ONE

Tools for Tough Circumstances

If you've picked up this book, it's likely that the grim statistics on treatment failure come as no surprise to you. As therapists, we can all recall cases in which, despite our best efforts, our usual ways of working failed our clients. When clients come to us prone to emotion dysregulation, with multiple, serious, chronic problems, and with a history of failed therapy relationships, we know the odds are against us.

"It doesn't matter what I do, nothing changes."

Marie is in her mid-20s. She comes to her third session of individual therapy agitated and tells her therapist that she has "completely lost it" at work. She's going to be fired, and that means she will be evicted when she can't pay the rent. When the therapist asks what happened, Marie angrily jerks her body, kicking the coffee table in the process. It's not clear if she meant to kick the table or if it was an accident, but she flushes red from head to toe, becomes mute, and curls up in the chair. She begins to bang her head against the armrest. This derails any help the therapist might have offered regarding the crisis at work, and the way she acts in therapy creates a new situation about which Marie will feel shame. As the therapist gets Marie to stop banging her head, Marie says quietly, "I just need to end this." Given Marie's history of near-lethal suicide attempts, the therapist now must manage to assess imminent suicide risk with a mostly mute, overwhelmed, and soon-to-be-homeless client.

If you met Mark at a party, you'd assume he worked in a funky, successful high-tech firm. You'd never guess he barely scrapes by on temp work as a software programmer. His life has become more and more restricted

by anxiety and brief manic episodes that are followed by crashes into self-loathing. For months, he stays trashed with marijuana, alcohol, and anti-anxiety medication. He sleeps 18 hours a day, leaving his house only to get food. After 15 years of working with many therapists, he's not sure whether to blame them or himself that his life remains miserable.

For clients like Marie and Mark, exquisite vulnerability to emotions and intense emotional pain defeat a quality life. Unrelenting misery makes thoughts of suicide or nonsuicidal self-injury among the few things that offer relief. Repeated treatment failures make therapy itself evoke intense hopelessness.

Treatment decisions we make in such circumstances are extremely complicated. When we focus on how the client needs to change, the client panics because such efforts have often failed in the past. It also triggers either anger or shame at the implication that change is possible: you, the therapist, don't have a clue about how impossible change actually is, or else you believe, as others have, that the problem is the client's poor motivation or personality flaws. When, in response, we drop a change orientation and instead focus on accepting vulnerability and limitations, this too sets off panic in the client, especially despair that things will never change. Out of desperation, your client may reject the help that you offer and demand help that you cannot give. Suicide attempts, threats of suicide, and the anger directed at us are stressful. Our own emotions, confusion, or skills deficits complicate matters further, leading us to expect change beyond the client's capability and to fail to offer sufficient warmth, flexibility, or resourcefulness when needed. The non-stop effort of striking the right balance—accepting the client's true vulnerability while also insisting on change—wears us down. It might as easily have been us, as therapists, saying, "I can't take this. It doesn't matter what I do—nothing changes."

Dialectical behavior therapy, or DBT (Linehan, 1993a), evolved to help therapists and clients in exactly these circumstances, and a growing number of randomized clinical trials support its efficacy (see review by Lynch, Trost, Salsman, & Linehan, 2006). When clients have complicated, severe, chronic problems and multiple treatment providers, when misery makes suicide seem the client's only option, DBT helps therapists find order amid chaos. As a comprehensive outpatient treatment package, DBT structures the treatment environment into weekly individual therapy, weekly group skills training, telephone coaching, and a peer consultation team of DBT therapists. Within that environment, DBT consists of a hierarchy of treatment priorities and core strategies for addressing those priorities. These features offer systematic guidelines for clinical decision making that help therapists treat life-threatening and therapy-interfering behaviors as well

as their own emotional reactions. This book presents how DBT is conducted from the perspective of the individual therapist, illustrating why, when, and how to use DBT's tools to achieve therapeutic progress.

In the same way that protocols and procedures in an emergency room allow coordinated action, comprehensive DBT is essential for clients with suicidal crises like Marie. In cases like Mark's, you may not need the full model yet DBT's basic theories, hierarchy of priorities, and treatment strategies remain relevant. For this reason, I have organized this book to help clinicians in both sets of circumstances. You can adopt only those elements of DBT most likely to be helpful to you and your clients while also coming to understand the full therapeutic framework of DBT as a package so that you can structure the treatment environment and your clinical decision making when needed.

