CHAPTER 1

Introduction and Overview

When I first bring up phone coaching during talks or workshops, many audience members get that shocked deer-in-the-headlights look, as if I have just suggested that they should ask their clients to move in with them. Yet phone coaching is an important aspect of treatment, and can be managed in a way that doesn't end up by turning clients into roommates. In this book, I focus on why we do it, how to make it effective, and ways to avoid common pitfalls. I am excited to have the opportunity to put what I have learned about phone coaching in dialectical behavior therapy (DBT®) on paper, and to give clinicians clear principles and practical guidance on how to approach this aspect of treatment.

As anxiety-provoking as phone coaching can be, it is an integral part of treatment. DBT clinicians share a common goal: to ensure that our clients receive full, comprehensive DBT (including individual therapy, group skills training, and phone coaching). And this unfortunately requires them to be available to their clients in between sessions, largely during their personal time. Even therapists who have read the original DBT manual (Linehan, 1993a), which only included under 10 pages on the topic, might find themselves ill-equipped and reluctant to navigate phone coaching. Moreover, many clinicians wonder (and worry about) how phone coaching works in a practical sense. How many calls can you expect to receive? How many is it reasonable for you to be willing to receive? Do you truly need to be available 24 hours a day, 7 days a week? How do you get off the phone with clients who won't hang up? What do

you do when a client calls too often? How can you manage suicide risk during a brief phone call? This book will help answer all these practical questions and more.

In this first chapter, I provide a brief overview of phone coaching in DBT. I begin by discussing whom this book is for and what phone coaching is and is not. I also describe the primary reasons for and functions of phone coaching in DBT. Subsequently in this section, I discuss common concerns and dispel myths about phone coaching. Finally, I will provide some guidance on how to navigate the rest of this book.

Who Can Gain from Reading This Book

This book is addressed to mental health clinicians, students, or other professionals who would like to incorporate phone coaching into their practice. Although the focus is on phone coaching as it is conducted in DBT, I have tried to make these principles relevant to a range of clinical populations and professionals trained in other treatment modalities. You do not need to be a well-trained DBT clinician to start to make use of these principles and strategies right away.

If you have not received any significant DBT training or primarily provide cognitive-behavioral therapy (CBT) or other treatments, the material in this book may help you to enhance your practice in many ways. The establishment of new, effective coping strategies is a common benefit of CBT and other approaches. For new coping strategies to make a difference in clients' lives, however, clients need to use and practice them in everyday situations. Phone coaching is designed to help clients do just that. Regardless of your treatment approach, therefore, the principles and strategies in this book will give you new ways to help clients learn and apply effective coping skills to learn more about themselves, manage stress, improve relationships, and achieve their important goals. Moreover, as phone coaching was developed in the treatment of complex patients (i.e., those with borderline personality disorder or who are highly suicidal), I believe the strategies discussed in this book can be useful for a range of clients, especially those whose emotion regulation (ER) problems play a role in their difficulties.

For those who are experienced DBT or CBT clinicians, the book offers practical guidance on how to conceptualize and implement phone coaching. I am a seasoned DBT and CBT clinician, and I have probably

made most of the top 10 mistakes a clinician can make with phone coaching (and there actually is a list of such mistakes; see Manning, 2011). In fact, I could have used a book like this one much earlier in my own career, and I probably couldn't have written it without learning from my many mistakes! Finally, I believe this book could be useful for practitioners who may only rarely use phone coaching but would like to incorporate more coaching and generalization strategies into their clinical work.

What Is Phone Coaching?

Phone coaching involves the clinician being available between sessions to guide the client in the use of skills learned in therapy. Although such coaching typically occurs over the phone, clinicians increasingly have used other forms of communication, such as e-mail, texts or other instant messaging (e.g., What's app?), or video-calling platforms, such as Skype, FaceTime, or others. With the advent of e-therapy, therapists increasingly use various messaging mechanisms (often built into apps or through secure Web interfaces) to coach and guide clients through various therapy modules. Throughout this book, I continue to refer to all of these forms of between-session communications as "phone coaching," but at times I discuss specific issues pertaining to electronic communication methods.

The primary goal of phone coaching is to guide clients to use skills effectively in their natural environments. Clients might, for example, call the clinician when they are particularly upset about an interpersonal conflict and unsure how to cope effectively with their emotional reactions. In those instances, the clinician provides the client with suggestions on relevant skills and how to use them to deal with his or her specific situation.

