to put on clean but dingy socks. She was insistent that they were dirty while I was insistent that they were clean. Finally realizing her positive intent, wanting to wear clean clothing, I was able to disengage from a fruitless and relationship-damaging fight and instead validate her and come up with a collaborative solution. When clients engage in seemingly destructive, aggravating, or unhelpful behaviors, attempts to see the positive intent shine light on the adaptive.

Dialectically, there is always function in dysfunction, something adaptive in what is maladaptive. Therapists who find the nonpathological bring strengths and resiliencies to the clinical picture.

## Nurturance versus Accountability

Most therapists are naturally inclined to nurture clients. By contrast, many therapists struggle with holding clients responsible to the therapy agreements and their own treatment goals. Perhaps counterintuitively, too much nurturance can be harmful to the therapy alliance.

Overnurturance implies that clients do not have resources or are not expected to use them. This implied message sets up a care-giver and caretaker dynamic that potentially undermines the collaboration that underlies the therapeutic alliance. At an extreme, clients become increasingly passive while therapists become increasing active, resulting in an unsustainable situation. Eventually clients in this behavioral exchange demonstrate greater dependence and require more than therapists can give.

Further, not holding clients accountable in treatment undermines trust as therapists fail to follow through on the very expectations they themselves

said were important. As trust erodes, so do therapeutic alliances. As uncomfortable as it sometimes is, therapists must respect clients and the therapy enough to benevolently but assertively address accountability issues.[1] Accountability in treatment shows therapists' willingness to do what is difficult out of genuine concern and regard for their clients. Paradoxically, accountability can reflect caring and respect more effectively than nurturance. When clients struggle with accountability, I have frequently used an intervention called "playing the caring and respect cards." With this intervention, the therapist says to the struggling client, "How would I be showing you caring (or respect) if I didn't address this issue with you?" Used with genuine concern, playing this "card" opens clients up to the idea that accountability happens in their own best interests.

## Freedom versus Structure

Clients, and their therapy, become more chaotic as life and treatment lose increasing amounts of structure. While individuals all have their own "sweet spot" in terms of structure, we all need some amount of structure to function well in life. Schedules, routines, and knowing what to do and when organize our behaviors and keep us emotionally regulated. As a rule, people who manage themselves skillfully may have less reliance on structure (or be in an effective structure) compared to those who lack self-management skills. By definition, the more difficulties a client has, the greater the need for structure. For this reason, Pederson and Sidwell Pederson (2012) created a supplemental skills module on creating routines and daily schedules.

For clients who underregulate emotions and behaviors, freedom and choice exist within therapeutic and life structure, for without sufficient structure freedom and choice are replaced by emotionality and reactivity. However, for clients with overregulation of behaviors and emotions, the goal is to let go of a degree of structure and embrace greater spontaneity. Dialectically, what is missing is emphasized as appropriate.

Remember that structure is one of the five functions of comprehensive DBT and a therapeutic factor in successful treatments.

[1] Nurturance versus accountability has parallels in supervision and consultation relationships.

## Active Client versus Active Therapist

As repeatedly noted, effective therapeutic alliances require active collaboration between therapists and clients. As a pattern, neither should be working harder than the other. Education during the pretreatment stage about the roles of therapists and clients along with the expected tasks of therapy sets up the collaboration, as does continuing to orient clients throughout the treatment process. Educating and orienting clients is discussed in Chapter 16.

When the activity of one versus the other gets out of balance, the situation should be directly addressed, soliciting feedback on the state of therapeutic alliance and the level of agreement on the goals and methods.

## Consultation to the Client versus Doing for the Client

Linehan (1993a) emphasized the importance of consulting to the client, which calls on clients to practice their skills to do for themselves. Consultation to the client assumes that clients can trust their judgment and be active agents in their own lives without being dependent on others to make decisions and take action. Nonetheless, consultation to the client does not assume that therapists are passive in their interest or involvement. On the contrary, therapists make themselves available to teach, coach, and cheerlead clients as they gain competences and put them into action.

Sometimes therapists take over for clients because they can accomplish a task more efficiently, because they trust themselves more than clients to obtain an outcome, or for other reasons. Sometimes therapists experience discomfort in seeing their clients struggle and want to rescue them from mutual distress. Consultation to the client requires acceptance of clients, situations, and the process.

The rule with consultation to the client is to intervene as minimally as possible, guiding clients toward desired results. As treatment progresses, the level of therapist intervention will tend to decrease. The spirit of this approach is similar to the teaching concepts inherent in scaffolding. Scaffolding gives students the tools to succeed (e.g., by teaching and linking to skills) and then independence is learned in part by decreased increments of teacher intervention until relative autonomy is achieved, knowing that the support of teachers remains a constant when needed.

A caveat to consultation to the client is that therapists must be prepared to intervene when clients do not have the ability to accomplish the goal,

when the outcomes are essential, or when the environment is too powerful. Consultation to the client is also not a substitute for care coordination; although clients can remain in the lead in terms of team communication, it is unrealistic to assume that they can or will communicate everything relevant to high-quality coordination between treatment providers.

## Dialectics and Evidence-Based Practice

Often researchers think that their findings have paramount importance and should dictate the practice of therapy. At the same time, therapists frequently ignore research and practice independent of emerging findings. Both sides have a history of alienation that has resulted in a noticeable gulf between them. Dialectically speaking, best practice indicates an integration of broad-based research with clinical practice, respecting the relative merits and interrelatedness of both. In fact, this integration is the essence of evidence-based practice as defined by the APA (2005). Effective DBT respects the reciprocal relationship between research and practice. Chapter 3 and Chapter 28 explore the relationship between research and practice in detail.

## When *Not* to Be Dialectic: Dialectical Abstinence

Dialectical abstinence means that clients and therapists take an undialectical stance when particular behaviors are so harmful that engaging in them cannot be justified (Koerner, 2012; Pederson, 2013). For example, alcohol and drug use can be so destructive (or impossible to engage in moderately) that clients with dependency problems must commit to 100% abstinence. This 100% commitment means that the sole focus is learning and using skills to establish abstinence and develop long-term sobriety. Similarly, clients who self-injure or have suicidal behaviors hopefully recognize (although not always initially) that those actions are incompatible with having a decent life. With that recognition, clients then commit to dialectical abstinence by not arguing for those behaviors' upsides and instead putting total effort into eliminating them.

Dialectical abstinence does not mean total mastery and success happen the moment the commitment is made. Reality dictates that many people who work to change harmful behaviors have setbacks. When setbacks happen, the goal is to remember the commitment to dialectical abstinence to

avoid a full-blown relapse of the behavior and to instead get back on track. In the chemical-dependency field, Marlatt and Gordon (1985) identified the abstinence-violation effect, which is the tendency to follow a relatively small setback with more extreme self-sabotaging behaviors. This tendency is avoided with a nonjudgmental but accountable approach to the setback in which one learns from the mistake, quickly repairs it, and gets immediately back into effective behaviors. In my skills manual on DBT for dual-disorder mental illness and chemical dependency, the term "slip" is defined as "*s*kills *l*earning *i*mproves *p*rogress" (Pederson, 2013), reflecting the dialectical concept that mistakes can be the best teachers.

Many metaphors illustrate the concept of dialectical abstinence. When rock climbers lose their footing, they do not just throw themselves off the mountain! Instead, they quickly restabilize, check their anchors, make necessary adjustments, and get back to climbing.

Successful people in any pursuit (e.g., parenting, business, or sports) make mistakes, but the key difference between them and less successful people is that they learn from mistakes and apply dialectical abstinence to avoid further unskillful behaviors. For parents who yell at or hit their children, dialectical abstinence dictates that aggressive parenting tactics must be 100% avoided, with the goal to learn and practice skillful parenting behaviors. For people in business who lose accounts due to poor customer care, dialectical abstinence would say that less than quality care cannot be practiced and that the goal is to be responsive to all customer needs. Similarly, when pitchers give up home runs, they regroup and continue to try to get strikeouts, putting all of their efforts into avoiding hits. In all of these cases, mistakes will be made, but those who apply dialectical abstinence get back on the horse and ride with new learning as their compass.

The concept of dialectical abstinence can be used in any situation where a particular behavior has little to no benefit while causing a disproportionate amount of harm.

## Dialectics with Clients

DBT holds a philosophy that clients struggle with dialectical tensions and conflicts that block the process of change. When these conflicts are apparent, therapists note the opposites in tension. The awareness of conflicts in the moment causes clients to confront where they are stuck and then navigate a behavioral solution. Highlighting these conflicts is central to *entering the paradox*, a dialectical strategy covered in Chapter 22. Often, simple awareness of the tension creates a psychological discomfort that is

relieved by a change in perspective or behavior. Therapists therefore do not solve dialectical conflicts for clients insomuch as they highlight them to allow for natural shifts. Box 6.1 lists common dialectical conflicts that clients experience.

**Box 6.1** Common Dialectical Conflicts in Clients

- wanting to be different yet resisting change
- being pulled into versus stepping out of unskillful behaviors
- wanting to use or self-injure yet knowing it will be harmful
- seeing only one side to a situation
- being independent yet still needing help
- taking things personally when it isn't about you
- having a mismatch between your values and behaviors
- deciding a relapse in any target behavior means total failure
- wanting to be like others who don't struggle with substances or mental illness
- feeling good in the moment with substances, knowing it will lead to feeling lousy later
- having difficulty deciding between telling a lie or the truth
- wanting respect but not practicing respect
- telling too much versus too little to others
- having difficulty balancing your wants and needs with those of others
- having difficulty separating feelings and facts
- having difficulty staying nonjudgmental in difficult situations
- leaving open options to act unskillfully
- taking an "all-or-nothing" approach to anything
- having difficulty balancing indulgence versus restriction
- having difficulty balancing emotion with reason
- experiencing conflict between goals and current behaviors.

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# 7

# The Biosocial Theory

## *Emotional Vulnerability, Invalidating Environments, and Skills Deficits*

Different theoretical orientations have different explanations for how and why problems come into existence and how to remedy them. While each approach has its own explanation, these are simply theories that guide practice. The usefulness of a theory rests on how plausible and convincing it is to clients (and to the therapists who conduct the therapy). A well-accepted theory that "fits" with clients contributes to cocreating a coherent and effective course of therapy. DBT has its own pathogenic theory (Linehan, 1993a; Marra, 2005) that has recently been expanded by the work of Thomas Lynch (Lynch et al., 2003, 2007, 2013).

Linehan (1993a) postulated that emotional dysregulation that transacted with invalidating environments was at the root of borderline personality disorder. Although Linehan has focused on populations with borderline personality disorder, this emotion-based theory has utility with other populations too, so long as it is plausible and convincing to them (i.e., consistent with the contextual model). Clinical issues other than borderline personality—such as depression, anxiety, and anger—can be characterized as disorders with emotional dysregulation at their core, with the associated issue that others do not understand their problems (i.e., they feel invalidated by others). Werner and Gross (2010) indicate that problems with emotional regulation account for upwards of 75% of disorders

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Lane D. Pederson.

in the *Diagnostic and Statistical Manual of Mental Disorders*,[1] making the biosocial theory widely adaptable.

Emotional dysregulation consists of being emotionally sensitive and emotionally reactive and having a slower return to baseline when emotions are activated (Linehan, 1993a; Linehan et al. 2007). Although emotional dysregulation is biologically based and may be a biological disposition for some, Marra (2005) has noted several causes of emotional sensitivity including attachment problems, loss, trauma, and invalidation. Ultimately, biology, psychosocial factors, and behaviors maintain reciprocally interactive influences on one another, making psychosocial and behavioral interventions beneficial in changing biology.

When people have frequent, intense, and prolonged emotions, these neural pathways become sensitized and may be activated in an automatic, default manner. This chronic state of hyperarousal and reactivity has been referred to by researchers as a "kindling effect." Like a campfire that appears extinguished the next morning, the emotional "coals" remain warm to hot, ready to flare back up into a firestorm when something as small as a leaf blows across them. These states of elevated and prolonged emotional arousal are difficult to tolerate, making it seem impossible to choose effective behaviors in their wake and predicting increased emotional susceptibility in the future.

These painful emotions lead many people into escape and avoidance behaviors that can be reinforcing in the short term but have significant costs in the long term, continuing the cycle of emotional turmoil (Marra, 2005). The most dangerous escape behavior is a suicide attempt, and others include self-injury, substance use, eating-disorder behaviors, gambling, and overspending.

One challenge in treatment is making sure that clients do not exchange one escape and avoidance behavior for another. Depending on the behavior, some are positively reinforced (e.g., eliciting the support of others) and some are negatively reinforced (e.g., muting a physical or emotional pain). Some behaviors are both positively and negatively reinforced. For example, substance use can be positively reinforced by the initial effects of drugs or alcohol (and possibly other factors) and negatively reinforced by the self-medicating removal of painful feelings and sensations. Unfortunately, the medicating of emotions is only a temporary fix as chronic escape from and avoidance of emotions ultimately lead to their intensification, playing into cycles of maladaptive behaviors.

[1] I assume the same would be true using the ICD-10 as a reference for diagnosis.

Mood-congruent behavior is another problem related to emotional dysregulation since emotions often activate behaviors (Linehan, 1993a; Linehan et al., 2007). As examples, depressed people engage in depressive behaviors, anxious people engage in avoidance, and angry people act hostile toward others. Like some escape and avoidance behaviors, mood-congruent behaviors can be reinforced through the avoidance of what is perceived to be or is in reality aversive. The depressed person who shuts down and avoids life's everyday challenges and the anxious person who dodges fears are spared the intensity that comes from approaching them, and the angry person masks vulnerability through a sense of power and control. Like escape and avoidance behaviors, mood-congruent behaviors also lead to the ultimate intensification of emotions.

Providing a dialectical antithesis to Linehan's thesis of emotional dysregulation, Lynch et al. (2003, 2007, 2013) propose that some clients suffer from emotional overregulation, leading to inhibited or disingenuous emotional expression, minimized emotional experience, and isolated and disconnected relationships. Clients on this end of the continuum can be expected to have excessive self-control and a lack of adaptive flexibility. Similar to Linehan's theory that invalidating environments contribute to emotional dysregulation, Lynch's theory also recognizes environmental contributions to overlearning emotional control, behavioral self-control, and inflexibility. Disorders theorized to involve overregulation include some treatment-resistant depressions, anorexia nervosa, obsessive-compulsive disorder, obsessive-compulsive personality disorder, and autism-spectrum disorders.

In contrast to clients with emotional dysregulation, those with emotional overcontrol require an approach that emphasizes awareness, self-inquiry, and flexible control as well as teaching flexible social and environmental responding (Lynch et al., 2003, 2007, 2013).

In an approach called radically open dialectical behavior therapy (RO-DBT), Lynch et al. (2003, 2007) have studied this adapted DBT with refractory depressed older adults characterized by emotion inhibition, rigidity, and thought suppression. In these two randomized clinical trials, RO-DBT plus medications outperformed medication-only conditions. An open trial with anorexia nervosa (Lynch et al., 2013) has also shown promise. Those who work with clients characterized by emotional overcontrol are invited to study the referenced literature for a detailed explanation of the theory and a complete explanation of RO-DBT.

The ultimate goal with clients, whether under- or overregulated in terms of emotions, is to have them emotionally engaged and experiencing what

is felt in a flexible yet contained manner. The ability to do so lies with mindfulness and emotion-regulation skills.

## The Role of Invalidation

Validation is communicating the nonjudgmental acknowledgment and acceptance of one's own or another person's feelings, thoughts, and experience. In Rogerian (1957) terms, it is understanding the phenomenological nature of a person, really seeing life from his or her perspective, and "prizing" the person. Validation requires pausing to connect and be with experience in the moment to find and communicate its truth. Validation almost always decreases the intensity of emotions, and, by contrast, invalidation can be thought of as any interpersonal response that rejects or negates experience, thereby increasing the intensity of emotions.

Linehan (1993a) and others (Koerner, 2012; Van Dijk, 2012) have discussed the role of invalidating environments in maintaining and intensifying emotional dysregulation. While no environment is perfectly validating (nor should it be), environments that are consistently and chronically invalidating fuel emotional fires. The observation of common interactions between people highlights that emotionality often invites invalidation and vice versa.

Some forms of invalidation are obvious, as are their contribution to problems. Many people who were raised in and/or are currently in abusive and/or neglectful environments will struggle with mental illness and/or substance use. Similarly, actively sending the message that a person's experience is wrong or otherwise distorted leads a person over time to mistrust his or her own experience and, consequently, that individual does not learn how to self-validate. Without validation from self and others, self-judgments and painful emotions thrive.

Other forms of invalidation are more subtle. The passive failure to acknowledge a person's experience (i.e., being nonresponsive), purposefully or as an oversight, sends the message that feelings, thoughts, and behaviors are insignificant and do not matter, or that a situation is "no big deal." Expecting someone to do something that is not in his or her behavioral repertoire, or only focusing on the negative and expecting "more" when someone is already working hard, are other forms of invalidation. Yet another type of invalidation is the "poor fit," meaning that a person does not mesh well with the style of the family or environment (Van Dijk, 2012).

Anytime that a person's emotional experience is denied, debated, minimized, or judged, invalidation occurs. Box 7.1 lists common invalidating comments.

**Box 7.1** Examples of Invalidating Responses

- Don't look so serious (depressed, down, etc.).
- That's ridiculous!
- What's your problem?
- Be rational. (Use your head; be logical.)
- What's eating you? (with sarcasm)
- It's not that bad.
- Grow up!
- Get over it! (Deal with it; give it a rest.)
- You're just going through a phase.
- I'm sick of hearing about it!
- You're making a mountain out of a molehill.
- You're too emotional. (You're impossible; you're too sensitive.)
- I can't say anything to you.
- Don't let it bother you.
- Drop it!
- Is all you do complain?
- Stop being a crybaby!
- Do you ever consider other people?
- It's only you that has a problem.
- There's no reason to be upset.

## How the Biosocial Theory Guides Practice

In concert with the biosocial theory, it follows that DBT interventions should serve to regulate emotions and validate experience to initiate change. Thus, the theory guides therapists to use validation as a primary, if not *the* primary, intervention.

Whereas invalidation intensifies emotions, which leads to ineffective behaviors, accurate and precise validation reduces acute emotional arousal to manageable levels. Because validation down-regulates and holds emotions within safe containment, clients can then experience what is felt without escape and avoidance, and they learn that emotions can be

tolerated. As such, validation can be thought of as an exposure technique (Koerner, 2012). Further, if the client is a product of invalidating environments, therapist validation provides a corrective experience, new learning, and perhaps a bridge to self-validation.

Validation can also be thought of as an operationalization of the therapeutic alliance (Duncan et al., 1992). When therapists understand the context of their clients' emotions and experiences, alliances are bolstered and the process of change is facilitated. In treatment, validation facilitates therapeutic factors, opens clients to change, and is a potent change agent in and of itself.

DBT also teaches mindfulness for clients to change their qualitative relationship with experience and with emotions in particular. Once emotions can be experienced as they are, without amplifying or pushing them away, ineffective escape and avoidance behaviors such as self-injury and chemical use decrease too. Research shows that mindfulness has a regulating and balancing effect on one's systems (Lutz et al., 2008; Tang et al., 2007), decreasing extremes and stress in general. Moreover, practice with acceptance, nonjudgment, and one-mindfulness improves self-management and increases the ability to respond to others and situations effectively rather than reactively.

Supplementing mindfulness, DBT teaches other skills that flow from the biosocial theory. Emotional regulation teaches clients about emotions, so that they can have greater influence over their own. When clients understand how emotions happen, they can practice behaviors to create more positive feelings (e.g., "build positive experience") as well as opposite behaviors (e.g., "opposite-to-emotion") that assist them in stepping out of behaviors that keep negatively experienced feelings around. Finally, emotional regulation emphasizes self-care behaviors (e.g., PLEASED skills) that reduce vulnerability to intense emotions.

Even when mindfulness and emotion-regulation skills work well, everybody still needs healthy behaviors to cope with crisis and to get a break from emotional intensity. Emotionally dysregulated clients fall into ineffective coping behaviors that ultimately complicate their lives and intensify the very emotions they attempt to avoid. Distress-tolerance skills are therefore taught to replace unhealthy coping behaviors with healthy ones. As clients practice these new coping skills, the older and less effective coping behaviors fall away.

While mindfulness, emotional regulation, and distress tolerance target restoration of emotional balance when dysregulation thrives, it remains that clients who come from invalidating environments have often not learned effective interpersonal behaviors. DBT instructs on interpersonal

effectiveness in order for clients to better get their wants and needs met, to build their self-respect, and to develop and maintain quality relationships. Fulfilling relationships contribute to better emotional balance for clients.

To summarize, therapists conceptualize from the theoretical grounding and then deploy interventions that fit with it. Practice of DBT (and any approach) becomes more organized, coherent, and consistent when golden threads flow from theory to application. In choosing from and applying the full breadth of DBT interventions, remember that the theory predicts that validation should be a primary intervention, and that it should usually precede other interventions. On the whole, interventions will be effective when they:

- provide safe and contained exposure to emotions
- aid in regulating the experience of emotions
- reduce and eliminate harmful escape and avoidance behaviors
- reduce and eliminate mood-congruent behavior
- teach coping skills to tolerate crisis and painful emotional (and other) experiences
- work to improve self-respect and relationships with others.

## Being Flexible to the Client's Theory of Change

As noted above, the biosocial theory can be widely applied, and it is certainly widely accepted. In my experience it has tremendous face validity with clients who readily recognize that they have disproportionally more emotional difficulties than others and do not get sufficient support and understanding from those in their lives.[2]

Despite the wide applicability and acceptance of the biosocial theory, it does not capture everyone's theories of their problems and how to solve them. When a client has different change theories, there are a couple potential avenues for the therapist to follow. The first is to accept the client's theory and adapt your orientation to it. Consistent with the contextual model, the client's theory of change trumps the therapist's theory as it is already accepted (Duncan, Solovey, & Rusk, 1992). Just as DBT's theory can be widely applied, so can its interventions. Use of validation, learning

[2] The theory that clients struggle with emotions and that others actively misunderstand and invalidate them is both generic and specific at the same time. It represents a near-universal truth that is experienced personally, and it is precisely why a high percentage of people seek therapy.

about patterns, teaching new behaviors, and most other DBT techniques cut across many theories. For instance, many people with substance-use disorders view their addiction as a disease, not a behavioral problem. However, rather than selling an alternative or complementing theory, a DBT therapist can simply assert that people with a physical disease need skills to manage it, just as someone with type I diabetes may need skills to reliably manage insulin and blood sugars.

If DBT cannot be brought into accord with the client's theories, the second option is finding a preferable treatment for the client. A client who does not subscribe to DBT and its methods will have a poor shot at succeeding with the therapy. This idea is consistent with the assumption that clients cannot fail in DBT but that the treatment can fail them (Koerner, 2012). Fitting therapies to clients, and not the other way around, is the best practice. Fortunately, research supports the diversity of available therapies for clients.

# 8

# Client, Therapist, and Treatment Assumptions

In DBT, the ways in which we think about clients, ourselves, and the therapy are as important as what we do with clients in treatment. DBT assumptions orient the client and the therapist to effective attitudes and practices that increase the probability of therapeutic success. The following assumptions are both traditional (Linehan, 1993a) and newly introduced (marked with an asterisk).

## Client Assumptions

### Clients are responsible for solving their own problems, regardless of who may have caused them

Although clients and therapists work collaboratively toward agreed-upon goals, the ultimate responsibility for change lies with the client. This assumption explicitly acknowledges that people cannot change one another, at least not with any consistency or reliability. Speaking to the dialectic of internal versus external locus of control (Rotter, 1966), DBT motivates clients to own their change process and gives them the tools to do so instead of waiting for others and the world to be more suitable to their needs and preferences.

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Lane D. Pederson.

### Clients are doing their best in the moment and need to do better

As explained in Chapter 6, on dialectics in practice, this assumption leads to a compassionate and validating stance on the part of therapists and others in both therapeutic and natural environments. Few if any people want to make mistakes, alienate others, or otherwise complicate theirs or others' lives. This realization keeps therapists from personalizing clients' behaviors and prevents unneeded frustration and misery that might short-circuit effective responses. Once clients are supported in the moment, therapists can dialectically shift to aiding clients to be more effective. Although this assumption is listed under client assumptions, it holds true for therapists and others too.

### Clients cannot fail in DBT, but DBT can fail them

Therapies need to be adapted to clients, not the other way around. In American football, it is often said that quarterbacks get too much blame for defeats and too much credit for victories. In therapies, it may be that clients get too much blame for poor outcomes and that therapists and therapies get too much credit for successful outcomes. This assumption keeps therapists looking for effective responses rather than giving up on clients, and it may also mean that another type of therapy is indicated if DBT methods cannot be brought into accord with some clients' needs and preferences.

### Clients want to improve yet need skills to do so

Nobody wants a painful and unsatisfying life. Even when clients' behaviors appear grossly ineffective and self-defeating, DBT assumes that clients want to improve. At times clients are caught in dialectical conflicts that temporarily interfere with improvement, sometimes they lack motivation or feel helpless and hopeless, and at other times they literally lack the skills to make changes. Consistent with the previous assumption, it is the job of therapists to motivate clients, attend to their emotional (and other) barriers, and teach skills to overcome deficits.

### Skills need to be generalized to all relevant areas of life

Many clients appear skillful in therapeutic settings but that apparent competence belies what happens in outside life. Similarly, some clients perform skills well with certain people and/or in certain situations but struggle in other areas. As examples, clients can be assertive at work but not

with friends and family (or vice versa), or clients can use distress-tolerance skills with certain stressors but not with others. Therapists need to conduct a careful functional assessment to determine where clients need to apply skills and then make sure that clients generalize to those areas.

## Therapist Assumptions

### Therapists practice empathy, respect, genuineness, and validation in therapeutic interactions*

These "therapist-provided variables" (Duncan et al., 1992) set the foundation for the therapeutic alliance. While all therapies theoretically endorse these therapist qualities (Lambert, 1986), these qualities do not appear uniformly, automatically, or without mindful intention and practice on the part of therapists. Shortcomings with these variables are especially evident in work with clients who have chronic and severe difficulties. It is the responsibility of therapists to seek consultation when they struggle with the behavioral manifestations of these variables.

### Therapists assume a nonjudgmental approach to clients

Acceptance and nonjudgment characterize the DBT approach, and, when Linehan was developing DBT, these attitudes toward clients with borderline personality disorder were novel. Sometimes clients have behaviors that therapists struggle to manage effectively, and those clients become labeled as difficult, impossible, or worse. Then the client is treated in a judgmental and pejorative fashion. Not having a working therapy alliance and effective interventions is not the fault of the client, and blaming the client for his or her struggles in and out of therapy is an anti-DBT tactic. A demoralized, judgmental, and ineffective therapist needs consultation to hopefully repair the alliance and have more effective interventions to use with clients who can be uniquely challenging. Oftentimes, client difficulties arise from clients' sense of being misunderstood, and effective validation founded in nonjudgment can remedy the situation.

### Therapists must be unrelentingly yet genuinely and appropriately strengths-based*

The recognition of clients' strengths keeps therapists compassionate, develops the alliance, and engages clients in the therapeutic process as well as providing needed dialectical balance to the so-called "killer Ds":

deficits, disability, disease, disorder, and dysfunction (Duncan, 2005). Most clients appreciate having strengths noticed and reinforced, and each client strength is an opportunity to identify existing skill use to build on. However, being unrelentingly strengths-based does not mean being Pollyannaish. Inauthentic attempts to point out strengths will not be effective. Thankfully, clients are almost always doing *something* effective, *somewhere*, with *someone*, in *some* context.

## Therapists require consultation to stay motivated and effective

Therapists who operate on an island are sure candidates for burnout, at least with certain clients. Therapy is a difficult job in the best of circumstances, requiring constant mindful attention and participation as well as the demonstration of genuine caring, validation, and responsiveness to clients. On top of that, therapists must remain suitably objective while engaged in emotionally charged relationships and be ready to intervene with a range of interventions, carefully choosing ones that promise the best results on a moment-by-moment basis, all while keeping clients and themselves accountable to the treatment structure, agreements, and plan. This wash, rinse, and repeat cycle of therapy focus and tasks can wear us down.

DBT consultation has been called "therapy for therapists" (Koerner, 2012) as it actively attends to therapists' needs and difficulties in addition to the more traditional focus on clients. Consultation aims to increase both the motivation and effectiveness of therapists by applying DBT principles, practices, and skills to one another. Consultation is discussed in detail in Chapter 27.

## Therapists, like clients, need to practice skills

Practicing skills in life is a day-to-day endeavor. Although most therapists do not have behavioral deficits that necessitate therapy, all therapists have behavioral challenges of one type or another. "Walking the walk" with skills models willingness, coping, and effectiveness and demonstrates the authenticity of the approach.

## Therapists should favor consulting to the client over intervening for the client

Also discussed in Chapter 6, on dialectics in practice, consulting to the client means coaching clients to practice their skills and be their own agents in life. As a rule, therapists want to intervene only when clients literally do not have the necessary skills and when the outcome is essential. Even

then, therapists strive to intervene only to the extent necessary to reach the identified goal.

In regard to professional service providers, clients are expected to be in the lead in terms of communication and coordination of their care. Clients are coached to communicate directly about their needs and concerns, and therapists want to avoid talking for clients or trying to resolve concerns or complaints on behalf of clients. This policy will decrease the chance that therapists will be "split" or triangulated with other service providers.

While clients are expected to be in the lead with care communication and coordination, the consultation-to-the client principle does not absolve therapists of also communicating and coordinating care consistent with best practices. Not all clients can be expected to communicate everything potentially relevant about their care, and in those cases therapists need to bridge the gap to ensure quality services.

## Treatment Assumptions

### The treatment milieu needs to be nonjudgmental and accountable*

This assumption is an extension of the expectation that therapists approach clients with nonjudgment. An acceptance-based and nonjudgmental milieu makes inherent sense but is not always uniformly and consistently realized in practice. Therapists and support staff strive to show caring and respect to all clients regardless of background, presenting issues, and behaviors. This philosophy can be challenging when clients behave in ways that push therapists' boundaries or activate their personal issues (signaling that consultation is needed). In these situations, it is beneficial to remember that these behaviors constitute the reasons why clients are in treatment in the first place.

To be effective, an acceptance-based and nonjudgmental milieu also needs to be accountable. Keeping clients accountable to treatment agreements and rules demonstrates caring and respect, as addressed in the next assumption.

### Treatment must emphasize and reinforce behaviors that "work in life" while not allowing clients to practice behaviors in treatment that do not work in life*

Treatment is a place to practice skills that will result in a more satisfying life, not to practice behaviors that result in life problems. Clients

being late, absent, or unprepared or having rude or disrespectful behaviors are examples of behaviors to disallow and address therapeutically. As a rule, any behavior that would not be tolerated at school, at work, socially, or in healthy relationships should not go unaddressed in therapy.

# 9

# The Five Functions of Comprehensive DBT

In addition to following assumptions about clients, therapists, and treatment itself, DBT must follow five basic functions to be comprehensive in nature. These five functions include motivating clients, teaching skills, generalizing skills to natural environments, motivating and improving the skills of therapists, and structuring the treatment environment (Linehan, 1993a; Koerner, 2012).

## Motivate Clients

Motivation comes from understanding clients' goals; identifying relevant strengths, resources, and barriers; and ensuring collaboration on the methods enlisted to reach goals. It is often necessary to highlight the dialectical discrepancies between what clients want and need, and how current emotions, behaviors, or behavioral deficits interfere with accomplishing those things.[1]

[1] Motivational Interviewing (MI) techniques can be a helpful addition to DBT and vice versa. Whereas MI assumes that motivated clients can then move toward goals, DBT recognizes that sometimes motivated clients still need practical skills to be successful.

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Lane D. Pederson.

To be motivated, clients need a responsive mix of validation, coaching, cheerleading, skills training, and reinforcement for effort and accomplishment. Deciding what to do and when requires therapists to be mindful in the moment, responsive in the alliance, and centered on the treatment plan. Use of commitment strategies, outlined in Chapter 15, can also be deployed to shape and build movement toward goals.

## Teach Skills

As discussed, skills training is an essential function of DBT. Unlike other approaches, DBT does not presume that clients have the necessary behaviors in place to actualize their goals. Skills training addresses functional deficits, replaces unhealthy behaviors that are self-defeating and self-damaging, and provides the means to be more physically and psychologically healthy and functional.

Importantly, *skills training without the other functions in place is not comprehensive DBT*. Many providers mistakenly assume that skills training alone is sufficient to help clients. While this may be true with lower intensity clients who are motivated to change, it is generally not with clients with chronic, consistent, and severe problems. These clients most often require attention to the other functions of DBT, especially having structure and dedicated processing time within therapy, either individually or in groups. Generally speaking, DBT skills only are not enough of a treatment dose in terms of level of care to be effective for high-need clients.

## Generalize the Skills with Specificity

Clients need to demonstrate skills across situations, people, and settings. Many clients can be skillful in one area while struggling in others. To be functional and have satisfying lives, clients need to practice skills where they are most needed.

The good news is that any instance of skillful behavior can become an opportunity to generalize it elsewhere. Often, clients can exhibit skills in therapy and then the task is to assist the client to practice the skills in the world. For example, clients who can regulate their emotions at work can explore what skillful behaviors happen there and then transport them to home. Or clients who accurately validate friends can then practice those skills with a partner or spouse.

Therapists frequently make the mistake of believing that generalization will naturally happen on its own. A complete functional assessment of all relevant areas of life is necessary to identify where increased skill use is indicated. This assessment with agreed-upon areas of generalization allows us to generalize with specificity.

## Motivate Therapists and Maximize Effective Therapist Responses

To be effective, therapists must stay motivated to work with clients, especially those with challenging behaviors. Similarly, therapists need ongoing assistance to stay centered in the approach and effective in response to the ups and downs of therapy. Burnout and iatrogenic therapist behaviors destroy the alliance and short-circuit the outcomes, making this function essential to DBT. This function is met primarily through consultation, discussed in Chapter 27.

## Structure the Environment

Structure refers to the treatment framework as well as clearly defined rules, expectations, and tasks of therapy that are agreed upon by clients and therapists. In short, aspects of structure include anything that results in responsible attitudes and behaviors on the part of clients and therapists (Weinberg et al., 2011), providing the parameters that create safety, containment, and focus.

The treatment framework is the service-delivery system by which the theoretical orientation is disseminated to clients. The original treatment framework for DBT is the standard model, although other frameworks will work too as long as they are matched to the level of care required by clients, providing a high enough "dose" of DBT. In fact, differing settings and populations require different treatment frameworks, and these adapted DBT services have become increasingly prevalent in published research and may be the norm in community settings.

Underlying the treatment framework, the modalities (e.g., individual therapy, psychoeducational skills group, telephone coaching, group psychotherapy, home visits) that comprise the service delivery also need to be structured.

Treatment structure is explained in Chapter 10.

# 10
# Treatment Structure

Structuring the treatment environment is one of the paramount goals in work with clients who have complex comorbidities, and failure to provide adequate structure for clients with significant difficulties is one of the most iatrogenic mistakes a therapist can make. Structure is what creates predictability and safety, and, as mentioned, structure also assists in maintaining therapeutic focus and determining what to treat when, as covered in Chapter 11, on treatment stages and the treatment hierarchy.

Research establishes that clients with resistance and other difficult-to-treat behaviors do better in structured treatment environments (Beutler et al., 2002) and that treatment structure is a primary therapeutic factor shared by EBTs for borderline personality disorder (Weinberg et al., 2011). Specific to DBT, Koerner (2012) emphasizes that, the more multiple and complex the problems, the more important the treatment structure becomes. Koerner includes within treatment structure the existence of clear policies and procedures that address crisis, safety, and other situations that require clarity of response to effectively guide practice.

Weinberg et al. (2011) define structure as a "clear, detailed, and mutually-agreed-upon framework in terms of appointment times, fees, cancellation policy, and termination policy" as well as anything deemed vital to "orient patients to therapy and elicit responsible attitudes toward maintaining workable treatment relationships" (p. 4). This definition

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Lane D. Pederson.

encompasses everything from the service-delivery framework of the treatment to small but critical details such as starting and ending sessions on time. Similar to receiving an employee handbook at the start of employment, information about all of the particulars of treatment must be reviewed at the start of therapy, including but not limited to rules, expectations, agreements, and regular tasks of therapy. Attending to structural details defines the therapy "contract" that is a vital part of a collaborative therapeutic alliance. Structure is "saying what you do" so you can then "do what you say." Behaviors consistent with the structure and agreements, on the part of therapists and clients, constitute the foundation of trust, which again is central to the alliance.

This chapter describes treatment structures both big and small, from differing DBT treatment frameworks to the finer details of structuring the treatment environment. Sections include level-of-care considerations, treatment models, structuring sessions within treatment models, and suggested expectations for therapists and clients.

## How Much Structure? Level-of-Care Considerations

Treatment-delivery frameworks must be responsive to level-of-care issues for the target population. Health maintenance organizations have established practice guidelines to evaluate and determine the appropriate level of care needed by clients. Important considerations include the level of risk related to suicide and other safety-related concerns, the clinical history (including the course of illness and past treatment effectiveness or lack thereof), current presenting problems, diagnosis, comorbidities (psychological, physical, and other), functional impairment, psychosocial factors, and current progress or lack thereof in treatment. Another consideration is that there should be no equally effective treatment available that is less intensive or that occurs in a less restrictive setting.

Generally, clients with more severe problems require more treatment contact, and clients who are referred to DBT programs have often not made progress in lower levels of treatment intensity. If clients have significant comorbidity with functional impairments across several domains (e.g., work, school, social, family), they typically require a program that meets more than once weekly or that otherwise has two or more coordinated therapy contacts. If clients have significant comorbidity, functional impairments across several domains, and suicidality or other safety issues, they minimally require standard DBT or an intensive outpatient level of

care. Additionally, clients who cannot clearly commit to safety and/or to not engage in harmful target behaviors between sessions should be moved to a higher level of care. Box 10.1 lists level-of-care options with brief descriptions. As treatment effectively progresses, the standard of care is to identify less intense and less restrictive treatment options and to transition clients accordingly.