This book recognizes that the science on which DBT draws is constantly evolving: new data from research on the development and evaluation of DBT as well as the psychopathology and disorders it is used to treat must be continually integrated in order to offer our patients the best possible clinical care. Linehan (1993a) developed DBT first as a treatment for chronic suicidal behavior, and then subsequently for borderline personality disorder (BPD). However, the very diagnosis of BPD has undergone extensive revision and will likely continue to do so. As new data emerge, we can expect the components of DBT to change as well as the kinds of clients for whom it is indicated. To date, for example, published randomized controlled trials conducted by different research teams support the efficacy of DBT across a wide variety of behavioral problems, including suicide attempts and self-injurious behaviors (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Comtois, Murray, et al., 2006; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Verheul et al., 2003), substance abuse (Linehan et al., 1999, 2002), bulimia (Safer, Telch, & Agras, 2001), binge eating (Telch, Agras, & Linehan, 2001), and depression in the elderly (Lynch, Morse, Mendelson, & Robins, 2003; Lynch et al., 2007). This makes it important to realize that DBT is not only indicated for chronically suicidal behavior and BPD. DBT's set of principles and protocols can be applied more broadly to arrange cognitive-behavioral and other theoretically compatible strategies to treat disorders characterized by pervasive emotion dysregulation. An important aim of this book, therefore, is to make it easy for you to flexibly use DBT's comprehensive package or its components to keep up to date with the latest research findings.

A first step in helping you use DBT flexibly is understanding the core problem of clients like Marie and Mark: pervasive emotion dysregulation. Linehan's biosocial theory, described next in this chapter, explains

how this core problem can lead to such diverse and difficult secondary problems. DBT's treatment components follow from an understanding of pervasive emotion dysregulation and its impact. These components are described in the second half of this chapter. Key among them is the way that client problems are ranked according to the threat they pose to a reasonable quality of life. This hierarchy of treatment goals and targets guides case formulation (covered in detail Chapter 2) and in-session clinical decision making. The therapist uses it to give the most important tasks priority over the less important. Three sets of core treatment strategies are then used to move the client toward therapeutic goals. The core strategy sets—behavioral change strategies, validation strategies, and dialectical strategies—are first introduced in this chapter and then described in detail in Chapters 3, 4, and 5, respectively. Chapter 6 brings the three sets of strategies together, illustrating how they are used in the context of the case formulation and hierarchy of treatment targets. Finally, Chapter 7 emphasizes the crucial importance and workings of the DBT peer consultation team—a requirement of comprehensive DBT. The consultation team is a community of therapists treating a community of patients while also applying DBT to themselves. The team strengthens therapists' skills and provides emotional support needed to meet the challenges that arise when clients face tremendous suffering and emotional pain. Understanding DBT starts with understanding this core problem—pervasive emotion dysregulation.

THE CORE PROBLEM OF PERVASIVE EMOTION DYSREGULATION

Linehan explained the etiology and maintenance of BPD with a biosocial theory of emotion dysregulation. DBT has since been adapted for use across disorders and patient populations (e.g., substance abuse, bulimia, and antisocial and other personality disorders), but the biosocial theory has remained central (see Crowell, Beauchaine, & Linehan, 2009, for a recent review). It proposes that pervasive emotion dysregulation arises from the combination of vulnerable biology and invalidating social environments. Emotion dysregulation is the inability, despite one's best efforts, to change or regulate emotional cues, experiences, actions, verbal responses, and/or nonverbal expressions under normative conditions. Pervasive emotion dysregulation is when this inability to regulate emotions occurs across a wide range of emotions, problems, and situational contexts. (Linehan, Bohus, & Lynch, 2007). Such difficulties with dysregulation lead to maladaptive behaviors (e.g., suicidal behavior, purging, abusing substances),

because these behaviors function to regulate emotions or are a consequence of failed emotion regulation.

Biosocial Theory: The Impact of Vulnerable Biology and Invalidating Social Environment

Vulnerable Biology and Its Consequences

Linehan hypothesized that three biologically based characteristics contribute to an individual's vulnerability. First, people prone to emotion dysregulation react immediately and at low thresholds (high sensitivity). Second, they experience and express emotion intensely (high reactivity), and this high arousal dysregulates cognitive processes too. Third, they experience a long-lasting arousal (slow return to baseline). In fact, the data do suggest that those who meet the criteria for BPD experience more frequent, more intense, and longer-lasting aversive states (Stiglmayr et al., 2005) and that biological vulnerability may contribute to difficulties regulating emotion (e.g., Juengling et al., 2003; Ebner-Priemer et al., 2005).