Although the primary goal of phone coaching is to remind clients how to best use their skills, there are other key topics that can be addressed over the phone. Sometimes clients want to address relationship issues that have arisen in a previous session. The client might, for example, call the clinician if he is upset about an interaction that occurred in the therapy session and believes the issue can't wait until the next session. For instance, if the client felt hurt or angry in response to something that the clinician did or said, and delaying the discussion might lead to other problems (e.g., the client avoiding the next session or arriving in an emotionally dysregulated state), then talking this through might avert adverse consequences.

Another common reason for clients to call is that they are experiencing an emergency or crisis. When this occurs, clinicians help clients use skills to manage or reduce the crisis or avoid making it worse (e.g., by engaging in harmful behaviors), as described in Chapter 7. Although suicide crisis calls regularly occur in DBT, most DBT clinicians encourage their clients to call long before crises occur.

In less frequent instances, clients may call to report on progress, provide updates about critical or important issues, or discuss other less pressing matters. Finally, sometimes clinicians themselves might use phone coaching in creative ways to enhance progress. A clinician might, for example, use scheduled phone coaching calls to help a depressed client get out of bed or to encourage a client to use skills to make it to her therapy session. In other cases, a therapist might use phone coaching as a form of contingency management to reinforce progress. A client, for example, might be allowed to call the therapist only when he has made progress or engaged in specific, agreed-upon behaviors, such as the practice of a specific skill or the completion of a particular task like submitting a job application.

What Is Phone Coaching Not?

Phone coaching is not therapy over the phone. Imagine that you are a coach for a hockey team (some readers are going to have to put up with the fact that the author is Canadian). Coaching on the fly, during the game, is akin to phone coaching in DBT. Given that the game is so fast-paced and the stakes are so high and that intense coaching focus and rapid-fire decisions are required, you must efficiently convey your message to the players during the couple of minutes when they're on the bench. You also might need to call out directives or make suggestions while the players are actually on the ice. Your statements need to be clear, succinct, direct, and to the point. You also need to focus on the present and the near- or short-term future (e.g., the next 5 minutes of the game). This would not be the time for intense analysis of the players on the other team, how your own players can improve their game over time, thoughts and feelings about their performance, how to improve fitness, prepare for the playoffs, and so on.

Similarly, phone coaching involves efficient coaching when the client is in the middle of the game, living his everyday life and navigating

challenging situations. As such, phone coaching tends to be brief, directive, present-focused, to the point, and efficient. A phone coaching call is not the venue in which to solve the client's relationship problems, school or employment difficulties, depression, or other challenges that require consistent therapeutic work over time. The focus is on the here-and-now and typically on what the client can do now and in the near future to regulate or tolerate his or her emotions.

Coaching also is not crisis management or suicide prevention. Phone coaching in DBT is often mistaken for a crisis call or suicide prevention service. As I discuss in Chapter 3, which focuses on orienting the client to phone coaching, it is important for the clinician to clarify that the primary purpose of phone coaching is to generalize skills from therapy to the client's everyday life. The primary goal is not to prevent suicide, to manage suicide risk, or to navigate emergencies. Although a client may call in the midst of a suicidal crisis, the ideal goal is to help her reduce suicide crisis calls over time and use phone coaching primarily to transfer skills to everyday life.

Why Do We Use Phone Coaching?

There are several reasons to use phone coaching. The paramount reason is to help the client generalize skills from therapy to the natural environment. When skills coaching occurs while the client is navigating real-life situations, he can try out the skills right then. In typical outpatient therapy, the clinician spends only 1 to 2 hours per week and sometimes even less time with the client. Therapy typically takes place in a setting that is markedly different from the client's everyday life. Even the therapy relationship differs dramatically from the client's relationships with family, friends, partners, or colleagues. It's not always clear whether the client can use skills learned in the therapy context in everyday life when she or he needs them most. Phone coaching, therefore, is one of a variety of generalization strategies (some of which are discussed in Chapter 9) geared toward helping the client transfer skills from the therapeutic setting into relevant everyday-life situations. Phone coaching should not be the only generalization strategy used in the treatment of complex clients. Rather, I recommend that clinicians embed phone coaching within a broader set of generalization strategies. Over time, of course, it is useful to help the client learn to guide him- or herself in the use of skills. In Chapter 9, I

discuss a broader set of generalization strategies as well as ways to help the client develop self-coaching skills.