**Box 10.1** Level-of-Care Continuum from Lowest to Highest Amounts of Treatment Intensity

- *Individual therapy*: Individual sessions usually scheduled a maximum of once a week for 60 minutes.
- *Intensive outpatient treatment/day treatment*: A band of treatment intensity that typically ranges from two to five treatment days a week. These services usually occur in a group modality and work in coordination with other services (e.g., individual therapy, case management). Intensive outpatient/day treatment can be relatively brief to ongoing, based on treatment needs.
- *Partial hospitalization*: A treatment intensity that typically meets five to seven treatment days a week. These services usually occur in a group modality and work in coordination with other services. Partial hospitalization is indicated when clients need services more intensive than intensive outpatient/day treatment but do not require 24-hour-a-day monitoring. Partial hospitalization commonly lasts from one to six weeks, based on treatment needs.
- *Hospitalization*: Required when there is imminent danger to self or others, when the client is nonfunctional due to severe symptomology, or when the client requires 24-hour-a-day supervision and/or medical monitoring (e.g., to change medications). Hospitalizations can be brief to ongoing, based on treatment needs.
- *Residential treatment*: For clients who require 24-hour, seven-days-a-week nonemergency treatment and supervision for severe and persistent problems with mental illness and/or substance abuse. Residential treatment can last from one month to ongoing, based on treatment needs.

## Program Treatment Models

This section outlines two service-delivery frameworks for DBT programs: the standard model and group-format DBT. As with any implementation, clinical outcomes (as discussed in Chapter 28) must be collected and used to evaluate and improve the general services of programs and the specific services of individuals who attend them.

### The standard model

The standard model is Linehan's researched DBT service-delivery framework. Standard DBT is a multimodal treatment structure with weekly individual therapy and weekly group skills training components, plus 24/7 phone-coaching availability provided by individual therapists and a weekly consultation group for therapists.

In the standard model, the functions of DBT are assigned to the particular modalities designed to meet them (Linehan, 1993a). The individual mode aims to increase the motivation of clients, the skills-training mode aims to increase capabilities of clients, the phone-coaching mode aims to increase the generalization of skills, and consultation aims to increase the motivation and skill of therapists.

Linehan (1993a) had a rationale for structuring the treatment in this manner. Because her clients had multiple problems and intensive needs, Linehan recognized that individual therapy rightly focused on the most significant problems but left inadequate time to systematically teach skills. She therefore devised skills group to have dedicated time to teach the new behaviors. Linehan also recognized that many clients in this treatment intensity require assistance between the two scheduled weekly therapy contacts (i.e., the individual session and skills group) to generalize what they have learned. To address generalization and other issues that might arise between the gaps in therapy contacts, the model incorporated phone coaching. Last, Linehan recognized that therapists who treat clients with severe difficulties need support to stay effective, which necessitates weekly consultation.

Within this service-delivery framework, each mode is further structured. The suggested structure for individual therapy is discussed below. Therapists who practice DBT across levels of treatment intensity, including those who provide only individual DBT in outpatient care, should follow this structure. The suggested structure for skills-training groups is also discussed below, and structure and practices for phone coaching and consultation are covered in Chapter 24 and Chapter 27, respectively. Readers

interested in full descriptions of standard DBT should review Linehan's (1993a, 1993b) source texts.

The standard model represents a singular level of treatment intensity. As implied above, it is too much DBT for some clients and too little DBT for others. If a particular treatment population is considerably different from the researched population in terms of required level of care, the application of DBT should be adjusted accordingly. Clients without multiple problems and safety concerns typically do not need standard (or other programmatic) DBT, and clients with more acute and intensive difficulties compared to the researched population need more than standard DBT offers. The standard model also may not work in many settings for other reasons unrelated to level of care (e.g., impracticalities in implementing the standard model, lack of resources, problems with reimbursement). My opinion is that communities benefit less from multiple clinics offering the same service option and more from clinics offering a diversity of service options, including a diversity of DBT services.

When the standard model is not the preferred service delivery, other treatment frameworks can be implemented. As Linehan (1993a) originally noted, standard DBT is a service-delivery model and "in principle, DBT can be applied in any treatment mode" (p. 101). No a priori reason exists to say that a group-format treatment program (or another modality or mix of modalities) coordinated with other services (e.g., individual therapy, psychiatric services, case management) cannot be implemented to meet the functions of comprehensive DBT. As already noted, the research literature consists of more adapted service deliveries compared to standard DBT.

## Group-format DBT

DBT in a group format is conducive to most levels of care, especially the higher ones, and it is far more adaptable than standard DBT in its implementation. In a group format, the individual mode of DBT is transferred to a group setting. The group follows a structured agenda, is process based, and uses most of the same tools, techniques, and interventions characteristically found in individual DBT therapy sessions, including behavioral analysis. The DBT group-therapy mode stays structurally different from the group skills-training mode, and the two modes meet the same respective functions as individual therapy and group skills training in the standard model, with the key difference being that they both happen in a group-based service delivery. Just as in standard DBT, the modes of phone coaching and consultation remain, although they may be in adapted forms when clinically or otherwise indicated.

Linehan (1993a) stated that, although she had not researched group-based DBT, "it is conceivable that the individual DBT described above could be duplicated within a group therapy context" and that "group DBT might supplement or replace the individual DBT component" (p. 104). In many treatment settings, transporting the tasks and functions from individual therapy to group therapy creates a flexible and practical framework for practice. For DBT done in a short-term hospitalization setting, for example, seeing patients in individual therapy is much less practical than working with them in groups.

In community settings, many clients who seek DBT programs have had previous contact with mental- and chemical-health systems, and they often have existing individual therapists, case managers, medication prescribers, and other supports. Recognizing that the elements of a treatment team, albeit not a DBT one, often already exist, comprehensive DBT programs designed in a group format allow referred clients to stay with existing providers. One important aspect of EBP is respect for client preferences, and offering a group-based DBT option respects clients' continuity of care with existing providers who support the DBT programming through regular care coordination. In my experience of conducting DBT in a group format, non-DBT providers nearly always practice in ways that support the client and the program. When an outside provider practices in a way that is contraindicated by the program (e.g., does trauma work before stability has been established), the issue is addressed and successfully resolved through care coordination.

One way to structure group-format DBT is with three separate sessions that occur each program day. The first session consists of skills training conducted similarly to a standard-model skills-training group. Like a standard-model skills group, this session follows a skills-training curriculum and has skills-training homework customized to each individual's treatment plan that is assigned and reviewed during each session.

The second session covers interactive diary-card review, in which clients present their cards, receive validation and other feedback, and identify treatment targets for the third session, which is therapy based. In the diary-card review session, clients each have five to 10 minutes to go over their diary cards. To practice interpersonal skills, clients ask other clients to write their diary cards up on a whiteboard for review, and, during each client's review, other clients participate by validating difficulties, identifying and encouraging skill use, modeling the use of skills, and doing brief problem-solving. Diary-card review time keeps clients informed and connected to one another, and it provides peer accountability for meeting treatment goals and objectives. As valuable as diary-card review may

be, there are sometimes reasons to forgo it depending on the treatment setting or the program design (e.g., time constraints). In those cases, it is recommended that clients write an abbreviated version of their diary cards on the whiteboard prior to the start of group so that a brief scan of them can be used to set the agenda. Or, alternatively, diary cards can be shared with the therapist, who then sets the agenda for the group therapy time.

During the subsequent DBT group-therapy session, clients with treatment targets on the hierarchy are prioritized for treatment time, although it is important that the time be equally allotted. Allowing more time for people with target behaviors and less time for people who are doing well sets up a contingency that will promote illness over health. Some group therapists use a timer while others enlist the members to share time-management skills. There are pros and cons to both; what therapists should avoid is being the *only* people responsible for time management. Clients will get sufficient therapy when they are cued to be prepared for their treatment time and to ask for the type of feedback they want (e.g., validation, support, suggestions, skills, problem-solving). As with individual sessions, therapists should leave enough time to successfully wind down sessions, ideally ending with mindfulness.

Based on the level of treatment intensity required, clients can attend a group-format DBT program anywhere from once weekly to every day of the week in the most intensive settings. In the majority of settings, clients in this treatment framework may be expected to maintain their existing individual therapists or they can choose to be referred to DBT individual therapists. Factors that influence decisions about who provides the individual therapy and whether the therapist is a DBT therapist or not include the anticipated length of stay in the program setting, the relative effectiveness of the existing individual therapy, and the severity of the client's presentation. Sometimes a client is well connected in individual therapy that is effective in many ways but the client needs more than is provided by that level of care. In this case, it probably makes sense to stay with this provider. However, another client may have relatively ineffective individual therapy for myriad reasons that likely include needing highly intensive and coordinated treatment. In this case, a referral to a new therapist who is DBT-oriented may provide the best option for success.

Those hesitant about transporting individual DBT therapy to a group format can rest assured that group-based therapy enjoys benefits that individual therapy lacks and that its efficacy is well established in the research

literature. Yalom and Leszcz (2005) note the following general advantages of group therapy that I also observe in DBT group therapy:

- *Universality*: Clients recognize that others share experiences and that recognition validates, normalizes, and decreases isolation.
- *Altruism*: Clients contribute to one another in ways that bolster self-worth and well-being.
- *Instillation of hope*: Clients are inspired by witnessing other members overcome obstacles through applying the therapy.
- *Imparting information*: Clients learn important facts about the treatment or other helpful services or activities in the community.
- *Imitative behavior*: Clients observe members modeling interpersonal and a variety of other skills that they then practice in the group setting.
- *Development of socializing techniques*: Clients' interpersonal skills are shaped through practice and reinforcement from other members.
- *Cohesiveness*: When group therapy is properly facilitated, clients experience belonging, acceptance, and validation in group. Cohesion can be thought of as parallel to the therapeutic alliance, and as such should be considered a therapeutic factor.

In addition to these benefits, a meta-analysis by Burlingame et al. (2003) demonstrated that recipients of group therapy are better off than 72% of the untreated sample on average. This outcome is comparable to the benefits reported for individual therapy (Wampold, 2001). Further, a meta-analysis on the effectiveness of group cognitive-behavioral therapy (GCBT) for general symptomology reported that "in comparison to individual CBT, GCBT interventions appear competitive" (p. 107). Considered alongside the economy of providing services in a group format, these findings generally support the provision of group-based DBT.

The economy and efficacy of group-format services notwithstanding, a couple of caveats must be considered with traditional DBT populations. The first has to do with the level of detail shared in a group. Potentially triggering topics such as suicidality, self-injury, chemical use, and sexual (or other) abuse must be discussed at a general and not specific level of detail. For example, clients can be free to discuss that nightmares, intrusive thoughts, or other symptoms related to childhood sexual abuse have increased as well as share the associated feelings and other experiences. Even with general description, group members can validate and offer helpful suggestions. However, the *details* of the sexual abuse, if they are to be

discussed, are triaged to the individual therapy, which is one reason why group-format programs require an individual therapist.

Regarding safety issues such as suicidality and self-injury, enough general detail can usually be discussed in group to assess for risk and to develop an effective safety plan and commitment to safety. If the level of detail needed becomes too specific and/or if secondary gains of discussing these issues are suspected, the safety *assessment* can be done briefly outside the group with the subsequent safety-planning and commitment to safety brought back into the group process. While therapists must monitor the level of detailed disclosure, they must also realize that overcontrol of details sets up an artificial environment. Clients will be triggered at times, and those times can be opportunities to practice skills in a supportive environment. Where to draw the line on disclosure is a clinical decision that can be aided with consultation. Dialectics play into these clinical decisions.

The second concern that Linehan (1993a) has warned about is contagion. Contagion is when clients pick up and try out the target behaviors of other clients. With any target behavior (e.g., alcohol and drug use, binging and purging, unhealthy sexual practices), therapists set the tone for these behaviors being viewed as problems that require accountability. Target behaviors should never be allowed to be presented or talked about in a way that glamorizes or in any way, shape, or form promotes their use. In nearly 15 years of doing group-based programs for people with suicidality, self-injury, and other target behaviors, I have seen contagion occur in only a few instances. The behaviors in those situations were swiftly addressed and extinguished before they took hold. Maintenance of clear guidelines in regard to dialectical abstinence with target behaviors and expectations that skills are to be actively practiced in and out of therapy greatly diminishes the risk of contagion.

## Treatment models: Practical guidance

The standard model and group-format DBT are just two of many possible treatment frameworks in which DBT can be applied. The overarching concept is to have a clear service delivery and structure from which to operate that is effective with your clientele. No book or manual can provide a "how-to" on implementing therapy that fits all situations. Dimeff and Koerner (2008) have edited a volume on implementing DBT across settings and populations that provides extensive guidelines and suggestions that can assist a great many providers, especially those interested in staying

as adherent as possible to the standard model. Box 10.2 succinctly answers frequently asked questions in regard to setting up a program.

**Box 10.2** Common Questions Regarding DBT Programming

**What is the best available treatment for the population and setting? Would DBT be an appropriate option?**

DBT can be adapted to numerous populations, but it is important to evaluate whether another treatment that already serves the population well exists. For example, my clinics have a program for schizophrenia and other psychotic disorders based in illness management and recovery, a well-established treatment for this population. It was decided that adapted DBT was unnecessary when a suitable treatment already existed. That is not to say that an adapted DBT program could not be as effective.

If you are considering adapting DBT to a particular population (e.g., children, prisoners, college students) and/or setting (e.g., school, group home, inpatient unit), first check the empirical literature. The broad range of adapted DBT articles might include your population and setting. If you cannot find anything in the literature, conduct a search to determine whether the adaptation exists in community settings, and consider consultation from those providers with successful adaptations to help you problem-solve barriers. Try not to recreate the wheel if it already exists. With the implementation of any program, a solid plan is paramount to success, carefully determining all relevant aspects of the program from service-delivery framework and structure to everyday protocols. Start small with a pilot program, collect data, and work continuously on program improvement.

Last, if you want to do DBT with a particular population in a particular setting, chances are you have experience in those areas. EBP would direct you to use your expertise to determine how to change DBT to be responsive to your clients. Doing DBT adherently to how it was developed for white women with borderline personality disorder in a research setting makes little sense for applying it to children or in a prison, as examples. Balance guides on DBT with your knowledge and experience, grounded in clients' culture, characteristics, and treatment needs.

**How heterogeneous can a DBT population be? What populations/diagnoses should be excluded?**

DBT can be used broadly across diagnoses. Borderline personality disorder has tremendous diversity within the diagnostic category, and it also has extensive comorbidity in terms of traditional Axis I diagnoses and features of other personality disorders. In the real world, a DBT program will have a range of diagnoses. Exclusionary criteria for a typical DBT setting would include antisocial personality, narcissistic personality, and clients with psychotic disorders or active psychotic features. (Note that those "excluded" populations may benefit from individual DBT or a customized DBT program in which the population is homogenous and not mixed with others.) Clients with developmental and intellectual disabilities may or may not be a fit with a typical DBT program, and programming that is tailored to clients with these issues is preferable in most cases.

**Mixed or same sex?**

There are pros and cons of both mixing sex and keeping them separate. In my experience, it has been helpful and mostly nonproblematic to have mixed-sex programming. Both sexes live in the world, and clients need to learn and practice skills with the other. Overall, it is my view that mixing sexes is a net positive in most, but not all, cases.

**What is the length of stay?**

DBT programs often ask clients to commit to an amount of time or sessions. This commitment is frequently based on how long it takes to teach the skills curriculum. At the same time, length of stay should be determined by medical necessity, with clients moving to a lower care level when indicated.

**Is it an open or closed program?**

Open and closed programs both have upsides and downsides, but overall an open program provides the most practicality and flexibility in most situations. An open program allows for clients to move fluidly in and out of the program based on medical necessity and

other factors that affect participation in programming. The mix of new and more tenured clients also creates opportunities for instilling hope among newcomers, having them see skills modeled by peers and having those peers benefit from being in a mentoring role.

**When can new members start?**

Some programs have clients start only at the beginning of a new skills module (e.g., when the mindfulness module comes back around). However, the skills do not need to be learned in any particular order, and who knows what skills individual clients need first. My perspective is that clients who have the medical necessity to receive programmatic services should be initiated into the program at the earliest possible opportunity.

**Do groups have cotherapists?**

Ideally groups have cotherapists who complement one another in style, and cotherapists are a requirement of standard DBT skills groups. Nonetheless, sometimes practical constraints make cotherapists a luxury or even impossible. Some DBT providers may practice in underserved areas where there are few available DBT therapists to provide services, and some clinical settings may not have the ability to fund cotherapists. The dialectical tension lies in balancing the best practice of having cotherapists with real-world limitations.

**Can clients à la carte the program?**

Sometimes clients will express a desire to participate in one part of a program while wanting to opt out of another part. Examples include wanting only skills training or individual therapy. Avoid à la carte participation in an organized program as it undermines the structure and accountability. If a client wants only one type of service, such as individual therapy without skills training, it is up to the therapist to assess whether that is appropriate to the level of care and whether he or she is able to provide it. In that case the therapist makes clear that the service provided is a stand-alone one and not part of the program. If the client's assessed level of care necessitates the full program, the

therapist should stay firm to the expectation that the client participate in all aspects of the program. If the client refuses, appropriate referrals should be provided.

## Individual Therapy Treatment Structure

DBT individual therapy has a recommended structure of how it unfolds (Linehan, 1993a). The structure remains almost the same regardless of whether the individual sessions are a component of a DBT program or whether they constitute the sole mode of delivery of the treatment. If the individual sessions are the sole mode of delivery of DBT, the structure should vary to incorporate skills training, covered immediately after this section.

Individual sessions begin by greeting the client with warm engagement, exchanging in social niceties as appropriate, and then observing and noting the client's current affective state. Once therapist and client are situated in their respective seats, the first task of the session is to do mindfulness for a few minutes. Examples of in-session exercises are listed in Appendix A. Starting with mindfulness grounds both therapist and client and prepares them for the work of the session.

Following mindfulness, the therapist checks in with other aspects of the DBT and associated treatments. Therapists will want to know what is happening in the skills group to integrate that work into the session and to problem-solve issues in that modality if they exist. Further, if the client has had a recent psychiatric appointment, a visit by a case manager or other provider, and/or another professional appointment, details of those appointments are discussed briefly, with any significant issues included in the agenda that is formulated from the diary-card review.

Next, the therapist and client review the diary card to identify treatment targets, giving target behaviors identified on the treatment hierarchy priority over lower intensity problems and behaviors. The diary-card review incorporates a mix of therapist validation, support, encouragement, and reinforcement of skills among other interventions. This process typically takes from a few minutes to 10 minutes, depending on the client and the situation. From this review a clear agenda for the session is mutually outlined.

At this point, the main work of the session occupies the next 30 to 40 minutes, depending on the total length of the appointment (e.g., a 50-minute versus a 60-minute session). During this segment, strategies such as behavioral analysis can be used to microstructure the session. The depth and amount covered will vary greatly based on the stability of the client. Two general but related rules govern the process. First, do not open therapeutic doors that cannot be closed during your therapy, and, second, manage time and material in a manner that promotes stability and the successful ending of the session.

As the therapist transitions from the session work, the emphasis shifts to homework and obtaining commitment to complete it. If possible, do the first step of the homework in session and/or be specific about when the client will complete it (i.e., times and places).

Following homework, the therapist and client close with a few minutes of mindfulness, and the therapist ends with a reminder of the next appointment and a sense of positive anticipation about seeing the client then.

This type of structured approach to treatment maximizes benefit for the client and minimizes distractions, diversions, and meandering, all of which therapists easily fall into with clients when the session lacks clear purpose and focus.

Chapter 25 discusses how to address safety issues in sessions, and Box 10.3 outlines the structure of individual therapy.

**Box 10.3** Structure of an Individual DBT Session

1. Greet the client with warm engagement.
2. Note the client's affective state, if possible.
3. Begin with mindfulness.
4. Check in with other aspects of the client's treatment.
5. Check in with assigned homework.
6. Review the diary card to craft the agenda.
7. Do the established work of the session.
8. Assign and, if possible, initiate homework.
9. End with mindfulness.
10. Send the client off with reminder of next appointment.

### Incorporating skills into individual sessions

As mentioned, clients with low-intensity treatment needs do not typically require a DBT program. These clients can be seen in individual DBT only, with skills training incorporated into sessions. This can be accomplished through several methods that can also be combined.

First, for clients with sufficient reading abilities, skills training can be assigned as bibliotherapy. There are over a dozen choices for DBT skills manuals that can be read and applied by clients with and without therapist support, many of them designed for particular diagnoses. A meta-analysis of bibliotherapy showed a moderate to large effect size, demonstrating that use of self-help resources shows efficacy for many clients (Gregory et al., 2004). Bibliotherapy can easily be worked into homework, and Pederson and Sidwell Pederson (2012) have written a DBT skills manual designed to be read and practiced in small and manageable chunks.

A second method of incorporating skills into individual therapy is to change the structure to account for five to 10 minutes of targeted skills training at the beginning or end of the session. If this amount of time is insufficient, either the session can be further altered to build in more skills training or the therapist can alternate scheduled individual therapy sessions with individual skills sessions. If that is done, clear definitions, expectations, and boundaries must be drawn so the client understands the different tasks of each appointment, and the therapist must stick to therapy in one and skills training in the other. Marra (2005) recommends that, when therapists provide distinct therapy and skills-training sessions to clients, they make efforts to use a different room (e.g. conference room) or otherwise adapt the treatment environment (e.g., arrange the furniture toward a white board) to cue the differing tasks of each service.

Last, it is expected that all individual therapists will informally teach skills to apply throughout sessions, often picking and choosing skills that best match the necessities of the moment. For instance, a client presenting with a relationship problem may need interpersonal skills, distress-tolerance skills, self-care skills, or some other skills depending on the particulars of the problem. Only the therapist and client can determine what category of skills and what specific skills are most applicable to the situation.

## Group Skills-Training Session Structure

The structure of a group skills-training session is similar to following a classroom agenda. The session opens by greeting the group members and

engaging in a few minutes of mindfulness. Then the therapist checks in on homework assignments, and, after homework review, the group members are oriented toward the teaching topic. The majority of the session is spent training the skill or skills scheduled for that session, allowing time for experiential practice. It is natural for clients to bring up personal examples during the course of a skills-training session. What is important is that the session does not morph into therapy or problem-solving. When a client example becomes a distraction from the agenda, it is politely but firmly triaged to the next therapy session, be it individual or group. As the skills-training session winds down, the therapist assigns homework and ends with mindfulness.

## Additional Treatments and Services

DBT encourages clients to participate in additional treatments and services that promise to enhance their outcomes and lives. Other treatments and services include but are not limited to case management, medication management, support groups, recovery groups, mental-health-rehabilitation services, and other services for issues not directly addressed in DBT, such as grief and loss or chronic pain management. Whenever practical, use both consultation to the client and traditional care coordination to maximize benefit.

### Friends-and-family meetings

Many DBT programs provide friends-and-family meetings to educate clients' support systems about the treatment and related topics. Topics commonly covered include validation, basic behaviorism, recognizing and fostering strengths, personal self-care, and how to best support loved ones with mental illness. These meetings are commonly scheduled monthly, and in our DBT clinics the feedback about them from participants is exceedingly positive.

## Expectations, Rules, and Agreements

Implementing an effective treatment framework is but one part of the treatment structure. Beyond clear and structured service delivery, explicit expectations, rules, and agreements establish the behavioral contingencies that

are central to successful programs and therapy. DBT is founded on a balance of validation and accountability, and clients cannot be held accountable to treatment if they do not know what is expected. Clear expectations help clients identify what they are working on and what behaviors are not acceptable, and they create containment that maintains safety and promotes treatment progress. Operating within structure is also a life skill as most natural settings are structured to varying degrees. As a rule, it is effective to practice in therapy what works in the world, and too little structure does not work in treatment or in life.

Remember a time when you have been in a nebulous, unstructured situation without a clear idea about what you were supposed to be doing. Often these situations cause anxiety, fear, frustration, or other emotions that can be difficult to tolerate. Clients who already have emotional dysregulation and chaotic, unskillful behaviors need clarity in their environments in order to learn skills. Not being clear about what is expected is unfair and puts clients in needless distress, an iatrogenic treatment response.

When clients agree to do DBT, think about informed consent as the first opportunity to establish structure. Discuss the diagnosis, the treatment indicated, the expected course of treatment, the pros and cons of treatment, treatment alternatives, and treatment outcome data that support your treatment as well as any financial obligations and the limits of confidentiality. Then discuss the particulars of your DBT program, including the required treatment components, when and where the appointments are, the attendance policy, and the rules of the program. The items in this paragraph are meant not to be exhaustive but rather to underscore that there is a lot of discussion to be had in properly structured treatment. Have all important policies in written form to present to clients, validate that the amount of information can be overwhelming (but be matter of fact, not apologetic), and let clients know that questions and discussion are welcomed.

These initial conversations are good times to start talking about treatment as an active collaboration, requiring both of you at the table, working hard together in a therapeutic alliance to reach agreed-upon treatment goals and objectives. Research shows that early agreement on the goals and objectives of treatment underlies the therapeutic alliance and is predictive of positive outcomes. For hesitant clients, the full use of commitment strategies (discussed in Chapter 15) will be interspersed in orienting clients to treatment. A complete understanding of the undertaking ahead represents mutual agreements that form a therapy contract. Once agreements are in place, there is a clear architecture as to what will transpire.

When presenting expectations and rules, consider having clients tell you the rationale for each one instead of explaining it to them. This type of presentation lets clients "own" agreements. In addition, be sure to clearly post expectations and rules in program areas.

Sometimes we have clients who resist expectations, rules, and structure, and the accountability can cause behavioral outbursts that buck the system. These reactions can tempt us to abandon ship and allow for greater flexibility and a lack of accountability. However, if you abandon your structure or change your rules (programmatically or individually) for a client, or if you fail to address a broken rule or agreement, you are participating in therapy-interfering behavior (TIB) with the client. Clients do not always need to agree with the philosophy of certain expectations and rules, but they need to respect them and follow them. Sticking to agreements is difficult for both clients and therapists, but it models what tends to be effective in real life. If you have difficulties holding clients accountable, seek consultation. Difficulties by either clients or therapists in following what is expected in the treatment framework should be openly discussed in consultation and addressed at the earliest available opportunity.

Remember that it is compassionate to have expectations and rules and to stick to them, even if the consequence is discharging a client from the program or from individual therapy. Predictability and consistency are paramount to success, for to do otherwise may recreate the type of environment that contributed to clients' problems in the first place.

Box 10.4 has expectations and rules for a DBT program, and Box 10.5 has expectations and rules for individual DBT therapy. These guidelines serve as examples and may require additions, subtractions, and other changes based on differing populations and settings. For example, specifics regarding attendance policies are likely to vary; the key is to have a policy that makes sense and to stick to it.

**Box 10.4** Program Expectations and Rules

- Clients must attend *all* scheduled sessions. Cancelled or missed sessions will be treated as therapy-interfering behavior unless negotiated up front and cleared by the therapist.
- Clients in the program who miss sessions will be accountable to the attendance policy of the program (e.g., 90% minimum

attendance of all DBT sessions). Violation of the attendance policy may be grounds for discharge.
- Clients are expected to be on time for sessions.
- Clients are expected to attend all scheduled professional appointments and comply with prescribed medications.
- Clients are expected to complete homework and change analysis as assigned.
- Clients are expected to participate in safety assessments and safety planning. Being unable to commit to safety or being unwilling to engage in safety assessments and planning for suicidality will result in hospitalization.
- Clients are to maintain confidentiality. Individual and program issues are not to be discussed outside program or during break times. Breaking confidentiality may be grounds for discharge.
- Clients are expected to participate in skills training, to complete assignments, to present diary cards, and to give validation, support, and suggestions to peers.
- Clients are expected to take therapy time to problem-solve and practice skills whenever significant distress is reported.
- Clients are not to engage in suicidal or self-injurious behaviors when on premises. Engaging in these behaviors on premises will be grounds for immediate discharge.
- Clients are not to come to program under the influence of drugs or alcohol.
- Clients' feedback and behavior are expected to be respectful at all times. Anyone giving disrespectful feedback or engaging in disrespectful behavior may be asked to leave.
- Clients are encouraged to form relationships with others in program. However, clients are expected to be clear about their personal boundaries and be respectful of others' personal boundaries.
- Romantic or intimate relationships are not allowed between clients.
- Relationships with others in program may not be private and must remain skillful.
- Clients are not allowed to use alcohol or drugs or to engage in unskillful behaviors together.
- Clients are not allowed to exchange or share medications.
- Clients are not allowed to keep secrets regarding other program members' harmful behaviors.

- Clients are encouraged to use other clients for support outside the program. However, clients are not obligated to be available to others outside the program. Again, clients are expected to be clear about their boundaries and respectful of others' boundaries.
- Clients may not call other clients after they have been engaged in target behaviors. Clients must call *before* acting on those behaviors or not at all.
- Clients are expected to honor payment agreements for copays, deductibles, and uncovered services.
- Clients are expected to follow other rules and policies of the clinic not listed here.
- Violation of program rules may result in consequences including homework, behavioral analysis, suspension, and/or discharge.

Adapted from Pederson and Sidwell Pederson, 2012. Reproduced with permission.

**Box 10.5** Individual Therapy Expectations and Rules

- Clients are expected to attend *all* scheduled sessions. Cancelled or missed sessions will be treated as therapy-interfering behavior unless negotiated up front and cleared by the therapist. Cancellations require 24 hours' notice.
- Clients who miss sessions will be accountable to the attendance policy (i.e., 90% minimum attendance of all sessions). Violation of the attendance policy may be grounds for discharge. Two no-shows (not coming to session and not calling ahead to cancel) to individual therapy will result in discharge.
- Clients must attend all other therapy-related appointments (e.g., medication prescriber, case manager).
- Clients are expected to be on time and prepared for sessions.
- Clients must complete homework and behavioral analysis as assigned.
- Clients are expected to participate in safety assessments and safety planning. Being unable to commit to safety or being unwilling to

engage in safety assessments and planning for suicidality will result in hospitalization.
- Clients are expected to honor payment agreements for copays, deductibles, and uncovered services.
- Clients are expected to follow other rules and policies of the clinic.

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# 11

# DBT Treatment Stages and Hierarchies

Linehan (1993a) outlined treatment stages and a hierarchy for target behaviors to make therapy with clients who have safety issues and frequent crises more manageable. Chronic and complex problems often present a crisis du jour, and clients and therapists can lose track of treatment priorities. Further, clients *and therapists* commonly interfere with and even sabotage the treatment, often unwittingly. Treatment stages and the hierarchy provide the road map for therapy to move forward with formal consistency rather than devolving into a reactive crisis-response service.

DBT has a pretreatment stage followed by four other stages.[1] The hierarchy for target behaviors is active across stages, but it is especially relevant in early stage one treatment. Linehan's (1993a) hierarchy establishes relatively fixed guidelines as to treatment priorities, but thoughtful adaptations to target relevant issues not in the original hierarchy may be made with clinical judgment. For example, Pederson (2013) presented an adapted hierarchy for populations with substance-use disorders that emphasized those issues immediately following safety. Further, because the stages and hierarchy were designed for high-intensity clients, many of the issues the stages and hierarchy were designed to address may be irrelevant to lower intensity clients. These clients may start in a later stage with lower-order

[1] Stage one is the focus of most DBT research. Linehan is just beginning to research stage two.

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

hierarchical targets. Linehan's (1993a) stages follow, with the hierarchy embedded under stage one as it is used most often in that stage.

## Pretreatment Preparation

Pretreatment preparation should not be overlooked as it sets the therapeutic factors into motion. Successful treatment depends on more than initial rapport-building. The therapeutic alliance rests on education, on orientation, and on mutual goal-setting and agreement on the methods for obtaining those goals. Linehan (1993a) wisely recognized that pretreatment preparation establishes the foundation for everything that follows.

In a review of the literature, DeFife and Hilsenroth (2011) outlined therapeutic factors necessary for successful outcomes. Consistent with the contextual model, a plausible and accepted rationale for the presenting problems needs to be established, along with an approach to remedy those problems. In DBT, this involves a brief explanation of the biosocial theory, of how the treatment approach flows from the theory, and of how it is responsive to the client's problems. The therapist and client should then collaboratively develop a treatment plan responsive to the client's problems, with the therapist fostering positive expectations about treatment outcomes and how change unfolds over time being central to this discussion.

DeFife and Hilsenroth (2011) also emphasize establishing the roles of therapists and clients and the activities of treatment as soon as possible. The structure of treatment and the treatment agreements should be clearly delineated. A detailed orientation ensures informed consent and leaves no stone unturned about who does what and when, so all parties enter the treatment with eyes wide open. The orientation should cover the amount of therapy contact (including availability between sessions), the structure and content of sessions, and the activities done in session and assigned between sessions. Additionally, expectations regarding fees, attendance, cancellation, and potential discharge issues are covered. Anything relevant to treatment or likely to come up is discussed at this stage so there are minimal surprises later. Because of the amount of information, it is helpful to have an orientation packet with these details.

Pretreatment planning is vital but can be overwhelming, so the use of validation and commitment strategies is needed to navigate this stage.

## Pretreatment and the "Butterfly" Client

"Butterfly" attachment styles are characteristic of many populations including those with abandonment issues, those with ambivalence about treatment, and those with cooccurring disorders (Dimeff & Linehan, 2008; Linehan, 1993a). These clients drop in and out of treatment, and, just when the therapist thinks they have them committed, they fly away. Therapists should discuss this potential attachment issue when initiating therapy, and, if it applies, develop a collaborative plan with clients to address it.

When butterfly attachment is interpersonal and based on past abandonment, therapists and clients can have a frank discussion on the importance of consistency and predictability in order to establish a therapeutic alliance. Moreover, therapists can provide reassurance in regard to their availability and willingness to work with clients so long as they do not overpromise in terms of what can reasonably be provided and do not go outside the established treatment framework, including its rules and expectations. The goals of this conversation are clarity, predictability, and putting the cards on the table. The message should be: "If you are willing to do your part, I am willing to do my part, and you can count on me if I can count on you."

If ambivalence to treatment is the heart of the attachment issue, therapists should consider the client's stage of change and not push clients too hard to change problems that rest in the precontemplation (engagement) and contemplation (persuasion) stages. Instead, therapists can lean more heavily on interventions that are better received in these stages, such as validation, rapport-building, symptom management, and solving practical problems. Remember that, if clients seem unwilling to work on certain goals, the task becomes finding out what they are willing to work on now. The subsequent agreement on initial goals can be reflected on the treatment plan, and commitment to work on them together can secure the attachment.

Practically speaking, Dimeff and Linehan (2008) emphasize considering increased client contact by phone, secure email, or other outreach methods until the client is clearly connected to treatment. They also recommend knowing where clients can be reached in the case of no-shows. Early on, therapists can also enlist the support of family and friends with the client's consent. This information should be put into an action plan to use if the client appears to have dropped out.

Nonetheless, I believe that therapists have to be clear up front about the amount of client "tracking" and "chasing" that will happen (e.g., a limit can be made by clear attendance expectations and defining the point

at which discharge from treatment happens). Therapists who as a pattern show more commitment and hard work than clients are typically not effective; a dialectical balance is needed in these situations. Further, practitioners need to be careful not to reinforce a pattern where clients gain what appears to be more support for being out of treatment versus being in it.

## Stage One: Stability and Behavioral Control

Stage one focuses on high-intensity behaviors that threaten the client's life, cause self-harm, and interfere with therapy. The theme of stage one is stability: the elimination of suicidal and self-injurious actions, frequent hospitalizations, and unrelenting crises. As a rule, it is difficult to make progress with clients who lack foundational skills and have basic safety and life needs unmet, so follow the simple guideline of "stability first." To secure stability, stage one is particularly geared toward skills training and application, which can be accomplished with written skills plans that are practiced daily. For stage one, Linehan (1993a) established the following hierarchy for target behaviors.

### 1. Suicidal urges and behavior (suicide ideation, SI)

As the top treatment priority, therapists assess and intervene with suicidal urges and behavior. Although the hierarchy offers direction and can be adjusted in general, there is no situation that is elevated above life-threatening safety issues.[2]

### 2. Self-injurious behavior (SIB)

All self-harming urges and actions, including behaviors such as cutting, scratching, picking, burning, hitting, and head-banging, fit into this category. Astute therapists assess for idiosyncratic SIB too. For example, one homosexual client who felt shame about his sexuality would make advances toward clearly homophobic men with the intent of getting beaten up. Another client cut off her hair (which she highly valued) when in a state of rage. Yet another client would drink an excessive amount of vodka with the intent of inducing a miserable hangover. All of these behaviors

[2] Homicidal urges and behaviors, though relatively rare in most settings, would fit into this top category.

**Table 11.1** Examples of Therapy-Interfering Behavior (TIB)

| *Client TIB* | *Therapist TIB* |
|---|---|
| Missing appointments | Missing appointments |
| Lateness | Not starting or ending on time |
| Not completing the diary card, behavioral analysis, or other homework | Being too nurturing or pushing too hard toward change |
| Being dishonest or leaving out important information | Being judgmental |
| Not addressing important issues | Not sticking to agreements or addressing broken agreements |
| Engaging in behaviors that will lead to discharge | Blaming the client for not progressing |
| Refusing to participate | Not assigning or following up with homework |
| Not paying copays, deductibles, or other fees | Refusing to consult or being resistant to feedback |
| Not practicing skills outside therapy | Poor self-care |

are self-injurious (with two of them potentially being life-threatening at an extreme). Most of the time SIB is not treated as an emergency and does not require hospitalization. However, there are some cases in which SIB must be treated in the same manner SI.