Consider the impact of such biological vulnerability. Difficulty regulating emotion means difficulty regulating most areas of one's life: most of what we do and who we are depends on mood stability and adequate emotion regulation. The same action may feel easy or hard depending on our mood. Take the common experience of schmoozing with strangers at a cocktail party. In a great mood, you breeze right up to chat with the most interesting person in the room; in a vulnerable, insecure mood, you cling to the wall, barely making eye contact. You put off a dreaded task for months. Later, in the right mood—voilà—you tackle it in an afternoon. Those of us who can regulate emotion without much effort take this ability for granted. We occasionally have bouts of mood-dependent behavior, but for the most part we muddle through.

Imagine, however, that due to biological vulnerability your emotions instead vary wildly. You can't predict what mood you'll be in. If your behavior varies wildly at social gatherings based on your mood, are you a shy person or an outgoing person? If you can manage responsibilities when you're "together enough" emotionally, does that make you irresponsible and lazy when you can't manage? Are you cut out for school or a certain type of work? How can you tell when your ability to perform seems largely beyond your control and dependent on your emotional state? The impact of this unpredictable variability affects all areas of life. Like living in a nightmare, your efforts have no effect or go terribly wrong. This biological vulnerability is exacerbated, and in some cases even created, by transactions between the emotionally vulnerable person and a social environment that is pervasively invalidating.

Invalidating Social Environment and Its Consequences

Think first about emotional development in an optimally validating environment. Emotion evolves as a rapid, whole-body response: our physiology, perception, actions, and cognitive processes coherently fire together, orienting and organizing adaptation to continual changes in the environment and in our bodies. We hear an unexpected noise, and immediately emotion fires, orienting us so we're prepared. In healthy emotional development, caregivers respond to a child in ways that strengthen the links between environmental cues, primary emotions, and socially appropriate emotional expression while weakening the links for socially inappropriate expression. Our caregivers' responses validate what is effective, appropriate, and makes sense about our responses and invalidate that which is ineffective, inappropriate, and does not make sense. For example, based on these processes of acculturation, we learn to interpret certain noises as cues for interest or fear, and learn to modulate how we express what we feel. Others' validating responses teach us to use emotion to understand what is happening within and outside our skin as a moment-to-moment readout of our own state and our needs with respect to the environment. In an optimal environment, caregivers provide contingent, appropriate soothing for strong emotions. They strengthen and help the individual refine the naturally adaptive, organizing, and communicative functions of emotions.

None of us get the perfectly optimal environment, of course. Even the best parents are tired; they're stressed. They are themselves habitually anxious, angry, or depressed. From these compromised states, they punish or minimize valid expression of primary emotions. We consequently learn more or less dysfunctional ways of expressing and making sense of our emotions. Bigger problems arise, however, when caregivers *consistently* and *persistently* fail to respond as needed to primary emotion and its expression. Pervasive invalidation occurs when, more often than not, caregivers treat our valid primary responses as incorrect, inaccurate, inappropriate, pathological, or not to be taken seriously. Primary responses of interest are persistently squelched or mocked; normal needs for soothing are regularly neglected or shamed; honest motives consistently doubted and misinterpreted. The person therefore learns to avoid, interrupt, and control his or her own natural inclinations and primary emotional responses. Like a creature in a chamber with an electrified grid for the floor, he or she learns to avoid any step that results in pain and invalidation.

For example, say that in contrast to my well-regulated siblings, I express more need for affection or express emotions longer and more intensely than fits my caregiver's tolerance. This repeatedly provokes

impatience and scorn (invalidation). Eventually I attempt to inhibit my behavior, perhaps by learning to inhibit both overt behaviors that express my need for affection and maybe even my private experience of needing it. In pervasively invalidating environments, fear conditioning takes place—we not only avoid the electric grid of invalidation, but also avoid any experience of the private events (thoughts, sensations, or emotions) which might lead anywhere near the grid. We become extremely sensitized to all cues that might bring on the painful zap of invalidation. We become phobic of our own valid, natural responses. Histories of pervasive invalidation leave people not only hypersensitive to others' invalidation, but sensitive to any response of their own, valid or not, that might prompt others to invalidate them. Responding naturally is often as evocative as dropping a spider in the lap of someone with a spider phobia.