Another potential benefit of phone coaching is that a well-timed phone coaching call may prevent short-term problems and help clients avoid compounding already stressful situations. When we teach clients distress tolerance skills in DBT, we often emphasize the notion that some of these skills (crisis survival strategies; Linehan, 2015) help the client to avoid making a difficult situation worse. Phone coaching can work in the same way. The client experiencing emotional distress following an interpersonal conflict, for example, might receive the suggestions, encouragement, and motivation she needs to avoid behaviors that might further inflame the situation. I have had many phone coaching calls with clients experiencing urges to engage in actions that would make their situations worse, such as self-injury, angry outbursts, revenge seeking, stalking, drug use, and so on. Particularly for clients in the first stage of DBT ("stage one"; Linehan, 1993a), impulse control and self-regulation are not well-developed skills. These clients, therefore, may need a little extra help and support from a clinician who knows the skills and can help encourage and motivate them to use the skills. Although it may sound like this benefit of phone coaching is akin to simply putting out fires in the client's life, some fires must be extinguished in order to avoid disastrous long-term consequences (e.g., suicide). Individual therapy sessions are there to help clients learn how to avoid starting these fires in the first place.

A third key benefit of phone coaching is the sense of support and connection that the client often feels when a caring and helpful clinician is available for assistance. Although this book is meant to be broadly applicable across many clinical populations, I will make a brief point here about treating people with borderline personality disorder (BPD) and related complex mental health problems. Marsha M. Linehan (1993a) has described people with BPD as the "ultimate outsiders." They often feel alienated, afraid, and drawn to interpersonal connection all at once. The biosocial theory underlying DBT suggests that invalidating environments in which the individual did not receive adequate care, support, or guidance in understanding and managing emotions contribute to the development of BPD (Crowell, Beauchaine, & Linehan, 2009; Linehan, 1993a). Indeed, people with BPD often have serious interpersonal dysfunction that persists for many years (Choi-Kain, Zanarini, Frankenberg, Fitzmaurice, & Reich, 2010). Establishing an effective, caring, and

supportive relationship with a clinician who is willing to help in the client's everyday life may decrease interpersonal conflict and alienation. Interestingly, theories of suicide historically have emphasized the role of alienation and social disconnection in suicidal thoughts and behaviors (e.g., "egoistic suicide"—Durkheim, 1897; "thwarted belongingness"—Joiner, 2005). While phone coaching is not a suicide prevention service, and it would be naïve to think that we can prevent suicide, this mode of intervention (perhaps more so than many others) may help to address clients' feelings of disconnection or alienation.

Finally, another benefit of phone coaching is that it can give the client the opportunity to learn how to ask for help effectively (Linehan, 1993a). Effectively asking for help can be considered a skill, and some clients (and probably many clinicians) could use help with this skill. Some clients ask for help in a demanding, aggressive manner; others ask for a tremendous amount of help without considering the effect of this help seeking on their social supports; others never ask for help and consequently don't get the support they need. Still others become hurt and angry when others don't provide the support they need but never asked for. Phone coaching is an excellent training ground for clients to learn to effectively seek help and support. To ensure that clients receive effective training, the clinician should notice and comment on effective and ineffective help-seeking behaviors, and regularly debrief phone coaching calls during individual therapy sessions (discussed in Chapter 3 on structuring phone coaching calls).

Common Concerns and Myths

Many clinicians fear how phone coaching will affect their personal lives. Many assume that emotionally dysregulated clients will "bother" them at all hours of the day and night. They fear that their availability by phone will set a problematic precedent, blurring the boundaries of the therapy relationship and fostering dependency on the part of the client. Now that DBT has been disseminated broadly, most clinicians are already aware of and willing to use phone coaching. That said, several myths about this intervention persist. Below, I explore common clinical concerns, many of which turn out to be unfounded. I am also hoping that, throughout this book, you will learn that phone coaching can be a powerful and manageable intervention.

Phone Coaching Will Lead to Stress and Burnout

Perhaps the most common concern about phone consultation is that the clinician will be overwhelmed with calls, and suffer from stress and professional burnout. Fortunately, many of us who have been doing DBT for a long time have discovered that we are rarely in this situation. Anecdotally, among the DBT clinicians that I know, most of us have had only a few DBT clients with whom we have approached burnout in relation to phone coaching. The vast majority of clients do not even call. In fact, I have had to encourage reluctant clients to call far more often than I have confronted clients who were calling too much. Those who do call tend to use phone coaching appropriately and are grateful for the help. Over 90% of the time, I end phone coaching calls feeling good about the call and satisfied that I have helped my client.