If an SIB could reasonably result in serious injury or death, it must be treated more like SI, regardless of intent. For example, if a client cuts so deeply that a major vein or artery could be severed or that nerve damage could result, the client needs to have a clear commitment to safety or be hospitalized. Similarly, if a client would experience severe, life-threatening medical issues if she relapsed on alcohol, the client would be hospitalized if she did not have a clear safety commitment to stay abstinent. More on safety issues is presented in Chapter 25.

### 3. Therapy-interfering behavior (TIB)

Therapy-interfering behavior includes anything that the client *or the therapist* has an urge to do or does to disrupt therapy or that risks the therapeutic alliance. Table 11.1 shows common examples of TIB.

Consistent with other interventions, TIB is addressed in a respectful and matter-of-fact manner. While specific techniques such as behavioral analysis can be used with TIB, therapists should elicit client feedback

about the therapeutic alliance, the goals, and the methods to make sure that TIB is not a symptom of an ineffective alliance or approach. Further, although TIB can be artificially classified as stemming from either the client or the therapist, it is more dialectical, practical, and fair to view it as resulting from both parties. This balanced perspective diffuses blame and sets the stage to reengage and recommit to a plan moving forward.

To be most effective, any TIB should be addressed the first time it occurs instead of waiting for it to be a pattern. Therapists need to be appropriately assertive with clients, and with each other, to address these distractions from and road blocks to treatment.

## 4. Quality-of-life-interfering behavior (LIB)[3]

These behaviors interfere with the client's ability to accomplish important goals and live a reasonably satisfying life. Like TIBs, the list of possible LIBs is innumerable but could include alcohol and drug use, excessive conflict, passive involvement in one's life, and insufficient attention to activities of daily living.

Sometimes questions exist about where certain behaviors fit on the hierarchy. For example, drug use is often listed as an LIB, but it could be treated as a TIB if the person was too hungover to participate in treatment, as a SIB if it was causing serious physical harm, or as an SI if it was causing imminent, life-threatening physical harm.

As guidelines, if a behavior has a clear and imminent risk to life, treat it like SI. If it causes clear physical harm, treat it as SIB. And, if it causes a clear disruption to treatment, treat it like TIB. Otherwise, treat it as an LIB. Obviously, sometimes clinical opinions differ as to how to categorize certain behaviors. In these cases, address SI first and other important treatment targets in the order that seems prudent based on your clinical expertise in combination with consultation with the client and other professionals.

Remember that clients who have target behaviors on this hierarchy also need them to be reflected in the treatment goals and in safety and skills-implementation plans. Attending to behaviors on this hierarchy requires constant consideration of training skills, shaping effective behaviors, and building on existing and emerging strengths. While attention to treatment targets is important, therapists cannot forget that *at least equal* attention

[3] Linehan did not coin the term "LIB." However, acquainting clients with this concept and how it is addressed on the hierarchy leads to increased attention to these important behavior targets.

and reinforcement need to be placed on positive behaviors. Most clients spend more time not engaging in target behaviors (i.e., doing something skillful) compared to time acting on them.

## Stage Two: Treating PTSD, Significant Stress Reactions, and Experiencing Emotions More Fully

When clients are stable, they transition to stage two treatment. Linehan's second stage treats posttraumatic stress disorder (PTSD) and other significant stress reactions when they exist. If PTSD is not an issue but the client has significant difficulty relating to emotions, stage two attends to more complete and less problematic emotional experiencing. In stage two, clients begin to develop a qualitatively different relationship to emotions, meeting them with an attitude of acceptance, and this change decreases getting stuck in suffering and/or needing to avoid and escape experience. The interventions used in this stage center on advanced mindfulness and contained exposure to experience.

## Stage Three: Solving Routine Problems of Living

Stage three has no predetermined or empirically studied treatment targets. Stable clients without intense stress reactions can fully focus on the problems and goals that lower intensity clients routinely bring to therapy.

## Stage Four: Finding Freedom, Joy, and Spirituality

The fourth stage also has no predetermined or empirically studied treatment goals. This stage centers on the actualization of freedom, joy, and spiritual connection, working toward greater peace and fulfillment. Stage four is for clients with low functional impairment who face basic existential concerns and are striving toward personal growth.

A common question pertains to the length of each stage of treatment. For example, Linehan's stage one research is most commonly based on a year-long DBT protocol. Practically speaking, the length of each stage is determined with clinical expertise in combination with each client's own clinical presentation and progress. Behavioral benchmarks (e.g., sustained safety, increased skill use, decrease in ER visits or hospitalizations) along with

outcome data will inform collaborative decision-making about moving to the next set of goals or revisiting a previous stage.

When navigating these stages and the hierarchy, therapists are reminded to also follow the therapeutic factors hierarchy described in Chapter 12. Box 11.1 contains a case study in which issues around treatment structure and priorities from a DBT perspective are considered.

**Box 11.1** Structure Case Study

A non-DBT therapist sought consultation about a client she was seeing in individual therapy. The client presented with a history of trauma, mixed personality features, and frequent dissociation. The therapist indicated that, as a result of extreme dissociation, sessions had recently become extended, taking as long as two hours when they were scheduled and billed for one hour. Further, the therapist said that she was now seeing the client for three sessions a week, being paid for only one of those sessions, because the therapist had become so concerned about the client's level of dissociative symptoms.

The consultation centered around two themes, the first being structure. The therapist had left her treatment framework by extending the length and frequency of the sessions, not in a planful manner but as a reaction to the client's increase in dissociation. Further, it became apparent that the sessions themselves did not follow a structure but were free-form in nature. The recommendation was that the therapist needed to "reset" her therapeutic availability and stick to one session a week contained to 60 minutes. If the client then needed more than could be obtained in individual therapy, the suggestion was to refer her to additional services or a program. The therapist also received instruction on how to structure sessions like DBT sessions.

The second theme that arose was that the therapist had been attempting trauma work, which predictably preceded the dissociation. Again related to structure, the recommendation was that stage one stability needed to occur before any attempts to work with the trauma.

The therapist adopted the recommendations and referred the client to a DBT program for skill-building. The therapist later reported that taking a structural and skills-oriented approach had resulted in improved outcomes for the client and much less stress and uncertainty for the therapist.

# 12

# The DBT Therapeutic Factors Hierarchy

Linehan's (1993a) treatment hierarchy streamlines clinical decision-making about what to prioritize with multiproblem clientele. In the course of treatment, therapists benefit from similar guidance as to what factors that affect outcomes should be prioritized. The DBT therapeutic factors hierarchy outlined below orients therapists to prioritize the areas that most impact change and provides DBT suggestions to maximize the factors' effectiveness. Though brief, this chapter draws from deep research on therapeutic factors (Duncan, 2010) and promises to enhance outcomes with your clients.

## 1. Develop and Maintain the Therapy Alliance

The therapeutic alliance should receive attention above all else, both when initiating treatment and when moving through it. Without a working alliance, therapy outcomes will suffer. DBT interventions that speak directly to the alliance include validation, reciprocal communication (especially related to warm engagement and taking wants and needs seriously), and therapist-driven attitudes and qualities such as nonjudgment, authenticity, and respect. In regard to the alliance, the match or goodness of fit between the client and therapist needs to be discussed at the onset of treatment and throughout it as necessary (Linehan, 1993a). It is important that

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Lane D. Pederson.

both parties have confidence that they can collaborate and have an effective working relationship. Further, in group settings the match between the client and other group members needs to be addressed as cohesion with other members is an extension of the therapeutic alliance (Burlingame et al., 2002, 2011). Take the time and effort required to build a strong alliance. Many therapists make the mistake of assuming that alliance will be a given, will simply happen in time, or that good "rapport" is synonymous with alliance. Contrary to these assumptions, alliance building is an active process that involves constant attention to its well-being. Throughout treatment, the best way to monitor the alliance is with client feedback (Duncan, 2014), as discussed in Chapter 28. Do not assume that clients will tell you if they lack connection, so be sure to initiate conversations about the state of client–therapist relationships.

## 2. Develop Mutual Goals and Collaboration on Methods

Remember that agreement on goals, collaboration on methods, and commitment to treatment underlie the working relationship. Although mutual goals and collaboration are addressed in the pretreatment stage, they often need to be revisited as clients and therapists frequently get derailed during the course of treatment (or worse, treat goals as an afterthought or even fail to explicitly establish them!). When therapy is off-track, reestablish an agreed-upon goal that is specific, measurable, and attainable. At this point, therapist allegiance to DBT methods can also be reemphasized with the hope that the belief and expectancy of the client can be bolstered. Once on board, therapist allegiance and client belief and expectancy result in therapy/model delivered, the supercharged application of DBT (or any therapy) (Duncan, 2010).

To summarize the first two targets of this hierarchy, remember that the alliance is the basis of effective treatment and it is the *first* area to check when therapy fails to get off the ground or is ineffective. Importantly, if a therapeutic alliance cannot be established, a referral is indicated. Similarly, if the client and therapist cannot establish a goal or the client does not believe in the DBT approach and methods, then the therapist needs to either adjust or change the approach or make a referral. In this process, therapists remain open to client feedback, use outcome data together with clients, and seek consultation to address therapist motivation and other potential issues.

## 3. Identify and Engage Client Strengths and Resources to Maximize Helpful Extratherapeutic Factors

The activation of client strengths to improve outcomes has been demonstrated in numerous studies (Flückiger & Grosse Holtforth, 2008; Gassmann & Grawe, 2006; Smith & Grawe, 2003, 2005). Strengths consist of internal client attributes that can improve functioning and outcomes, and resources consist of external material and service assets that clients can use to their benefit. Strengths include health, a sense of humor, willingness, ingenuity, persistence, kindness, courage, and different types of intelligence. Resources include social support, access to treatment and services, transportation, a degree or special training, owning a phone or computer, having sufficient finances, owning a pet, and having housing. Connecting clients with strengths and resources fosters hope and lights pathways to accomplishing goals. Listen closely to clients to elicit strengths and resources and consider using a formal inventory to draw those qualities out while also connecting clients to a variety of resources outside therapy. Always consider (dialectically) what is "right" with clients.

Along with building strengths and resources, actively identify and problem-solve extratherapeutic factors that interfere with treatment.

## 4. Establish and Maintain the Treatment Structure

Establish or reestablish the treatment framework, expectations and rules, and protocols and guidelines as required. Make sure the level of treatment structure is conducive to the amount of medical necessity and level of care. Educate and orient clients to the purposes of treatment structure and how these benefit them, and follow the structural components of treatment consistently.

The therapeutic factors hierarchy is to be used in concert with the hierarchy for treatment targets. To address major targets such as SI, SIB, and TIB, therapists must simultaneously attend to therapeutic factors. Dialectically, the application of these factors requires constant adjustment based on therapist expertise in conjunction with feedback and involvement from the client, knowing that the context of therapy and therapeutic interactions changes constantly. Such a philosophy is shared by both the dialectical nature of DBT and the contextual model.

# 13

# Self-Monitoring with the Diary Card

The diary card is the characteristic method of self-monitoring in DBT. The diary card keeps clients responsible for tracking important therapy-related information and changes in everyday life. Research shows that clients value increased self-knowledge and the identification of patterns (Johansson & Werbart, 2009), and the diary card accomplishes these goals among others.

The diary card is the primary tool used to identify the treatment priorities that craft the agenda of each therapy session. Because it contains a wealth of information, both client and therapist can instantly see what has improved, gotten worse, or stayed the same. Moreover, the diary card tracks the hierarchical DBT targets including safety issues, treatment-interfering behavior, and other behaviors that significantly impact the client's quality of life as well as the skills being used to address these concerns.

Virtually any information relevant to therapy can be monitored on a diary card. In a traditional DBT setting, tracked categories must include suicidal urges, self-injurious behavior, and treatment-interfering behavior. In a chemical-dependency setting, clients would track urges related to drug and alcohol use and other behaviors related to maintaining abstinence and moving into sobriety. With eating-disorders work, it is vital to track information relative to those applications of DBT and recovery from those symptoms. Of course, many diary cards have clients track the

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Lane D. Pederson.

commonly reported symptoms of depression, anxiety, and anger as well as areas such as sleep and self-care. It is also effective to have clients track their own treatment objectives and progress toward goals. While there might be widely adopted versions of diary cards, it is important to customize them to unique populations and programs to optimize clinical and personal relevance.

Clients typically fill out a detailed diary card on a daily basis for the previous 24 hours, noting average levels of symptoms and urges along with other information. However, depending on the client, population, or clinical issues, changes might be needed. For example, when working with younger adolescents or children, you may choose to use a simplified diary card (perhaps based on visual analog scales) that is supplemented by a diary card that the parent fills out. Or, with a client with depression, you might design a diary card that tracks depression hourly or by averages in the morning, afternoon, evening, and nighttime rather than on a daily basis. Again, make changes that increase the relevance or enhance the information provided by the diary card.

Clients must be given clear directions for how to fill out the diary card and be oriented to the purpose of it and why it is important *for them* to complete it thoughtfully. Most clients can expect to spend five to 15 minutes a day on their diary card, and they will be most successful in completing it if they choose a time and place that is consistent and predictable. Therapists can also use the Premack Principle (explained more fully in Chapter 20) to get clients to fill out their diary card. For example, a client who engages in a predictable and/or pleasurable activity everyday can be asked to complete the diary card before he or she engages in that activity.

When clients fail to fill out their diary cards, do them at the last minute, or otherwise complete them without thoughtful intention, address those behaviors as treatment-interfering and obtain commitment to get the diary card back on board. Many times clients simply forget to complete diary cards (which is why establishing specifics around time and place helps), so consider coaching the client to set an alarm on their watch or smartphone as a reminder.[1]

Diary cards are as relevant as we make them, so maximize their therapeutic value. Beyond being a tool for the purposes delineated above, the diary card can be seen as a direct line to what the client experiences day by

[1] It is increasingly common for clients to use diary-card apps on smartphones, iPads, and other mobile electronic devices in place of paper-and-pencil versions. So long as a chosen version tracks the information needed for sessions, electronic diary cards can be a preferred method for some clients.

day. As such, they can be used to enhance the therapeutic alliance through validation of what is impactful and through reinforcement of effort and effective skill use.

Box 13.1 shows sample expectations, instructions, and a diary card. This sample is representative of a traditional diary card, but additional versions of diary cards in the public domain can be found with an online search. Diary-card apps available for purchase online can also be used with some clients who prefer that medium.

**Box 13.1** Diary-Card Expectations and Instructions

Diary cards track symptoms, skills, and other information relevant to your treatment. Over time you will gain greater awareness and will see the progress that comes with skill use. Diary cards also help to identify treatment targets so your therapist can support and help you more effectively. Please follow these expectations when completing your diary card:

- Fill out your diary card *every day*. Take approximately 10 minutes to do it thoughtfully. Establish a specific time and place to complete it.
- Incomplete or last-minute attempts to fill out your diary card will be treated as therapy-interfering behavior.
- Report honestly on your diary card. Your therapist cannot be helpful with missing or incomplete information.
- Any time you indicate a "yes" for suicide ideation, self-injurious behavior, or treatment-interfering behavior, these issues will be addressed as treatment priorities.

**Diary-card instructions**

The diary card develops awareness and helps you and your therapist to set the agenda for sessions based on what is most important. Please follow these instructions to fill out your diary card:

- Fill out your diary card everyday at the same time. Do it thoughtfully and bring it to all therapy sessions.

- *Medications (RX)*. If you took all your medications as prescribed in the previous 24 hours, use a Y (yes) under that category. If not, use an N (no).
- *Depression (DEP), anxiety (ANX), and anger (ANG)*. Use a 0 to 10 scale to rate the average level of each area for the previous 24 hours.
- *Suicide ideation (SI), self-injurious behavior (SIB), and treatment-interfering behavior (TIB)*. Use a 0 to 10 scale to rate the average urge level of each area for the previous 24 hours. Additionally, use a Y (yes) or an N (no) to note whether you acted on the urge(s) or took planning steps to act on the urge(s) (e.g., "9/N" for SIB would be a high urge with no action on it).
- *Sleep*. Note the total hours of sleep for the previous 24 hours. Draw a slash mark (/) through the number if the sleep was disjointed or not restful.
- *Energy*. Use a 0 to 10 scale to rate your average level of energy for the previous 24 hours. 0 means no energy and 10 means agitated or manic-like energy.
- *Drugs and alcohol (D/A)*. Use a 0 to 10 scale to rate the average urge level for using drug and alcohol, including the use of over-the-counter medications for the previous 24 hours. Additionally, use a Y (yes) or an N (no) to note whether you acted on the urge(s) or took planning steps to act on the urge(s).
- *Self-care PLEASED skills (PL)*. Use a Y (yes) or an N (no) in regard to *efforts* toward self-care.
- *Other*. Track any other symptoms, behavior, or issues important to your treatment.
- Under each category, record the skills used to address these areas.
- On the backside: Record your feelings, positive experiences, and gratitude for the previous 24 hours.

## Diary card

| | RX | DEP | ANX | ANG | SI | SIB | TIB | Sleep | Energy | D/A | PL | Other | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MON | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |
| TUE | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |
| WED | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |
| THU | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |
| FRI | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |
| SAT | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |
| SUN | | | | | | | | | | | | | |
| Skills | | | | | | | | | | | | | |

| Day | Feelings | Positive Events | Gratefulness |
|---|---|---|---|
| MON | | | |
| TUE | | | |
| WED | | | |
| THU | | | |
| FRI | | | |
| SAT | | | |
| SUN | | | |

# 14

# Validation

## *The Cornerstone of the Alliance*

Validation requires active listening and accurate, nonjudgmental acknowledgment of the client's experience, and it is a primary intervention for building the therapeutic alliance. It is difficult for clients to change when others do not adequately recognize their emotions and experiences, and, as guided by the biosocial theory, a primary goal of treatment is to create an explicitly validating environment where clients feel understood and valued and feel that the therapist is present with them. Through validation we stay in the moment with the client by not getting too far ahead or too far behind, and in this process we open the client to change-oriented interventions. Even so, it is important to know that validation is not intended to be a means to an end (i.e., something done to get to an intervention) but is a healing intervention in its own right.

To accurately validate clients, therapists need to suspend their propensity to fix and problem-solve as well as leave enough space for clients to connect and stay with an experience for some period of time, perhaps a bit longer than is comfortable for both parties. Paradoxically, tolerating and accepting the moment is actually the change needed for many clients, and, when change and problem-solving do not seem to work, revisiting acceptance and validation is often indicated. Therapists must make sure clients feel understood before moving on to change or problem-solving.

Validation can be better understood from a couple of vantage points. First, validation provides a corrective interpersonal experience in which a

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Lane D. Pederson.

person receives what has long been missing: understanding that is helpful in and of itself. When this occurs, so does new learning. Clients who previously have been invalidated (punished) by others for their expressions learn that they will be accepted at least in the treatment setting, reinforcing more disclosure and experiencing over time. The increase in disclosure that begins with validation is vital as people must frequently attend to emotions and experiences, often painful ones, before other behavioral changes happen.

As clients attend to these experiences, they learn that what is painful can be tolerated, and, whereas clients might otherwise escape and avoid their feelings, the use of validation provides a safe container for their expression. This contained way of experiencing is similar to the use of an exposure technique (Koerner, 2012). Because validation nearly always down-regulates affect, clients in a validating environment learn to feel in an emotionally balanced way, develop a sense of self-efficacy with emotions, and allow more complete expression of those emotions. Because emotions have adaptive functions, expressing them in a contained manner is more adaptive than escape and avoidance or the problems that come with dysregulated expression.

As therapists (and clients) gain skill with validation, they can apply it with increasing depth and accuracy through the use of levels of validation.

## Levels of Validation

Linehan (1997) established six progressive levels of validation with the therapeutic goal being to validate at the highest level possible. The first level is being *mindfully attentive and alert*. Being "awake" in the moment with 100% of your attention and concentration is not easy and is a gift to the client (how often do you think you have that level of others' attention?). To accomplish this level, therapists need to put aside all distractions and use mindfulness to "tune in" to clients.

The next level is the out-loud *acknowledgment of what the client says*. This level calls for reflecting verbal information, and, while it can be done word for word, it is best to reflect the major themes rather than repeat word for word what the client said. To illustrate this and subsequent levels of validation, imagine that a client comes in "referred" by the court system. This client has frequently been in power struggles with well-intentioned service providers trying (unsuccessfully) to get her stable and healthy. The court has directed the client to attend treatment or be committed to a regional hospital for an extended stay. The following exchange shows what the second level of validation with this client might sound like:

**CLIENT (C):** (*looking down, closed-off body language, with semihostile tone*) I'm just here because I have to be. Won't do no good. Therapy's always been a waste of time.

**THERAPIST (T):** (*attentive and understanding*) I understand you were told to come and that therapy hasn't helped you.

The next highest level acknowledges both what the client says and *what is communicated nonverbally* and with tone. It builds on the client's words with what was not said but is present in the experience. With this level the interchange might sound like:

**C:** (*looking down, closed-off body language, with semihostile tone*) I'm just here because I have to be. Won't do no good. Therapy's always been a waste of time.

**T:** You're frustrated (*picking up on tone*). No wonder if you have to be here and therapy's been a waste of time. (*pauses*) It looks hard to open up right now (*picking up on body language*).

Validation on the fourth level articulates how the client's experience *makes sense given history or biology*. In the present example, the therapist might say:

**C:** (*looking down, closed-off body language, with semihostile tone*) I'm just here because I have to be. Won't do no good. Therapy's always been a waste of time.

**T:** You sound frustrated. Therapy's been a waste, and who wouldn't close off being made to do something. I bet you're tired of being bossed into therapy and in therapy!

The succeeding step of validation connects with how the client's experience *makes sense in the present* moment, right now. At this level the therapist's response might be:

**C:** (*looking down, closed-off body language, with semihostile tone*) I'm just here because I have to be. Won't do no good. Therapy's always been a waste of time.

**T:** You're frustrated! No doubt with being bossed around so much. Who would want to come to treatment if it's been a waste, and, you know, why should you expect me to be any different? I might be just another person trying to give you what you don't want.

Validation at its highest level (or alternatively the foundation of validation) is *being in genuine human contact with clients*. To do this, therapists must let go of being in a therapist or expert "role" and instead risk being an authentic person with their clients. This sixth level of validation no doubt has profound impacts on the quality of the therapeutic alliance. As validation is used, it is important to differentiate it from a related but different technique, normalization.

## Validation versus Normalization

Many therapists confuse validation with normalization, but there is a stark difference. Validation is about connecting with the unique experience of an individual whereas normalization is about communicating that other people have the same experience.

Sometimes normalization can be needed and enormously beneficial. The knowledge that others share an experience can make it seem less extreme or less pathological, or result in feeling less alone. Anyone who has felt behind in a class or at work only to discover that others did too knows the value of normalization, as do parents who learn that it's not just their child who melts down or experiences a particular problem. Similarly, going to a therapy program and meeting people with similar issues normalizes and often brings relief to clients.

The caveat to normalization is that it causes invalidation when a client does not feel that his or her individual experience is adequately acknowledged. In some cases, normalization belittles individual experience with the inadvertent message that emotional pain and other aspects of the issue are shared when they are really extraordinarily personal events.

The following two examples show the differences between normalization and validation.

### *Example 1*

C: I feel so guilty. I mean, what kind of mom doesn't feel like spending time with her kids? I haven't wanted to attend their practices, their games, in weeks. It's hard to just get to the dinner table.

T: You know I work with a lot of people like you. Depression saps their interest and energy. You're not alone. This is what depression does. (*Normalizes the experience.*)

*Example 2*

C: I feel so guilty. I mean, what kind of mom doesn't feel like spending time with her kids? I haven't wanted to attend their practices, their games, in weeks. It's hard to just get to the dinner table.

T: It's so hard for you to get moving, and most the time you don't feel up to it. I can see how debilitating this depression has become, and, if that wasn't enough, now you're caught in guilt too, with how it might be affecting your children. (*Validates the experience.*)

Although the first example might work, it could also provoke a response in which the client feels misunderstood or as if her concern is being brushed off. The client may think, "So what if other people have this too—what does that have to do with *me*?" The second example attempts to connect with the client's experience. Yes, other people have similar experiences, but the exchange is about how the experience affects the client, not others. The decision to normalize versus validate is clinically based and determined by a particular client's needs, and the two techniques can often be used successfully in tandem. The key is to know the difference between the two and to get the desired result. As a rule, validation is the preferred intervention.

To conclude, validation is essential for clients to feel understood and to open them to learning skills and practicing change behaviors. Since clients often come from or are in invalidating environments, validation creates a corrective experience and new learning for clients who in turn increase the amount of their disclosure. Disclosure and expression in a validating environment are healing in and of themselves; validation soothes and contains emotional experience, creates gentle exposure to what is uncomfortable or painful, and allows for more complete, and theoretically adaptive, expression of emotions. Ultimately, clients learn that emotions can be tolerated and feeling them becomes an alternative to escape and avoidance behaviors. In time, validation from the therapist develops a bridge to self-validation. Because it flows directly from the biosocial theory and operationalizes the therapeutic alliance, validation should be used liberally in therapy.

# 15

# Commitment Strategies

Commitment strategies significantly increase compliance with therapy tasks and completion of therapy itself. Linehan (1993a) emphasized the use of commitment strategies, many of which have been culled from the social-psychological literature and are used extensively in advertising, in the field of sales, and to increase prosocial community behaviors. Cialdini (2008) emphasizes that commitments work because once people take positions they want their behaviors to be consistent with them.

In DBT, commitment strategies are first used to obtain an agreement to attend therapy and work toward stabilization or other goals. Many programs for clients with multiple and severe problems require a significant time commitment of up to one year, with the opportunity to recommit to further therapy following the initial contract. Even with shorter-term applications of DBT, it is not a given that clients will show up for a course of even five to 10 therapy sessions. Clients commonly have reservations about investing in something new and uncertain, especially for the long haul.

If a client struggles to commit to the expected course of treatment, a middle-ground option is to try the DBT program or individual therapy for a length of time or a number of sessions that will enable a realistic evaluation on both sides. Consistent with the pretreatment stage, the

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Lane D. Pederson.

client and therapist might commit to a number of sessions or length of time to evaluate whether a therapeutic alliance with agreed-upon work can be established. The actual number of sessions or time length can vary by client, although a defendable standard is based on a realistic estimate of the expected time required to connect and experience benefits. You cannot test drive a car indefinitely before a decision to buy has to be made, and therapists and clients cannot ethically meander along for too long without an agreed-upon treatment plan. The important point is that therapists and clients agree on timelines, expectations, and how progress will be evaluated.

Commitment agreements, whether standard to your program or individual to each client, should be openly discussed up front and preferably put in writing. Used alongside other techniques such as validation and motivational interviewing, the following commitment strategies delineated by Linehan (1993a) enlist clients to try treatment or simply a new behavior.

The first strategy is *Foot in the Door*, also called *Offer You Can't Refuse*. This technique has clients agree to something that virtually anyone would agree to in order to shape commitment. The key is to start small and build commitment from there. A client resistant to longer term treatment might be asked whether he or she could commit to the next session, and, if the clients agrees, the therapist might ask whether the client can commit to the next four sessions too. Or a suicidal client might be asked whether he or she would like to have a life in which suicidal urges were not a constant struggle (who would say no to that?) as a precursor to getting commitment to develop a safety plan. Another example might be getting the commitment to practice one self-care skill to improve health and wellness and then seeing whether the client would commit to using multiple self-care and/or other skills toward the same goal.

The dialectical opposite of Foot in the Door is *Door in the Face*. This technique asks for a deliberately large commitment expecting that the client might refuse it. However, after refusing large requests, clients will typically agree to smaller ones. A therapist might ask, "Will you come to treatment on an indefinite basis until your problems are resolved?" If the client agrees (which is highly unlikely), the therapist has a large commitment. If not, the therapist will follow up with a more reasonable request such as, "Can you try this program for four sessions, and then we can discuss what's working and what's not?" Similarly, when the client is presented with a list of skills, the therapist may request that he or she practice all of them. If the client balks, the therapist can then request a smaller commitment, maybe trying two or three of them.

The next commitment strategy is *Doing a Cost–Benefit Analysis*. For clients with unbearable lives, therapy brings the possibility of improvements even if the process has emotional, financial, and other costs. Often, a discussion of the pros and cons of therapy results in the identification of desired behaviors that would signal change. It may be determined that treatment will result in being emotionally stable enough to have a job, a relationship, or another desired outcome or that treatment will provide the client with coping behaviors to replace the target behaviors that necessitated therapy in the first place. Usually the cons focus on the perception that something else will be lost—for example, the opportunity to enter college or obtain or keep employment. Nonetheless, clients with significant functional impairment would struggle to be successful with those other opportunities without treatment, and coming to that realization often diminishes their ambivalence.

The fourth commitment strategy, called *Tying to Prior Commitments*, can be used in two ways. The first way is a reminder to clients about past commitments they have made. This in-the-moment application creates dissonance when a current behavior or possible choice contradicts an earlier agreement. For instance, a client who has committed to abstinence might say, "Screw it! I'm going to the bar, and I'm going to get wasted." The therapist would then reply, "But you've committed yourself to giving up those old drinking behaviors." This reminder brings the commitment-to-change issue to the forefront. The second way of tying to prior commitments capitalizes on the success of past accomplishments and relates them to the present moment. So, with the same client, the therapist might say, "You've accomplished not drinking everyday for the past three weeks, and you stuck with it. I know you're upset, but how can you use the same resolve you've shown today too, when things are extra hard?" This statement reemphasizes the commitment, notes the success with it, and moves the conversation to problem-solving. In a similar fashion, the therapist could generalize past follow-through to a present situation. In consultation, a therapist described the multiple problems of a current client who was missing sessions. The consult group validated the difficulty of making progress when the client was absent from treatment, and there was agreement that commitment strategies to secure attendance were needed. The group decided that tying to prior commitments applied and noted that this client had completed his master's degree in the past year. The therapist subsequently had a discussion with the client about his commitment, resolve, and follow-through in completing his degree, and she wondered aloud whether the same "stick-to-it-ness" could be used to make it to sessions too. The client agreed that he had the ability to get his attendance

on track, and then he and the therapist discussed the skills needed to attend sessions before shifting to commitment around addressing the client's presenting problems.

The fifth strategy is *Freedom and Choice in the Absence of Alternatives*. This technique emphasizes that limited options are on the table while encouraging the client to make the most of what is available. If it is really the last chance to attend treatment, save a relationship, or meet another goal, then perhaps it makes sense to throw all effort into the available option. This strategy confronts the realities of a given situation and plays up self-determination and choice to get an outcome, even if the means are not preferred ones. The message is to choose to take what you can get and make the most of it in the face of diminishing options. Sometimes clients come to therapy because the alternative would be long-term hospitalization or other options so undesirable that they are not considered viable. For example, if the options are treatment or an undesired alternative consequence (e.g., going to jail, losing custody of a child, having to move into a group home), getting the client to agree that successful therapy is the best choice creates a voluntary participant.[1]

The last commitment strategy is *Devil's Advocate*, which means arguing the other side of the dialectic or creating a counterargument relative to the client's position in order to get him or her to explore further. Devil's advocate is another intervention that can be applied in a couple situations to either change or solidify the client's position, depending on the desired outcome. First, when clients express ambivalence about change, therapists can play devil's advocate and make the arguments for staying the same. A therapist might say to a client who continues drinking, "Maybe it makes sense to continue using. Not having the responsibilities of relationships, a job, or a home to maintain could have its advantages." Or a therapist may say to someone reluctant to commit to therapy, "It may be better to continue on as things are now. Creating a better life brings expectations as well as something to lose." This (at times irreverent) approach is obviously used with nuance, skill, and insight into clients' true desires, as statements like these emphasize what clients want but are unlikely to obtain without change. Clients subsequently begin to argue for the change side of the dialectic, and then therapists move to solidify the commitment. Second, devil's advocate is indicated when clients offer up commitment that comes

[1] DBT is always considered a voluntary therapy. Even if the client feels compelled or "forced" by others to attend, he or she still has a choice. The therapist explicitly accentuates this choice. There are certainly people who "chose" an undesirable consequence to avoid therapy.

*too* easily, perhaps not recognizing the difficulty that may lie ahead. If a client starts treatment overenthusiastically, the therapist might ask, "Are you sure you want to commit to the program? Things get hard, and emotions get messy, and you may even want to quit if times get tough." The goal here is not to overplay the therapeutic hand and scare the client out the door. Instead, the therapist wants the client to double-down on his or her commitment, which the therapist remembers and conjures up later when useful.

Commitment strategies remain central to the pretreatment stage of DBT, but they are also used throughout the entire course of treatment. Use them not only to get clients connected to therapy but also in concert with dialectical abstinence to get clients to eliminate target behaviors including suicidal acts, self-injury, chemical use, and other destructive behaviors. Moreover, commitment strategies can be deployed whenever therapists want to shape responsible behaviors with everyday therapy tasks such as the diary card, behavioral change analysis, and homework.

Box 15.1 has a sample commitment agreement form.

**Box 15.1** Commitment Agreement Form

The following information has been explained to me, with an opportunity to ask questions for clarification:

- my diagnosis
- my expected course of treatment
- my individualized treatment plan with initial goals
- the program and/or individual rules and expectations
- the program and/or individual attendance policy
- the cost and my financial responsibility (e.g., copays, deductibles, payment agreements)
- other important information.

I agree to make a good-faith commitment to the DBT program and/or individual therapy with my willing participation for a period of ____ _____ or _____ sessions. As a part of this commitment, I agree to follow the DBT program and/or individual expectations, rules, and attendance policy. At the conclusion of this commitment

period, my therapist(s) and I will evaluate the course of treatment and decide between the following options:

- continue the DBT program and/or individual therapy with a new commitment agreement
- make an appropriate referral
- determine other arrangements.

Signed by client: _____ Date: _____
Signed by therapist: _____ Date: _____
**Original to client; copy to chart.**

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# 16

# Educating, Socializing, and Orienting

The DBT process is intended to be straightforward and transparent to clients. Many clients enter therapy with the idea that something magical happens in the therapeutic process or that the therapist will fix their problems (or them). The reality is that change happens through mutual investment in the therapeutic alliance, increasing self-awareness, practicing new behaviors, and engaging with expectancy in the everyday tasks of the treatment. Even if a client has had multiple courses of therapy in the past, assume that the processes and tasks of the current treatment have to be elucidated. Educating the client about the treatment is as important as teaching a kindergarten student about the classroom or a new employee about the workplace. Failing to educate and socialize the client is a sure setup for attenuated treatment outcomes, which is why education about treatment and socialization to it are a mainstay of cognitive-behavioral treatment (Beck, 1995; Linehan, 1993a).

As mentioned in the section on pretreatment, clients need to be taught and socialized to the DBT model at the earliest possible convenience. In addition, clients should continue to receive ongoing education and socialization to the tasks of therapy as they happen. If a mindfulness procedure is used, clients require information as to why it is relevant. When an intervention is suggested, such as experiencing an emotion, making a cognitive shift, or participating in a role play, clients need to see the connection

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Lane D. Pederson.

between the suggestion and their goals. Education and socialization to the treatment elicit cooperation.

Orienting is a technique that means describing how the therapy task at hand (e.g., obtaining commitment to treatment, explaining a skill, requesting a behavior change) will be of benefit to *clients'* goals (Koerner, 2012). Understanding what clients want and are striving toward is vital to orienting, not simply defaulting to the therapist's assumption of what they want. For example, the goal of someone with a substance-use problem may not be to cut down or quit use but instead to play in a band, get a significant other, have a peaceful family life, or get a more fulfilling job. Astute therapists will suss out what is underneath and tie the commitment or the suggestion to that motivation or goal. Here are two orienting versions of the above example, the first suggesting skills to meet the therapy's goals (quitting substance use) and the second suggesting skills to meet the client's goals.

### *Example 1*

**C:** I just have so much fear. I'm scared I'm not good enough for my girlfriend, that I'll be rejected, that I'll never make it being a musician. It's paralyzing and gets to the point of not being able to do anything but smoke pot.

**T:** It sounds like the fear shuts you down, freezes you, and all you can think of to cope is to use drugs. I can teach you some skills to quit smoking pot.

### *Example 2*

**C:** I just have so much fear. I'm scared I'm not good enough for my girlfriend, that I'll be rejected, that I'll never make it being a musician. It's paralyzing and gets to the point of not being able to do anything but smoke pot.

**T:** It sounds like the fear shuts you down, freezes you, and all you can think of to cope is to use drugs. I can teach you skills to manage those fears and anxieties so you can enjoy time with your girlfriend and work on your music.

In both examples the therapist validates, but in the first one she orients skill use as a way to stop drug use (the therapist's goal) and in the second one

skill use is framed as a way for the client to have a better relationship and get into his work as a musician. The second example speaks to his most immediate wants and identifies the core reasons he smokes marijuana. The first only addresses what covers the symptoms, the use of drugs, and as such may be less motivating to the client. For this reason, the second version is probably more effective orienting. That is not to say that stopping drug use would not be a primary target. However, the best ways of orienting always show clients "what's in it for them."

In summation, educating, socializing, and orienting clients is like checking the map before a road trip and periodically throughout the journey so everyone knows where they are at, where they are going, and why one road may be preferable to another to reach the destination. Start the trip with an informed copilot, and, whenever the therapeutic process seems lost, these techniques can be used to get it back on track.

# 17
# Communication Styles

DBT has two primary and dialectically balanced communication styles: reciprocal communication and irreverent communication (Linehan, 1993a). Reciprocal communication values clients and their wants and needs and offers warm engagement. Additionally, reciprocal communication means that therapists offer some of themselves to the therapy process. Irreverent communication, by contrast, is an unconventional and unexpected means of responding to clients and their situations. Used much less often than reciprocal communication, irreverence is intended to take the client by surprise to initiate dialectical shifts in emotions, thoughts, or behaviors.