In Linehan's theory, different combinations of biological vulnerability and social invalidation can result in fairly similar experiences. People may also travel different developmental routes yet end up with the same difficulties. For those with a high biological vulnerability to emotion dysregulation, even a "normal" level of invalidation may be sufficient to create serious problems. Like those with attention deficits, they face enormous but often hard-to-perceive difficulties. For example, if one child with normal attentional processes and one with attention-deficit/hyperactivity disorder (ADHD) are playing a board game and getting too rowdy, a stern "Settle down in there!" from an adult in the kitchen is enough for the kid with normal attention capabilities to comply. But the kid with ADHD may need the adult to come in and provide step-by-step coaching: "No. It's not your turn. Give the dice to Joey. Sweetie, look at me. Set the dice down. Thanks. OK, now watch. It's Joey's turn. No, put your hands in your lap. That's it. Let's see, he got a five . . ." (and so forth). Over time and with practice, such coaching turns into self-regulation. The same active coaching approach is also needed to help those trying to manage pervasive emotion dysregulation. As with attention dysregulation, additional guidance and structure are required to develop self-regulation of emotion. Few parents know how to provide such help; most parents can be overwhelmed by the needs of a highly vulnerable child. Consequently, such emotionally vulnerable children seldom learn effective strategies to manage their overwhelming emotional experience. DBT targets these deficits and explicitly teaches the skills required to regulate emotion.

Other people begin life with very little biological vulnerability, but experience such extreme and persistent invalidation over time that they develop problems regulating emotion. Childhood sexual abuse is a prototypical invalidating environment related to BPD (Wagner & Linehan, 1997, 2006). However, not all individuals who meet BPD criteria report histories of sexual abuse, and not all victims of childhood sexual abuse develop

BPD. It remains unclear how to account for individual differences (e.g., see Rosenthal, Cheavens, Lejuez, & Lynch, 2005, for one line of research beginning to piece together the mediational factors between BPD symptoms and childhood sexual abuse). Linehan (1993a) has therefore argued that it is the experience of pervasive invalidation that is causal rather than any one specific type of trauma. Such histories leave people extremely sensitized to invalidation.

The difficulties I've described so far follow from the core problem of emotion dysregulation. When the environment poorly fits our needs, whether due to biological vulnerability or pervasive invalidation, we learn a range of problematic emotion regulation strategies. When our normative experience and expression of emotion elicits discomfort in others who then withdraw and criticize rather than help and support us, we learn that who we are and how we are evokes interpersonal rejection. We thereby learn to avoid our valid primary responses and instead develop patterns of blunting, masking, and/or distorting our experience and expression of emotions. Avoidance may be subtle: we protect ourselves when we sense a slight inattention in our friend as we speak by changing what we were going to say to a less risky self-disclosure; without awareness we rapidly escape a vulnerable first flash of sadness or shame by feeling irritated. Avoidance may be obvious, full-out escape: our emotional state is so aversive that we either involuntarily escape it by dissociating or find desperate methods such as intentional self-injury to end emotional pain. While such learning processes affect us all, those prone to emotion dysregulation experience more pervasive social invalidation and come to alternate between strategies that overregulate and underregulate emotion and its expression. These problematic behavioral patterns wreak havoc in clients' lives and in therapy and are discussed next.

Dialectical Dilemmas: Secondary Behavioral Patterns

Managing emotion vulnerability and ongoing invalidation often strands the client in a dilemma between overregulating and underregulating emotional experience and expression. Linehan called these patterns "dialectical dilemmas" because an essential idea of "dialectics" is that any one position contains its own antithesis or opposite position. The client's inevitable failures to regulate emotion lead to increased invalidation ("Why are you so sensitive?," "You're crazy!," or "Get over it!"), which in turn leads to redoubled efforts to self-regulate in order to avoid further invalidation. At the other extreme, clients may escalate expression as they try to communicate why their responses *are* valid ("I'm not crazy! You don't understand!"). Over time, common behavioral patterns develop as clients attempt to resolve the dilemmas inherent in pervasive emotion

dysregulation. Through clinical observation, Linehan characterized three patterns in which clients flipped from underregulated states in which the client is overwhelmed by emotional experience to overregulated states with rapid avoidance of emotional experience.