Although few studies have addressed the topic, findings suggest that clinicians should be able to incorporate phone coaching into their work with minimal risk of burnout. In one study of complex clients with eating disorders receiving 13 weeks of DBT, less than half (47.2%) of the clients made use of phone coaching, only 3% of all calls lasted 20 minutes or longer, the average duration of calls was approximately 6 minutes, and the average number of calls was less than five (Limbrunner, Ben-Porath, & Wisniewski, 2011). In this study, 54% of calls occurred on the weekend, and 67% were between 4:00 and 11:00 P.M. In another study of 51 adults with BPD who attended 6 months of DBT, the average number of phone coaching contacts per month per client was 2.55 (Oliveira & Rizvi, in press). The highest utilizers of phone coaching (n = 4 participants, or 11% of the sample), accounting for 56% of all calls, made 79–143 calls over the 6-month period (Oliveira & Rizvi, in press). These data are consistent with the clinical experiences of many DBT clinicians. Infrequent, brief calls are the norm, mitigating the risk of clinician burnout. Furthermore, there is some evidence that phone calls with clients may reduce suicide attempts (Vaiva et al., 2006).

Clinicians Must Be Available at All Times

Another assumption is that the clinician must be available 24 hours a day, which would exceed many clinicians' personal and professional limits. In her original DBT manual, Linehan stated her belief that suicidal patients "must be told that they can call their therapists at any time—night or day, work days or holidays if necessary" (1993a, p. 503).

As we say in DBT, there is a dialectic here: On one hand, it is crucial to be available to highly suicidal clients, and, on the other hand, 24-hour availability can intrude in clinicians' lives; thus, some clinicians would choose not to do phone coaching if they had to be this available. As discussed further in Chapters 3 ("Orientation to Phone Coaching") and 8 ("Principles and Strategies to Address Challenges in Phone Coaching"), it is both important to be as available as possible and to observe limits and address therapy-interfering behavior (i.e., clients calling too much or during undesirable times) as it occurs. In many places where DBT is practiced, clinicians are permitted to have and observe their own limits around phone coaching. In our DBT team, for example, we accept clinicians' individual (and sometimes idiosyncratic) limits but emphasize that the approach most consistent with DBT principles is not to set limits ahead of time but to observe them as needed (monitor whether the client's behavior is pushing your limits). We ask that clinicians avoid narrowly defined limits, and that they accurately communicate their preferences to their clients ahead of time.

I try to maintain and observe limits that will keep me motivated to sustain phone coaching over the long term. For example, I often tell my clients that they can call me at any time, but that I generally go to bed between 9:30 and 10:30 P.M. and awaken around 5:30 or 6:00 A.M. I tell clients that, although I'm willing to take calls in the night, they might have difficulty reaching me, as my phone might not be readily available. I also mention that if they do reach me, I likely won't be as helpful as I am during regular waking hours. In case clients can't reach me in the middle of the night, I help them devise plans to use skills (e.g., a crisis survival plan, using some of the DBT distress tolerance skills; Linehan, 2015) or access support (e.g., calling others in their support networks, contacting crisis lines) during that period. I also tell clients that I nearly never answer my phone when it rings; thus, they must leave a brief message describing the kind of help they need, and I'll call them back when I'm available. I tell them that I prefer brief voice messages, and that I don't want them to leave messages reporting suicidal thoughts or urges. I also let them know I will sometimes get back to them quickly and sometimes several hours later. Normally, I say that I'll at least get back to them before I retire for the evening (I got this from Linehan's example; Linehan, 1993a), but that, at times, I may not be able to get back to them until the next morning. On my voicemail message, I state that I'll do my best to return calls within 24 hours. I also mention that clients experiencing

a clinical emergency who can't wait for my call should access emergency services, contact a crisis line or their family physician, or visit the emergency room, and so forth.

Other colleagues navigate phone coaching differently. Some are available 24/7, whereas others are available only between 8:00 A.M. and 6:00 P.M. Still others answer their phones right away. Some of my colleagues prefer to receive a voice message or text indicating the seriousness or urgency (e.g., by the client texting 911) of the call, so they know how quickly to call back, and others want a detailed voice message describing the kind of help the client needs.

There are many ways to navigate phone coaching, and I encourage clinicians to consider their own limits, how phone coaching might affect their everyday lives, and to choose a method they can sustain. Phone coaching is, in some ways, analogous to incorporating some new self-care activity into your life, such as regular daily exercise. It's sometimes hard to find the time to do it, and if you take on more than you can sustain (e.g., deciding to get up at 4:00 A.M. and work out for 3 hours every day), you're likely to burn out and quit. For self-care, I encourage people to only make changes they can feasibly keep up for more than a year. Similarly, clinicians who diligently observe limits around phone coaching will find themselves much more able to sustain this practice over the long run, compared with clinicians who fail to observe limits or those who set rigid limits up front and then become frustrated when their clients inevitably cross these limits. Many times, I've seen clinicians fail to observe limits and continue to take on more than they could sustain. This often results in burnout and urges to quit phone coaching entirely. Interestingly, clinicians in this situation often blame the client for calling (or texting/emailing) too much, when the clinician could have prevented this problem early on by observing limits consistently and seeking consultation and support from colleagues.