## Reciprocal Communication

Reciprocal communication bolsters the therapeutic alliance with responsive attention to clients, explicitly treating them and their concerns with the utmost importance. At its base, reciprocal communication means being interpersonally accessible, warm, and connected to the client in the moment, ready to listen and respond with validating verbal and nonverbal communication.

Unfortunately, therapists can be rejecting of the perspectives and preferences of clients, and sometimes of clients themselves. Often certain diagnoses, such as personality disorders and substance-use disorders, carry

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inherent judgment, as do certain demographics. To engage clients, therapists need to be self-aware of biases and willing to seek authentic connections in the spirit of Roger's (1957) unconditional positive regard.

Reciprocal communication calls for therapists to avoid relating as only an expert therapist, counterbalancing that role with being an authentic person in the encounter. Being "real" in connection with the client can be risky, especially for therapists who struggle with self-awareness around boundaries and with what a concept such as authenticity really means. Although some level of disclosure is inherent in reciprocal communication, therapists should not make the mistake of overdisclosing by being an "open book," for example by sharing personal issues or personal information that is not germane to the therapy. Being responsive and "who you are" is not synonymous with imparting information, just as knowing facts about a celebrity reveals nothing about the essence of that person. At the same time, reciprocal communication does involve several types of therapist self-disclosure, but those disclosures require thoughtfulness, with the sharing of personal information being in the service of the client and his therapy.

Using self-disclosure in the service of therapy occurs in several typical ways. First, therapists can share benign and human examples of skill use and practice. Examples of how skills are used to cope with everyday ups and downs assist clients in making connections and personalize the learning. Many times a personal (but not too personal) example of how to use a skill is received better than an example from a manual.[1]

Next, therapists can affirm clients' skillful behaviors by sharing that they responded to a reported situation in a similar manner. This communication is especially impactful with clients who look to their therapists as "models" of skillful behavior. Thus, these disclosures essentially communicate that clients are on the right track. If the therapist would have felt the same way or done the same thing in a given situation, the client often feels understood and supported.

Last, therapists might disclose their reactions to the client in the moment for a couple of purposes. One purpose is to let the client know how they stand in the therapeutic alliance. A client who fears rejection can be comforted to know that the therapist has warm and accepting feelings toward him or her. Similarly, a client who thinks that the therapist is angry may be relieved to learn that he or she does not feel that way. Alternatively, if the therapist is angry, it might be helpful to disclose that emotion, what it

[1] Examples from your personal life disguised as generic examples or cited as originating from a source other than you can also be effective in skills training and therapy.

means in the context of the relationship, and how both client and therapist can deal effectively with it. Once, an impulsive suicidal client ran from my office without a safety commitment, resulting in a somewhat dramatic hospitalization after she was tracked down within the building complex. When the client returned to treatment after discharge from the hospital, she was extremely anxious having sensed my frustration about her attempt to flee the necessary hospitalization. She was extremely worried about the state of the relationship. She sheepishly asked whether I was still angry, and the reply was that I had been angry at the time of the hospitalization, mainly because underneath the anger I was concerned for her and her safety.[2] I then reassured her that I was over it and that we would both learn from the experience. A visible wave of relief washed over the client, and we initiated behavioral analysis to learn from the situation. In this case, some disclosure was called for to get the alliance on track.

Another purpose is to provide information that manages the relationship contingencies to create new learning. For example, some clients have been invalidated or punished for expressing emotions or opinions, learning that they should stay silent. For a client like this, a therapist might share how a disclosure touches him or her. The therapist's own disclosure, along with warm engagement and validation, would teach the client that there are safe places to feel and disclose. Another example could be sharing that a client's "yes, but" responses to suggestions result in the therapist feeling frustrated and wanting to withdraw support, teaching the client that help-rejecting may burn out supports. Of course, this type of disclosure requires careful balance with validation and making sure that it is in the service of building and not rupturing the alliance.

The following example demonstrates using reciprocal communication, among other techniques, with a client making suicidal threats:

**C:** I should just off myself. No one would care anyway.
**T:** (*assesses, matter-of-fact, leans back slightly, folds arms*) Julie, when you say you should "off yourself," do you mean that you have a plan to kill yourself today?
**C:** No, I just feel like I don't matter to anyone.
**T:** (*clarifies safety*) So you are safe today and until our next appointment and will not act on suicidal thoughts or urges?
**C:** Yes (*and nods*).

[2] Therapists must take caution in sharing frustration and anger to ensure that it is done from an emotionally stable and therapeutically mature stance. The question is, "Does the disclosure build or risk the alliance?"

**T:** Thank you for being clear with me about your safety. (*reinforces safety commitment*) What I heard after the "off myself" statement is that you think you don't matter, that no one cares … that's a lonely place … very alone (*validates true issue*).
**C:** (*tears up*) Yeah.
**T:** Do you wonder if I care, if you matter to me? (*said with warm engagement/reciprocal communication*)
**C:** Yes.
**T:** Then please ask me. (*avoids providing the answer because the client has not actually asked; instead encourages the use of interpersonal skills*)
**C:** (*hesitantly*) Do you care?
**T:** (*leaning in, with a warm tone*) Yes, you matter to me, Julie. I *care* about you. And you just did a great job using DEAR MAN to ask. (*reciprocal communication and reinforces skill use; then notices positive affective shift*) It looks like that helped, to hear me say that right now.
**C:** It did help.
**T:** Can I tell you something? (*solicits permission and cooperation*)
**C:** Yes.
**T:** When you say to me, "Well I should off myself," or something like that, I hear something that scares me and my natural reaction is to pull myself away. Did you notice that I got matter-of-fact after you said that, just focusing on safety? Did that feel warm and like what you wanted or needed? (*shares reaction; highlights contingency that suicidal statements decrease warm engagement and prompt safety assessment*)
**C:** Not really.
**T:** But when you asked if I cared, when you used your skills, my natural response was to want to help and support you, to reassure you that I am here for you. You did a nice job practicing that. (*highlights new learning that using interpersonal skills gets warm engagement*) What are you feeling right now?
**C:** A little better. A little less alone. (*client noticeably more engaged*)
**T:** Good. So asking directly, rather than making a suicidal comment, seems to work better. Are you ready to talk about what happened this morning? (*reinforces learning and shifts to therapy agenda item*)

In this example, the therapist used a combination of techniques, but became interpersonally cooler after the suicidal statement while also setting the client up to use a skill to elicit a subsequently warmer interpersonal

response. Thus, the client learned that skills, not threats, are the ticket to support. This approach would not be appropriate for every safety issue, but in this case the therapist knew that the client had a history of tossing out suicidal statements to get support from others as opposed to being in actual imminent danger of acting; in essence, the therapist tested a hypothesis and was correct.

In contrast to reciprocal communication, the disclosure of personal information that does not relate to the treatment ought to be minimized or avoided. This guideline has *some* flexibility based on differing boundaries, but as a rule if personal information is not relevant to the client's therapy then there is no need to share it. This means that it is important for therapists to proactively consider their limits, including the personal touches on display in their office. When in doubt about disclosure, the "colleague" test provides clarity. The colleague test has therapists imagine their disclosure being witnessed by an audience of peers. If the therapist would be alright with the disclosure being public, it is probably okay. If not, the disclosure should be avoided.

Thankfully, most clients show limited interest in their therapists' personal lives. Nonetheless, be prepared to observe and disclose your limits in regard to personal information when needed. Often, therapists simply need to set a polite limit, perhaps validating the client's interest. At other times a therapist may ask what a personal inquiry means to the client while still maintaining the boundary.

While it may seem obvious, do not share personal problems or issues with clients. The last thing clients need is to be worried about their therapists or to be subject to the therapy roles being flipped. When in doubt about disclosure, seek supervision or consultation.

## Irreverent Communication

The intention of irreverent communication is to use its offbeat nature to shift emotions, thoughts, or behaviors (Linehan, 1993a). Irreverent communication often gets clients' attention through its surprising nature. It also causes clients to think about and process issues from alternative perspectives and on different cognitive levels. Being bold and straightforward, irreverence upsets the applecart to bring change, and it is most effective when deftly balanced with reciprocal communication.

The concept of irreverence in therapy is not new or unique to DBT. Anecdotally, many non-DBT therapists identify with the use of irreverence with clients from time to time. Irreverence can be traced to Albert Ellis (1977)

and his use of emotive shocking and humor in therapy to create shifts in emotions and perspectives. Irreverence should not be confused with sarcasm, and when it is done well it oftentimes, though not always, has a playful quality. In DBT, the use of irreverence takes several forms (Koerner, 2012; Linehan, 1993a).

One form of irreverence is to respond to a client's communication in an unexpected way that picks up on an unspoken aspect of the communication. For example, in response to a client with multiple, severe problems who impulsively declared that she was going to quit treatment, one therapist deadpanned, "That would be a great way to get a handle on your life." The client then paused and stated that she appreciated how her therapist had a tendency to "call out her BS" in such a direct way. Another example happened in a DBT day-treatment program when an obviously upset client said she was "fine" and was met with a unique definition of the word. Without missing a beat, a peer trumpeted, "Oh, you mean fed up, insecure, neurotic, and emotional!" The program members, including the upset member, burst into laughter, bringing levity to a formerly tense moment. This intervention worked because the client knew she was cared for by her peers.

One of my favorite examples of irreverence came from an older and quite dignified therapist. This therapist reported that she had had an intake appointment with a teenager who excessively used the f-word. In response to the barrage of profanity she began to stare at her watch. After a minute or so the young client demanded to know why she was looking at her f-ing watch (using the actual word, of course). The therapist emphatically responded, "I am a 66-year-old woman, and I have never been fucked 39 times in under a minute before!" This particular statement was effective for two reasons. First, it communicated that the client was being excessively profane and that he needed to stop using foul language. And second, it communicated that, even though she was much older than this young client, she could deal with whatever he was going to offer. He did not succeed in shocking her, but she sure did shock him!

Some other irreverence takes the form of directly calling out the elephant in the room, or, as Linehan (1993a) has said, "going where angels fear to tread." Often, this irreverence has a confrontational tone. After celebrating recent success, a client with a history of self-sabotage was asked point-blank, "How are you going to mess this up?" The client responded with a big, knowing smile and a willingness to discuss what skills were needed to avoid undoing her accomplishments. With an excessively demanding client, the therapist said bluntly, "I think the intensity of

your requests makes people not want to help you much." Another therapist, when confronted with a suspect client report, would pull out a large, red novelty buzzer with the word "bullshit" blazoned on it, sounding it off with dramatic effect. Of course, these direct statements work to the extent that there is an effective alliance and that clients sense an undercurrent of benevolence on the part of their therapists. The following brief clinical example shows irreverent communication used by a psychiatric nurse with an unpopular patient referred to her in a long-term hospitalization setting:

C: (*sarcastically*) Nice to meet you, Cindy. I'm sure you're thrilled to get me, the nightmare patient nobody likes.
T: (*bluntly*) You're right. You're nobody's favorite here, and not many people have enjoyed working with you. (*long pause*) But I am willing to give you a clean slate and work with you if you are willing to work with me (*said slowly with warm engagement*).

This communication was the start of a successful course of treatment. The nurse boldly stated the obvious where others might have dishonestly and disingenuously reassured the client that she *was* liked when she clearly knew that was not the case. However, the bold and blunt statement worked because, in addition to being honest, it was followed by an authentic desire to build a working alliance.

Some therapists also use irreverence by vacillating between seriousness and humor, recognizing that tragedy and comedy are dialectical opposites. One client stuck in a suicidal depression struggled to identify skills that could improve her situation. After validating how stuck she was, the therapist lightheartedly suggested that they could brainstorm ways to make the depression even *worse*. Over the next few minutes the client and therapist became more and more absurd in their "suggestions," and the client experienced a positive affective shift. The therapist then suggested that the client could do the opposite of the ineffective list to feel better, and the client agreed.

A therapist may also use irreverence to express either impotence or omnipotence, depending on the situation. For example, if a client tries to make the therapist responsible for his or her change process, the therapist could go in either direction. An impotent response might be, "I haven't changed a single person in my life, and I doubt you'll be the first." An omnipotent response might be, "I'll be responsible for your life if you promise to follow all my directives exactly." Both responses indicate that the client and not the therapist is responsible for his or her change.

Although adherent DBT providers will encourage the use of irreverence because it is an ingredient of the approach, I believe that its use is a matter of personal style. Some therapists have great success with a somewhat irreverent style while others may not. In fact, one DBT expert shared that he disagrees with Linehan on irreverence and does not think that it has any place in therapy (T. Marra, personal communication, 2011). When irreverence is a genuine extension of a therapist's personality, it is more likely to "fit" with the therapy. If it does not naturally extend from a therapist's personality, it can be avoided altogether; like any other therapy ingredient, irreverent communication is not vital in terms of outcome.

Especially out of context, examples of irreverent communication may seem provocative. To use irreverence, therapists assume that clients are not fragile, yet it is important to make sure the technique rests on a solid therapeutic alliance. Like any technique, this change-oriented communication style must be balanced with validation, and therapists need to closely observe its effectiveness (or lack thereof) with particular clients. I like to say that enough relationship currency must be in the bank for irreverent checks to clear.

Therapists should note some final caveats on irreverence. Similar to telling a joke, how irreverence is received relies heavily on the audience. If an irreverent statement may compromise the alliance, it should be avoided. Moreover, irreverence should never be at clients' expense, and therapists should not attempt irreverence when they are frustrated or having strong personal reactions in the moment.

Last, irreverent communication is contraindicated and could be harmful with some client populations. For example, clients with Asperger syndrome struggle with the nuance that comes with irreverent communication, so it will likely be misinterpreted and not have its desired effect. Caution should also be used with clients with hypersensitivity to criticism and rejection, who are likely to see this type of communication through that lens. As with any intervention, clinical expertise and common sense dictate the use of irreverence, but my advice is, when in doubt, leave it out.

# 18
# Mindfulness

Mindfulness is being aware and experientially present in the moment in an acceptance-based, nonjudgmental fashion. To be mindful, one collects and focuses attention, sustains concentration, and makes responsive behavioral choices. Responsive choices are faithful to one's values and reflect one's true intentions in life. Although mindfulness is frequently associated with Eastern philosophies such as Buddhism, its goals and practice can be secular in nature. And, while the semantics may differ, many mindfulness concepts are not new to Western therapies. Many treatments place a premium on awareness, being present in the here and now, using acceptance of self and others, and making thoughtful choices.

DBT encourages mindfulness practice for both clients and therapists. The pursuit of mindfulness can be compared to the pursuit of physical fitness: There is no finish line or terminal goal to reach. Instead, the daily practice of mental and physical fitness is worthwhile in and of itself to be as healthy as possible. Research continues to show that mindfulness practice has lasting positive effects on brain chemistry and overall health (Davidson et al., 2003; Lutz et al., 2008; Tang et al., 2007). Mindfulness skills are taught to clients and mindfulness is ideally practiced in each session to cultivate a meaningful relationship with the moment-by-moment unfolding of life outside treatment.

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Lane D. Pederson.

Many of us suffer from what could be called an untrained mind, sometimes referred to as "monkey mind," conjuring an image of internal jumping, screeching chaos! Like a body that has not been systematically exercised, an untrained monkey mind does not perform well. It falls victim, often without awareness, to intense emotions and urges and to the barrage of stimulation that is encountered daily. Reactive and unquiet minds create mental and physical stress and a reactive and disconnected lifestyle. Just as physical exercise leads to optimal physical performance and a relaxed body, mindfulness practice creates optimal mental performance and relaxes and quiets the mind, creating peace, connection, and more responsive choices. But, like fitness, the benefits of mindfulness do not happen overnight, and the trainee needs to adopt habits that develop them. Box 18.1 has universal guidelines for mindfulness practice and Appendix A lists mindfulness exercises.

**Box 18.1** Guidelines for Mindfulness Practice

These near-universal ideas taken together form the fabric of mindfulness.

**What we can experience mindfully**

- Emotions, thoughts, physical sensations, what comes through our senses, activities, situations, others, the world, and intangibles such as a sense of well-being and spirituality.

**Mindfulness means**

- Being awake and aware in the present moment, here and now, collecting your attention and focusing your concentration, gently letting go of distractions without judgment and being of one mind.
- Connecting to experience as it is, without clinging to it or pushing it away, without amplifying or muting, without leaning away or into it, without trying to change it.
- Being fully engaged and participating by immersing yourself in what you are doing or experiencing.
- Being responsive and choosing your focus and behaviors not based on aversion or pleasure but from your true self, flowing from your true intentions.

**Qualities that enhance mindfulness**

- *Beginner's mind*: Observe like a child sees for the first time, not letting past experience cloud the here and now.
- *Compassion*: Show empathy and concern for yourself and others, knowing that everyone suffers and that care heals.
- *Tolerance*: Understand that discomfort is universal and learn to experience it without judgment or trying to change it.
- *Trust*: Be assured that mindfulness practice eases suffering and builds connection.
- *Patience*: Remember that reality unfolds in its own time, without concern for individual preferences.
- *Nonstriving*: Stay connected to the process of being, without clinging to a goal or particular outcome.
- *Practice*: Mindfulness practice has ebbs and flows and takes time and commitment. Accept that your best will vary from day to day. Benefits come with consistency.

The benefits of mindfulness come from relating to experience without addition, subtraction, or judgment. The phrase "it is what it is" characterizes accepting the reality of each moment. Mindful acceptance of what is desirable is not usually a challenge for people (although not making positive judgments is also a part of mindfulness), but accepting undesirable emotions (or anything else uncomfortable) as they are is a novel idea to many clients who typically default to judgment and other ineffective strategies. Unfortunately, judging emotions tends to be counterproductive as it intensifies them over time, making emotional regulation more problematic and ineffective behaviors more frequent. The solution, though paradoxical to clients, is the willingness to accept and mindfully relate to emotions to move through them. Many Buddhist practitioners have noted that it is the willingness to relate to our suffering that ultimately ends it, whether the suffering is related to emotions, physical pain, loss, or any other difficult experience.

Too often clients (and people in general) try to escape from and avoid their uncomfortable and unpleasant experiences, or, alternatively, they sometimes unwittingly participate in behaviors that intensify those experiences, such as ruminating or falling into certain active mood-congruent behaviors. Both sets of responses, *escape and avoidance* and *intensification* behaviors, are antithetical to mindfulness, and, while all of these behaviors

**Table 18.1** Examples of Escape and Avoidance and Intensification Behaviors

| *Escape and Avoidance Behaviors* | *Intensification Behaviors* |
|---|---|
| • suicidal behavior<br>• self-injury<br>• drinking/drug use; overeating; overspending; gambling<br>• passive mood-congruent behaviors (e.g., isolation, shutting down) | • rumination<br>• judging<br>• catastrophizing<br>• active mood-congruent behaviors (e.g., screaming, aggression, destruction) |

intensify experience over time, intensification behaviors do it immediately whereas escape and avoidance behaviors intensify with delayed effects. For example, self-injury can have the primary effect of escape and avoidance (e.g., relieving emotional pain) with the secondary effect of intensifying emotions (e.g., creating painful guilt and shame emotions). Escape and avoidance can be thought of as "running away" from experience and intensification as "running into" it.[1] Table 18.1 details escape and avoidance and intensification behaviors to replace with mindfulness practice.

In DBT, therapists coach clients to mindfully sit with and nonjudgmentally relate to emotions and other experiences as an alternative to the vicious cycles of pushing away through escape and avoidance behaviors or amplifying through intensification behaviors. Being with experience means centering with it rather than running away from it or running into it. When clients practice mindfulness, first in session and then in life, they learn that emotions can be experienced, tolerated, and ultimately transformed. In this way, mindfulness is similar to an exposure technique in which self-efficacy with what has traditionally been painful and uncontrollable happens over time.

As with any exposure-based protocol, therapists lead with education, orienting clients to the purpose of the intervention, obtaining commitment to try it, and then teaching core skills such as breathing techniques to ensure success. Box 18.2 lists breathing exercises. Once clients demonstrate competency with basic mindfulness, they can use these skills to experience what has been overwhelming. However, like exposure, self-efficacy and transformation come from starting slowing and moving gradually up a hierarchy.

[1] This idea came from Moffitt's (2008) view that people can lean into or away from experience.

**Box 18.2** Breathing: The Anchor to Mindfulness

Breathing is the essence of life, is fundamentally acceptance-based, and is the most fundamental anchor to mindfulness in the present moment. Breathing can also be an "incompatible skill" as its practice is directly incompatible with many problematic emotions, urges, and behaviors. The practice of breathing counters stress, anxiety, anger, and impulsivity among other things, all of which are problematic issues.

An Eastern belief holds that each person has a finite number of breaths and that, once that number has been used, the person dies. While likely not literally true, the belief reflects a great deal of wisdom. Quick and shallow breaths never get the optimum amount of oxygen into the body, causing its systems to run inefficiently, causing a greater load and stress to take its toll (i.e., the finite breaths get used quickly, leading to early death). Alternatively, slow and deep breaths get the optimum amount of oxygen into the body, its systems run better, and stress diminishes, resulting in a longer life with increased peace and serenity.

Practicing more effective breathing is free, takes relatively little time, and can be done anywhere. To reap its rewards, breathing exercises should be practiced throughout the day with dedicated effort toward skill development. Below are sample breathing exercises.

**Breathing exercises**

Have clients practice at least one of these exercises at least three times a day and when strong emotions, judgmental thoughts, or impulsive urges occur. Have them observe and describe their level of distress before and after each exercise. These exercises are also great for general mindfulness and health.

- *3-5-7 breathing technique*: Start by exhaling completely. Then inhale through your nose for a count of three, hold it for a count of five, and completely exhale through the mouth for a count of seven. Do not be afraid of making a little noise as you exhale!
- *Counting breaths*: Breathe in and say "one" in your mind as you exhale, then continue breathing and counting on each exhalation until you reach 10. Once you reach 10 (or if you lose your count), go back to one. Do this exercise for three to five minutes.

- *Cue to breathe*: Decide on five to 10 stimuli in your environment that will now "cue" you to take one to three deep breaths. Possible examples of cues to breathe include seeing a certain color, having your child misbehave, seeing someone you don't like (or do like) walking through a doorway, being at a red light, or sitting at your computer or workstation.
- *Frustration to peace*: As a variation of the above exercise, pick five common frustrating events that will cue you to breathe deeply. Remember also to practice being nonjudgmental and to accept the moment. Try repeating a mantra such as "life is like this" along with your breathing.
- *Bellows technique*: Breathe rapidly in and out through your nose, trying to get three cycles of inhaling and exhaling in per second. Continue for 10 seconds. This technique is designed to stimulate and give an energy boost.
- *Alternate nostrils*: Hold your left nostril closed and breathe in through your right nostril; then open your left nostril and hold your right nostril closed while you breathe out through the left nostril. Breathe back in through your left nostril, and continue the exercise, alternating back and forth. This technique is designed to bring balance.
- *Square breathing* (Moonshine, 2008b): Breathe in for four seconds, hold it for four seconds, breath out for four seconds. Repeat four times.
- *Breathing with waves*: Go to a natural body of water that has the sound of waves, or play a recording of wave sounds. Inhale and exhale along with the sounds of the waves.
- *Music appreciation*: Pick music that has a slow and rhythmic pulse. Breathe along with the music.

Mindful exposure to emotional and other pain is but one of the applications of mindfulness. The dialectic is that mindfulness of what is painful is offset with mindfulness of alternative experiences. Sometimes, the best use of mindfulness is moving attention away from pain to alternative experiences, such as a healthy distraction or a potentially positive experience. A common clinical question centers on when to have the client be mindful of what is distressing versus shifting attention to another focus. As with exposure, consider subjective units of distress. If a client is in low or moderate

distress (e.g., 1 to 6 on a scale of 10), mindful awareness of the experience is indicated. However, if the client is in high distress (e.g., 7 to 10), shifting attention elsewhere or using a deescalation technique such as breathing might be most beneficial. In this case, the client is coached to mindfully use a skill from the distress-tolerance toolbox.

Ultimately a balance must be struck in sessions and in life. Clients who attend mindfully to distress to transform it *and* attend to healthy distractions and everyday life experience the most benefits. Thus, therapists do both. Mindful exposure and practice in therapy help clients to determine which path will be more effective in any given moment based on self-trust and wisdom rather than aversion and reaction. The eventual goal is greater self-regulation and an increase in responsive behaviors. To do this, clients (and therapists) develop a mindfulness practice and incorporate mindfulness into everyday life. The results will go beyond clinical relief of symptoms to include connection, peace, and enhanced enjoyment of life.

# 19
# Skills Training

Training clients to use new skills and behaviors to replace ones that are no longer effective, are unhealthy, and/or are unsafe is a hallmark of DBT. Unlike other approaches, DBT does not assume that people have the inherent capabilities to change without new learning. In fact, expecting change without assessing whether effective behaviors are in place can be invalidating, and, without more effective behaviors, pushing toward change can be counterproductive and harmful to the therapeutic alliance. Teaching new behaviors to reinforce is a benevolent method of promoting change, and the skills themselves provide shared concepts and language that benefit clients.

Linehan (1993b) designed four primary skills modules: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. Each module comprises skills that reflect the overarching goals of the module. Beyond psychoeducation, experiential practice is needed to develop behavioral competencies with the skills.

The *mindfulness* module teaches that emotion and reason can be dialectically synthesized into "wise mind," a grounded, intuitive, and responsive state from which people can make effective choices. The module further explains how six core mindfulness skills create a path to wise mind. These six skills are divided into three "what" skills and three "how" skills. The what skills are what a person does to get to wise mind, and the how skills are how a person does the what skills to reach this goal. The what

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

skills include "observe," "describe," and "participate" and the how skills include "non-judgmentally," "one-mindfully," and "effectively."

The *distress tolerance* module outlines healthy coping behaviors to replace harmful ones with the goal of surviving painful events and experiences without making them worse. Distress-tolerance strategies include variations on distractions, improving the moment, self-soothing, and practicing acceptance of what is.

The *emotion regulation* module explains a model of emotions, emphasizes the importance of self-care to decrease emotional vulnerability, and instructs on skills to increase positive emotions and step out of mood-congruent behaviors that maintain negative emotions. Whereas distress tolerance is designed to be responsive to crisis, the main purpose of emotional regulation is to proactively create emotional stability.

Last, the *interpersonal effectiveness* module delineates skills to increase self-respect, improve relationships, and practice assertiveness to get wants and needs met. In this module, the FAST skills center on sticking to values, being honest, and being fair; the GIVE skills teach clients to focus on others to build and maintain relationships; and the DEAR MAN skills outline a model for assertiveness.

Building on Linehan's original manual, a number of other manuals (Marra, 2004; McKay et al., 2007; Moonshine, 2008b; Van Dijk, 2012) provide comprehensive skills-training explanations, exercises, and even supplemental skills and modules for use with clients. Pederson and Sidwell Pederson (2012) significantly expanded skills training with modules on dialectics, shifting cognition, boundaries, problem-solving, and developing routines and structure. When conducting DBT skills training, consider using a variety of resources to customize skills training to diverse clients and treatment settings. To this end, Linehan states that there is no empirical reason why skills manuals cannot be substituted for one another, and what she recommends is "that if you do not use the DBT skills training manual as is, you consider either writing one of your own or modifying the manual to suit your own purposes" (Linehan, 1993a, p. 155).

In the course of skills training, remember that how the skills are taught is as important as the skills themselves. It is therefore important to remain acceptance-based and nonjudgmental about behavioral deficits and the skill concepts (e.g., emotion mind is neither "good" nor "bad") and to stay grounded in therapeutic factors. Note and reinforce extratherapeutic skill use, build hope and expectation that skills will improve life, and use the alliance to engage and collaborate with clients about skills. Compared to other interventions, it can be tempting to think that skills are psychoeducational and will work once the information is imparted. However, *skills*

*constitute another ingredient, and they are maximally active in the context of the alliance*. In other words, the way therapists and clients engage with each other during skills training will be predictive of the skills' relative success.

In treatment virtually any situation is a skills-teaching and learning moment. In individual therapy, skills become interwoven in the approach. In programs, there will be dedicated skills-teaching time. In both, therapists should encourage the generalization of skills outside therapy. Regardless of the level of care, the importance of continual skills training and practice cannot be overemphasized. To do this, training must go beyond the intellectual understanding of skills to the experiential application, starting with skills rehearsal and practice in therapy followed by experiential practice in clients' naturalistic settings through targeted homework, telephone coaching, and skills-implementation plans (see Appendix B for an example of a skills-implementation plan) when in vivo treatment is not possible.

In teaching, applying, and generalizing skills, continue to troubleshoot and refine the skills, going from the course to the nuanced use of them. Other than meeting the client's goals for therapy, there is no finish line in the use of skills, only continued striving to be effective in life with ongoing efforts to learn and implement skills. Like mindfulness, skill use is a daily practice for all of us.

In-depth explanations of each DBT skill are beyond the scope of this book. In addition to Linehan's skills manual (1993b), well-received and well-reviewed manuals include Marra's (2005), McKay's (2004), Moonshine's (2008a, 2008b), Pederson and Sidwell Pederson's (2012), and Van Dijk's (2012). Box 19.1 contains a list of common DBT skills with brief definitions.

**Box 19.1** DBT Skills with Brief Definitions

The following DBT skills are grouped together in their respective modules. Following each skill name is its common abbreviation. Complete explanations of these modules and skills can be found in *The Expanded Dialectical Behavior Therapy Skills Training Manual* (Pederson and Sidwell Pederson, 2012).

*Life vision (LV)*: A questionnaire to determine goals in major life areas (Pederson & Sidwell Pederson, 2012).

*MIDDLE Cs (MC)*: An acronym designed to identify and resolve dialectical tensions (Pederson & Sidwell Pederson, 2012).

*Wise mind (WM)*: The dialectical balance of emotion and reason. Wise mind is reflective of one's true self, in which one responds in a manner that is effective and fits with one's true intentions and self (Linehan, 1993b).

*Core mindfulness skills*: The three *what* skills and three *how* skills used to get to wise mind (Linehan, 1993b).

- *What skills*: What one does to get to wise mind.
  - *Observe (OB)*: Just notice experience.
  - *Describe (DE)*: Put words on experience.
  - *Participate (PA)*: Immerse oneself in the experience.
- *How skills*: How one does the what skills to get to wise mind.
  - *Non-judgmentally (NJS)*: Let go of labels and strong opinions. Be open to "what is."
  - *One-mindfully (OM)*: Focus attention and concentrate on one thing.
  - *Effectively (EF)*: Do what works.

*Teflon mind (TM)*: Let things slide off and not stick.

*ACCEPTS*: An acronym for distress-tolerance skills (Linehan, 1993b).

- *Activities (AC)*: Keep busy and involved.
- *Contributing (CON)*: Do something for others.
- *Comparisons (COM)*: See that others struggle too or compare how you are doing now to a past time when things were more difficult.
- *Emotions (EM)*: Do something that creates other emotions.
- *Push away (PA)*: Shelve your problem for later.
- *Thoughts (T)*: Think about something other than your distress.
- *Sensations (S)*: Do something physically engaging.

*Self-soothe (SS)*: Relax mindfully through the senses (Linehan, 1993b).

*Ride the wave (RW) or urge surfing (US)*: Ride the ebbs and flows of emotions and urges without reacting (Moonshine, 2008).

*Bridge-burning (BB)*: Remove the means to act on harmful urges (Linehan, unpublished).

*IMPROVE the moment*: Another acronym for distress-tolerance skills (Linehan, 1993b).

- *Imagery (IM)*: Relax or practice skills visually in your mind.

- *Meaning (ME)*: Find the "why" or silver lining to tolerate a difficult time.
- *Prayer (PR)*: Seek connection and guidance from a higher power.
- *Relaxation (RE)*: Calm the mind and body.
- *One thing at a time (OT)*: Focus on one thing when life is overwhelming.
- *Vacation (V)*: Take a brief break.
- *Encouragement (EN)*: Coach yourself with positive self-talk.

*Pros and cons (P&C)*: Weigh the benefits and costs of a choice (from the Latin phrase *pro et contra*).

*Grounding yourself (GY)*: Use OB and DE to come back to the here and now (Pederson & Sidwell Pederson, 2012).

*Radical acceptance (RA)*: Acknowledge "what is" to free yourself from suffering (Linehan, 1993b).

*Everyday acceptance (EA)*: Accept daily inconveniences that occur in life (Pederson & Sidwell Pederson, 2012).

*Willingness (WI)*: Remove barriers and do what works in a situation (Linehan, 1993b).

*SOLVED (SO)*: An acronym for problem-solving (Pederson & Sidwell Pederson, 2012).

- *Step back and be objective*: Define your problem.
- *Options*: Brainstorm ideas and determine available options.
- *Limit barriers*: Recognize emotional and other barriers and actively address them.
- *Values-based*: Solve problems in ways that maintain your values.
- *Effectiveness first*: Do what works to reach a solution.
- *Dialectical thought and action*: Effective problem-solving does not always fit our preferences. Consider middle-ground options.

*PLEASED (PL)*: An acronym for self-care skills (Linehan, 1993b; adapted by Pederson & Sidwell Pederson, 2012).

- *Physical health*: Get regular check-ups, treat illness, and tend to your health.
- *List barriers and resources*: Determine what gets in the way of self-care and your resources for overcoming these barriers.
- *Eat in a balanced way*: Eat healthy foods in healthy amounts. Decrease and eliminate foods that have little or no nutritional value.
- *Avoid mood-altering substances*: Stay away from substances that dysregulate emotions.

- *Sleep*: Get the amount of sleep that benefits you.
- *Exercise*: Get regular exercise and move your body.
- *Daily*: Practice self-care everyday.

*Build mastery (BM)*: Do things to feel competent and in control (Linehan, 1993b).

*Build positive experience (BPE)*: Engage in events and relationships that create positive feelings (Linehan, 1993b).

*Attend to relationships (A2R)*: Connect with meaningful people in your life (Pederson & Sidwell Pederson, 2012).

*Mood momentum (MM)*: Perform balanced behaviors to maintain positive moods (Pederson & Sidwell Pederson, 2012).

*Opposite-to-emotion (O2E)*: Do the opposite of the behavior a negative emotion pulls you to perform (Linehan, 1993b).

*ROUTINE (RO)*: An acronym for developing routines and schedules that build a satisfying life (Pederson & Sidwell Pederson, 2012).

- *Responsibilities*: Keep current with your "have-tos."
- *Ongoing structure*: Maintain a schedule that is ongoing, predictable, and repeating.
- *Use of skills*: Work your skills into everyday life.
- *Traditions*: Develop traditions that add meaning to life.
- *Interests included*: Keep current with your "want-tos."
- *Novelty*: Do not overschedule; leave room for flexibility and spontaneity.
- *Envision a satisfying life*: Use routines, schedules, and structure to build the life you want. Stay focused on priorities, goals, and values.

*BOUNDARY (BO)*: An acronym for observing limits and boundaries in relationships (Pederson & Sidwell Pederson, 2012).

- *Be aware of self*: Be mindful of your own disclosure and behavior. Notice what is healthy and what is unhealthy.
- *Observe others and the situation*: Be mindful of others' disclosure and behavior. Notice what is healthy and what is unhealthy.
- *Understand your and others' limits*: Establish and maintain your boundaries from wise mind. Be respectful of others' boundaries.
- *Negotiate sometimes*: In important relationships, boundaries are sometimes adjusted from wise mind.
- *Differences exist*: Be aware of and accept differences based on personality, personal history, culture, ethnicity, situation, setting, and other important contextual factors.

- *Always Remember your values*: Healthy boundaries are values-based.
- *Your safety first*: Healthy boundaries protect safety; do not compromise safety to be liked or to fit in.

*FAST (F)*: An acronym for building self-respect.

- *Fair*: Be fair to yourself and others.
- *Apologies*: Do not be overly or unnecessarily apologetic.
- *Stick to values*: Stay firm to your value system.
- *Truthful*: Be honest and accountable to yourself and others.

*GIVE (G)*: An acronym for building and maintaining relationships (Linehan, 1993b; adapted by Pederson & Sidwell Pederson, 2012).

- *Genuine*: Be authentic and act from your true self.
- *Interested*: Listen, make eye contact, and be mindful of body language.
- *Validate*: Acknowledge another person's experience nonjudgmentally.
- *Easy manner*: Take an easygoing approach.

*VALIDATE (V)*: An acronym for the nonjudgmental acknowledgment of another person's experience (Pederson & Sidwell Pederson, 2012).

- *Value others*: Genuinely care about another person.
- *Ask questions*: Use questions to draw out and clarify experience.
- *Listen and reflect*: Closely attend and reflect back major themes.
- *Identify with others*: See the situation as the other person does, accepting differences.
- *Discuss emotions*: Talk about how the other person is feeling.
- *Attend to nonverbals*: Focus on communication from tone, body language, etc.
- *Turn the mind*: Especially in conflict, be willing to turn away from your view to see things as the other person does.
- *Encourage participation*: Keep trying, even when validation is difficult.

*DEAR MAN (DM)*: An acronym for asserting yourself, saying no, or setting a boundary (Linehan, 1993b).

- *Describe*: Detail the facts of the situation.
- *Express*: Share your opinion or emotions if helpful.
- *Assert*: Clearly ask, say no, or set a boundary.
- *Reinforce*: Reward others for meeting your request.
- *Mindful*: Stay focused on your goal.

- *Appear confident*: Look assured and express yourself with assurance.
- *Negotiate*: Compromise and be willing to give to get.

*REASON (RE)*: An acronym for dialectically shifting thoughts when needed (Pederson & Sidwell Pederson, 2012).

- *Rational*: Does the thought work or fit all of the facts in the present situation?
- *Emotions matter*: Respect and validate your feelings.
- *Alternative, dialectic views*: See whether another viewpoint works or fits all of the facts better in the present situation.
- *Self-trust*: Develop trust in your ability to adjust your thinking.
- Old beliefs balanced with …
- … *new thoughts and beliefs*: The process whereby less helpful thoughts and beliefs naturally give way to more helpful thoughts and beliefs.