Emotion Vulnerability and Self-Invalidation

Biological vulnerability and a history of pervasive invalidation create exquisite sensitivity. The slightest cue can set off emotional pain, the equivalent of touching third-degree burns. Because the individual cannot control the onset and offset of events that trigger emotional responses, the person can become desperate for anything that will make the pain end. For many, it's as if their physical body cannot withstand the forces raging through it. Even dysregulation of positive emotions creates pain. For example, a client reported, "I got so excited when I saw my friends, I couldn't stand it. I laughed too loud, talked too much—everything I did was too big for them." "Emotion vulnerability" refers not only to the exquisite sensitivity but further to the consequences of living as a person who is exquisitely sensitive. Unavoidable day-to-day experiences trigger intense emotional pain to the point where having emotions can become traumatic: people in this situation cannot tell when they will be undone by emotions. Performance becomes totally unpredictable because it is tied to emotional states the person is unable to control. This unpredictability foils personal and interpersonal expectations leading the client and others to feel frustrated and disillusioned. The person despairs because she experiences her emotional sensitivity as biological, as part of her temperament, and therefore as something that will never change. The client finds herself trapped in a nightmare of dyscontrol. Life is a continual fight to endure a typical day's events. Suicide may seem the only way to prevent future excruciating suffering. Suicide can also be a final communication to unsympathetic others.

For exquisitely sensitive people, nearly any therapeutic movement evokes emotional pain, much as debridement does in the treatment of serious burns. Sensitivity to criticism makes it painful to receive needed feedback. As we saw in the case of Marie at the beginning of this chapter, in-session emotion dysregulation (dissociation, panic, intense anger) interrupts therapeutic tasks. The generalization of changes and plans made in session goes awry due to emotion dysregulation in daily life. Therapy itself may be traumatic because the client cannot regulate the emotion evoked in therapy. Clients often feel humiliated by their helplessness in the face of overwhelming emotion. Understanding emotion vulnerability means the therapist must understand and reckon with the intense pain involved in living without "emotional skin."

People learn to respond to their ongoing vulnerability to emotion dysregulation by invalidating themselves, just as others have done. Self-invalidation takes at least two forms. In the first, the person judges dysregulation harshly ("I shouldn't be this way"). Here, the person attempts to control and avoid natural primary responses. When this fails, the person turns against the self with self-blame and self-hatred. Intentional self-injury may be used to punish oneself for failure. In the second, the person may deny and ignore the vulnerability to dysregulation ("I am *not* this way"), block emotional experience, and hold unrealistically high or perfectionistic expectations. In doing so, the person minimizes the difficulty of solving life problems and fails to recognize more help is needed. This pattern often defeats attempts to change as the person won't tolerate the trial-and-error learning needed to acquire self-management strategies.

Active Passivity and Apparent Competence

Over time, people learn to respond passively when they are left with problems that are beyond their capability while the difficulties of solving them are minimized. At times, remaining passive activates others. Seeing a vulnerable-looking woman staring helplessly at a flat tire on the side of the road in a bad neighborhood might prompt someone to stop to help. If help doesn't arrive, she might express more distress—frantically checking her watch and beginning to cry. Active passivity is the tendency to respond to problems passively in the face of insufficient help while communicating distress in ways that activate others.

For example, Mark, who we met at the start of this chapter, barely scrapes by as a software programmer because his perfectionism, procrastination, and moodiness have led to many missed deadlines—so many that his latest employer did not renew his contract. Devastated and ashamed, he hides out, refusing to answer calls and putting his mail into a drawer unopened. When his landlord's patience ends, he asks Mark to move out. Instead of searching for a new place to live, Mark spends the day in bed and is silent during therapy despite all efforts by the therapist to encourage active problem solving. Mark experiences himself as unable to do what is necessary and he actually is unable to act without more help. If he had just broken a leg, help might be forthcoming. However, without observable deficits, others view him as lazy. When he asks others for help he is ineffective—others experience him as demanding and whiney. Mark's experience, however, is that the situation is hopeless no matter what he does. From the therapist's perspective, the situation worsens into a crisis that could easily be solved if Mark would cope actively (e.g., check Craigslist to find another place). When this pattern of active passivity is habitual, it increases life stress as problems go unsolved; it

alienates helpers; and it makes suicide one of the few means of communicating that more help is needed.

Apparent competence is deadly. At one moment the client appears able to cope and then (unexpectedly to the observer) at other times it's as if the competency did not exist. Clients have learned to "appear competent" that is, to hide emotion and vulnerability so that observers see very little expressed emotion. Often clients may verbalize negative emotions but nonverbally convey little, if any, distress. Yet their internal experience is that they have just screamed their distress—they have become so sensitized to their own expression that simply saying anything at all feels naked and raw. When verbal and nonverbal expressions of emotion are incongruous, we all default to believing that the nonverbal is the more accurate expression. Therapists (and others in the client's life) are likely in these instances to misread. If a client says to you, "That really bothered me" in a matter-of-fact voice, it is easy to think that he or she is basically OK and miss the actual experience of extreme but unexpressed distress. A second misreading can come from the typical assumption that behaviors generalize (i.e., if I am friendly and outgoing at one party, I will be friendly and outgoing at the next party). However, as described above, mood influences how difficult or easy it is to perform many behaviors. When the core problem is emotion dysregulation, clients have little control of their emotional state and therefore little control over their behavioral capabilities. This will produce variable and conditional competence across settings and over time. Yet observers (and the client herself) will expect continuity and be repeatedly surprised when a competency fails to generalize as it might with more emotionally regulated people. Because others misread, they inadvertently create an invalidating environment, failing to help because they cannot see the distress. In the worst cases, others interpret the absence of expected competence as manipulation and become less willing to help.