Phone Coaching Leads to Boundary Violations

Another common concern is that phone coaching invites boundary violations. Most mental health professionals are taught to avoid problematic multiple relationships or boundary violations, and some clinicians are vigilant regarding these issues. As such, clinicians sometimes believe that communication with clients during personal time changes the professional relationship into a more personal one. Instead of maintaining all

therapeutic contact within the confines of a professional setting (or during professional working hours), the clinician is allowing the client to call (or text, e-mail, etc.) much like a friend would allow her to call for help or support. Clinicians might be concerned that the client will start viewing or treating them as friends.

Interestingly, although generalization of skills is the primary goal of phone coaching, another reason Linehan included phone coaching in DBT was that she wished to ensure that the therapy relationship contained the same elements as a real, genuine relationship (Linehan, personal communication). In any close relationship, people can freely call, e-mail, or text one another for support and help. We expect that our friends or family will be unavailable sometimes, but not that they are only accessible during working hours! And yet, these limitations often are the rule in therapy and can sometimes seem artificial or unnecessary to clients. Effective DBT phone coaching, therefore, involves balancing the qualities of genuineness and caring with principles, elements, and procedures promoting an ethical and professional therapy relationship.

Chapter 3, which focuses on orienting clients and observing limits, will provide guidance on how to set the therapeutic frame with respect to phone coaching. Problematic multiple relationship issues can often be avoided with adequate orientation to the roles of the clinician and the client and the procedures and expectations of phone coaching. Observing therapeutic limits consistently also can help the client and clinician catch and solve relationship issues related to phone coaching before these issues harm therapy.

Phone Coaching Will Encourage Clients to Be Dependent

Clinicians are understandably concerned that phone coaching will foster client dependency. The client might learn to call the clinician instead of use his or her own coping skills to manage difficult situations, which could possibly lead to an unhealthy dependency. In fact, some clients do indeed become dependent on phone coaching. I had a client who called me several times per week and always seemed to feel better following our calls. He thanked me profusely for my help, and I found the whole experience very gratifying. I thought I was doing good work and furthering the therapy by helping him through phone coaching. In reality, his frequent calls stretched my personal limits. The first clue to my rising resentment was a mild feeling of dread when I noticed his number on the call display.

I also noticed that the calls were not decreasing over time (which I might expect to see as therapy skills increasingly generalize to the client's life). I brought this issue up in our session, highlighted the effect of the phone calls on me, and discussed how they were working for the client. In doing so, we both discovered that phone coaching had become the client's primary method for regulating his emotions. Calling me had become the client's go-to skill. Once we discovered that, we knew exactly what needed to happen. We gradually reduced the frequency of the phone calls while helping him figure out how to use other skills to tolerate distress and regulate difficult emotions. Therefore, even if signs suggest that a client is becoming dependent on phone coaching, this dependency can usually be managed effectively in the context of an open, collaborative therapy relationship.

Dialectical Theory Applied to Phone Coaching

Because DBT is a *dialectical* treatment approach, dialectical principles influence how clinicians navigate phone coaching in DBT. Dialectical theory holds that reality consists of polar opposites, such as thesis versus antithesis, positive versus negative charge, matter versus antimatter, and so on. In DBT, the polar opposites are acceptance and change. In developing treatment for highly suicidal, complex clients, Linehan realized that a purely change-oriented approach, consisting of cognitive and behavioral interventions, was untenable, as clients experienced this approach as invalidating. The message was that all they needed to do to overcome a lifetime of intense suffering was to change their thoughts and behaviors and learn new coping skills. Change alone was inadequate. Acceptance alone, consisting of validation, empathetic listening, responsivity, warmth, and so forth, also was fundamentally invalidating and inadequate, as suicidal clients experiencing intense misery need their lives to change. To attain lives worth living, clients need to accept themselves, their thoughts, their emotions, and their experiences, and then they need to solve their problems and change their lives. To help complex clients, clinicians need to accept their clients the way they are and to help them improve and change in ways that bring them closer to their goals.