# 20
# Changing Behaviors

DBT's core change strategies consist of behavioral techniques that are well established in the empirical literature. A behavioral approach brings several advantages to clients and therapists. First, behaviors can be observed and measured, so changes can be easily monitored and tracked. If a client comes in with a baseline frequency of self-injury that occurs an average of six of seven days and that frequency drops to two of seven days after one month of treatment, it is readily observable that therapy is working. Second, behaviors precisely define more abstract concepts. For example, clients often want better self-esteem, but what exactly does that mean? Together, clients and therapists can determine what behaviors would represent better self-esteem (e.g., assertive communication, an increased number of social contacts, use of self-care behaviors) for individual clients, again providing trackable measures. Observable and trackable behaviors facilitate treatment planning and evaluation. Next, behavioral interventions give clients concrete means to better manage themselves and to more effectively navigate environments to get their wants and needs met. Consequently, behavioral interventions empower clients, a dialectical counterargument to the perspective that behaviorism is controlling. Last, behavioral interventions work across populations and clinical presentations. While some therapies are contraindicated for certain populations (e.g., insight-oriented therapies for people with cognitive disabilities), there are virtually no populations to which behaviorism cannot be

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

applied. This chapter reviews the basics of behaviorism, explains the most effective methods to change behaviors, and discusses the use of behavioral contingencies.

DBT's behavioral interventions center on functional analysis. Functional analysis is concerned with understanding the function of clients' behaviors and those behaviors' relationship to others and the environment. The behaviors examined in functional analysis are referred to as target behaviors, and the functional understanding of a particular target behavior comes from an examination of what precedes it and what follows it, including organismic variables such as biological, cognitive, and emotional factors. These antecedents, consequences, and other factors determine the context that surrounds target behaviors and the reasons why they occur. A clear and detailed functional assessment of a target behavior sets the stage for problem-solving by applying skills to each link in the behavioral sequence. The process of behavioral analysis and problem-solving with skills is detailed in Chapter 21, on behavioral analysis, a cornerstone of DBT.

Consequences of behaviors determine whether those behaviors increase or decrease. Positive[1] reinforcement following a behavior makes it more likely that the behavior will happen again. For example, praising clients for being on time to a skills group or providing another reward for the behavior establishes timeliness. Another example is providing warm engagement to clients who demonstrate in-the-moment efforts to practice a skill or accomplish a therapeutic task. With ineffective behaviors, positive reinforcement that is identified should be removed if possible. If a client self-injures and then receives inordinate amounts of care and concern immediately following the behavior, the intervention would be to remove the reinforcement and create a plan with the client that reinforces behaviors that replace self-injury. If the injury did require immediate intervention, such as administering medical attention, then that would be done in a respectful but straightforward way that minimized gains.

The best positive reinforcements for behaviors are those that occur naturally in environments or those that are self-rewarding. Of course, many of the skills that DBT teaches become self-rewarding with practice. As examples, self-soothing behaviors are rewarded with increased well-being, sleep-hygiene behaviors are rewarded with increased energy and vitality, and assertive behaviors are rewarded with getting more wants and needs met.

[1] In behaviorism, positive and negative do not mean "good" and "bad." Positive means something is added and negative means something is taken away. Similarly, "consequence" is intended to have a neutral connotation, not a negative one.

The other reinforcement consequence that increases a behavior is negative reinforcement. Negative reinforcement means that an aversive stimulus is removed following a behavior, making the performance of that behavior more likely. The classic example is that buckling your seat belt is reinforced by the removal of the aversive beeping. Negative reinforcement maintains many symptom presentations. Anxious people who avoid stressors have their avoidance reinforced by not being subjected to the aversiveness of those stressors. Similarly, depressed people who isolate and shut down get those behaviors reinforced through avoiding the perceived or real adversity of trying and failing. And some people use drugs to avoid life hassles and responsibilities.[2] This type of negative reinforcement is called "avoidance learning."

In DBT, clients sometimes increase healthy coping behaviors to replace target behaviors that would result in behavioral change analysis; in these instances, behavioral change analysis serves as a negative reinforcer for skills. Another example of negative reinforcement in therapy is removing extra accountability when clients perform responsible behaviors, such as when a therapy-attendance contract is discontinued once reliable attendance has been established.

Just as there are two methods of increasing behaviors, there are also two methods of decreasing them. Positive punishment is when an aversive consequence is applied following a behavior, thereby decreasing the likelihood of the behavior, and negative punishment, sometimes called a response cost, is when something desired is withheld following a behavior. Punishments should be used rarely in therapy and other environments because they have considerable downsides. First, punishment disrespects the therapy alliance, creating hostility rather than collaboration. Second, punishment does not teach people what to do or anything else that is new or helpful. And third, punishment often intensifies emotional states, which is the opposite goal of DBT. Nonetheless, sometimes clients will experience an intervention as a punishment. In these cases, it is the task of the therapist to validate the experience and associated emotions and then to orient the client to the purpose of the intervention. This process happens with a benevolent and respectful yet matter-of-fact tone. Any intervention that could be perceived as a punishment must always be applied for the benefit

[2] Note that some behaviors are maintained through both positive and negative reinforcement. Drug use brings an initial high (positive reinforcement) and also allows the person to avoid withdrawal symptoms (negative reinforcement). Self-injury may elicit an endorphin rush (positive reinforcement) while providing an escape from emotional pain (negative reinforcement).

of the client and never applied out of therapist frustration or bias. The most common punishment I have used in practice is asking a disrespectful client who cannot be redirected to leave the session. Such a request is then followed up later by a phone call to establish a plan to repair the alliance, and the disrespectful talk or behavior is treated as a treatment-interfering behavior in the next session.

As clients try new skills and behaviors, it is important to use continuous reinforcement to establish them and then to change to another reinforcement schedule once they have been established, as continuous reinforcement can lose its novelty and potency over time. Reinforcement schedules can be based on a fixed number of times the behavior occurs (i.e., a fixed ratio) or they can be based on a fixed time interval (i.e., a fixed interval). Eventually, or as an alternative, reinforcement can be moved to a variable schedule based on averages of behavior occurrences or time intervals. The benefit of this intermittent style of reinforcement, which operates similar to a slot machine, is that it is quite resistant to extinction.

To illustrate the use of reinforcement schedules, consider an adolescent seen in a DBT program who presents with depression, anxiety, and the associated difficulty of completing homework assignments. A cyclical pattern is evident in which the symptoms interfere with homework, which in turn increases the client's symptoms. One of her treatment goals could be defined as completing homework from a baseline of one out of five days a week to four out of five days a week or more by the fifth treatment session. In skills training, she is taught new behaviors to manage her symptoms and to complete homework. For each day she practices her skills to complete her homework, making progress toward the weekly goal, she receives continuous positive reinforcement through a social reinforcer such as praise (which is free, generally effective, and relationship positive) or with a token, star, or dollar amount to be used for a larger reinforcement of her choosing. In addition to the continuous reinforcement, she can also receive additional reinforcement of one type or another on a fixed schedule for meeting the weekly goal (e.g., receiving an additional token, star, or dollar amount or getting a trip to the mall or entertainment center). Once homework completion has been well established, the continuous reinforcement can be faded to a more intermittent schedule while maintaining fixed-schedule reinforcement for completing the weekly homework goal. In time, when homework completion is no longer problematic, formal reinforcement can give way to a naturalistic manner, especially if performing the new behaviors has become self-reinforcing or reinforcement is happening through other environmental means.

When clients have new behaviors, keep in mind that if reinforcement is not continued formally or naturally in the environment then the newly established behaviors are in danger of extinction. Extinction is when a reinforcer is withheld, thereby decreasing the frequency of the behavior. Whereas extinction is to be avoided with skillful behaviors, the use of it is indicated with certain target behaviors. Say a client arrives for the program and sits silently in the corner with his head down and his face covered by the hood of his sweatshirt. The therapist or other program members might attempt to engage him by making marked efforts to draw him out of his shell. If the observed outcome is that the client increases withdrawn behavior to solicit support, it can be concluded that the engagement efforts have inadvertently reinforced the "withdrawal" presentation. In this case, the therapist would put the withdrawal on extinction by removing attention from it. At the same time, the therapist would coach the client to speak up about what he wanted or needed and be prepared to immediately recognize and reinforce any signs of assertive behavior in order to shape it. Because the silent withdrawal has been put on an extinction schedule, it may increase before decreasing. The increase in the target behavior is called a behavioral burst (ironically, in this example), and when a burst happens the therapist must stick to the extinction schedule lest the behavior be put on an intermittent reinforcement schedule. Note that extinction only works when the reinforcer is known and it can be removed. Simply ignoring behaviors that still receive reinforcement from elsewhere or that are self-reinforcing is not effective.

There are considerations to remember in regard to reinforcement and punishment. First, what is a reinforcer versus what is a punishment is determined by the observed outcome. If the consequence increases the behavior, it is a reinforcement; if it decreases the behavior, it is a punishment. Praise is a common reinforcer, but to some people it may be experienced as a punishment, in particular if it is associated with a negative outcome (e.g., if the praised client is then rejected or taunted by jealous peers). Being told to leave the session for disrespectful behavior that cannot be redirected may be a punishment for some (as described previously) but it may be a reward for a client who would rather leave anyway. Thus, when applying consequences it is vital to note the actual effects independent of what was intended to happen.

In outpatient DBT, most reinforcers for clients will be social. Social reinforcers include attention, engagement, and encouragement from the therapist and others as well as positive feedback regarding progress and increased status in group settings. As mentioned above, negative

reinforcement for positive behaviors may come from avoiding behavioral analysis or other work associated with target behaviors or avoiding the other negative consequences that stem from them (e.g., emotions such as guilt and shame). Moreover, the very process of successful change brings positive reinforcement in many ways (a sense of accomplishment or well-being, feelings of pride and happiness, recognition). In inpatient or residential settings, reinforcement can be expanded to include privileges for positive behaviors or the use of token-type economies[3] where chips or points are exchanged for a variety of reinforcers. In selecting reinforcers, determining what individuals find reinforcing is of paramount importance, as is selecting reinforcers on which clients do not satiate too quickly. One advantage of a token economy is that it can be more responsive to individual desires and the variety of choices may decrease the possibility of satiation.

In working with clients, it is often helpful to frequently ask yourself what is being reinforced and what is not in terms of client behaviors.

Box 20.1 has a summation of behavioral factors to consider, and Box 20.2 has a behavior case example.

**Box 20.1** Behavioral Factors to Consider

- Are effective behaviors reinforced? On what schedule? Maintain desired behaviors on appropriate reinforcement schedules.
- How are ineffective behaviors reinforced? On what schedule? Remove reinforcement from undesired behaviors to extinguish them.
- How can effective behaviors be shaped while extinguishing ineffective behaviors? Break effective behaviors down and shape them into manageable steps.
- What skills, alternative behaviors, or incompatible behaviors can be trained as replacements for ineffective behaviors?

[3] There is occasionally a bias that using a token economy to track and reward positive behaviors should be reserved for children or those with developmental disabilities. However, consider that most of us work for currency, which is essentially a token economy. In my clinics, employees nominate each other for a bonus by writing and posting positive behaviors on paper stars. Each week a few "stars" are selected for a monetary bonus. Instead of being viewed as childish, the professionals experience reinforcement by being recognized and socially praised even if their star behavior is not selected for the bonus.

- What is reinforcing to the client? Do a variety of reinforcers need to be introduced? Are there issues with satiation with the reinforcer(s)?
- Is the behavioral plan clearly defined, clearly understood, and administered consistently?
- Has the plan been created in collaboration with the client?

**Box 20.2** Behaviorism Case Example

In DBT, behaviorism is not just applied by therapists but also actively taught to clients and people in relevant environments. Often, it is important to teach the difference between behavioral intentions and the actual functional relationship, and it is vital that therapists remember the difference between intentions and functions too. For instance, in a group-format program a therapist would frequently give one-to-one therapeutic feedback to a client during break. Over a couple of weeks, the client and therapist were doing more and more "individual" therapy at break times and the client was no longer bringing her treatment issues to the group. The therapist's intention was to be supportive, but the functional outcome was that the client was rewarded for seeking individual support during break times, which in turned undermined her therapy in the program. To correct the situation, the therapist had to discuss the behaviorism in play with the client and then set the limit that she would no longer be available for individual support on break times. The therapist also coached the client on skills to reengage with the group members and reinforced the client's efforts to do so. This correction extinguished the help-seeking on break and got the client reconnected to members of the treatment program.

## Behavioral Contingencies

The consequence of a behavior influences what is learned when there is a temporally close connection between the behavior and consequence and especially when the consequence happens only if the behavior occurs.

Learning the relationship between the behavior and its consequence then influences what will happen in the next similar situation with a similar context. This *if–then* learning is called a contingency.

Every observable consequence or response is a contingency, with explicitly defined contingencies being the most powerful. Chapter 10, on treatment structure, outlines suggestions in regard to expectations and rules. These expectations and rules, and all of the other discussed agreements in DBT, are contingencies. Proactive definition of these contingencies leads to responsible behaviors when the consequences are known up front. However, to work effectively the therapist must be consistent in the actual follow-through or clients learn that expectations, rules, and agreements do not hold water (which is an unhelpful contingency!).

Consider the real-world example of speed limits. If you speed in your car, you will get a ticket. This contingency keeps many people within the speed limit if they reasonably expect the consequence, but, if a speeding ticket is not expected, drivers sometimes choose to exceed the limit. Of course, drivers' predictions as to the possibility of the consequence influence driving behavior, and those predictions will be based on the consequences of past behavior. People adjust their behaviors accordingly.

To parallel this example in therapy, if therapists are present and mindfully responsive with contingencies, clients adjust their behaviors for the better, and, if therapists are not, clients might adjust their behaviors for the worse. Thus, it is not enough to establish if–then contingencies; it is also vital that consequences are delivered in a reliable and predictable manner or else there is not a real relationship between behaviors and consequences. When clients behave differently with various therapists in various settings, it is often because contingencies become defined differently and/or are followed through on inconsistently. To illustrate, consider three therapists with three approaches to attendance. The first therapist sets the expectation that clients attend 100% of sessions and treats absences as treatment-interfering behavior. In addition, this therapist makes it known that if a client misses three sessions in a specified time period then the client will be discharged. This therapist not only defines the contingency but also is known to follow through on it. The second therapist has the same expectations about attendance but is known to give considerable "wiggle room" in the expected consequences by not treating most absences as treatment-interfering and by giving "second chances" when clients miss the fourth (and fifth, and sixth, etc.) sessions. The third therapist sets no expectations and has a laissez-faire style, taking things as they come. Who will have the most consistently attending clients? The first therapist will, because clients know the expectation and trust that the consequence will occur. With the

second therapist, clients unfortunately learn that the agreements cannot be trusted, and attendance (and perhaps other) issues will thrive. With the third therapist, clients will be predictably unpredictable just like their therapist.

Beyond explicitly defined contingencies, how therapists respond to clinical situations sets up how clients participate in treatment as well as influencing how clients generalize skills. Therapists who shape and reward effective behaviors and provide instructive feedback on the if–thens of particular behaviors and predictable consequences will have better treatment outcomes than therapists who stay oblivious to contingencies. For instance, in response to a client who complains and then rejects assistance, the therapist can dial back therapeutic warmth and explain that complaints followed by rejection of help will teach others to withdraw support since there is no reinforcement to giving it. Of course, the therapist then teaches appropriate skills to address the situation and instantly dials up warmth as the client begins to practice these skills.

Another example comes from clients' use of the hospital. Some clients overuse hospitalizations because the contingencies support them instead of supporting progress in the community. Clients who use the hospital for a "break" often find nurturance and support there and a lack thereof in the community. Moreover, being in the hospital commonly mobilizes friends, family, and service providers to increase contact, and that increased contact does not necessarily involve accountability work for clients to learn from hospitalizations and avoid future ones. With contingencies like these, who can blame clients for choosing to go to the hospital?

The alternative is to adjust the contingencies to reward safety in the community and hard work on the treatment plan outside the hospital. To do this, friends and family are taught and encouraged to increase support when clients show engagement in practicing skills in the community and to not visit the hospital when their loved ones are there. DBT therapists also follow the contingency that clients in the hospital cannot get therapy contact or coaching from their therapists (Linehan, 1993a). The idea is that clients in the hospital get 24/7 care and friends, family, and therapists have no need to increase the amount of support given in these instances. Further, hospitalizations being experienced as a break can be minimized by increasing therapy work to learn from those situations. Clients who go into the hospital should be assigned behavioral analysis, be required to update safety plans, and be expected to stay current with DBT skills readings and other homework. These alternative contingencies reinforce doing well in the community and provide appropriate consequences for hospital use.

Setting limits and boundaries with clients is another way of establishing contingencies. If a client misses a session, it is appropriate to suspend coaching calls for a defined period of time (although the therapist may alternatively choose to coach the client *only* on skills needed to attend the next session). This contingency teaches that coaching calls support but are not a substitute for coming to sessions. Therapists may also adjust a limit such as availability based on clients' efforts. Again, the idea is to be more available and provide more reinforcement when clients work hard. When therapists change up availability, or set any limit, it is important that the contingency and the reason for it be taught to and made explicit to clients. In addition, holding to any contingency that might be subjectively experienced as punishment must be done with validation, compassion, and benevolence. Box 20.3 has examples of contingencies.

**Box 20.3** Examples of Behavioral Contingencies

In considering behavioral contingencies, ask yourself, "What am I teaching the client?" or "What is the client learning?" Successful contingencies reinforce effective behaviors and extinguish ineffective ones. Here are some examples of contingencies:

- If a hierarchal target is on the diary card, that issue will be addressed first.
- If you do a target behavior (self-injury, substance use, binge-eating, therapy-interfering behavior, etc.), a change analysis will be assigned.
- If you cannot clearly commit to not acting on suicidal thoughts and urges, you will be sent to the hospital.
- If you drop below the established attendance standard, you will be discharged from therapy.
- If you come late, the session will begin with examining that treatment-interfering behavior.

## Behaviorism and the Therapist

Linehan (1993a) observed that clients sometimes reward therapists for ineffective therapy and punish them for effective treatment. Therapists need to consider how the contingencies of behaviorism apply to *them*, not

just to clients. In supervising therapists, I have sometimes made the point that the most helpful intervention is not always the easiest one. In other words, doing the tough but necessary intervention does not feel rewarding in the moment, and avoiding the tough intervention can be negatively reinforced. Some clients express anger, do passive-aggressive behaviors, or otherwise punish others for holding them to agreements. In other cases, the very act of being assertive and discussing a treatment-interfering or other problem behavior feels so uncomfortable to therapists themselves that they avoid it. Unwitting therapists can therefore be shaped by environmental contingencies to provide unaccountable therapy. Being self-aware and seeking consultation when needed assists therapists in overcoming these behavioral challenges.

## The Most Effective Methods of Changing Behaviors

Certain behavioral techniques have greater effectiveness than others. The best techniques transcend behavioral principles because they promote a healthy therapeutic alliance. The concept of cold behaviorism, working in a vacuum devoid of human relationships, underestimates the power of what is known to account for the majority of change (and would be anti-DBT). Many therapists who have attempted the rote application of behaviorism with people have experienced attenuated effects and disappointment. Behavioral techniques, like other interventions, do not hold up without applications that respect relationships. This section centers on behavioral methods that are effective partly due to the positive focus of their applications.

### Provide noncontingent reinforcement

People need both contingent and noncontingent reinforcement to be healthy. Many clients perform target behaviors to get attention,[4] caring, and support. Noncontingent reinforcement involves providing a sought-after reinforcer at a high enough rate that the client does not need to resort to target behaviors to receive it. Once the reinforcement is in place, the target behavior is put on extinction. For example, some clients have learned

[4] All people need attention, and, if people do not get positive attention, they may do behaviors to obtain negative attention. In the world, saying that someone does a behavior for attention often has a negative connotation; that connotation is not intended here. A nonjudgmental stance toward attention-seeking behaviors is useful.

that presenting with exaggerated complaints is the only way to get concern from others. If the treatment environment provides enough caring and concern for clients irrespective of the intensity of their issues, then the need to present in an exaggerated fashion diminishes. Of course, noncontingent reinforcement is combined with providing reinforcement that is contingent on performing effective behaviors.

In clinical practice, establishing a milieu where clients get taken seriously, are treated with respect, and are explicitly valued as people diminishes problem behaviors because the atmosphere is saturated with the reward of being noticed and considered without the need to engage in ineffective behaviors. Whenever problem behaviors thrive, consider whether enough noncontingent reinforcement is in place. Environments that are disrespectful or unresponsive or that come across as uncaring of clients will predictably endure an increased amount of problem behaviors, with the inverse also being true.

## Model effective behavior

Many learned behaviors, for better or worse, come from imitating what is modeled by others. In DBT, the assumption that therapists also practice skills sets them up to be effective models for clients. In treatment, therapists pair skills training with the modeling process so clients understand the contextual factors that make a response more or less effective. In an intense moment, the therapist might say, "Wow, I'm feeling a lot of stress in my body—I'm going to take a few deep breaths to calm and center myself" and then perform the breathing behavior. Next, the therapist will invite the client to practice the same response, and briefly process the effects before moving the agenda along. In this example, the therapist has modeled effective self-talk, self-validation, and a healthy coping response to stress along with coaching the client to imitate these behaviors and then reinforcing him or her for doing so.

Every observable behavior is an opportunity to model coping, emotional regulation, interpersonal effectiveness, and other desirable behaviors such as self-care. Once I was absent from a skills group because I was ill, and when I returned and explained the reason for my absence, one of my clients exclaimed that it meant a lot to her that I actually practiced DBT skills and stayed home to get well. She went on to say that observing my self-care helped her to practice it herself. For reasons like this, therapists need to be self-aware of their behaviors, and, when clients imitate effective behaviors, therapists need to appropriately reinforce them.

## Reinforce nonproblem behaviors

Clients nearly always emit more effective than ineffective behaviors. Unfortunately, many therapists pay greater attention to deficits and problems and neglect what is working well. This imbalance not only is substandard behaviorism but also undermines the therapeutic alliance. Excessive focus on deficits and problems can demoralize clients and can even reinforce maladaptive responses in some situations. By contrast, actively recognizing strengths, efforts, effective behaviors, and the positive intent behind seemingly ineffective behaviors builds up clients, shows genuine respect and regard for them, and shapes effective behaviors.

A positive, strengths-based approach does not mean that behavior problems go unaddressed. Rather, it means that at least as much effort goes into supporting what is working. For example, a client who reports a self-injury (or another target behavior) will frequently be assigned behavioral analysis as a consequence of the behavior. Deployed with care and precision, behavioral analysis supports skill use to replace the harmful behavior. However, if the client reports no self-injury, the absence of the target behavior is often not given equal importance. The therapist may breeze over the success and move on to another deficit or problem behavior. Thus, the client really does not get deserved recognition, and the opportunity to build on an important accomplishment is lost.

An analogy illustrates this point. People who struggle to put laundry in the clothes hamper will always hear from conscientious others about a sock left on the floor (i.e., the problem) but often do not receive credit for the rest of the clothing that made it into the hamper (i.e., the success). This imbalance causes friction in relationships and misses opportunities to reinforce what works. As therapists, we need to prioritize acknowledgment of the clothes in the hamper, focusing on the sock on the floor as a secondary target (consistent with the therapeutic factors hierarchy outline in Chapter 12).

Reinforcement of nonproblem behavior falls into a few categories. The first is differential reinforcement of other behavior (DRO). DRO means reinforcing behaviors that occur in the absence of target behaviors. The basic idea is that it is desirable to reinforce any response that is nonproblematic. While reinforcement of DRO is important, one drawback is that it does not actively teach new replacement behaviors; clients simply receive reinforcement for not engaging in the problem behavior.

A better and more precise intervention is differential reinforcement of alternative behavior (DRA). With DRA, clients are reinforced for actively performing a replacement for a target behavior. For example, a client could

be taught to call a therapist, a sponsor, or another support when urges to use drugs, self-injure, or engage in another target behavior are high, especially if isolation is a significant antecedent to acting on urges. Of course, the client would then receive reinforcement for performing the alternative behavior. Or a client prone to yelling at others could be reinforced for using self-care skills that would presumably decrease emotional vulnerability or for taking a break from a stressful situation.

Even more specific and precise is differential reinforcement of incompatible behavior (DRI). The use of DRI develops new behaviors that directly compete with and are incompatible with target behaviors. In a sense, DRI operates from an either–or dichotomy in which the two behaviors cannot be performed at once. Social behavior is incompatible with isolation, mindful eating is incompatible with overeating or binge-eating, and a walk around the block is incompatible with self-injury in the bathroom. Many DBT skills work due to their incompatibility with presenting problems. Build Mastery and Build Positive Experience counter inactivity, PLEASED (self-care) skills counter self-neglect behaviors, and opposite-to-emotion directly instructs clients to do behavioral opposites of ineffective mood-congruent behaviors.

Regardless of the category of differential reinforcement, the takeaway remains the same: Actively reinforce beneficial and skillful behaviors on the part of clients.

### Train skills to reinforce

Unlike other approaches, DBT does not assume that insight or motivation alone is enough to decrease target behaviors and overcome deficits. Some clients need to actively acquire new behaviors to be successful. For this reason, DBT teaches skills to bridge the gap between deficits and goals. If clients want to or are asked to give up an ineffective behavior, therapists should offer at least one replacement behavior. The rule is to never subtract without adding.

Teaching new behaviors to reinforce is a benevolent way of creating change, and DBT therapists are continuous skills trainers. The value of skills training is obvious in DRA and DRI.

### Make a high-probability behavior contingent on a low-probability behavior

Using a technique known as the Premack Principle, therapists can make high-probability behaviors contingent on performing low-probability

behaviors to increase the frequency of desirable but scarce behaviors. This principle, also known as Grandma's Rule, is made simple by remembering grandma's instruction, "If you eat your vegetables (i.e., the low probability behavior), you can go out to play (i.e., the high probability behavior)." Parents use variations of this technique when children must complete homework to watch television or to do some other desired activity. Because the high-probability behavior tends to be naturally rewarding, the Premack Principle has built-in reinforcement to establish new behaviors.

All that is required for the Premack Principle is an assessment of common daily activities from most desirable (e.g., going to a coffee shop, doing a yoga routine, calling a friend) to least desirable (e.g., cleaning the kitchen, responding to emails, completing boring tasks). Then, if–then contingencies can be established. If the client cleans the kitchen, he or she can go to the coffee shop. If the emails get responses, the friend can be called.

In treatment, clients who struggle to fill out diary cards or complete homework can be told to complete these tasks as the ticket to engaging in frequent and desirable behaviors, such as watching a favorite television program, reading an engaging book, or taking a walk. Or, if clients enjoy mindfulness exercises, the structure of the sessions can be adapted to have them come after the completion of the skills or treatment agenda.

A variation of this principle can be used in the beginning of therapy when clients are reluctant to learn skills to give up a reinforcing target behavior. Say a client is not sure he or she wants to give up self-injury; the therapist could ask for a commitment to try five skills before engaging in the target behavior. The hope is that a good-faith effort to practice the skills will provide benefit and undermine the drive to do the target behavior. Of course, this intervention is paired with other ones, such as continued cost–benefit analysis of the behavior, behavioral change analysis when the target behavior is conducted, and continued efforts to shape commitment to giving it up. This type of intervention also has an important caveat: *it is absolutely counterindicated with target behaviors that are moderate to severe in intensity and duration*. Use this intervention only when the target behavior is of low intensity and duration, and make clear that the behavior is not being endorsed or approved of but that this is a step in learning how to give it up for replacement skills.

### Lower vulnerability and meet organismic needs proactively

Behavioral analysis is particularly useful in identifying what vulnerability factors precede target behaviors and what needs those behaviors meet.

Some clients only perform target behaviors when vulnerable (e.g., suffering from poor sleep, not having enough nutrition or exercise, or when behind with work, home, or other tasks), and all target behaviors have some form of payoff, especially in the short term. Direct interventions that decrease vulnerabilities and that meet important needs proactively without clients having to perform target behaviors pay high dividends.

First, skills targeted to specific vulnerabilities should be deployed. If stress is a vulnerability, stress management is indicated, targeting the specific sources of stress. If self-care is lacking, building a foundation of these skills is a priority. If the vulnerability is environmental, influence and change it to the extent that is possible. Next, identify what specifically reinforces target behaviors as those reinforcers will suggest healthy replacement behaviors. To work well, the replacement behaviors should be performed proactively to satisfy what motivates the problem behavior before the client defaults to it. For example, the motivation to escape overwhelming pain motivates many clients to self-injure, binge eat, or use substances. The use of skills to provide healthy escape before emotions reach a high intensity will decrease the motivation for target behaviors and create new behavior patterns with time and practice.

## Harness higher motivations to leverage change

Higher level, values-based motivations can also direct change. Emphasis on clients' values, what they really want, and who they really want to be can provide the basis for trying new behaviors. Harnessing motivation in this manner is a cornerstone of motivational interviewing, an evidence-based practice. In motivational interviewing, a dialectical technique called "developing discrepancy" is used to illustrate the disconnect between values and target behaviors, and the resulting discrepancy increases the motivation to initiate steps toward change (Miller & Rollnick, 2002). For instance, a client may realize that being an effective parent means modeling healthy coping to his or her children. The client may therefore be motivated to stay abstinent with substances, to interact in respectful ways with the children, and to practice distress-tolerance skills rather than participate in self-injury. Similarly, a client who realizes that he or she wants friends may be motivated to practice relationship skills.

When higher motivations are mobilized, it remains vital that the client's current behavioral abilities to reach identified goals are assessed and that skills training is used to compensate for behavioral deficits.

Box 20.4 has a behavior-change case study.

**Box 20.4** Best Methods of Behavior-Change Case Studies

A client in a DBT program would take out her cell phone to check and return text messages during program time. Directives from the therapists and the program members to put the phone away were ineffective, and the feedback, like the cell-phone behavior, was beginning to strain the therapeutic alliances and group cohesion. On the third occasion of the client taking out her cell phone, one therapist, with a curious and warm tone, asked why she continued to check her phone during program time. The client replied that she wanted to stay connected to her sister, with whom she was extremely close. The therapist validated the client's desire for closeness with her sister and then stated, "I wish a lot of my clients were more motivated to stay connected with important people in their lives. How could you use that strength, your relationship motivation, to stay connected with us during program time?" The client, sensing the discrepancy between checking her phone and being connected to peers in the moment, promptly put her phone away. At that moment, the therapist moved in with reinforcing praise, and the program day carried on. During a natural break in the agenda, the therapist pointed out the client's use of relationship skills and solicited feedback from the client's peers about her improved participation, spurring a round of reinforcement from her peers. Over the next week, the therapist continued to intermittently reinforce the client for not taking out her phone and for a variety of interpersonal skills the client performed in program. Harnessing the motivation to stay connected and using positive reinforcement techniques in a way that respected the relationships solved the problem.

# 21
# Behavioral Analysis

Behavioral analysis[1] can be as simple as ABC: identifying *a*ntecedents, *b*ehaviors, and *c*onsequences. Behavioral analysis builds awareness of what comes before and what follows behaviors to understand the context that surrounds them. With this awareness, clients and therapists can do active problem-solving with skills to reduce vulnerabilities, to respond more effectively to prompting events, to choose alternatives to target behaviors, and to handle consequences skillfully so that they do not cycle back into vulnerabilities. Behavioral analysis also provides a means of understanding and applying skills to emotions, cognitions, physiological events, and other factors that influence and result from target behaviors.

At its best, behavioral analysis is a structured way for clients and therapists to engage and collaborate to reach agreed-upon goals. At its worst, behavioral analysis is experienced as punishment for problem behaviors, sometimes because therapists intend for it to be punishing. Importantly, *behavioral analysis should never be positioned as or intended to be punishment*, as punishment damages the therapeutic alliance and sabotages learning. When using behavioral analysis, it is important to consider whether the technique is serving or risking the alliance on a case-by-case basis. Thus, considering therapeutic factors is important in setting up behavioral analysis to be successful, as is the ongoing framing and application of the technique.

[1] "Behavioral analysis" is commonly called "chain analysis" or "change analysis" in clinical practice.

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

Successful behavioral analysis always begins with checking the alliance and ensuring common goals and agreement on this methodology. Clients often feel shame and other painful emotions around target behaviors and can be sensitive to real and perceived blame and criticism. Acceptance, nonjudgment, and validation surrounding target behaviors are required to build collaboration. Acknowledgment that clients are doing their best also fortifies collaboration and leads to the next step of educating clients about how behavioral analysis can assist them in reaching stated goals, properly orienting them to the benefits of the technique.

Therapists can achieve this step with relative ease when they discuss behavioral analysis with clients early in the treatment process, before it is suggested for a "hot-button" behavior or situation. This education should occur during the pretreatment stage, when the method and its purposes can be openly discussed and presumably agreed upon. The description of behavioral analysis as a "learning tool" to apply skills in the interest of what clients want is usually accepted by them. Other useful tips include using behavioral analysis in skills-training examples and also to analyze the antecedents and consequences of effective behaviors instead of using it only for target behaviors. Emphasizing what worked in situations in which the client did not engage in problem behaviors (i.e., the exception rule) brings positivity to the use of behavioral analysis, develops hope and expectancy, builds the alliance, and creates tolerance for when it is used to address problem behaviors.

Nonetheless, even when therapists do the groundwork to set up behavioral analysis correctly, some clients, at least sometimes, will experience it as a punishment. In these situations, therapists should validate clients' subjective experiences and refocus on therapeutic factors in an attempt to reengage clients. Never place behavioral analysis or other techniques above therapeutic alliances. If a good-faith attempt at behavioral analysis is not working, change strategies to another method that might be more readily accepted. Be flexible to options including revisiting validation, discussing skills, or asking clients what they think would be helpful to reach their goals. You may consider revisiting a hot-button situation when it becomes a cold-button issue. In addition, therapists familiar with behavioral analysis can deploy it in an informal, conversational style with clients who bristle at the idea of going through one.

While behavioral analysis can be as simple as ABC, the following steps illustrate a more comprehensive analysis. Note that one of the functions of behavioral analysis is to establish a sequence, but therapists and clients can work backward or forward from a target behavior or bounce around within the analysis so long as a clear picture emerges from the exercise.

1 *Identify the behavior to analyze*. The behavior to analyze is frequently called a problem behavior or target behavior, but a generic term such as "behavior" or "action" can be used too (and can sound less judgmental). The key is that whatever is analyzed be precisely defined as a behavior. For example, "depression" is a symptom, whereas "isolating," "missing an appointment," and "staying in bed" are behaviors. Similarly, "angry" describes a feeling, whereas "screaming at my kids" or "punching a wall" elucidates actions to address with skills.
2 *Identify the prompting event*. Prompting events are also called "triggers." The prompting event is the most salient antecedent, or what "set off" the behavior.
3 *Identify vulnerabilities that made the behavior more likely to occur*. Vulnerabilities precede the prompting event in the analysis sequence. They can be few or numerous and should be defined as specifically as possible. Examples of vulnerabilities include disrupted sleep, missing medications, arguing with a friend, already feeling a strong emotion (or lack of emotion), or ruminating about an injustice.
4 *Identify emotions that followed the prompting event*. Remember to search for both surface and underlying emotions. Surface emotions are what we feel first and most obviously while underlying emotions are what are experienced most profoundly. For example, if a child ran into a busy street, the parent might react with anger on the surface and with profound fear underneath.
5 *Identify the self-talk that followed the prompting event*. Suss out automatic thoughts and core belief systems that may not fit the facts of the situation or that cause harm.
6 *Identify action urges that followed the prompting event*. Recognizing an urge marks a decision point with behavior. Sometimes action urges motivate helpful behaviors but oftentimes they motivate target behaviors. Investigating the relationship between urges and behaviors aids learning.
7 *Identify consequences of the behavior*. Detail what happened after the behavior. In particular, note gains and costs in both the short and long term. Also determine whether consequences cycle back to become vulnerabilities. Last, figure out whether the client needs to make amends with others for their behaviour and develop a plan for them to do so.

## Behavioral Analysis Example

In the following example, note the chains of events leading to and coming after a target behavior, in this case self-injury, as well as the active

problem-solving with skills. This particular behavioral analysis occurred with a client who was approximately three months into treatment and had been learning and applying skills.

**T:** Okay, the diary card tells me you've had a real tough week. Very depressed, very anxious, and it looks like things were so tough you had self-injury yesterday. Yet you did a great job with safety regarding suicidal urges … you used a lot of skills there. (*Uses the diary card to check in and begins to set the agenda for the session. Praises safety and skill use for suicidal urges.*)

**C:** Yeah, but I'm feeling really guilty about cutting again (*client is looking down*).

**T:** We've talked about improvement being up and down, and it's hard to take a step back. In addition to the guilt, you're looking down and away, like you are feeling some shame right here right now. (*Uses validation, especially noticing nonverbal communication and its connection to shame for this client.*)

**C:** Yeah, it's hard to feel good about myself.

**T:** What do guilt and shame usually lead to for you? *(Asks question knowing that client would skip sessions in the past following self-injury. Looks to highlight the change from the previous pattern.)*

**C:** In the past I would skip the appointment, but even so, I still want to avoid the whole thing.

**T:** And you made it here! Some opposite-to-emotion, yes? What if we could practice some nonjudgmental stance and try to learn something from the self-injury? Would you be willing to try a chain analysis? (*Highlights a skill used and suggests another while soliciting collaboration to do a behavioral analysis.*)

**C:** I don't really want to ….

**T:** Who would? What would your wise mind say to do? (*Activates wise mind.*)

**C:** I'm not getting out of this, am I?

**T:** No. I want to help. Please describe what you did (*said with warm engagement*).

**C:** I cut two times on the top of my leg.

**T:** Two separate events, or one event with two cuts? And for how long did the behavior or behaviors last? *(Assesses frequency and duration of the self-injury. Note that frequency, intensity, and duration are established to determine baseline rates and track improvement over time.)* Did it require medical attention? *(Assesses for intensity/severity of the self-injury.)*

**C:** It was one time, with two cuts. It all took only a couple minutes, and it wasn't deep, and it only bled a little bit. It didn't need checking out. I bandaged it right after, it stopped bleeding, and it has been okay.