Unrelenting Crisis and Inhibited Grieving

Unrelenting crisis refers to a self-perpetuating pattern in which a person both creates and is controlled by incessant aversive events. An emotionally vulnerable person may impulsively act to decrease distress; this can inadvertently increase problems that quickly snowball into worse problems. For example, Marie "lost it" at work, and is going to be fired which in turn can lead to eviction from her apartment. Another client yells in anger at a case worker and impulsively ends an interview. This means that the needed housing application is not completed. When another appointment cannot be scheduled, the client ends up in a homeless shelter. Residing in a homeless shelter then exposes the client to a host of cues that remind her of a past rape, setting off daily flashbacks and panic attacks. Such

unrelenting crises can dominate therapy to such an extent that it is difficult to make progress.

Inhibited grieving is an involuntary, automatic avoidance of painful emotional experiences, an inhibition of the natural unfolding of emotional responding. The tragedies that some of our clients have endured have been shattering. They may inhibit grief associated with childhood trauma or revictimization as an adult, or grief evoked by current losses that are the consequence of maladaptive coping or inordinately bad luck. To stop the emotional pain, they avoid and escape which inadvertently increases sensitization to emotion cues and reactions. Some clients constantly experience loss, start the mourning process, automatically inhibit the process by avoiding or distracting from relevant cues, reenter the process, and cycle through contact with the cue and escape, over and again. The individual never fully experiences, integrates, or resolves reactions to painful events.

The three behavioral patterns described above are the developmental fallout from the toxic combination of biological vulnerability and social invalidation. While all of us develop habitual, somewhat problematic reactions to our own emotional pain, these three patterns wreak havoc. Daily life and therapy in particular offer a gauntlet of evocative cues: the client's own behaviors or others' behaviors may prompt dysregulation. These secondary responses to dysregulation, in which the client oscillates from under- to overregulating emotion, create further serious problems. Consequently, the behavioral patterns themselves become treatment targets in DBT.

In summary, then, the first key component of DBT is the biosocial theory of disorder. It proposes that (1) problematic or disordered behavior, particularly extremely dysfunctional behaviors, may be a consequence of emotion dysregulation or an effort to re-regulate emotion; (2) invalidation plays a role in maintenance of current difficulties regulating emotion; and (3) common patterns subsequently develop as a person struggles to regulate emotion and deal with invalidation; these patterns become problems that themselves must be treated. DBT's overarching treatment rationale therefore is to teach and support emotion regulation and to reinstate the natural organizing and communicative functions of emotion.

HOW DBT TREATS PERVASIVE EMOTION DYSREGULATION

DBT treats pervasive emotion dysregulation and the subsequent common patterns that develop as the individual copes with pervasive

emotion dysregulation with the following: a combination of core treatment strategies—change, acceptance, and dialectical strategies—summarized in Table 1.1 and a framework of guidelines that structures the treatment environment and prioritizes treatment goals and targets according to the extent of the client's disorder.

Core Treatment Strategies

Change Strategies

DBT's first set of core strategies focus on change, weaving together behavioral principles and protocols from cognitive-behavioral and other theoretically compatible strategies to treat pervasive emotion dysregulation. Behavioral chain analysis—a form of functional analysis—is used to identify the variables that control specific instances of targeted problems such as self-injury. DBT case formulation is based on the functional patterns that emerge from these chain analyses. Treatment plans address what needs to go differently in the behavioral chain so that the client does not engage in the problem behavior. Some clients, like Mark introduced earlier in this chapter, lack basic capabilities needed to regulate emotion and, therefore, part of DBT's solution is to teach skills to remedy these deficits. Skills training is discussed later in this chapter.