The dialectical framework of DBT reminds clinicians to seek a balance or synthesis of acceptance and change. Across modes of DBT, the central dialectic is that of validation versus problem solving. In phone

coaching more specifically, the clinician seeks to balance validation of the client's experiences with problem solving in the form of skills coaching, which arguably solves the problem of the client's difficulty using skills when needed. Because of the brevity of phone coaching, the balance tends to weigh more heavily on the side of problem solving (skills coaching) than validation.

The clinician also should seek to balance the skills emphasized during phone coaching calls. Some of the DBT skills are more acceptance-oriented, such as mindfulness and some of the distress tolerance skills, whereas others are more change-oriented, such as interpersonal effectiveness and most of the ER skills. One of my clients, for example, recently presented with great difficulty tolerating boredom. He periodically felt keyed up, agitated, confused, and had difficulty concentrating, and when this happened, he began to have urges to engage in impulsive behavior, such as overspending. I believe I did an excellent job of coaching the client in skills to combat boredom, brainstorming stimulating activities, and encouraging the client to use distraction and opposite action. What was missing, however, were skills to accept and tolerate the experiences that accompanied boredom. Sometimes, life is boring, and there's value in learning how to experience boredom without having to avoid or escape it. Indeed, his urges to overspend could be considered a "symptom" of the broader problem of difficulty tolerating and accepting aversive inner experiences. Therefore, it's helpful for clinicians to remain attentive to their emphasis on acceptance versus change-oriented skills during phone coaching and to try to strike a balance that works well in view of each client's unique circumstances.

Another dialectical principle that I find especially helpful during phone coaching is that of working for synthesis. In phone coaching, the clinician and client will, at times, become polarized. The clinician might strongly urge the client to use skills and not to attempt suicide or self-injury, and the client might firmly insist that the skills won't work, and that she should harm herself. Whenever I become polarized in this or other scenarios, I remember a story from back when I was learning couples therapy in graduate school. My supervisor used to ask the couple to remember the last time they were in a heated conflict and to consider what their primary goal was in the heat of the moment. Most commonly, partners would say that their goal was to win the argument. Oddly enough, I never heard them say that their goal was to bring the relationship to a new, exciting level of intimacy. In any case, once the partners

said that their goal was to win the argument, my supervisor would ask them, "What's the best possible outcome if you win the argument?" and then tell them that the best outcome was that "You're now married to the loser!"

Remembering this story and the dialectical strategy of working for synthesis, when I become polarized with clients during phone coaching, I try to remember to search for the wisdom or kernel of truth in the client's perspective and find a way to bring both of our perspectives together. A client, for example, once insisted that distress tolerance skills wouldn't fix her problems and are just superficial solutions at best. She said she spends most of her time trying to tolerate distress already. Meanwhile, I was urging her to use distraction and self-soothing (key distress tolerance skills) to get through a breakup without acting on urges to self-injure or making the situation worse by stalking the ex-girlfriend. She was refusing to use skills to "simply tolerate" her emotions, and I was insisting that she needs to tolerate for a period before we can do anything to improve the situation. We weren't getting anywhere. I had to step back, try to understand where she was coming from, and determine why she didn't want to use distress tolerance skills before we could move on. I asked her what was really making her not want to use these skills, and she told me she felt like she was out of gas, that she couldn't keep simply treading water and tolerating her feelings, and that she felt incredibly lonely and desperately wanted to reach out to her ex-girlfriend. Both of our positions were valid. She needed to ride out her self-injury urges and avoid making the situation worse by stalking her ex-girlfriend (my position) *and* was unlikely to find continued distraction successful and probably needed more support. Once we brought both of our positions together, we were able to come up with a plan that worked to get her through the evening. Working for synthesis, therefore, often involves bringing together the true or wise aspects of each person's position. A common way to do this in DBT is to use "both . . . and . . ." statements. Some examples are listed below:

- "It is *both* true that it is ridiculous for me to ask you to take suicide off the table when having an exit door makes life more tolerable *and* that if you stay camped out at the exit door, you won't be able to benefit from therapy and build a life worth living."
- "It's *both* true that you need a lot more support and more phone calls this week, *and* that I can't have any more calls with you without becoming burned-out and ineffective."

- "It's *both* true that self-injuring might take away your pain more quickly and easily than the skills I have to offer, *and* that the skills still work and won't make things worse."
- "It's *both* true that we need to solve the problems making you miserable, *and* that those problems are too big and complicated to solve on the phone right now."

Throughout this book, I try to demonstrate a dialectical approach to phone coaching. Aside from dialectical theory, other theoretical perspectives and principles also are applicable to phone coaching, including theory and principles for skills training, emotions and ER, and others. These are discussed in subsequent chapters in this book.