**T:** Okay, so when did it happen and where were you? (*Assesses contextual factors.*)

**C:** It was about eight last night, in my bathroom.

**T:** Why is the time here important? I mean, you know I'm fast asleep at eight pm, as are all your friends and family! (*Uses irreverent communication to highlight missed opportunity for support.*)

**C:** I know, I know. I could have called someone.

**T:** (*emphatically*) Yes! Some DEAR MAN could help when you're getting into trouble. So, what set off the cutting? (*Labels a skill to use and asks about the prompting event, moving from assessment into the analysis.*)

**C:** I got home from work about six and opened an email from Brad. It wasn't a big deal really, but he wanted to come by this weekend to get the rest of his stuff. I'm just dreading it.

**T:** Sounds like a big deal. Seeing him reopens things, emotionally … it hurts to just get the email, let alone have him come to pick up his things. So you get home, open the email, see his request … what next? (*Uses validation, recaps, and prompts next link. Develops hypothesis that rejection is a prompting event.*)

**C:** I started to cry, I mean I miss him, and then I just felt alone. Sad, lonely, and I started to think about how I screw up everything and will probably never have a decent relationship. Then I felt like giving up, so I went to the bathroom, got the razor and cut. And then I felt better for a bit, relief, but then I felt worse, guilty and shameful.

**T:** Okay, so a lot here. We're getting somewhere. Just sit with this emotion a bit. You've been sad and lonely since the breakup, and sometimes it seems you'll never have a good relationship, and you should just give up (*pauses and waits*). (*Provides brief encouragement and then validates and gives space for client to experience and tolerate the emotions in the moment.*)

**C:** (*sits quietly with sad affect*)

**T:** Let me know when you are ready.

**C:** (*sighs deeply*) I am.

**T:** So you came home, opened the email, saw that he wanted to get his stuff. Then you felt alone and sad, and thought that you screw up everything, will never have a good relationship, and you wanted to give up. Then you went into the bathroom and cut. Immediately you felt some relief from the feelings, and then shame crept in. Am

I missing anything so far? (*Reestablishes the links in the analysis. Identifies relief as a reinforcement for the cutting.*)

**C:** No, that's what happened. And then once the shame came I just isolated and got stuck in the depression and loneliness. I still feel like shit about the whole thing.

**T:** So vulnerable again. Cutting gives momentary relief, but then it takes from you, pushing you to a place where you're set up to act on it again. Feel tired of that cycle? (*Emphasizes negative consequences that result from SIB and explores willingness to change.*)

**C:** Yes.

**T:** You've done great, and we are going to get to some problem-solving to break this cycle. But we are still missing something … was anything leading you to feel more vulnerable to cut yesterday? Anything happen at work, or earlier, before the email? (*Loops around to the beginning of a behavioral analysis to identify vulnerabilities. Recall that the links can be explored in any order so long as the sequence is clear when finished.*)

**C:** Hmmm (*thinking*). Well. (*pauses*) The only thing I can think is work was really rushed and kinda stressful, and I really didn't come down from that when I got home. I just sat down to check my emails right away.

**T:** Okay, so you came in keyed up and stressed and opened up this hot-button email straight away?

**C:** Yes. That's the only vulnerability I can think of right now. I've been doing pretty good overall.

**T:** You have. I like that you noticed that. Anything else before we plug in skills? (*Shifts toward problem-solving with skills.*)

**C:** Not sure. (*pauses*) I guess in the past I would go to Brad after cutting, and he would be understanding and drop whatever to be with me. I thought about replying to his email and telling him how much I hurt, telling him that I cut, but I didn't. It's obvious he doesn't care anymore.

**T:** That's a big deal, to not fall into that old pattern of cutting to draw him in. I'm sure that used to reinforce the cutting along with the immediate relief from feelings, but you've learned that hurting yourself ultimately sabotages your relationships. (*Identifies an old reinforcer, the care from Brad, and highlights contingency that using self-injury to elicit care burns people out.*)

**C:** Yeah, I guess I'm kinda proud I didn't do that, or at least glad. I want him to see that I can cope, that I am doing better, even if he never wants me back.

**T:** Right. It feels good to make progress with coping. That's going to work better in relationships, knowing how to cope. Okay, so let's start with the one vulnerability, coming home stressed. What would be helpful? (*Notes client's statement that not calling Brad and showing better coping leads to an improved emotional state and then shifts to problem-solving.*)

**C:** I could try to self-soothe, maybe take a shower and change out of my work clothes, listen to music. I feel a pull to check my emails, but I can use O2E [opposite-to-emotion] to wait.

**T:** Good, nice. Do some decompression after work. Now the prompting event, the email. By history you cut when you feel rejected, right? So what skills would help here? (*Makes connection between rejection and self-injury to test hypothesis. Invites client to reject connection and calls for skill use.*)

**C:** Yes, right. It's so hard, but you said to call you, someone, for support. That would take some O2E, but I guess reaching out when I feel rejected would be skillful.

**T:** Yes, DEAR MAN, O2E. Using your words to let others know you're feeling hurt, rejected, and needing help. If you couldn't get hold of someone, what else could you do? (*Repeats skills and tries to establish contingency plans if others are not available for immediate support.*)

**C:** (*thinking*)

**T:** Hey, pull out your safety plan. How did that not occur to either of us? What does the plan say? *(Coordinates use of safety plan with behavioral analysis. Waited on this suggestion to assess the client's spontaneous problem-solving.)*

**C:** Lots of stuff. Distract with reading, watching Netflix, there's self-soothe again. Radical acceptance, using nonjudgmental stance. Doing a positive experience.

**T:** Okay, you're on a roll. Dealing with the feelings is really tough, and you have some guilt and shame hanging around, some hurt and sadness. How are we going to keep those feelings from taking over and setting you up again? (*Uses lower level validation with more problem-solving.*)

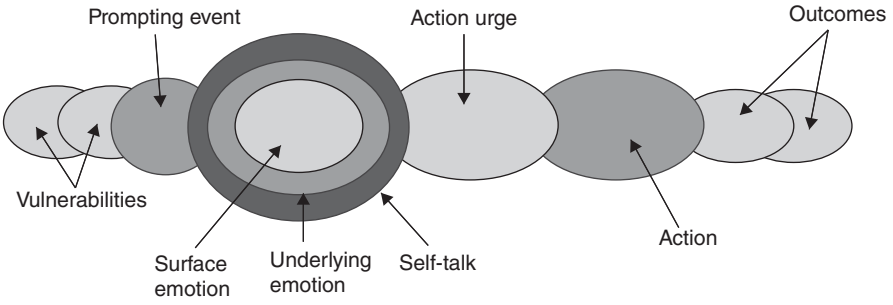
**C:** Well, some of the same stuff I just said. I can accept my feelings and cope in healthy ways. You always nag about self-care (*smiles*). I need to be doing that.

**T:** Yeah, I nag because I care. I want you to take what we've been doing with this chain and the skills, and bring it home and keep working on it. You have a big test this weekend, with Brad coming

over. Bigger than the email. I think we need to get to that with our time left. (*Shifts away from active work on the behavioral analysis to focus on what would be another prompting event for self-injury with developing a plan. Assigns further work on behavioral analysis as homework.*)

This behavioral analysis took about 10 minutes. With behavioral analysis, therapists and clients can always dig deeper into the analysis by chaining further back, chaining off in different directions, or getter increased level of details around each link. In the present example, the therapist could have done more exploratory work with emotions or thoughts, or gotten into physical sensations or more skills application. However, the level of detail gleaned from behavioral analysis depends on the amount of available time and the other treatment priorities that also require attention. It is best to make sure enough time remains in session to at least begin applying skills. As clients progress through therapy, they become more efficient with and gain greater detail from behavioral analyses, often completing them on their own between sessions to simply be reviewed with therapists. Box 21.1 and Box 21.2 show a visual behavioral analysis with instructions and a visual behavioral analysis that clients can complete.

**Box 21.1** Visual Behavior-Change Analysis: Directions

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**Directions**

The more you understand about behaviors you want to change, the more you can be effective in the use of your skills to meet that goal! Start anywhere on the change (chain) analysis and work

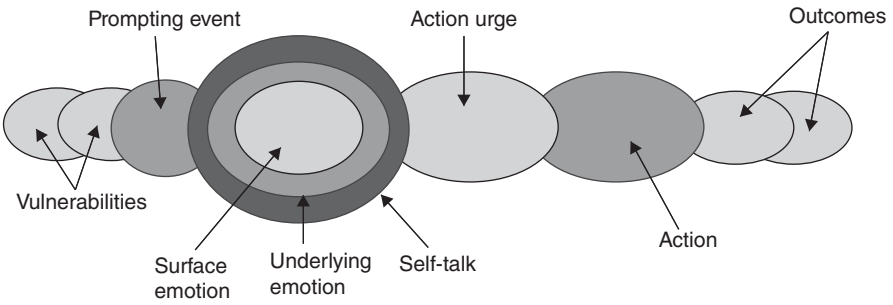
forward and/or backward to figure out each link, then identify other skills or choices you could make with your new awareness. Remember to be *nonjudgmental* with yourself, the situation, and others. The following explains each identified link, but remember that you can add as many links as you need to understand your process and that *every link presents an opportunity for change!* Also, look for skills that you might have already been using but not noticed or for which you need more practice. Chances are you have been using skills!

- *Vulnerabilities:* What made you vulnerable to the prompting event (and what unfolded after it)? Examples might include not doing self-care, having a tough day, getting into a conflict, or other stressors. Be as specific as possible.
- *Prompting event:* What happened? Use nonjudgmental, descriptive words.
- *Surface emotion:* What feeling(s) occurred after the prompting event that was/were most easily noticed?
- *Underlying emotion:* Was there a feeling or feelings further below the surface? Examples might include feeling hurt or embarrassed under anger or feeling guilty under depression.
- *Self-talk:* What automatic thoughts or beliefs were happening that fed your emotions and the following action urge?
- *Action urge:* What did the feelings pull you to do? This link is a critical moment of choice in changing a behavior.
- *Action:* This is the behavior you might want to change. However, remember that using skills at earlier links might effectively change your action/behavior.
- *Outcomes:* What happened after the behavior you want to change? What did you gain and/or lose, in both the short term and the long term? Did the outcomes cause a new vulnerability or stressor and/or cycle back to the beginning again?

**Solutions**

At each step, brainstorm skills or choices that could create behavior change and more effective outcomes. Also plan for how you can deal skillfully with the outcomes you are experiencing, *including how you may need to make amends with others*.

**Box 21.2** Visual Behavior-Change Analysis Form




Source: Pederson and Sidwell Pederson, 2012. Reproduced with permission.

Describe your vulnerabilities:

Describe the prompting event (what set off the action?):

Describe your emotion on the surface (the one mostly easily noticed):

Describe any underlying emotions (the ones hidden underneath):

Describe your self-talk:

Describe the action urge:

Describe the action:

Describe the outcomes:

**Solutions**

Fill in alternative skills and choices that would have been more effective at each step. Consider how these alternatives would have altered the outcomes for you and for other people.

Describe how you will use skills effectively to deal with the outcomes that exist:

Describe who else was affected by your choice(s):

Describe how you will make amends with these people (if appropriate):

# 22
# Dialectical Strategies

Linehan (1993a) outlined dialectical change strategies that create emotional, cognitive, and behavioral shifts. These strategies are most impactful when used fluidly in balance with acceptance and validation strategies. Dialectical strategies added to Linehan's originals are marked with an asterisk.

The first dialectical strategy is called *entering the paradox*. This strategy brings contradictions that keep clients stuck into their awareness. Entering the paradox creates cognitive dissonance, the uncomfortable psychological state that stems from contradictions between beliefs, values, and behaviors. When incongruity is brought into awareness, the client needs to make a cognitive shift to alleviate the psychological distress. For example, a client who was at risk of losing custody of her two children started missing therapy appointments. Her therapist directly asked how jeopardizing her treatment placement and progress would look to the child-protection agency. Feeling heightened anxiety and psychological stress about losing her children, the client quickly engaged in problem-solving to get therapy attendance and progress back on track.

Astute therapists stay on the lookout for incongruities and contradictions and point out these dialectical tensions. The following clinical vignette shows a mismatch between the client's words and behaviors, illustrating how this technique is used:

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

C: I'm okay. You don't have to worry about me.
T: Okay, so you tell me you're okay and I don't need to worry, and yet you are isolating yourself, not returning calls, not taking care of your apartment, and thinking more about suicide. Do I trust your words or your behavior? (*Uses direct communication, enters the paradox, and waits for an answer.*)
C: (*visibly more anxious*) I know things aren't going well. I need your help.
T: Okay, good. You do need some help, and I'm glad you're asking for it rather than saying things are fine when they're not. We can figure things out when we're on the same page. (*Reinforces congruency, the DEAR MAN skill, and invokes therapeutic alliance.*)
C: (*showing some relief*) Okay.

With entering the paradox, it is often preferable to allow clients to engage in and navigate through the dialectical tension or dilemma rather than solve it for them. Explicitly showing the client where to shift has a less profound impact compared to clients doing the work and finding the balance themselves. Box 6.1 lists frequent dialectical tensions experienced by clients. Box 22.1 lists additional discrepancies for entering the paradox.

**Box 22.1** Discrepancies for Entering the Paradox

The following examples illustrate opportunities for therapists to use entering the paradox with clients. With this technique, clients are made aware of the discrepancies in order to create dialectical shifts in thoughts, feelings, or behaviors.

- Client has a mismatch between verbal and nonverbal behavior.
- Client shows a discrepancy between values and behavior.
- Client has awareness of what would be helpful yet chooses inaction.
- Client is stuck between a preferred reality and the actual reality.
- Client presents a self-concept of failure when the client demonstrates strength and resiliency.
- Client wants a relationship yet engages in relationship-destroying behaviors.
- Client demands respect from others but treats them disrespectfully.

The next dialectical strategy is *refusing right and wrong*. This strategy recognizes that opposing viewpoints can both be true, that a viewpoint can be both true and false, or that answers can be both yes and no. For example, therapists can care about their clients *and* set limits on their time and availability. Further, in some situations therapists may decide that the best way to help a client is not to help, or they may recognize that sometimes it is necessary to buffer or save clients from consequences whereas at other times it is important to have clients experience the complete effects of consequences. Refusing right and wrong does not mean that there are not preferred or more beneficial methods of dealing with situations; it means that getting caught in believing that there is one right answer or intervention for everyone and everything hamstrings the options. The paradox is that there are no *ultimate* right ways or wrong ways while there may simultaneously be a more favorable way depending on context.

A clinical example of refusing right and wrong occurred in a couple's session in which the wife lamented that her husband's attentiveness "didn't count if she had to ask for it." The therapist validated the wife's sadness and disappointment and then pointed out that, while it's true that spontaneous affection can be preferred (as indicated by the wife's comment), it is also true that spontaneous affection might sometimes be unwelcome, such as when she was under deadlines at work. The therapist further reframed her asking for affection as a positive, assertive behavior that clarified her needs, and suggested that more communication about her desires might be in order, even though having to communicate needs could be disappointing too. She was then encouraged to consider what worked in getting her needs met, trying to recognize that categorizing into buckets of right or wrong, or what mattered or didn't matter, didn't seem to improve her feelings or her relationship with her husband. The client came around to realizing that right and wrong were relative to each situation, and she increasing used a nonjudgmental stance and assertiveness with her husband, improving the marriage.

The next dialectical strategy is *use of metaphor or stories* to illustrate alternative points of view. A client resistant to therapy who was known to enjoy cleaning and organizing was told that the therapy process was like spring cleaning for the mind. Another who complained of a "shitty life" but questioned the value of skills training was told by a peer, "Someone drowning in shit should learn some swimming skills." Most therapists (and clients) have their favorite metaphors to cue effective behaviors. An extremely popular one to emphasize coping with reality rather than trying to control it is, "You can't control the winds but you can adjust your sails."

Metaphors facilitate learning, create a memorable visual, and are usually well received by clients as they communicate a personally relatable point in a nonconfrontational manner.

Teaching stories are similarly well received by clients. In teaching nonjudgmental stance and the relativity of "good" and "bad," I frequently tell the following well-known story:

> A farmer with many horses left his gate open, and they escaped. His neighbor, noticing the loss exclaimed, "What a terrible thing!" The farmer replied, "We'll see." The next day his horses returned with a number of wild horses following them into the corral. When the gate was closed, the farmer had doubled his horses! His neighbor, witness to the event, blurted out, "You are one lucky guy!" The farmer replied, "We'll see."
>
> The following day the farmer's son, in an attempt to ride one of the wild horses, was bucked off and broke his leg. Seeing the son injured, the neighbor said with sympathy, "What an awful thing, just horrible." The farmer replied, "We'll see." The day after, the military showed up to recruit young men for the war effort, but had to leave the farmer's son because he could not fight with a broken leg.

Upon hearing this story, clients can reflect on the idea that getting caught in judgments is short-sighted and does not account for the complexity of life.

The fourth dialectical strategy is *devil's advocate*. This technique has the therapist propose a counterargument to a client's stated position to expose a missing truth and/or to bring about a more balanced stance. In playing devil's advocate, the therapist does not have to actually believe the counterposition so much as sell the idea that there are alternative positions. When a love-struck client proclaimed that she was getting married after a week-long romance, her therapist stated that marriage can stifle love and romance and that the client should protect the relationship by putting off marriage indefinitely! The client put off the wedding plans and ultimately ended the relationship after several months without needing a divorce attorney. This technique can also be used in consultation group where assigning the role of devil's advocate to one therapist can increase balance and decrease the probability of groupthink.

Another dialectical strategy is *extending*. Therapists use extending when they join and flow with the client's energy rather than meeting it with opposition. This results in the client's position being overplayed, leaving the client off balance and in need of self-correction. When a client well known for willfulness would come in "stuck" and resistant to engage, his therapist

would first join with him by saying warmly, "It's okay with me if you're dug in. I'm sure you have valid reasons to be stuck like this."[1] He would then extend by asking with sincere concern, "Are we going to be in this place for the whole session, or maybe even for a few of them?" Alternatively, the therapist would extend with the suggestion of a potential (but unwanted in this case) consequence of unproductive therapy, scheduling a team meeting to discuss service options. He would say, "I don't like to see you having such a hard time. I think we need to get your service providers together to talk about your options and get some new ideas." Going with and extending the resistant energy in both cases resulted in the client self-correcting and being willing to engage in a productive session. These extending interventions worked because they took the client's behavior to natural but undesired consequences (i.e., the client did not want to stay stuck for a significant period of time, and the client really did not want a meeting of his providers). To avoid these consequences, the client had to decrease the resistant behavior and engage in the session. The following brief exchange demonstrates another example of extending:

C: (*angry and in emotion mind*) I'm fed up with you and this whole program! I quit!
T: (*said quietly*) It's true we're in a down spot. I'm going to do you a favor and gather up referrals so we can get you connected to another program today.
C: (*assertively*) Oh no you don't! You're not getting rid of me that easily!

Like the above examples, the therapist flows with the energy and treats a potential consequence (ending treatment) with utter seriousness, knowing that the client actually wants something else out of the interaction. In this case, the client was upset about being assigned a behavioral analysis for treatment-interfering behavior, which was the real issue that needed to be addressed.

Extending can work well in situations where clients present a problem in an exaggerated or dramatic fashion. An adolescent who dramatically talks about a minor conflict with friends might receive the suggestion that she get a whole new peer group, or a client who presents with exaggerated symptoms might receive "helpful" proposals for extensive (but again

[1] Milton Erickson said that giving a client permission to resist changed the behavior to a cooperative one, changing the moment, resolving the stalemate, and redirecting the energy (Haley, 1993, p. 24).

unwanted) treatments (e.g., a hospitalization to change medications, a stay in supportive housing) until the symptoms remit. However, extending does come with an important caveat. This intervention requires a solid understanding of what the client truly wants, and the therapist needs to ultimately deliver. The point of extending is to illustrate that resistant, angry, dramatic, or exaggerated presentations could short-circuit getting what is really important. Extending often has shades of irreverent communication, so it needs to be rooted in the therapeutic alliance and be balanced with validation and teaching clients how to better get their needs met.

Another dialectical strategy is *wise-mind activation*. This intervention asks the client to consider the present situation or problem from a wise-mind perspective. An emotionally activated client might be asked what his or her "wise mind might say" or direct him or her to do. Clients who understand the states of mind taught in the mindfulness module can almost always articulate a wise-mind response. Activating wise mind sometimes comes from invoking the "missing" state of mind. The emotional client might be asked to channel his or her reason mind. Similarly, a stoic, intellectualizing, or overly logical client can be directed to speak from his or her emotion mind. In couples' counseling, activating (a collective) wise mind might mean that a logical partner works on validation and an emotional partner works on planning and thinking through options (i.e., balance comes through practicing some of the style of the other). The following illustrates wise-mind activation:

**C:** (*talking through reason mind*) I understand why I was let go. Last hired, first fired. There has to be a method for deciding who to downsize, otherwise the process gets messy. The economy has been so bad, it's natural that people in my field are without work, given supply and demand.

**T:** I know you understand the reasons why you were let go, and you can rationalize the situation, but what does your emotion mind say about it?

**C:** (*pauses and thinks*) I'm angry. I brought more to the table than a lot of people with seniority who kept their jobs.

**T:** What else?

**C:** It's embarrassing. I feel like a failure, and I'm scared. How am I going to pay my bills?

**T:** It's humbling to be downsized; you feel angry, that it's unfair. (*pauses*) And you're fearful about making ends meet. The feelings are there, and acknowledging them might be more beneficial than reasoning them into submission.

C: (*sitting, experiencing her emotions*)
T: (*after a brief time*) These feelings are real. So we acknowledge and experience, and figure out rationally what comes next, both.

*Making lemonade out of lemons* is the next dialectical strategy. From the popular saying, "When life gives you lemons, you make lemonade," the idea is that realistic optimism, adaptive coping, and a willingness to embrace change result in surviving and maybe thriving in adversity. The Buddhist saying "Is this a tragedy or good practice" captures this concept. So does the irreverent client acronym AFLO: another frickin' learning opportunity! This strategy points out the silver lining, the upside, or the opportunity in a problem. When a client was confronted with a serious health problem, she cancelled her cable television, stopped eating fast food, and joined a walking club. In six months she had reversed her health crisis, saved money, made friends, and (perhaps unsurprisingly) felt better physically and emotionally than she had in years.

*Allowing natural change* is another dialectical strategy. A core feature of dialectics is the ever-changing nature of the world. Allowing natural change means teaching clients how to skillfully adapt to the ups and downs of everyday life as an alternative to being paralyzed in the face of change or trying fruitlessly to control reality. A core element of allowing natural change is acceptance along with a willingness to be effective with what life hands you. In a DBT program, when the primary therapist was out ill, some of the program members got upset and wanted to leave. Another member, who had made known on an earlier occasion that she did not care for the substitute therapist, stated that she was in a skills program and that she would use her skills to deal with the change. Subsequently, the other members stayed and used skills to manage the change too.

In situations in which the therapist fears a particular reaction on the part of the client, *prescribing the feared behavior** can be used. This paradoxical intervention calls into awareness the potential for the behavior, which has the predictable result of having the client prove the therapist wrong by not engaging in the problem behavior. As an illustration, when a therapist fears that a client will feel criticized by an observation, he or she can simply say, "I want to share an observation with you, but I fear that you'll feel like I am criticizing you. Is it okay for me to share it?" Almost always the client will give permission to share the observation and will receive it from a wise-mind perspective. Not only does this technique get the needed observation across but also it sets up the client to respond in a manner that can be reinforced, thereby building a skill in the moment.

A tenth strategy, referred to as the *exception rule**, is adapted from solution-focused brief therapy (de Shazer et al., 2007). The exception rule considers the effective behaviors clients perform during times that target behaviors do not occur. Suicidal and/or self-injurious clients do not always act on urges with target behaviors even when the antecedents and overall context are similar to times when they engage in those behaviors. So what is happening skill-wise when they resist target behaviors? Perhaps they exercise, or remember their children, or go out with a friend, or read a religious text, or do some other helpful behavior to get through crisis. In kind, people who use drugs to manage stress have times when they avoid use, so what alternative behaviors do they perform otherwise? Mining the exceptions dialectically balances focus on deficits and identifies behaviors to strengthen and further generalize.

A final dialectical strategy is *role reversal**. This technique invites the client to conceptualize and argue a position from another person's point of view. Articulating alternative perspectives through explicitly switching roles allows clients to make dialectic shifts. An even more dramatic example of this intervention can happen with role play. A therapist found himself tired of having his suggestions rejected by his client, so he asked her to play him so he could respond as she typically did. The interchange was a bit irreverent and playful, and, after a minute of playing the therapist and having her ideas being rejected one after another, the client expressed new awareness of her help-rejecting complaining and how it caused frustration for others. This strategy has obvious application anytime two or more people get stuck in a dialectical conflict.

# 23

# Cognitive Interventions

As DBT evolved from CBT, the change strategies focused more on behaviors than cognitions. Belying its title, Linehan's *Cognitive-Behavioral Treatment of Borderline Personality Disorder* treats cognitive interventions almost as an afterthought, and Linehan (1993a) goes so far as to write that she has a "nondialectical" position on formal cognitive techniques with certain populations such as borderline personality disorder, fearing that cognitive interventions are invalidating and can reinforce the unfortunate message that struggles are "all in one's head" (p. 369).[1] Koerner (2012) also notes that traditional cognitive techniques that focus "on what is wrong with thinking" can be too "evocative and aversive" for many clients (pp. 108–109).

That said, cognitive interventions can be used effectively in plenty of clinical situations. As with other therapy ingredients, therapist expertise and judgment in the context of clients' needs and preferences will determine whether cognitive tools come out of the toolbox. However, to make cognitive work more effective with emotionally dysregulated clients, DBT cognitive strategies have important distinctions and modifications from traditional CBT strategies (Marra, 2005).

First, DBT has a different guiding theory from CBT that alters the relative importance of cognitive modification. The DBT theory based on

[1] This may be why the approach became dialectical behavior therapy and not dialectical cognitive-behavioral therapy.

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

emotional dysregulation transacting with invalidation places primacy on attending to emotions through validation and other techniques. Cognitive interventions are on the menu, but they are not necessarily the focus of treatment and they may not be used at all with some clients. In CBT, distorted thoughts are at the theoretical center of what causes difficulties, directing therapists to address thinking as the primary focus of remediating problems. Thus, the differing theories make modified cognitive work an option in DBT whereas cognitive work is the main focus of CBT.

Next, DBT does not use traditional CBT labels such as "distortion," "maladaptive thought," or "thinking error." These labels can be judgmental and poorly received by some clients, and they are unnecessary to do cognitive modification with most populations.[2] People often feel threatened by the suggestion that their thinking is distorted or inaccurate and that invalidation shuts down the process. Moreover, labels fail to recognize that from a dialectical perspective cognitions have validity given past and present context. To replace these labels, I renamed traditional CBT distortions "stuck thinking" (Pederson & Sidwell Pederson, 2012), which all people can be susceptible to at times. Box 23.1 outlines these traditional categories.

**Box 23.1** Examples of Common Stuck Thoughts

DBT therapists can teach and apply traditional cognitive categories that help clients identify common stuck thoughts and apply dialectical solutions. In DBT, these are not taught as distortions. Instead, therapists normalize these categories of thinking and invite clients to check whether they lead to better or worse functioning and whether a shift might be more helpful. Consistent with other skills training, teaching these categories of stuck thoughts can be more effective if reviewed when clients are not emotionally activated.

*Black-and-white thoughts (either/or; dichotomous thinking; all-or-nothing thinking)*: Extreme thoughts signaled by words such as "always," "never," "every," and "all the time." These thoughts lead to rigidity and inflexibility in situations and relationships.

[2] Explicitly labeling thoughts and beliefs as distortions is well tolerated by clients who are more thought than feeling oriented, and labeling might be important with some populations, such as people with criminal thinking or people who are abusive or predatory with others. Choosing between traditional cognitive work and DBT-style cognitive work or using a mix-and-match cognitive approach is both stylistic and clinical.

*Dialectical shift*: Think of opposite and/or middle-ground thoughts to increase cognitive flexibility and/or remember examples of situations that did not fit the extreme.

*Regret orientation (woulda, coulda, shoulda thinking; hindsight bias)*: Looks to the past with regret about what was done (or not done) in particular situations. Hindsight is "20/20" because information not necessarily available in the past is obvious in the present.
*Dialectical shift*: Do not dwell on past mistakes and instead focus on situational effectiveness in the present moment.

*Mind-reading*: Automatic assumptions about others that are unverified.
*Dialectical shift*: Check out assumptions with other people, especially the person whose mind is being "read."

*Minimization*: Takes something large or significant and reduces it to something that is very small. This buffers difficult realities and reduces the immediate emotional impact of them but results in emotional invalidation as well as insufficient coping and intervention.
*Dialectical shift*: Observe and describe the situation accurately without adding or subtracting. Do what is needed to be effective.

*Magnification*: The opposite of minimization. It happens when something that small or insignificant is exaggerated to be something that is very large. It is like looking at a kitten through a magnifying glass and seeing a tiger. Magnification amplifies emotions.
*Dialectical shift*: Like with minimization, observe and describe the situation accurately without adding or subtracting.

*Catastrophizing*: Magnification to the extreme. It takes a situation and builds it into a calamity with dire consequences.
*Dialectical shift*: Focus on the *one* situation or problem at hand without exaggerating it. Remember that most situations do not end up with extreme and dire consequences. Take one thing at a time. Alternatively, purposefully catastrophize to the point of absurdity to see that the extreme scenario is not realistic.

*Fortune-telling (crystal-ball-gazing)*: Attempts to predict the future, usually in negative ways with the assumption that the end is already

known. Fortune-telling commonly causes emotions of anger, anxiety, and dread.

*Dialectical shift*: Release negative predictions and instead focus on effective coping in the in-the-present moment.

*Overgeneralization*: Takes a small bit of information and applies it broadly across all kinds of people and situations.

*Dialectical shift*: Assume that the available information does not fit all people and all situations. Practice "beginner's mind" and be open to not knowing all of the facts.

*Selective information-gathering (selective abstraction; mental filter; confirmation bias)*: Gathering only information that fits with our current thinking. This approach limits effectiveness because it ignores other perspectives and options.

*Dialectical shift*: Gather alternative information and viewpoints that will lead to greater flexibility and more effective options.

*Labeling (judging)*: Takes a person or situation and reduces it to only a name. Labels fail to look at people and situations in a holistic manner and miss important subtleties and nuances.

*Dialectical shift*: Gently let go of the need to label a person or situation. Observe and describe nonjudgmentally knowing that the world is more complex than labels and judging.

*Personalization*: Personalization makes it all about you and creates unnecessary suffering. Even when situations feel personal, they often are not.

*Dialectical shift*: Use a Teflon mind and let things slide off you. Remember that most of the time it is not about you. Take responsibility for what is yours (if it fits wise mind) and gently let go of the rest.

*Emotion mind "reasoning"*: Allowing thoughts only from emotion mind without consideration of reason mind or wise mind.

*Dialectical shift*: Use core mindfulness to access wise mind and use distress-tolerance skills to soothe or distract yourself from emotions.

*Should statements*: Focusing on judgments rather than the realities of a particular situation or interaction without the acknowledgment that reality unfolds in ways that do not fit our preferences (i.e., what "should" happen).

*Dialectical shift*: Focus on "what is," not what "should be." Stop "shoulding" on yourself and others.

*Discounting positives*: Focus on the negatives or the downside of ourselves, others, and/or situations while minimizing or being blind to positives.

*Dialectical shift*: Seek out positives, upsides, and silver linings for balance. Own the positives about yourself and give yourself credit. Find the positives in people and situations that seem negative.

*Blaming*: Makes others responsible for our problems and difficulties. Blaming gives up our power and control and makes us dependent on others to fix a situation (or our lives).

*Dialectical shift*: Remember that your power and control come from a focus on how you can influence situations and your life, if only through choosing how you respond.

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Third, DBT assumes that even dysfunctional thoughts and beliefs, like overt behaviors, make sense given biology, history, and/or the present context, and that they serve adaptive functions. Thus, therapists strive to *validate* clients and their phenomenological experiences around thinking to help them regulate emotions and to make cognitive work less threatening. Validated clients feel settled enough to explore different views and make dialectical shifts and expansions, which leads to the last important difference in regard to the methods for analyzing thoughts and beliefs.

The last difference is that DBT cognitive analysis is dialectical rather than categorical. As mentioned above, dialectics recognize that cognitions may work well or fit the facts in some situations, or that they did in a formative situation. At the same time, those cognitions may not be as effective in other circumstances. The important distinction is that what works well or fits the facts is relative to many contextual factors, so dialectical analysis results in a more exploratory process that remains embedded in validation and open to relative truths.

In DBT cognitive modification, therapists and their clients explore alternatives and decide what thought, interpretation, or belief works best in a given context. Importantly, *therapists do not try to talk their clients out*

*of their thoughts or beliefs or aggressively dispute clients' "stuck" perspectives*. Such techniques can easily backfire, create more emotional dysregulation, and close off dialectical exploration and shifts. This contrasts with traditional CBT's categorical analysis, which uses more direct confrontation of so-called distorted thoughts along with encouraging clients to unplug, discard, and replace them with other thoughts assumed to have more of a market on capital-T truth. DBT instead validates that multiple perspectives have relative truth and function while simultaneously holding that *there may be one that is more effective or functional in any given situation*. The two bottom-line questions for clients after validation occurs are:

- Does this thought fit the facts of the present situation?
- Would another perspective be more helpful?

Clients who learn to *shift* and *expand* thoughts and beliefs rather than categorically replacing them ultimately gravitate toward more functional thinking with more people across more situations, gently letting go of what works less well. For example, clients who practice the cognitive skill of nonjudgmental stance gradually give up more and more judgments as they enjoy the benefits of acceptance of "what is." Similarly, clients who develop cognitive flexibility and adjust thinking based on what is functional rather than holding to categorical thoughts and beliefs discover emotional advantages to such an approach. Making cognitive adjustments therefore becomes self-reinforcing when dialectical thinking results in less emotional and relational suffering. In time, clients learn to trust their cognitive processes, respecting the functions of thoughts and beliefs while becoming more dialectically oriented *and* expansive in their views.

The following clinical vignettes show the DBT cognitive approach. In the first vignette a client who returned to work following two years on disability shares her experience and fears of not measuring up:

C: I was feeling so much anxiety at our staff training, and just thinking about how I don't belong. (*pauses*) That everyone there is so much smarter and more qualified than me. I have nothing to offer.

T: I see your distress in this moment. It feels overwhelming, and you think you have nothing to offer your coworkers, your employer … like they might find out you're a fraud (*therapist validates and resists a direct challenge of thinking, instead reflecting the client's thoughts*).

C: Yes. That's what it's like. And it makes me want to quit, before everyone finds that out.

**T:** I think I understand. You've been away from work for a long time, struggling to just feel okay without work pressures. And you've been over your head before, so when the nerves come, it's easy to think you won't measure up (*Therapist highlights context of thoughts and validates, again resisting a direct challenge of thinking, and noting how the client's thinking makes sense. A direct challenge might be experienced as invalidation or elicit examples of how the client has failed in the past or will fail in the future.*)

**C:** (*nods*) Yes (*said quietly*).

**T:** When your thoughts are there, what happens with your anxiety? (*Inquiry regarding function of thoughts.*)

**C:** It stays, it increases, it gets in the way.

**T:** Okay, so there are reasons those thoughts come up, but those reasons aren't helping you now so much. What kind of thought could help, or at least be neutral? (*Notes valid reasons for thoughts and invites a dialectical shift without a direct challenge of the thoughts.*)

**C:** We are all new there, and we all have our own strengths and limitations.

**T:** Say that again. (*Directs client to practice different thought.*)

**C:** We're all new; we all have strengths and limitations.

**T:** When you said that, especially the second time, you visibly relaxed some. (*Notes the in-the-moment emotional benefit.*)

**C:** Yeah. You know I'm there to learn, and I don't need to know everything; that's why I'm in training!

**T:** Don't get on a roll, you'll put me out of business! (*both laugh*). (*Uses irreverence and humor to reinforce dialectical shift and change in affect.*) So those thoughts help. Sure there are valid reasons why your original thoughts are there, but those thoughts aren't very useful when you're at work. Instead, do the shift when you notice those thoughts and the anxiety, and that'll help.

**C:** Okay. (*Smiles.*)

In the next example, the therapist works with a college freshman who had been a victim of bullying in high school. In this excerpt, the client discusses getting lower grades due to lack of class participation.

**C:** It's not fair. I know the answers. I get As on the tests. I shouldn't get docked just because I don't ask questions or get in the stupid class discussions.

**T:** You sound really angry and upset. It doesn't make sense why you should have to talk in class when you know the answers anyway. (*Validates emotions and client's perspective.*) (*long pause*)

**C:** (*Opens up*) It's so hard for me to talk. I was called everything in high school. (*Long pause*) People are so cruel.