But learning new skills is not always enough. For example, the capabilities Mark does have are often disrupted by conditioned emotional responses, problematic contingencies and dysfunctional cognitive processes. Therefore, DBT's change strategies include not only skills training but also three other groups of cognitive-behavioral procedures: exposure therapy, contingency management, and cognitive modification. However, because pervasive dysregulation leads to mood-dependent behavior and crises, the DBT therapist must often modify these standard cognitive-behavioral therapy (CBT) interventions to be successful. These modifications are described fully in Chapter 3. Change strategies also include techniques for increasing client motivation and commitment to change. These commitment strategies include pros and cons, devil's advocate, shaping, and others listed in Table 1.1. Behavioral expertise is required in DBT. A lack of behavioral expertise is a genuine barrier to the therapist who wishes to work from a DBT framework.

Validation Strategies

DBT's second core set of strategies, validation, emphasizes acceptance. For example, Mark's history has left him exquisitely sensitive to invalidation. This sensitivity led to him losing his job: his boss's requests for change

TABLE 1.1. DBT Core Strategies at a Glance

Behavioral change strategies (change-oriented)

- Behavioral chain analysis
- Task analyses
- Solution analyses
- Skills training (see Table 1.2)
- Self-monitoring: the DBT diary card
- Exposure
- Contingency management
- Cognitive modification
- Didactic strategies (psychoeducation)
- Orienting
- Commitment strategies
  - Pros and cons
  - Foot-in-the-door
  - Door-in-the-face
  - Freedom to choose; absence of alternatives
  - Linking prior commitments to current commitments
  - Devil's advocate
  - Shaping

Validation strategies (acceptance-oriented)

- Empathy + communicating client's perspective is valid in some way
  - Level 1: Listen with complete awareness; be awake
  - Level 2: Accurately reflect the client's communication
  - Level 3: Articulate unverbalized emotions, thoughts, or behavior patterns
  - Level 4: Communicate how behavior makes sense in terms of past circumstances
  - Level 5: Communicate how behavior makes sense in current circumstances
  - Level 6: Be radically genuine

Dialectical strategies

- Dialectical assumptions and dialectical stance
- Dialectical balancing
  - Change and validation strategies
  - Stylistic strategies: Reciprocal and irreverent
  - Case management strategies: Consultation to the client and environmental intervention
- Specific dialectical strategies
  - Dialectical assessment
  - Entering the paradox
  - Metaphor
  - Devil's advocate
  - Extending
  - Activating wise mind
  - Making lemonade
  - Allowing natural change

overwhelmed him and his prior therapist's attempts to help him change appropriately in response to the poor performance evaluations felt excruciating to him. Much of Mark's responding was ineffective and needed to change, but for clients like Mark, change interventions feel intolerable. Validation strategies therefore become crucial. Validation comes from the client-centered tradition (Linehan 1997b; see also the excellent book *Empathy Reconsidered*, by Bohart & Greenberg, 1997). DBT defines validation as empathy plus the communication that the client's perspective is valid in some way. With empathy, you accurately understand the world from the client's perspective; with validation you also actively communicate that the client's perspective makes sense.

It might be tempting to lump validation with "facilitative conditions" or "common factors," or to relegate it to "the sugar that helps the medicine go down," as if to coax the client to engage in the "real thing," of change-oriented strategies. However, validation, *in itself*, can produce powerful change when it is active, disciplined, and precise. Used genuinely and with skill, it reduces physiological arousal that is a normal effect of invalidation and it can cue more adaptive emotions to fire. Skill in the use of validation strategies centers on what (and what not) to validate as well as how to validate. Linehan (1997b) listed six levels of validation as shown in Table 1.1 and she advised therapists to validate at the highest possible level. Validation strategies are covered in depth in Chapter 4.

Dialectical Strategies

The tension between the need to accept clients' true vulnerabilities and yet encourage them to make necessary change is a constant dilemma for the therapist and often the root of therapeutic impasse. To navigate, therapists take a dialectical stance and use dialectical strategies. Dialectics is both a view about the nature of reality and a method of persuasion. In both, an essential idea is that any one position contains its antithesis or opposite position. Progress comes from the resolution of the two opposing positions into a synthesis. In other words, the way forward is to simultaneously accept the client *and* push for change. Polarization is natural and expected. Therapeutic movement happens by keeping both ends of a polarity in play. In DBT, therapeutic impasse signals the need to explore both poles of the dialectical tension.