Basic Rules and Procedures

It often has been said that there are only two fixed rules in standard DBT (Linehan, 1993a). The first rule is that clients who miss four consecutive sessions are out of therapy. Relatedly, clients are not out of therapy *until* they have missed four consecutive sessions. This is often referred to as the *four-miss rule* (Linehan, 1993a). This rule only pertains to phone coaching insofar as clients who are out of therapy are also out of phone coaching.

The second rule pertains specifically to phone coaching. This is called the *24-hour rule*: Clients are not to have between-session communication with their clinicians for a 24-hour period following an instance of self-injury or a suicide attempt. The rationale for this rule is that the availability of the clinician in the time closely following an act of self-injury or a suicide attempt might inadvertently reinforce these behaviors. Contemporary models of self-injury and suicidal behavior underscore the importance of avoiding such reinforcement. For example, Nock's four-function model of self-injury posits that positive or negative social reinforcement sometimes maintains self-injury (Nock & Prinstein, 2004). In a recent daily-diary study, 60 recurrent self-injurers monitored their emotions, thoughts, social support, urges and thoughts about self-injury, and acts of self-injury over a 14-day period. Among those self-injurers who reported that someone else was aware of their self-injury, social support following self-injury predicted engagement in self-injury the following day (Turner, Cobb, Gratz, & Chapman, 2016). Clinicians providing support

soon after self-injury might believe they're helping, but this kind of support might predict increased risk of self-injury.

In the therapeutic context, positive social reinforcement can include attention, warmth, validation, time spent interacting with the client, and other actions on the part of the clinician that occur contingent upon the client's engagement in self-injury. Negative social reinforcement might involve the withdrawal of demands or requests, the avoidance of distressing problem discussions, among other consequences contingent on the occurrence or report of self-injury. Social reinforcement, however, is probably not relevant to all clients who engage in self-injury or suicide attempts. For some clients, contact with the clinician immediately following self-injury might be aversive. One of my previous clients, for example, vehemently complained about the 24-hour rule for several months following the beginning of therapy. This client had a difficult time calling me and found the process of phone coaching to be incredibly embarrassing and anxiety-provoking. She also felt ashamed to ask for help. For her, talking to me immediately following self-injury might have been more likely to be punishment than reinforcement. My client almost convinced me to abandon or change the 24-hour rule, but when I finally said I was open to changing things, she said she would be more comfortable with me sticking to the treatment as it's supposed to be done! I'm glad I stuck to the 24-hour rule, as I think it's critical to eliminate the possibility, however remote, that I might exacerbate a client's self-injury. Notwithstanding, as DBT is a principal-driven rather than a rule-driven treatment, there may be times when the clinician chooses to abandon the 24-hour rule. Given the high-stakes and potential danger of reinforcing suicidal or self-injurious behavior, the clinician considering this should have a strong rationale for her or his decisions, based on a solid case formulation and ideally some evidence of the factors reinforcing or punishing the client's behavior.

It is important to note that some have argued that the 24-hour rule is not appropriate for most adolescents (Miller, Rathus, & Linehan, 2007). Adolescents may be less able to manage the aftermath of suicidal or self-injurious behavior, accurately estimate their need for medical attention, or access emergency services (Steinberg, Steinberg, & Miller, 2011). Clinicians should consider whether to apply this rule or some adapted form of it with older adolescents who are more capable of managing their risk (Steinberg et al., 2011). The key principle underlying the 24-hour rule is that it is critical to avoid reinforcing self-injury and suicidal behavior;

clinicians always should incorporate this principle (if not the rule per se) into their approach to phone coaching. If a clinician is available shortly after an episode of self-injury or suicidal behavior, he or she should ensure that the client does not receive any potentially reinforcing consequences that she does not receive when she has not recently self-injured or attempted suicide. The clinician might, for example, avoid being more warm or responsive than usual, dial-down reassuring or validating statements, get down to business quickly and spend less time than usual on the phone with the client, and so forth. The basic idea is that the clinician can take steps to avoid differentially reinforcing self-injurious or suicidal behavior even if he or she needs to talk to the client shortly after the behavior has occurred.

How the Book Is Organized

The first few chapters of this book discuss considerations to address when the clinician is either considering or starting to implement phone coaching. Effective phone coaching often requires preparation, including decisions regarding the use of phone coaching across the board, or only with specific clients; logistical issues and how phone coaching will fit within the clinician's practice setting; and limits to place on phone coaching. Clinicians using phone coaching also should consider whether they have a supportive network of peers or supervisors with whom to consult. These and other considerations are discussed in Chapter 2, which focuses on ways to set the stage for effective phone coaching.