**T:** People have been so cruel to you. You have been horribly mistreated. Thinking people are going to be mean, thinking that you shouldn't have to talk in class, these thoughts keep you safe, from being hurt again and again. (*Highlights the function of thinking that people are cruel.*)

**C:** (*Tears up, says nothing.*)

**T:** (*Allows a long pause for the client to feel the emotions.*) No one wants to be hurt. Yet you're stuck and not getting what you need when you take no chances. Being an open book is too dangerous for anyone, but is there middle ground here? (*Normalizes and then identifies dialectical conflict and invites dialectical thinking.*)

**C:** Maybe not everyone in college is like the jerks in my high school. I guess the worksheet would say I'm stuck with overgeneralizing. (*References worksheet from skills training and makes a cognitive shift.*)

**T:** Yeah, you know, there are real jerks in the world, and sometimes we have to be on the lookout to not serve ourselves up to them. That's true. And it's true that, if we think everyone's out to hurt us, we miss out on relationships, and we don't get the grades we deserve. (*Identifies dialectical tension, and the relative truth of both positions.*) What class would be safe enough to take a risk in, to speak up?

**C:** The people in anthropology seem to be okay. Maybe there.

**T:** Okay, great, not everyone's going to be mean; there are nice people out there too, and that shift in thinking will help you to take a calculated risk in anthropology. Let's try practicing some DEAR MAN right now to get a feel for speaking up. (*Emphasizes the shift from overgeneralization and moves to behavioral activation in the session.*)

The above text and examples detail more formal DBT modification, but informal DBT cognitive modification can be highly effective too (Koerner, 2012). Two informal cognitive techniques include the *wise mind test* and invoking *nonjudgmental stance*. The wise mind test involves observing whether the current thought comes from that state of mind or from emotion mind or reason mind (neglecting the dialectical opposite). If a parent exclaimed, "I'm a complete failure as a parent!" the therapist may simply ask, "What would wise mind say about that?" The parent would likely reply, "That's an emotion mind statement. I have my ups and downs like any parent." Activating wise mind creates the cognitive shift that brings

more balanced thinking and emotions. Similarly, the therapist could deploy nonjudgmental stance in the same situation. The client's use of nonjudgmental stance would allow him or her to release the judgment and simply accept that parents have fallibilities. The cognitive shift to an attitude of acceptance instead of judgment allows the focus to change to what is needed to be a better parent now rather than dwelling on a failure. However, note that nonjudgmental stance is accepting not that she is a complete parenting failure but that she is a fallible parent.

These two informal cognitive techniques are skills-based and can be incredibly straightforward and effective with a modest amount of teaching and practice. For the formal DBT approach to cognitions, Box 23.2 provides useful therapeutic guidelines.

**Box 23.2** Effective Application of DBT Cognitive Modification

To effectively apply DBT cognitive modification, remember the following guidelines:

- Clients need to be validated for cognitive modification to be effective. Do not attempt cognitive modification with an emotionally activated person.
- Cognitions have truth given biology, history, and other contextual factors.
- Cognitions, like other behaviors, have adaptive functions.
- Teaching cognitive shifting and flexibility is more important than determining a "correct" way to think.
- The ultimate test of a cognition is "what works" in a given situation.

# 24

# Telephone Coaching

The primary function of phone coaching is to generalize skills to everyday life between sessions, including how to proactively reach out for assistance, and a secondary function is to repair the therapeutic alliance between sessions in the event of a rupture (Linehan, 1993a). Telephone coaching may be the most controversial and misunderstood mode of standard DBT. The controversy arises from the requirement that individual therapists maintain 24-hours-a-day, seven-days-a-week coaching availability to their clients. The continuous coaching availability inherent in adherent DBT is rejected by a majority of therapists who see it as too excessive in scope. Further complicating the issue, many therapists reject the 24/7 coaching requirement because of the paucity or outright lack of reimbursement for their ongoing and near-total availability. Consequently, adherence to this mode required by standard DBT is a nonstarter for many therapists and clinics looking to provide DBT services, especially when their clients already have access to other (non-DBT) 24-hour crisis services.

Some of the controversy about phone coaching, especially when done adherently, comes from misunderstood aspects of it. First, many therapists have concerns that availability means being inundated with calls. This does not typically happen when phone coaching is set up properly, beginning with clear therapist limits. Limits are boundaries that let clients know that your availability must be counterbalanced by respectful use of it. If clients call too much, too often, or outside your established availability, it is

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

treated as therapy-interfering behavior. In the beginning, some clients will initially test to see whether you are there or push your limits to see whether you stick to them, but then they relax the contacts as your availability and limits are verified. Of course, therapists would discuss these outside phone contacts in session, reestablishing boundaries and addressing TIB as needed. The key is to make your availability and limits crystal clear to clients and to stick to them to avoid difficulties, just as you would stick to any other agreements. Therapists who refuse to or do not set and observe limits with phone coaching might be practicing and modeling obtuse and unskillful boundaries.

Regarding availability, another misunderstanding is that 24/7 phone coaching is a necessary component of effective DBT treatment. In fact, phone coaching has not been proven to be a necessary ingredient of DBT. Phone coaching is but one service delivery of DBT, and, while it may be an essential mode in some programs and levels of care, it may be better adapted or may even be unneeded in other DBT applications.[1] Dialectically, there are both upsides and downsides to 24/7 availability. Clients who do not have therapists with 24/7 availability learn that most life problems do not have immediate support and solutions and therefore practice their distress-tolerance skills. Further, these clients learn to rely on other people in their support networks and to access professional support proactively knowing that there are times when phone coaching is not available. Therapists who choose to set limits on their availability additionally model effective self-care and teach clients about individual differences with boundaries. My opinion is that therapists benefit from time spent away from thinking about and participating in their profession; 24/7 phone coaching always keeps the therapist tethered to the possibility of doing client work. Bluntly, if your profession is your life, you may need a life.

The last misunderstandings are that phone coaching amounts to extra therapy time and that calls take a long period of time. Phone coaching is not intended to be therapy, and it is never intended to be a "venting" call. It is intended to be hyperfocused on skills and on applying them to between-session life events. These calls remain brief, between three and 10 minutes, emphasizing the how-to applications of skills. Having clients complete a brief worksheet that defines their problems, what skills they have already tried, and what specific help they need brings focus to coaching calls, and

[1] And of course, in a few situations phone coaching or the delivery of services over the phone might be the only mode of treatment. I have trained therapists in DBT whose sole job was to provide telephone therapy to people in remote areas. In these cases, the phone contact was both scheduled as a DBT individual session, during which skills were also taught, and allowed during regular hours as skills coaching.

sometimes clients end up solving their own problems thereby not needing to call. In any event, doing the worksheet will nearly always assist clients in being mentally prepared to be coached. It is beneficial to set a time limit at the initiation of the call to keep it productive. If the call is not meeting the intended purpose, and if redirection to skills is not accepted by the client, it is best to politely but firmly end the call with the understanding that the concerns will be addressed in the next therapy session.

Like other aspects of DBT, phone coaching has to be well defined and understood by clients to maintain its purposes. Most importantly, clients must know that they have to call *before* acting on urges to self-injure, use substances, or act on any other target behavior. If they act on target behaviors, the use of phone coaching becomes unavailable for 24 hours to avoid the unintentional reinforcement of those behaviors. Box 24.1 has phone-coaching expectations for clients to follow.

Linehan (1993a, 1993b) introduced phone coaching over 20 years ago. Since that time changes in technology have introduced mainstream communication mediums such as email and texting, with further variations and advances likely. The clinical use of these tools shows promise and utility with certain clients, so long as the use respects client privacy and, like phone coaching, is defined in a structured manner with appropriate limits.

As an addition or perhaps as a substitute for phone coaching, the timeless use of written plans for safety, crisis intervention, and skills implementation can be used for the application and generalization of skills. Appendix B has examples of these plans.

**Box 24.1** Phone-Coaching Expectations for Clients

Phone coaching is available to help you practice skills between sessions. Please follow these expectations:

- Phone coaching is for the generalization of skills.
- Phone coaching cannot be used for 24 hours after engaging in SIB or TIB. Clients are expected to call *before* acting on urges.
- A phone-coaching worksheet must be completed before the call.
- Phone coaching will focus on skills and not be therapy oriented.
- Phone coaching will be limited to three to ten minutes.
- Not respecting the limits of phone coaching will be treated as TIB.
- Phone-coaching availability and limits are established and negotiated up front by therapists and clients.

# 25
# Dealing with Safety Issues

Clients with suicidal and other safety issues seek out DBT because of its empirical base with those populations. Depending on the setting and clientele, suicide and self-injury issues may happen daily or infrequently. Regardless of frequency, it is best practice to have clear guidelines and protocols in place to manage these concerns and assist clients in keeping themselves safe. If you do provide DBT, it follows that you will eventually have clients with these concerns and will have to be competent in assessment and interventions. This chapter provides a framework and suggestions for work with suicidal and self-injurious clients that includes essential practices, assessment basics, and interventions focused on safety plans. Nonetheless, this chapter is not intended to be comprehensive in scope, so Box 25.1 provides additional resources for safety assessment, intervention, and the latest research.

## Essential Practices

Jobes (2006) describes three truths about people with suicidality. First, most suicidal people do not want to die; they want their emotional and psychological pain to end. Second, most suicidal people will tell others, including therapists, that they are suicidal if they are asked. And third, suicidal people have poor coping mechanisms that therapists are able to

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**Box 25.1** Suicide-Prevention and Intervention Resources

Suicide Prevention Resource Center: www.sprc.org
American Foundation of Suicide Prevention: www.afsp.org
American Association of Suicidology: www.suicidology.org

address. These truths tend to apply to self-injurious people too. Keeping these ideas in mind, therapists with training and protocols for handling safety concerns can proceed with confidence.

To begin, *all* clients need to be assessed for suicide, self-injury, and homicide. These assessments should happen at the time of the intake process or first therapy contact and be complete in nature. For clients who have suicidal or other harming thoughts or urges, currently or by history, safety assessment is an ongoing task that happens at each therapy contact. Even clients without safety issues at intake or by history should be reassessed whenever significant stressors occur, when risk factors present themselves, and when significant clinical changes are evident. The diary card is an essential tool for ongoing safety assessment, and one of its main advantages is that safety concerns are tracked and can be efficiently monitored. Moreover, diary-card review reminds the therapist to inquire about safety by noting the presence (or lack thereof) of thoughts, urges, and behaviors and prompting further inquiry if necessary. The presence of safety concerns on the diary card is always a cue for assessment, *and the absence of them is always a cue to ask about and reinforce safety behaviors*.

For clients with safety concerns, the development of a clear and actionable safety plan has to occur. This plan must meet or exceed the standards of the profession and be appropriate to the level of treatment intensity indicated. A safety plan is a collaborative endeavor, and the creation and commitment to follow through with the plan must be "owned" by a willing client. Working harder than clients or having to coax or convince them to use a safety plan is unacceptable and does not constitute a true commitment to safety. Once the plan is established, follow-through with it is monitored by the therapist, who is prepared to move the client to a higher level of care or to the hospital for further assessment and supervised care if indicated. Consultation with other professionals, along with care coordination, is also indicated in high-risk situations.

The entire process from assessment, safety planning, consultation, and coordination through follow-through must be clearly documented. The rule of thumb is that, if it is not documented, it did not happen.

In a DBT program setting, all therapists must be trained in risk assessment and interventions. Additionally, treatment settings need policies that define uniform guidelines and protocols for managing safety issues. At a minimum, guidelines and procedures must be clear about when clients require hospitalization and how they will be transported there. Box 25.2 offers safety contingencies and expectations for therapists and clients to follow. These expectations make the contingencies around suicidal and other self-harm thoughts, urges, and behaviors clear and streamline effective decision-making and action.

**Box 25.2** Safety Contingencies for Clients

Safety will be assessed each session. Identify *all* safety concerns on your diary card. Clients with a history of safety issues will also be asked about safety and reinforced for effective safety behaviors.

**Safety expectations**

- All clients will accurately report safety issues on the diary card.
- All clients with current or a history of safety issues will develop a safety plan. The safety plan will be practiced, updated, and reviewed regularly.
- Clients will willingly participate in safety assessments in the time allotted. Clients unwilling to cooperate will be hospitalized.
- All safety assessments and safety planning must be completed in the allotted time and by the end of the session. Suicidal clients without a safety commitment by the end of the session will be hospitalized.
- All clients with safety issues will be asked to commit to safety. A safety commitment is a "yes" or "no" regarding willingness to use the safety plan and not act on suicidal or self-harm urges. Suicidal clients without a clear commitment to safety will be hospitalized.
- Clients hospitalized will be sent *only* by ambulance or police.
- Clients hospitalized will be sent with a behavioral analysis to work on and a safety plan to update. These assignments will be completed during the hospital stay or before returning to the program or individual therapy.

## Suicide Risk Factors

Suicide risk factors are well documented in the literature (Jobes, 2006; McGlothlin, 2008). It goes without saying that current ideation and urges, a plan with access and means, and an intent to act imminently on the plan define suicide risk. The following factors also contribute to suicidal risk (Jobes, 2006; McGlothlin, 2008):

- High comorbidity and chronicity of illness, either mental, physical, or both. Longer courses of illness with higher functional impairment increase risk.
- Coexisting substance-abuse and substance-use disorders. Substances pose particular risk because they impair judgment and have a disinhibiting effect that increases impulsive action.
- History of impulsivity and risky behavior in a variety of areas.
- History of personal suicidal attempts, especially serious ones.
- History of suicide and suicide attempts among family and friends.
- Recent losses especially related to relationships, health, finances, and status.
- Acute and extreme distress including depression, despondency, humiliation, guilt and shame, agitation, and insomnia.
- Hopelessness, feeling trapped and/or worthless, or that life has no purpose.
- Isolation and withdrawal from others and/or society.
- Unexplained shifts and changes in mood, especially dramatic. Beware of sudden unexplained positive shifts in affect too.
- Making unexplained "visitations" or giving away meaningful items.
- Current or former member of the military, especially if exposed to combat operations.
- Consider age, gender, race, and other factors. Younger and older individuals typically have higher risk for suicide, as do Caucasians and American Indians. Males also have more suicides across all demographics. See McGlothlin (2008) for a full review of demographic risk factors.

## Protective Factors

Fortunately, there are protective factors that mitigate suicidal risk. Inquiring about and building on protective factors fortifies safety. Over the years, I have found that emphasis on protective factors during safety planning is

central to clients' commitments to follow safety plans and not act on suicidal urges. Assess for and develop the following protective factors:

- A positive therapeutic relationship is one protective factor that therapists have direct influence in creating. DBT interventions that speak directly to this factor include validation, reciprocal communication, and taking an active role in clients' treatment.
- Positive social support buffers risk. Involvement in a program, especially with attention to cohesion with peers, is one place to build social support when it is lacking in clients' lives. In addition, community resources should be mobilized when possible to supplement treatment.
- Religion and spirituality are beneficial. When desired by clients, connect or reconnect them with these supports.
- Children in the home are usually a protective factor. However, it is important to assess for danger to children as some suicidal people may plan to kill their children as part of their suicide plans. This information usually comes up when assessing for homicidal urges, but it is always advisable to assess for danger to the client's children if the children are not viewed as a protective factor by the client. Of course, in these relatively rare situations, consultation and safety-planning that account for the children's safety are of paramount importance.[1]
- A sense of responsibility and meaning get people through difficult times.
- Coping and problem-solving skills provide options to clients who have felt trapped. Active skills training is essential to assist in problem-solving life stressors and tolerating distress.

## Suicide Assessment

A thorough suicide assessment leaves no stone unturned. Be direct and matter of fact. The goal is to understand the level of risk to determine appropriate action, so, if you do not think you have clear enough answers and information to make informed decisions, the assessment is incomplete. In that situation, be clear with the client as to what information you are

[1] Intention to kill children as part of a suicide plan has occurred a few times in my clinics, where thousands of clients have been treated over 13 years. While a suicide plan that involves killing children carries with it taboo and judgment, it is important to remember to be nonjudgmental and use validation. These are not bad people, and they share this information because they want help.

missing and be persistent in your inquiries. Throughout the assessment, have the template of a behavioral analysis in mind and use this template to determine vulnerabilities; prompting events for suicidal thoughts, urges, and behaviors; and other antecedents and consequences. As you assess, there may be natural times to transition into problem-solving. However, my recommendation is to prop open those doors as you go through the assessment but not depart from the main task of completing the assessment. Once the assessment is complete, you will revisit those open doors while constructing the safety plan.

For suicide, complete assessment covers past and present suicidal thoughts, urges, and behaviors, including access, means, and intent in regard to a suicide plan; activating events for suicidal behavior; general clinical presentation including level of hopelessness; impulsivity; and both risk and protective factors (McGlothlin, 2008). Begin by directly asking about current suicidal thinking and urges without mincing words. If the client denies current suicidality, ask whether suicidal thinking, urges, or behaviors are in the client's history, and whether the client's family has a history of suicidality. Whenever the client endorses suicidality, ask him or her about its frequency, intensity, and duration. With intensity, it is useful to employ a scale of 0 to 10, with ten being the highest; this intensity scale is replicated on the diary card and becomes a gauge of suicidality over time.

When the client establishes a level of intensity, inquire as to what that level means to him or her. Is it getting better or worse or staying the same? Does the client have control over their thoughts and urges at that level? What is a safe versus unsafe level for him or her? Ask whatever questions lead to greater understanding of the client's situation. Some clients can be absolutely safe at an intensity of 10, and others can be vulnerable to acting at a much lower intensity level. Begin to inquire about protective factors and what keeps the client safe as well as asking about precipitants to acting and risk factors.

Next, assess for a history of attempts, getting detailed information about what was done, what precipitated the attempts, and what were the outcomes. Knowledge of past attempts informs the current assessment and subsequent safety-planning. Remember to also ask about suicide among family, friends, and others in clients' social circles.

After taking the history, determine whether the client has a plan, has the means to act on the plan, and has access to the means. How lethal is the plan? All plans are serious, but plans with a high probability of completion along with a low probability of intervention bring extra

concern. Begin to consider how the plan can be interrupted through giving up the means or access to it, or, if that is not possible, how barriers can be inserted between urges and action to decrease impulsivity. Ask whether the client has taken any steps to act or otherwise put the plan into motion. Then assess for intent to act on the plan. Does the client intend to follow through on the plan? If so, assess the intensity of the intent and ask when the client plans to act. If the client does not have intent to act, why not? This question will identify protective factors and can be a time to prop open another door to problem-solving. If the client identifies *imminent* intent to act, the situation requires acute care measures to ensure safety, most likely hospitalization.

In addition to specific questions regarding suicide, the assessment is imbedded in a larger assessment of current mental status, current symptomology, and the consideration of other factors such as substance abuse, recent losses, hopelessness, and worth and meaning.

In the suicide assessment, the best practice is to use a structured format with all relevant assessment questions so that nothing is forgotten and everything is immediately documented. The use of a structured format, such as the SIMPLE STEPS acronym (McGlothlin, 2008), and the use of suicide-assessment tools, such as the Collaborative Assessment and Management of Suicidality (Jobes, 2006), are recommended. Creating a clear assessment form that covers and documents all relevant information can also be a suitable clinical aid. Box 25.3 covers suicide-assessment dilemmas.

**Box 25.3** Suicide-Assessment Dilemmas

**What if the client is uncooperative or refuses to give information?**

If the client refuses to answer questions about suicide, start by checking the alliance and inquiring about concerns. Also educate and orient on how the information will be used and why. Sometimes clients fear that therapists will overreact and hospitalize when it is unneeded, based on a history of having that happen. The goal is to hospitalize only when the client is at imminent risk. Ultimately, if the client continues to refuse to cooperate with the assessment, he or she will require an assessment with another provider, probably at the hospital.

**What if the client says the right things but is unconvincing?**

This occurs relatively rarely, but, if the client's words are unconvincing or ring hollow, the therapist must trust his or her gut and share his or her reaction with the client. In this case, *immediately* refer the client for further assessment by another professional, at the hospital if need be. It is better to inconvenience the client and be wrong than to trust empty words that precede an attempt.

**What if the client reports that he or she acted on suicidal urges immediately prior to the intake appointment or session?**

Assess what specifically was done and arrange for immediate transportation to the hospital. Communicate clearly with emergency services that the client has attempted and it is an emergency situation.

**What if the client obtains secondary gains through assessment and discussion of safety issues?**

Remove reinforcement from inappropriate engagement in safety issues when possible while developing reinforcement around cooperation and safety behaviors. Develop skills for the client to meet wants and needs directly rather than as a byproduct of assessment and discussion of safety issues. Center therapeutic work on the development of a safety plan and the practice of it, also using behavioral analysis and other homework that both addresses safety issues and creates a "downside" for meeting needs through them. Be prepared to label and treat "gamey" behaviour in regard to safety as therapy-interfering behaviour. A matter-of-fact stance on the part of the therapist around safety issues also decreases secondary gains.

## Self-Injury Assessment

Self-injury is different from suicidality. Both frequently share the theme of escape and avoidance, with suicide being the ultimate escape and avoidance behavior, but self-injury is not done with the intent to die. Rather, self-injury is carried out to escape and avoid pain or to otherwise attempt to manage emotions and life. Box 25.4 lists the most frequent reasons for self-injury.

**Box 25.4** Reasons for Self-Injury

- to distract from emotional pain
- to provide a sense of release and relief
- to ground oneself, to feel real
- to make emotional pain "tangible," to see it
- to communicate emotional pain to others
- to punish oneself to alleviate guilt
- other reasons.

Self-injury assessment has substantial overlap with suicide assessment. As in suicide assessments, appraise for current and past self-injurious thoughts, urges, and behaviors. Obtain specific information as to the self-injury planned or acted on, including data on the frequency, intensity, and duration of these behaviors. Inquire about what the behavior is, where it happens on the body, the degree of damage that occurs, and (if a recent event) whether it requires medical attention. In regard to medical attention, the client must provide common-sense information as to how a decision about medical attention was reached. If the information is credible that medical attention was not needed (e.g., the cutting was superficial with minor bleeding and had no signs of infection), move on with the assessment. If the information is questionable or if medical attention seems like it would have been indicated, inquire whether the client consulted a medical professional and the outcome of that appointment. If the client did not seek needed medical attention and there is a possibility that medical attention may still be needed as a result of a recent incidence, determine with the client how he or she will receive it that day. In those cases, clients often have to be coached on skills to use to seek medical attention, including being clear with medical professionals about what is needed (i.e., someone to examine the injury) versus what is not (i.e., being hospitalized). Failure to seek appropriate medical attention for self-injury is treated as therapy-interfering behavior.

As with suicidal behavior, the template of a behavioral analysis can be kept in mind to determine the contextual factors that surround self-injury. In particular, what vulnerabilities and other antecedents including activating events preceded the self-injury and what were the consequences that followed the behavior? Investigating when and where self-injury happens along with the emotional, cognitive, physiological, situational,

and behavioral factors sets the foundation for solution analysis and safety planning.

The assessment closes with ascertaining the client's current emotional state and whether he or she continues to have access, means, and intent to act on the self-injury along with his or her willingness to participate in following a safety plan. Ongoing assessment of self-injury will continue during the course of treatment using the diary card, and virtually all instances of self-injury are addressed with behavioral analysis. If a client is unable to meet safety-planning expectations, or if the self-injury increases in frequency, intensity, or duration, a higher level of care is indicated. Box 25.5 has self-injury assessment dilemmas.

**Box 25.5** Self-Injury-Assessment Dilemmas

**Do I look at the SIB?**

Unless the therapist is a nurse, doctor, or another provider who can make medical (as opposed to therapeutic) decisions, it is not recommended to look at the self-injury. This recommendation becomes increasingly important if reinforcement from others viewing the injury is suspected or if the self-injury is on a part of the body that is clothed.

**What amount of detail on self-injury is allowable in a group format?**

As mentioned in the section on group-format services in Chapter 10, therapists need to be mindful of the level of detail shared to not unnecessarily trigger other clients. General details of the injury are usually sufficient for both assessment and intervention. Gratuitous accounts or glamorization of self-injury are not allowed. As for fears of contagion, there is little empirical evidence that discussion of self-injury leads to others taking on those behaviors. In the rare instances in which that happens, it is immediately addressed and typically resolved.

**What if the client is unwilling to provide information on self-injury?**

In most of these cases the client is afraid of being misunderstood, judged, or unnecessarily sent to the hospital, or he or she is not ready to give up the behavior. Validate the client and explore the reasons he

or she is unwilling to share information. At the same time, be firm that to work together there must be collaboration and trust. Education and orienting about safety expectations and contingencies also let the client understand the nature of the questions and interventions. If the client still refuses, the therapist must decide whether he or she is willing to accept the liability of working with a client who has unknown safety concerns.

**Do I confiscate or hold "tools" for clients?**

Sometimes clients want to hand over razors, lighters, or other means of self-injury. It is up to individual therapists as to whether they want to receive these items. I have accepted self-injury tools from clients with the clear understanding that those tools will be disposed of and cannot be returned.

**Do I keep or dispose of medications for clients?**

Accepting medications from clients is a risky proposition for many reasons. The best place to dispose of medications safely is a pharmacy. Contract with your client to have him or her bring his or her unneeded medications there.

**When does SIB need to be treated like SI?**

Self-injury does not typically result in hospitalization, and its intended outcomes differ from the goal of suicide. However, when self-injury can reasonably result in serious injury or potential death, it has to be treated in the same manner as suicide. Examples include cutting that necessitates sutures, overdoses of medications with non-lethal intent, and substance use with clients who are medically fragile due to their history with substances (i.e., the use could reasonably result in a serious medical crisis).

## Creating the Safety Plan

A clear written safety plan is the initial goal for all clients with suicidal and/or self-injurious thoughts, urges, or behaviors. Many clients come to treatment feeling unsafe, but the structure and accountability that come with a written plan provide the containment and predictability that lead

to *being* safe. In a crisis, there is simply no substitute for a clear action plan that takes the guesswork out of how to respond; safety plans for clients are parallel to the protocols therapists follow to streamline decision-making in high-intensity situations.

The good news with clients who have suicidality and self-injury is that they all already have safety behaviors; they just may not have been able to label or name them. The lack of a name for such skills, along with the lack of a plan, makes it difficult for clients to use these skills consistently and effectively. Careful questioning will reveal clients' ways of staying safe and other strengths and resources to build on. Questions such as "What has kept you safe with high suicidal urges before?" or "What do you do to calm yourself if you cannot cut?" start to reveal effective alternative behaviors that clients have not previously labeled or organized into a plan. Knowing that there are times that they choose alternative behaviors also builds their confidence and commitment toward use of the safety plan.

The process for creating a safety plan is outlined below, and astute readers will notice substantial overlap with behavioral analyses and with the crisis-response plan in Appendix B. Understanding the function of suicidal and self-harming target behaviors gives skills and other change strategies traction. Once antecedents and consequences surrounding suicidal acts or self-harm are clear, apply problem-solving skills from the DBT skills modules.

A comprehensive safety plan starts with the client's reasons for not acting on target behaviors around suicide and self-injury. These reasons constitute protective factors that fortify motivation and keep focus on what is important to clients. Reasons for safety might include maintaining independent living, building trust with others, developing enough stability to go to school, or wanting to grow old enough to see grandchildren. If the reasons are important for the client, they work for the plan.

The next step is identifying vulnerabilities and warning signs for suicide and self-injury. These might include an increase in negative emotions, rumination or catastrophizing thoughts, declines in self-care, or neglect of responsibilities. Areas to explore with this step include emotions, thoughts, behaviors, situational and environmental factors, and what is experienced physically and in regard to health. As vulnerabilities and warning signs are revealed, the plan begins to emphasize early intervention with skills. Often, an early emphasis on self-care, stress management, and accessing support makes a tremendous difference.

Identification of activating events for suicide and self-injury follows identification of vulnerabilities and warning signs. Every suicidal act or self-injury has a prompting event. Vulnerabilities and warning signs

provide the fuel for these behaviors, and the prompting event ignites the blaze. Activating events may be rejection, abandonment, or a fight with someone important; a strong feeling such as guilt, shame, fear, or hopelessness; or anything that triggers acting. At this step, continue to identify skills that provide alternatives to suicidal behavior or self-harm if these activating events happen, as well as skills to avoid their occurrence in the first place when possible.

Next, identify what clients have gotten out of suicidal acts and self-injury. For suicidal behavior, it may be escape, receiving help, or getting a break from an overwhelming situation. For self-injury, it might be one of the reasons listed in Box 25.4. Identification of past reinforcement for these target behaviors gives rise to opportunities to meet those needs proactively through skills. The more proactive skill use is tailored to past reinforcement, the better. For example, if self-injury is reinforced because it calms the client, self-soothing and other relaxation skills work best. Alternatively, if the self-injury has been reinforced because it communicates distress, learning and using interpersonal skills to express oneself and ask for support would be a better place to start. Eventually, a solid plan will draw skills from multiple areas.

Once the safety plan identifies the antecedents and consequences of target behaviors and skillful alternative behaviors, have the client list specific support people to access when in crisis. The list should include both personal and professional resources along with their contact information and times of availability.

Last, have the client list any barriers to implementing the plan. With each barrier, list skills and action plans for overcoming it. Beyond systematic pattern recognition and problem-solving, remember to use all appropriate DBT interventions from validation and acceptance strategies to commitment as well as dialectical and other change strategies. Box 25.6 has additional safety tips.

**Box 25.6** Safety Tips

The following safety tips will assist in the use of successful safety plans.

**All clients with safety issues need a written safety plan**

There are no exceptions to this rule. Safety, especially for suicidal clients, is the top priority in DBT treatment.

**Make multiple copies of the safety plan**

Clients will occasionally misplace their safety plans. It is therefore important that they have more than one copy. Also make a copy for the client file.

**Clients need to be expected to review and practice the skills on the safety plan daily**

Practicing skills in crisis is difficult if they have not previously been tried out. Safety plans require active practice to be useful, just as we practice fire, tornado, and other safety drills to be prepared in times of emergency. Expect clients to practice skills and behaviors on safety plans even when not in distress. Safety plans are also "living" documents, both metaphorically and literally. Have clients actively revise and update safety plans as they learn and practice new skills. Check safety early in each session and dedicate some time to reviewing and building on the safety plan. Rehearse safety contingencies in sessions (e.g., What skills would you use if your spouse storms out? What if no one is home and you're scared? What skills can you use?).

**Review safety plans each session until safety issues have been definitively resolved**

Sometimes safety plans fall by the wayside when clients are not in crisis and doing relatively well. It only takes a brief amount of time to check in on a safety plan to keep it relevant. Not following this tip may mean that you end up in a "reactive" mode with future safety concerns.

## Safety or No-Harm Contracts

Safety contracts, also called no-harm contracts, have been used in some settings to provide written documentation of a client's promise not to harm himself or herself. These brief promissory notes should not be confused with comprehensive safety plans developed in collaboration with clients. Because these contracts have been used mechanistically by some, they do nothing to lower the legal liability of treatment providers. Bluntly, these

contracts are perceived as a "cover your ass" measure and not much more, *and their use is never a substitute for through assessment and appropriate intervention and follow-through*.

I have not used these contracts often in practice. Nonetheless, I have occasionally used them successfully with particular clients as a part of comprehensive assessment, safety-planning, follow-through, and documentation. In these few cases, the contract was of great value *to those clients*, who viewed signing on the line as a solid commitment and promise in the context of the therapeutic alliance. If it works, use it, but remember that on its own it is just a piece of paper.

## From a Safety Plan to a Safety Commitment

A safety plan is not synonymous with a safety commitment. Sometimes clients have thoughtfully constructed safety plans but they are unable to follow them for a variety of reasons. Safety assessment and planning always culminate with a straightforward question in regard to the client's willingness and ability to follow the plan and not act on suicidal or self-injurious urges. The commitment to stay safe is one of the few truly either/or issues in treatment. For suicidal thoughts and urges, a clear "yes" to the question of "are you safe" is the only answer that will result in the client staying in the community and avoiding a hospitalization. Answers to a safety-commitment question such as "I think so," "maybe," or "my wife (husband, parents, boyfriend, etc.) will keep me safe" are not acceptable responses. Neither is an alternating "yes-no-yes" response. Being unwilling or unable to follow the safety plan or having an unclear safety commitment when suicidal should initiate a hospitalization. A truly safe client will agree to follow the plan, stay safe, and telephone for emergency services or go to the hospital *without acting* on urges should circumstances change his or her commitment.

Safety commitments are expected to get clients from session to session; if the client is unable to maintain safety between sessions, a higher level of care is advisable. If the client shares services across providers, a commitment to safety that bridges from one therapist to another provider can work *only* if the providers are in agreement about this possibility and the communication between them is consistent and clear. Without each provider being on the same page, there remain cracks in this approach to safety.

Some therapists may fear that such a strict and dichotomous policy about safety commitments with suicidal clients will result in regular hospitalizations. However, that is not the case. Most clients do not want to go to

the hospital, and the clear contingencies create predictability, safety, and commitment to follow therapy guidelines to avoid going. Clients appreciate knowing exactly where the lines are, and they know that in a real emergency their safety will be ensured. Though relatively rare, some clients do have a history of playing games around their safety in dramatic fashion. The black-and-white simplicity of a yes or no commitment embedded in assessment and planning is an antidrama methodology that takes the sport out of it and extinguishes the vast majority of this type of behavior. Of course, the power of safety contingencies is only as valid as their follow-through. Suggestions for intervening with clients who seek hospitalizations are covered in Chapter 26.

Most of the time clients with self-injurious behaviors will commit to safety following assessment and safety-planning. If a client with self-injury refuses to commit, most of the time it is not a hospitalization situation unless the self-injury could reasonably result in severe injury or death. Because hospitalization is most often not an appropriate option, a therapist addressing a refusal to commit to safety with self-injury only has the therapeutic alliance and/or the placement in the program as leverage. If the leverage is good, the therapist can insist on cooperation with the protocol. If the leverage is tenuous, such insistence will be ineffective and lead to a power struggle, probably further eroding the leverage. This dialectical dilemma, along with the tolerance of therapists, guides the options. Some DBT therapists may insist that active work to reduce self-injury, including making safety commitments, is a nonnegotiable part of therapy. If the leverage is there, this is the best option. Other therapists work to shape commitment to practice skills before acting on self-injury urges with the hope that the benefits of skill use will make self-injury a less attractive option. I have had success with the second option in combination with attention to therapeutic factors when leverage is lacking. However, I make it clear that I do not endorse the behavior but want to respect the client's ambivalence about change in this area, especially since it has short-term upsides for them. Avoiding a power struggle that cannot be won and articulating the client's position often diminishes his or her opposition to working on self-injury, including making safety commitments. Nonetheless, I would follow the former, nonnegotiable stance in all self-injury situations that had severe risk or were worsening in frequency, intensity, or duration. In these cases, the stakes are too high and the liability too great to allow for leeway. Of course, if the self-injury carries this risk, the leverage of hospitalization is back on the table. As always, case-by-case specifics and consultation are invaluable in making these clinical decisions, as is continual work on therapeutic factors. Box 25.7 has two additional safety tips with clinical examples.

**Box 25.7** Safety Tips and Case Examples

On safety issues regarding medications, such as overmedicating and nonsuicidal overdosing, consult a pharmacist or poison control with any questions regarding risk and recommended medical intervention. For example, a client reported taking an overdose of 10 tablets of 200 mg acetaminophen two days prior to her session. A five-minute consult with poison control indicated that the client should have immediate medical attention to screen for liver toxicity. Following the call, the client was sent to the emergency room for medical intervention.

For a safety issue connected to medical health, consult a physician. For instance, a client reported stopping her blood-thinning medication without concern for how that might affect her health. Not knowing the medical risk, the therapist contacted the client's physician for a consultation. The physician said that she preferred that the client take the medication but that it was her opinion that the client was not at significant risk by not taking it. The behavior was addressed clinically as passive suicidality and with behavioral analysis, but immediate hospitalization was not necessary as the client had no imminent suicide plan. The client chose to take her medication again about a week later in response to the clinical interventions.

# 26

# Use of the Hospital

The use of the hospital is required when the client is at imminent risk of acting on suicidal urges or self-injurious urges that will reasonably cause severe injury or possible death. Hospitalizations can be roughly categorized as skillful or unskillful. Skillful hospitalizations occur when, in spite of best efforts, clients remain unable to stay safe. Sometimes clients do virtually everything under their control but symptoms become too severe or truly significant crises undermine their stability. At other times hospitalization is essential to make major medication adjustments. Skillful hospitalizations are characterized by clients following recommendations to achieve stability and transitioning back to therapy as soon as safety is ensured (or any other goal of hospitalization is accomplished). When a client exercises wise-mind decision-making and hospitalization is the best therapeutic option, the therapist reinforces this use of the hospital and encourages the environment to do so too. Reinforcement is especially important when a choice to be hospitalized before acting on urges is a new behavior that replaces past suicidal behaviors that resulted in hospitalization.

Other hospitalizations fall into the unskillful category, and in these situations the therapist actively removes reinforcement and encourages the environment to do so too. Contingencies for uncalled-for hospitalizations are reviewed in Chapter 20, with the idea of developing a "benevolent ordeal" for clients who overuse the hospital. Originating with

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

Milton Erickson, a benevolent ordeal means that the therapist strategically makes having a symptom worse than not having it (Haley, 1993). Clients who go to the hospital have a lot of work to do, from behavioral analysis to making up missed skills training and homework to revising safety plans. For clients who view the hospital as a break, or for clients who land in the hospital due to not cooperating with a safety assessment or for some other illegitimate reason, staying out of the hospital becomes the more attractive option. Other unskillful hospitalizations happen when a client breaks a safety commitment and ends up in the hospital from a suicide attempt. Although infrequent, this behavior creates a rupture in the therapeutic alliance that must be addressed, with concerted efforts by the client to reestablish trust through behavioral adherence to all treatment recommendations. Like the above scenario, these recommendations minimally involve behavioral analysis and revising safety plans as well as revisiting commitment to treatment and the elimination of suicidal and other target behaviors. Time and consistency mend trust, but therapists must also confront the issue of whether they want to invest in this process. An evaluation of individual circumstances with consultation informs this decision. Ultimately, clients would choose not to work with an untrustworthy therapist, and, it may seem harsh, but therapists can also choose to avoid work with untrustworthy clients. If discharge is the decision, appropriate referrals are provided along with a transition of care.