I have often found that challenges with students, supervisees, and clients regularly stem from inadequate orientation. When the client is well oriented to the purpose, structure, and expectations of phone coaching, this mode of treatment often precedes smoothly and effectively. The focus of Chapter 3 is on the orientation of the client to the purposes and practicalities of phone coaching.

Phone coaching is also most effective when it is structured appropriately. Given the brief nature of phone coaching, structure in this mode of treatment is perhaps even more important than it is in longer, standard therapy sessions. Structure can facilitate efficient work and often helps distressed clients to feel regulated and organized. Chapter 4, therefore, focuses on effective ways to structure and navigate the beginning, middle, and ending portions of phone coaching calls.

As the primary focus of phone coaching is on coaching the client in effective skill use, clinicians also must be familiar with key principles and practices of skills coaching. Chapter 5 focuses on principles of skills acquisition, strengthening, and generalization, as well as key strategies for effective skills coaching. These strategies are not unique to phone coaching and can be helpful during individual therapy, skills training, case management, and coaching in milieu settings.

Often, DBT phone coaching, partly because it is so brief, focuses primarily on helping clients use skills to effectively tolerate or regulate overwhelming emotions. There is not enough time for lengthy discussions of problem areas or long-standing problems. The focus is usually on emotions in the present moment and near future. As such, the clinician needs to know about key principles of ER. It is also useful to have some knowledge of ER and distress tolerance skills that are commonly used during phone coaching in DBT. In Chapter 6, I describe a practical ER framework to guide the clinicians' conceptualization and selection of skills. Subsequently, I provide some guidance on how to coach clients in some core DBT distress-tolerance and ER skills.

Although I recommend that clinicians deemphasize crises or emergencies as reasons to call, suicide crisis calls will occur from time to time. Indeed, this may be why some clinicians are reluctant to embark upon phone coaching: The worry is that they will not be able to adequately assess and manage risk and make critical decisions on the fly. Awareness of empirically based practical principles guiding suicide risk assessment and management can help guide effective decision making regarding suicide risk. As such, Chapter 7 focuses on principles and strategies for suicide crisis calls. Comprehensive books and resources on suicide risk assessment and management exist (Bongar, Shekykhani, Kugel, & Giannini, 2015; Maldonado & Garcia, 2016; Simon, 2012; Stolberg & Bongar, 2009). For the purposes of this book, in Chapter 7 I discuss key DBT principles and procedures guiding these calls.

If a clinician follows all of the guidelines in Chapters 2 through 7, phone coaching will likely proceed smoothly and effectively, with few bumps in the road. Inevitably, however, phone coaching involves challenges. Most clinicians will have a client who calls too often; becomes angry, critical, or defensive on the phone; refuses to use or talk about skills; repeatedly calls in suicidal crises; repeatedly e-mails or texts despite the clinician's limits on these behaviors; and so on. At the same time, clinicians also may interfere with phone coaching by inadequately orienting

the client to their limits, failing to observe limits consistently, staying on the phone too long, inadequately addressing suicide risk, expressing judgmental thoughts, trying to do therapy on the phone, among many other possibilities. Chapter 8, therefore, addresses these and other common challenges in phone coaching. The beginning of the chapter focuses on general principles in the management of therapy-interfering behavior, and the remainder addresses specific strategies and approaches to particular problem areas, with an emphasis on observing therapeutic limits.

Skills coaching in DBT is much like coaching or teaching skills in soccer, music, or math. Usually, the student or trainee receives more help and guidance in the early phases and then develops increased independence and the capacity to learn on his or her own over time. In addition to generalizing skills to daily life, clients will learn to be their own coaches, providing themselves with guidance, encouragement, and instruction, as well as seeking additional external support when needed. In the final chapter (Chapter 9), the focus is primarily on ways to help the client generalize skills to life outside of the therapy session and to the period following the end of treatment. In addition, Chapter 9 includes strategies to help the client learn how to coach her- or himself in the effective use of skills.

Before we move on to Chapter 2, there is one more important point to remember: Certain chapters in this book are purposely thorough and comprehensive. You may read through Chapter 4 on structuring phone coaching and think that there is no way you can do all of these things within a brief call. You would probably be correct. Think of some of the chapters in this book as very thorough prototypes or blueprints of DBT phone coaching. How you put everything together will vary according to your own skills, background, and situation, and how you plan to use phone coaching in your setting with your clients. You can always go back, however, to the blueprint whenever you are wondering how things have gone awry or what to do differently.

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