No matter the reason for a hospitalization, keep contact with clients in the hospital to a minimum. Clients receive around-the-clock care at the hospital, and they must follow the treatment regimens there for better or worse; it is not the place of a DBT therapist to influence the hospital in the care of its patient. Acceptable contact with a hospitalized client centers on the transition from inpatient care back to his or her outpatient treatment.

Clients who necessitate hospitalization must be transported by police, ambulance, or other qualified emergency personnel. If the client has imminent risk, qualified transportation is the only way to ensure safe transportation. Otherwise clients have the opportunity to flee, act on suicidal impulses in certain situations, or convince nonprofessional personnel that hospitalization is no longer needed. While this policy may involve fees or inconveniences, it constitutes the best practice. It would go without saying that people with medical crises would be transported by emergency personnel, so why would a psychiatric emergency be treated as any less serious? If a client is hospitalized, it is essential to communicate with the receiving facility. Not communicating the imminent risk and reasons for

transport to the hospital allow for miscommunication, client-splitting, and other gaps in service to occur. In regard to both transportation of clients and hospitalizations, make sure you understand applicable statutes, procedures, and requirements in your particular jurisdiction, and adhere to those practices. Last, remember to fully document each step in the process from assessment to hospitalization.

# 27
# Consultation

Consultation is a best practice regardless of therapy approach or model. In DBT, consultation functions to enhance the motivation and skill of therapists so that clients can receive the best possible therapy (Linehan, 1993a; Koerner, 2012). Therapy is a difficult occupation, and therapists who practice in isolation are prone to burnout, losing objectivity, and making iatrogenic interventions. Examples of iatrogenic behaviors include lack of structure and accountability, extreme responses (e.g., too nurturing or too strict), and causing or participating in boundary violations. Consultation is sometimes referred to as "therapy for therapists" as it strives to meet therapists' needs as well as promote the most effective possible interventions (Koerner, 2012).

Consultation can happen between individuals or in a formal consultation group. A typical consultation group will have six to 10 members and meet at least once weekly for 60 to 90 minutes. The group is often structured to begin with a mindfulness exercise and then a brief check-in with the members. During the check-in the needs of the members are collectively evaluated and the agenda is set with priority given to the most serious, high-need, and/or imminent concerns and issues. As the agenda is completed, the consultation group then ends with mindfulness. Some

*Dialectical Behavior Therapy: A Contemporary Guide for Practitioners*, First Edition.
Lane D. Pederson.

consultation groups also work continuing education in DBT and related areas into their meeting or set up a separate time to do so. Some time spent reading, reviewing, and doing homework on the tenets of DBT and related areas such as mindfulness and CBT reorients and prevents "drift," in which therapists move too far away from core DBT concepts and interventions. To supplement a consultation group, a consultative milieu is recommended in which therapists maintain an open-door policy with one another. This type of milieu ensures that therapists get what they need when they need it rather than having to wait for a meeting. Therapists who actively involve themselves with open-door consultation find their work to be more effective, more rewarding, and less stressful.

DBT consultation follows the same assumptions and philosophies held for clients. For example, like clients, therapists are doing their best yet need to do better, and therapists are expected to practice skills. Consultants must also balance validation and change with one another to be effective. When therapists feel unsupported and demoralized, it is difficult to get back on track without first being heard and understood. In this process, consultants practice nonjudgmental stance toward each other as well as humility and reciprocal vulnerability. Being nonjudgmental and recognizing our universal fallibility and need for support opens therapists to discussing problems, mistakes, and clinical shortcomings.

In addition to maintaining DBT assumptions and philosophies, therapists strive to be prepared, active, mindful, and involved in the consultative process. There are no wallflowers in DBT consultation, and every therapist's participation and feedback is an important part of the consultative process. When therapists do not follow DBT assumptions and philosophies or are otherwise not involved, this can be addressed respectfully in a manner similar to addressing therapy-interfering behavior with a client. In these cases, members may be asked to apply a certain skill or even to complete a behavioral analysis. Of course, for these interventions to be accepted, the same therapeutic factors that apply to clients also apply here. Namely, for therapists to prescribe interventions to each other, they must have solid working alliances, be in agreement on the goals and methods (including the idea that such interventions may occur), and have both buy-in and commitment to the process. To facilitate these "consultative" factors, therapists might sign a consultation agreement that clarifies the purposes of consultation, expectations, and any other information that results in responsible consultation attitudes and practices. Box 27.1 has an example of a consultation agreement. Additionally, new members can be oriented to and educated about the consultation group to get them acclimated to the process.

**Box 27.1** Sample Consultation-Group Agreement

This consultation group is a collective of therapists working together to benefit their collective clients. We meet weekly for 90 minutes, and members can also consult in person, by phone and through secure email between consultation groups. Participation in this consultation group follows these guidelines:

- Members agree to 90% attendance of all consultation-group meetings.
- Members will maintain a nonjudgmental stance toward clients and each other. We understand that clients and therapists are doing the best they can and need to do better. To do better, we need the regular support and guidance of consultation-group members.
- Members will follow basic DBT assumptions, philosophies, and guidelines and will balance validation and change strategies with each other.
- Members will be active and mindful, present on issues related to themselves and their clients, and give feedback to each other. Feedback is reciprocal and involves validation, encouragement, and suggested interventions.
- Members will come prepared with cases and will have completed agreed-upon reading, assignments, and homework.
- As needed, members will practice dialectics and move toward synthesis.
- Members will promote DBT in a positive manner that respects other providers and approaches.

While consultation has important upsides, there are a few caveats. First, an insular consultation group can bring the risk of excessive conformity, known as "groupthink." One form of groupthink is when members become overly concerned that member feedback and the group process should have excessively high adherence to DBT, thereby losing adaptive flexibility and creativity. While it is important to stay centered in the approach and protocols, there may be clinically important reasons to deviate from them at times. Remember that the ultimate benchmark is effective outcomes for clients and therapists, not how rigidly adherent a process stays.

A related form of groupthink occurs when members push for convergence of ideas and diversity of thought is subtly, and sometimes actively, discouraged. Therapists can inherently have the tendency to seek like-minded feedback when often the best feedback comes from another place on the dialectic. As an example, more nurturing therapists benefit from feedback from more accountable therapists and vice versa. It is important to seek advice and learn from therapists with different interpersonal and procedural styles as well as from therapists with different skill sets. Assigning a member to be a devil's advocate and to argue for the other side of the dialectic restores and keeps balance while breaking up groupthink (Linehan, 1993a).

The next caveat is that consultation groups can take on an elitist and exclusionary status. Unfortunately, some DBT providers lead with superiority and certitude along with an unwillingness to communicate with other treatment providers. Sometimes DBT teams within larger centers (and communities) take on a collective "expert" role and draw sharp lines between their work and status as compared to the general population of their colleagues. This behavior is disrespectful and unprofessional and unfortunately diminishes the field and client care. Put bluntly, superior attitudes should take the back seat until DBT regularly outperforms other bona fide therapies in clinical trials. Until then, DBT therapists can be confident yet humble and value the work of others equally.

Last, consultation should not become a substitute for independent thinking. Competent professionals learn to trust themselves to apply therapies with confidence while also seeking the checks and balances of consultation. Yet dialectically, competence and self-trust come from experience that is substantially enhanced by integrating regular consultation into one's practice. As therapists, we need to be able to intervene with independence while also recognizing our limitations and seeking assistance as required. Thus, consultation supports clinical expertise but it is not a substitute for it.

Paralleling the debate about adherence to standard DBT, experts have divergent opinions about the extent to which consultation must adhere to the approach or be provided by other DBT therapists. Koerner (2012) emphasizes that a chief goal of consultation is to ensure and increase adherence and competence in DBT. Across the dialectic, Marra (2005) points out that the dearth of trained DBT therapists in private-practice communities makes it "impractical for the DBT therapist to accept only other DBT therapists with whom to consult" (p. 222). Marra emphasizes that "if your consultation group has professionals who are more interested in understanding the patient with whom you are dealing than they are in proving that their theories are better than yours, then you're probably in

safe hands" (p. 223). Marra goes on to state that important features of high-quality consultation include providing fresh perspectives, examining therapists' own behaviors, and assisting the therapists in creating sustainable change for their clients (p. 223).

Both perspectives have important takeaways, and there is a dialectical synthesis. In a DBT program, it is important that consultation, while meeting client and therapist needs, also keeps therapists centered in conducting DBT and not eclectic, integrative, or other therapy. Moreover, consultation in this setting needs to follow the rules, expectations, and protocols that structure the program, standard or otherwise. Further, if a therapist wants to work exclusively as a DBT-oriented practitioner, again there is greater pull to find other DBT therapists for consultations. To do so requires therapists to open up and reach out to professional networking opportunities such as seminars, online resources, and other means to create a consultative community. However, if a therapist uses DBT in a technically eclectic or integrative fashion, DBT-only consultants become less important. Nonetheless, those working with non-DBT consultants can provide them with DBT literature and emphasize DBT theory and practice when discussing their cases (Marra, 2005). With all consultants, it remains beneficial to follow DBT consultative attitudes and philosophies as well as a consultative structure.

Once the consultative process is underway, quality advice and intervention rest on balancing five principles adapted from Beauchamp and Childress (2001). In essence, these principles recognize the ethics inherent in consultation and resulting clinical interventions.

Therapists first consider whether the proposed approach or intervention is likely to benefit the client, and, second, whether what is proposed has a low risk for harm. In behavioral terms, our approach to clients must support healthy behaviors while working to diminish and extinguish unhealthy ones. Two filters to use are, "What do we want to teach the client?" and "Is what we are doing with the client helping them to be successful in life?" As a rule, we promote in therapy what works in life. Basic examples include timeliness, attendance, and respectful interpersonal skills. We hold clients accountable to these behaviors because they are life skills. You need to show up on time for jobs, school, and friends, and be respectful, so these behaviors are addressed in treatment. Importantly, these behaviors are also prerequisites to obtaining support and making therapeutic progress. Beyond these examples, consultation needs to promote interventions that benefit clients with clear rationales.

The third consideration is whether consultative plans respect the client's autonomy. Consistent with consultation to the client, we want clients to

make self-determined choices and have agency in their own lives. Unfortunately, many consultations about clients fail to consider what they want and result in interventions done *to* them rather than *with* them. Respect for autonomy also supports greater independence in balance with other considerations such as safety, abilities, and resources.

The fourth principle is staying true to what was promised. A prime example is following established therapy agreements. Fidelity to what was promised has its own face validity, and it teaches clients to be (and that therapists are) trustworthy. Generally, every consultation should consider relevant therapy guidelines that have been discussed with clients and abide by them. When therapists need to deviate from what was promised, there have to be compelling and convincing reasons.

The last principle seeks to balance the client's rights with the rights of others. Occasionally a client is not program-ready and overly taxes other program members in a manner that actively interferes with their progress. In these situations, solutions that maximize the client's opportunity for success are explored, and the client may be referred to other treatment options if solutions are exhausted.

Aside from being guided by principles, consultation is often suggestive of interventions such as "validate the client" or "you need to use opposite-to-emotion and DEAR MAN to address how your clients are forming cliques in program." Suggesting interventions is important, but consultation on the intervention level is microconsultation that may neglect the macro issues. To address the macro issues, the best place to start is with the therapeutic-factors hierarchy and how it applies to therapists and clients in a *parallel* process. In other words, the macro nature of therapeutic factors as they happen among consultation members, and between therapists and clients, should be the first filter during consultation.

Step one is always alliance: If consultants do not have a working alliance and trust that they operate in each other's best interests, the process breaks down, just as it does if alliance issues exist between therapists and clients. Not much will be effective without paying attention to existing alliance issues. Much of why DBT consultation focuses on therapist issues and needs is that therapists must be settled with their own concerns before they can engage clients effectively. Before specific interventions are floated for consideration, *consultative* and therapeutic alliances demand attention and necessary adjustment. Accurate validation and understanding are the foundation.

The next step is agreement on goals. When consultation members become divergent and struggle with synthesis, common ground starts with

checking in on the goals of the consultation members relative to the process and to the client issues in question. When it comes down to brass tacks, everyone is pulling for successful outcomes, even when they have different ideas about how to get there. Articulating the common ground feeds the dynamics of dialectical synthesis. Similarly, therapists stuck with clients need to consider whether they are aligned with the clients' goals. I remember, as a student, witnessing a fierce debate between therapists in consultation as to what was happening with a client and what to do about it. As the process became more heated, more confused, and less productive, a therapist rang in with, "What are the client's goals?" The meeting fell silent as everyone realized that no one was considering that factor. Once the primary therapist articulated what the client wanted, the process took a beneficial turn. As with the therapeutic alliance, agreed-upon goals within consultation and with clients are a prerequisite to success.

Tenured consultants are typically, but not always, up to speed with DBT and oriented to not only the approach but also the reasons for following established structure and procedures. On occasion, therapists need (re)education on DBT methods and (re)orientation as to how those methods will assist them in reaching therapeutic goals. Ultimately, *belief* in the methods being beneficial on the part of therapists (similar to clients) must be in place, or alternative treatments should be considered.

The last factor to consider is whether extratherapeutic issues are interfering with consultation or treatment. When a therapist is "off," is there something in the therapist's background or current life circumstances inside or outside the therapy that is affecting the situation? As an example, a therapist became frustrated and judgmental with a parent who expressed anger and hopelessness about her child. Thankfully, rather than continuing from a judgmental stance, the therapist sought immediate consultation. The consultation revealed that her own history with her parents created a bias in the present situation, and the therapist responded by practicing skills to separate her own past from the therapy. In other situations, therapists might be lacking self-care, be behind on paperwork, be burned out and demoralized with a client, or have any other number of things that can affect their work. Who we are as therapists, our histories, and other extratherapeutic factors can benefit or detract from therapeutic success, so we use consultation to be mindful of therapist "extras" in the consultation or therapy room (just as we do for clients). With clients, we want to be alert for their extratherapeutic factors that can enhance treatment as well as be responsive, to the extent that we can, to problem-solving those who disrupt treatment. Examples include referring to community resources,

encouraging a medication evaluation, or assisting the client with obtaining treatment for a chronic medical condition.

When dialectical tensions and conflicts arise in regard to clinical issues, the goal of consultants is to seek the truth in each perspective, find what is missing, and move toward synthesis. Often, it is helpful to look to the assumptions, philosophies, and guidelines of DBT to see what solutions remain faithful to those principles. Whenever an "exception" is considered, there must be a clear clinical rationale that demonstrates the best interests of those involved. Clinical situations are nearly always complex and multifaceted, so it is important not to get caught up in right or wrong but to stay focused on the concepts of willingness and effectiveness. A healthy consultation means that members feel free to disagree but never get too personally invested in favor of flexibility and coming together over a sound plan. Again, in discrepant situations, the perspectives that best fit the tenets of DBT are usually the ones to follow.

It could be argued that the consultation group is one of the most effective aspects of DBT (or any other therapy approach) since it directly benefits the therapeutic alliance. Healthy and motivated therapists with competence and confidence bring their "A-game" to clients. Box 27.2 summarizes a consultative decision-making process.

**Box 27.2** Consultation Decision-Making Process

The following consultative process aids in streamlining clinical decision-making. This process can be used as a template for presenting cases in consultation groups.

**Step one**

Define client/therapist concern. Include inquiry about what has been tried and the results, and remember to include sufficient validation.

**Step two**

Check to see whether the concern is addressed by policy, procedure, protocol, agreements, or other guidelines (e.g., attendance policy, program rules, procedural best practices).

**Step three**

Discuss positions on the dialectic.

**Step four**

Move toward synthesis with the following considerations:

- Does the position best fit established program guidelines?
- Is there training/clarification needed for the client or therapist?
- Does the plan benefit the client, minimize risk, respect client autonomy, and stay true to agreements?
- Is the plan respectful and accountable?

**Tasks with fellow consultants**

- Check consultative alliances.
- Seek agreement on goals.
- Seek synthesis centered in program guidelines.
- Support appropriate action.
- Support fellow therapists.

**Tasks with clients**

- Check alliance issues first.
- Seek agreement and commitment on goals.
- Remind the client of agreements (if applicable).
- Orient the client to the purpose(s) of the intervention(s).
- Seek commitment to follow the plan.
- Follow through with the plan.

# 28

# Evaluation of Clinical Outcomes

Years ago I had a conversation with Barry Duncan about adherence and treatment fidelity and their relationship to clinical outcomes. Barry, an international expert on outcome evaluation, what works in therapy, and the use of systematic client feedback, said, "Lane, the only real way to know outcome is to measure outcome." This simple, common-sense statement has profound importance considering that a great many therapists and programs simply assume that they have sufficient outcomes. Unchecked practice with this assumption is also common among those who adopt evidence-based treatments such as DBT, who guess that if the treatment worked in clinical trials then it should follow that it works in community settings with community populations. Unfortunately, such an assumption neglects the all-important concept of external validity; there is no guarantee that research done with one population in one setting will transfer to other ones. Again, the only way to know is to measure outcomes.

Therapists need not be frightened by outcome evaluation. Monitoring outcomes provides data that informs and improves practice. Without data, opportunities to fine-tune treatment get missed and the quality of care suffers; with data, therapists can attain higher care standards, a shared goal of clients, providers, and payers of therapy. While not comprehensive in nature, this chapter provides practice-based examples of outcome evaluation and establishes basic guidelines to get DBT providers started

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Lane D. Pederson.

with outcome evaluation in their settings. In addition, a brief summary of systematic client feedback, a powerful method for soliciting direct feedback from clients to inform and improve practice, is provided.

The beginning of this book emphasized evidence-based practice as defined by the APA. Importantly, the APA policy casts a wide net for the types of research evidence it endorses, creating a teleoanalytic approach to determining treatment effectiveness that favors no methodology over another. The policy states that the "best research evidence refers to scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields" (American Psychological Association, 2005). Included under this definition of best research evidence is *practice-based evidence*, a research approach driven by practitioners in real-world settings who use a variety of methodologies to evaluate clinical effectiveness on a local level (Barkham et al., 2010). While practice-based evidence is on the other end of the research continuum from research conducted in laboratory settings, neither evidence base should be valued over the other. Instead, the dialectical goal is to synthesize these approaches with other forms of evidence.

In a DBT setting, one straightforward method of evaluating outcomes is to compare baseline rates of target behaviors to rates of those behaviors during and following a course of treatment. If the behavior can be defined (e.g., a hospitalization, an incident of self-injury, an occurrence of drinking and/or drug use) and quantified in terms of frequency, intensity, and/or duration, progress in treatment that addresses those behaviors can be determined. Data that are discrete, are observable, and can be easily counted and tracked are most useful, as are data that best fit your population and setting. Box 28.1 has a list of behaviors and data that can be tracked to monitor outcomes.

**Box 28.1** Examples of Behavioral and Other Data to Collect and Track

The following variables of interest can be tracked to monitor treatment outcomes and to inform practice. Focus on data that relate best to your population and treatment setting.

- hospitalizations, including number of days each occurrence
- emergency-room visits

- suicide attempts
- self-injurious behaviors
- substance-use behaviors (e.g., frequency of drinking and/or drug use)
- eating-disorder behaviors (e.g., episodes of binging or purging)
- days in treatment/length of stay
- rate at which clients meet measurable treatment objectives
- aggressive acts toward others
- number of incident reports in regard to client behavior
- days incarcerated
- days homeless
- employment (e.g., days weekly, hours weekly)
- frequency and duration of engagement in positive activities or social contacts
- frequency, intensity, and duration of observable symptoms (e.g., panic attacks, time spent isolating, compulsive behaviors).

Therapists and programs who track outcomes in this way establish baseline data and record the occurrences of behaviors on an ongoing basis, analyzing results at intervals that make sense relative to the type of population, setting, and information they want to report. A comparison of pre and post data is needed to draw conclusions about the treatment's effect on the variables of interest, although it may make sense to also analyze data at additional intervals in longer-term courses of treatment (e.g., every month, every three months, etc.). Getting posttreatment data (e.g., at one year following therapy) to evaluate if treatment gains are maintained is a gold standard, but those data become more difficult to obtain as clients tend to move on with their lives following treatment. Without going overboard on data collection, it is preferable to collect too much over too little data. You can always discard extraneous information, but it is often not possible or practical to gather data you would have liked to have after the fact.

From a practical perspective, establish the paperwork and systematic procedures required for organized data collection and then prioritize and stick to the plans. The diary card can be one way to track many of the behaviors of interest (e.g., hospitalizations, SIB) so long as those data are reliably transferred into a database. Careful planning and attention to data collection make the difference between meaningful and useless data. If you lack the background in tracking outcomes, consider hiring a consultant

to get you or your program going. Spending some money on consultation often saves time, effort, and costs in the long run, as an expert understands the subtleties on how to collect, analyze, and write up data to share it with clients, payers, and other stakeholders.

An ongoing hospitalization-rates study for my clinics was designed by a local expert in program evaluation and illustrates this type of outcome management. In this study, the number of hospitalizations along with the number of days spent in the hospital in the year prior to admission to intensive outpatient DBT programming was collected via a semistructured interview and hospitalization records. The rates of hospitalization were then tabulated on an ongoing basis during the course of clients' treatment. A recent analysis of this data showed that clients with a history of hospitalization had a 75% reduction in the annual number of days spent in the hospital, with an average decrease of 13 days' inpatient care to fewer than three. These results demonstrate not only dramatic reductions in hospitalization days but also significant savings in health-care expenditures.

Another example comes from a dissertation done by Druhn (2008) from archival data from my clinics. In this study, the first six months of treatment were compared to the last six months of treatment in regard to clients' reported rates of self-injury and the incidence of hospitalizations. The findings showed that the rate of self-injury had a significant reduction with a moderate effect size, and the rate of hospitalizations significantly decreased with a large effect size. Of note, these findings occurred with real-world clients with significant comorbidities, with nearly 43% of the clients carrying three or more diagnoses. In most randomized clinical trials, these clients would be unlikely to meet the inclusionary criteria.

If collecting and analyzing behavioral and other data seem daunting, the use of a reliable and valid outcome measure such as the Treatment Outcome Package (TOP), the Partners for Change Outcome Management System (PCOMS), or another measure listed in Box 28.2 might be a better solution. These measures tend to be straightforward in data collection and analysis, less time consuming, and more easily implemented by therapists, provided that the chosen measure tracks the symptoms and treatment variables relevant to your clients and setting. Some of these measures, such as the TOP and Symptom Checklist-90-Revised (SCL-90-R) capture broad-based symptomology whereas others such as the Beck Depression Scale II (BDI-II) and the Posttraumatic Stress Diagnostic Scale (PDS) capture a specific clinical syndrome. The use of two possible measures, the TOP and PCOMS, will be discussed in greater detail to illuminate how outcome measures inform clinical practice.

**Box 28.2** Examples of Reliable and Valid Clinical-Outcome Measures

These examples are copyrighted and must be purchased for use, with the exception of the ORS and SRS, which can be obtained at no cost for individual use.

- Treatment Outcome Package (TOP); available from Outcome Referrals
- Symptom Checklist-90-Revised (SCL-90-R); available from Pearson Assessments
- Brief Symptom Inventory (BSI); available from Pearson Assessments
- The Partners for Change Outcome Management System (PCOMS); available from the Heart and Soul of Change Project
- Beck Inventories; available from Pearson Assessments:
  - Beck Depression Inventory II
  - Beck Anxiety Inventory
  - Beck Hopelessness Scale
  - Beck Scale for Suicidal Ideation
  - Beck Youth Inventories—Second Edition (BYI-II)
- Posttraumatic Stress Diagnostic Scale (PDS); available from Pearson Assessments
- Alcohol Use Inventory (AUI); available from Pearson Assessments.

In addition to the hospitalization and other study mentioned above, my clinics have used the TOP since they opened in 2002. The TOP is a reliable and valid clinical outcome measure that as of 2012 has been used by over 23,000 clinicians for over 1.1 million clients to determine treatment concerns and progress toward goals (Outcome Referrals, n.d.). A broad-based measure, the TOP taps "depression, panic, mania, psychosis, sleep, sex, work, quality of life, substance abuse, suicide, and violence" (Kraus & Castonguay, 2010, p. 171). Clients who score above the clinical cutoff in any particular area have a mild to severe level of symptomology. Further, the TOP provides information on diagnostic and medical considerations, significant stressors, and critical items that signal safety concerns. The TOP also provides special alerts for when clients are not improving or are deteriorating so therapists can be responsive in adjusting their

treatment interventions. Individual TOP results are reviewed with clients to inform treatment plans, goals, and objectives and to track progress, and aggregate reports can be used to track the overall success of particular treatment programs or entire clinic outcomes. In many cases, providers can adjust for risk and other case-mix variables in order to benchmark and compare their outcomes with those who treat similar populations in similar settings. Last, the TOP includes a client-satisfaction survey in which results can be compared to industry standards. The aggregate results of the TOP data in my clinics demonstrate that clients in intensive outpatient DBT demonstrate clinically significant improvement in symptoms of depression, anxiety, and substance use and rate the quality of services and therapists above established industry benchmarks.

The PCOMS is another highly applicable, highly flexible outcome-assessment system with unique attributes. Comprised of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), PCOMS is a pan-theorectical system founded on therapeutic factors and makes systematic client feedback central to the therapeutic process (Duncan, 2014). The ORS obtains client feedback on outcomes and the SRS obtains client feedback on the therapeutic alliance, and this information is used in real time in collaboration with clients to immediately adjust and improve treatment. Each measure consists of four visual analog scales that can be quickly filled out by the client, and then the therapist calculates the results with a ruler or template and charts them over time. Importantly, the results are then discussed in session to inform, adjust, and customize therapy consistent with evidence-based practice. These measures capitalize on two important ideas reflected in the literature. First, clients who do not experience early change have greater risk of dropout and poor outcomes (Baldwin et al., 2009; Brown et al., 1999). Second is the interrelated finding that clients with a solid therapeutic alliance are more likely to remain in treatment and have successful outcomes (Norcross, 2010). Thus, careful monitoring of outcomes and the therapeutic alliance via PCOMS from the beginning of treatment serves as an early warning system to adjust therapy as needed before clients vote with their feet (Duncan, 2014).

PCOMS has demonstrated success in five randomized clinical trials, including three RCTs that resulted in the Substance Abuse and Mental Health Services Administration (SAMHSA) designating its use as an evidence-based practice (Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowland, 2009; Schuman et al. 2014). These three studies spanned individual, couple, and group psychotherapy respectively, and they all demonstrated that clients in the PCOMS condition showed significantly more reliable change compared to TAU clients among

other desirable findings. With its growing empirical base and ease of implementation, PCOMS is a practical option for DBT providers and their clients, especially since many traditional DBT populations have been stigmatized and discounted rather than respectfully included in the therapeutic process. More information on PCOMS can be found at https://heartandsoulofchange.com.

In sum, as you progress as a DBT therapist, solo or in a program, it is vital to embrace accountability in practice through monitoring clinical progress and adjusting treatment as necessary, an essential part of EBP. As one DBT expert stated in an online forum, "the more power to the person with the data." All DBT providers, regardless of differing philosophies about the application of the approach, share the same goal: effective clinical outcomes with real-world clients served by DBT. And that goal cannot be realized without the use of practice-based data.

# Appendix A
# Mindfulness Exercises

These mindfulness exercises have been shared with me by colleagues over the years, but they constitute only a small sampling of exercises out in the public domain. Each idea is intended to be a seed that can be developed into a fuller experience with practice. Be playful and creative, and adapt and expand on these ideas as you wish. Also stay on the lookout for ideas to expand your mindfulness repertoire.

- With a piano or another musical instrument, randomly play a note slowly and with intention. Breathe in as the note is played and breathe out as the note fades into silence. As you continue breathing in and out with each subsequent note, notice the silence between them. Contemplate the importance of silence (rests) between the notes. Does this also have meaning for life?
- Picture leaves floating downstream in a gentle river. As thoughts, images, or emotions arise, mentally place each one on a leaf and watch it float downstream.
- Begin each meal with five small, mindful bites. Through your senses, notice smell, taste, texture, and the relative warmth or coolness of each bite. Chew slowly. Immerse yourself in each bite from putting it into your mouth to completely chewing it to slowly swallowing it.
- Lie on your back and place a hand on your abdomen. Feel your belly rise as you breathe in and fall as you breathe out. Continue for several minutes or until completely relaxed.

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Lane D. Pederson.

- Place a hand over your heart or place both hands on your legs. Feel the exchange of warmth where your hand or hands touch your body.
- Play soothing music with a slow rhythm. Sync your breathing to the rhythms of the music, breathing along to the instrumentation.
- Take a piece of fruit and cut it into slices. Engage all of your senses in the experience of a single slice, not tasting it until you have fully explored it. As you eat the slice, immerse yourself in the experience, as if it is the last piece of fruit you will eat. (Option: Write down the time at the beginning of the exercise and then note the time at the completion. How much time passed on that single slice of fruit?)
- Get on the floor and play with a young child (or pet). Be in the moment, letting go of distractions to give the relationship your full attention.
- As you breathe in, imagine your heart filling with gratitude, and, as you breathe out, imagine sending good will into the world. Continue this exercise, noting how connection with gratitude and contributing to the world, if only through this exercise, affect your sense of well-being.
- Read a passage from an inspirational book and contemplate the meaning.
- Create a collage of changes you would like to realize in life.
- Take any common object and simply observe and describe it. Do not analyze it or think about it. Stay purely focused on descriptive qualities.
- Give your full attention to routine tasks that could be done mindfully, such as folding clothes, doing the dishes, cleaning, or mowing the lawn.
- Take a mindful walk, paying full attention to how your body moves, its connection to the ground with each step, and so on. Or, alternatively, get out of your head and mindfully observe your surroundings.

# Appendix B

# Plans for Safety and Skills Implementation

Have your clients use these plans for safety, skills implementation and generalization, and other clinical issues such as the management of specific ineffective behaviors. The first two plans are somewhat similar examples of crisis plans, and the third is an example of a skills implementation plan. These plans can be adapted as needed.

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Lane D. Pederson.

Distress-Tolerance Crisis Plan

Fill out this plan and continue to add to it as you learn more skills. Treat this plan as a "living" document: It needs to be continuously reviewed, practiced, and updated. Make several copies and always know where to find your plan. It is hard to know what to do when you are in the heat of the moment, and that is why you have this written plan.

Give copies of this plan to the people in your support system and discuss your use of the plan proactively. Again, practice, practice, practice—practice makes you prepared to be effective in life.

*My reasons for managing crisis effectively and/or staying safe:* List all of your priorities, goals, values, and people that matter to you. These are your "whys."

*My strengths and resources*: List what you have going for you. Ask for help if you are unsure.

*Warning signs*: These are the signals that you may be in crisis or unsafe or about to be in crisis or unsafe. Be as specific as possible. Look to your history for clues.

*Feelings*: Ask yourself what you are/were feeling before or during this time.

*Thoughts*: Ask yourself what you are/were thinking before or during this time.

*Behaviors*: Ask yourself what you are/were doing and/or not doing before or during this time.

*Sensations*: Ask yourself what you are/were experiencing physically or in your body before or during this time.

*Environment*: Ask yourself what your environment is/was like and/or what is/was happening in your environment before or during this time.

*Key triggers*: Ask yourself what sets off a crisis and/or what is unsafe for you.

*Barriers to skill use*: List what will get in the way of using your skills and this plan *and* list the skills you will use to address each barrier.

*Burn the bridges*: Write how you will remove the means to act on urges; be specific.

*Self-care skills to use*: List all of the ways you can care for yourself during this time.

*Mindfulness skills to use*: List specific behaviors.

*Distress-tolerance skills to use*: List specific behaviors.

*Emotional regulation skills to use*: List specific behaviors.

*Interpersonal effectiveness skills to use*: List specific behaviors.

*Other skills to use*: List specific behaviors.

*My personal support system*: List names and numbers of people/resources you can call, when they are accessible, and the specific interpersonal and other skills you will need to use these supports.

*My professional support system*: List names and numbers of people/resources you can call, when they are accessible, and the specific interpersonal and other skills you will need to use these supports.

*My medications and dosages:*

*My hospital of choice:*

*My commitment*: I commit to practicing my plan proactively and during times of crisis. I further commit to be safe and call 911 or go to the hospital *before* acting on suicidal urges.

Signed by client: _____ Date: _____

**Original to client; copy to chart**

## Suicide and Self-Injurious Behavior Prevention Plan

Complete this plan as a primary goal of treatment to build awareness about your suicidal and/or self-injurious patterns and to develop alternatives to these behaviors. As you learn more skills, revise the plan, and remember to review it daily and to practice it.

List the reasons why you want to work on eliminating suicidal and self-injurious behaviors:

List the short- and long-term consequences that often follow suicidal and/or self-injurious behaviors and/or how these behaviors interfere with your goals and life:

List your strengths and resources to avoid suicidal and self-injurious behaviors including skills and behaviors that have helped in the past:

List what makes you vulnerable to suicidal and/or self-injurious behaviors (e.g., consider feelings, thoughts, behaviors, physical sensations, self-care issues, and what is or is not happening in relationships and your environment):

List the skills and behaviors you can use to decrease your vulnerability to suicidal and/or self-injurious behaviors:

List the warning signs that often lead to suicidal and/or self-injurious behaviors (i.e., indications that you are in the danger zone):

List the skills and behaviors you can use to effectively respond to your warning signs:

List primary triggers that immediately precede and "set off" suicidal and/or self-injurious behaviors (e.g., consider feelings, thoughts, behaviors, physical sensations, self-care issues, and what is or is not happening in relationships and your environment):

List the skills and behaviors you can use to effectively remove and/or respond to your primary triggers and urges:

List ways you can burn the bridge between your urges and reacting with suicidal and/or self-injurious behaviors:

List the self-care skills and behaviors that decrease your overall vulnerability and that it is important to use *at all times*:

List the skills and behaviors to replace suicidal and/or self-injurious behaviors and to tolerate distress and/or crisis:

List the people in your personal support system, their contact information, and their availability:

List the people in your professional support system, their contact information, and their availability:

If you are unable to maintain your safety with suicidal behaviors, call 911 or go to the hospital for assistance.

Skills Implementation Plan

The skills implementation plan is used to supplement or replace phone coaching and to generalize skills to eliminate target behaviors. Develop a plan for each target behavior you fall into in order to apply skills most effectively.

**Crisis behavior**

Name your specific crisis behavior (e.g., isolation, stopping medications, self-injury, substance use, suicidal behavior, etc.). List situational factors, feelings, thoughts, physical sensations, and behaviors typically associated with the crisis behavior at each level of intensity.

0: No crisis

Typical situational factors:
Typical feelings:
Typical thoughts:
Typical physical sensations:
Typical behaviors:
Skills to use:

1–2: Early warning signs

Typical situational factors:
Typical feelings:
Typical thoughts:
Typical physical sensations:
Typical behaviors:
Skills to use:

3–4: Some distress

Typical situational factors:
Typical feelings:
Typical thoughts:
Typical physical sensations:
Typical behaviors:
Skills to use:

5–6: Increased distress

Typical situational factors:
Typical feelings:
Typical thoughts:
Typical physical sensations:
Typical behaviors:
Skills to use:

7–8: Intense distress

Typical situational factors:
Typical feelings:
Typical thoughts:
Typical physical sensations:
Typical behaviors:
Skills to use:

9–10: Crisis point

Typical situational factors:
Typical feelings:
Typical thoughts:
Typical physical sensations:
Typical behaviors:
Skills to use:

**Diagnoses and symptoms**

Medications

1. Dosage:
2. Dosage:
3. Dosage:
4. Dosage:
5. Dosage:
6. Dosage:
7. Dosage:

Medical alerts

**Contacts**

List people to call for support (family, friends, and team members to contact in the event of crisis):

| | |
|---|---|
| Family members: | Phone number(s): |
| Friends: | Phone number(s): |
| Therapist: | Phone number: |
| Psychiatrist: | Phone number: |
| Case manager: | Phone number: |
| Other: | Phone number: |
| Other: | Phone number: |

In case of emergency: Call 911 or go to your nearest emergency room.

# Appendix C
# Professional Growth in DBT

After 14 years doing DBT, I still continually learn new concepts, remember forgotten ones, and expand my understanding of DBT and therapy in general. Here are some suggestions for growth, in no particular order. Remember that professionals are responsible for their own development!

- Read a minimum of one DBT research article a month. Share and discuss it with your DBT team.
- Seek ongoing consultation or supervision from a DBT colleague with stylistic differences.
- Find other interested DBT therapists to create a consultation consortium or study group. Structure your time and create common goals and methods for reaching them.
- Pursue continuing education in DBT, mindfulness, third-wave CBT, and related areas. Strive to receive instruction from various trainers.
- Read the latest DBT books and manuals and post thoughtful reviews online.
- Get your team out of the office and do a fun or educational (or both!) activity together. Build your relationships.
- Break out of a rut by using a new DBT skills manual or handout, at least for one skills-training session.
- Seek out online resources on DBT therapy and skills.

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Lane D. Pederson.

- Develop your own skills materials and worksheets, perhaps even writing a specialized manual for your unique population and setting.
- Apply DBT skills to improving your health and well-being; to being a better parent, partner, or friend; or to accomplishing any goal. Create a written plan like you would ask a client to.
- Analyze your outcome data and consider how you can use it to improve your therapeutic skills or program.
- Read about other therapy approaches and consider their theoretical, philosophical, and intervention-based similarities and differences from DBT. Do any of the other approaches assimilate into DBT (or vice versa)? Are any of the other approaches counter to DBT in important ways?
- Go on a mindfulness retreat.
- Reread Linehan's book and manual.
- Write a DBT blog or share your DBT insights on a web forum.
- Consider a new (or new to you) method of applying DBT (new population, new setting, for self-help, etc.).

Consider and discuss with your colleagues what you think constitute the most important and effective elements of DBT.

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# Index

Page numbers in *italic* refer to figures and tables.



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