Dialectical strategies provide the practical means for both the therapist and the client to retain flexibility amid conflicting and even contradictory "truths." For example, in Mark's past therapies, when the therapist pushed too hard for change, Mark would no show for the next session. When the therapist dropped a change focus, accepting Mark's vulnerabilities, he

became despairing and highly critical of the therapist's ineffectiveness—then also failed to show for appointments. This tension between acceptance of vulnerability and need for change is even more pronounced with clients like Marie. Marie and her therapist made it through the tough session that started this chapter. By the session's end, they'd generated a crisis plan to help Marie avert a suicide attempt. Although Marie left the office in better shape, the therapist feared more crisis behavior on the part of his client. Later that afternoon, Marie saw her pharmacotherapist. Not wanting to be dishonest, Marie described to him how intensely she wished she were dead; she explained that she liked her new therapist but was not sure she could follow through on the crisis plan they created; she's terrified about her ability to control her suicidal behavior. The pharmacotherapist decided that Marie needed to be hospitalized. He sent her directly to the nearest emergency room for evaluation. The next morning, instead of the expected check-in call from Marie, the individual therapist arrived to a message from the charge nurse at the local state hospital: between leaving her pharmacotherapist's office and reaching the emergency room, Marie took an overdose and then was involuntarily committed for 72 hours' observation.

Taking a dialectical perspective means one understands that suicidal clients like Marie often *simultaneously* want to live and want to die. Saying aloud to her therapist, "I want to die" rather than killing herself in secrecy contains within it the opposite position of "I want to live." This doesn't mean wanting to live is "more true" than wanting to die: she genuinely does not want to live her life. Nor does the low lethality of her suicide attempt mean that she really did not want to die. It's not even that she alternates between the two—she simultaneously holds both opposing positions. The client sees suicide as the only option out of an unbearable life. Rather than become polarized, in a dialectical approach the therapist agrees that the client's life is unbearable and that the client needs a way out, and offers another route, using therapy to build a life that is genuinely worth living. As will be described in more detail in Chapter 5, adopting a dialectical stance means embracing a worldview in which you can hold the position of completely accepting the client and moment as they are while simultaneously moving urgently for change. This third and final set of core strategies involves the ability to resist oversimplification and move beyond trade-offs to find genuinely workable blends of problem solving and validation, reason and emotion, and acceptance and change.

Clients who have experienced repeated suicidal crises and psychiatric hospitalizations often face a complicated web of interconnected problems. In these complicated, high-risk circumstances, more is needed than the biosocial theory and core strategies described so far. For example, one client's hospitalizations were prompted by invalidating interactions with

minimally trained, overworked staff in her residential placement. The only way the client was able to get staff attention and help was through expressing extreme emotion and out-of-control behavior. In her case, providing crisis management as a stopgap to reduce acute problems could end up dominating therapy to such an extent that efficient, effective treatment becomes unlikely. Perhaps training the staff to better respond might be a better long-term solution. However, because staff turnover was sky high, whoever was trained would likely be gone within the month. Instead, it may be more efficient to train the client until her skills are so robust that she could regulate emotion even in the face of staff invalidation. But that would take time and, in truth, it would be an incredible challenge for anyone to regulate emotion in such a chaotic living situation. It's clear that without significant changes, leaving her in the residential setting will be a recipe for continued crises and psychiatric hospitalizations, yet making the needed changes within the setting appears daunting if not improbable.

Perhaps a better option would be to encourage her to move out of the residential setting. Yet without the structured activity of a residential placement, she will go downhill into inactivity and rumination. Her parents will panic at the thought that they will have to pick up the pieces if she is not living in a structured environment and it's not clear they would financially support such a move (or the therapist who proposes it!). For successful social activity outside a structured environment, she'd need friendships, which would require better social skills than she has. This in turn would actually require that she could tolerate your corrective feedback of her social skills and get through a group skills training session without becoming so dysregulated that she storms out of the room when invalidated.

Where to begin? Horst Rittel's term "wicked problems" (Rittel & Webber, 1973) captures the way that complex interdependencies among problems make it difficult even to conceptualize how to solve one aspect of the problem without creating another problem. With wicked problems, there are so many complicated relationships and dependencies among problems that beginning to work on one often leads to work on several others.

DBT's answer to wicked problems is to add structure. DBT structures the treatment environment according to the client's level of disorder. The more disordered the client's behavior, the more services are needed and the more comprehensive the treatment. Furthermore, with clients who have repeated suicidal crises like Marie, DBT adopts a framework of protocols and procedures that structure the therapist's clinical decision making and work in much the same way protocols and procedures in an emergency room allow coordinated action amid urgency and uncertainty.

Structuring the Treatment Environment

Standard comprehensive DBT as it has been manualized and researched is structured to provide all the treatment that a highly disordered client needs in order to achieve an acceptable quality of life. Comprehensive treatment for highly disordered clients, from this viewpoint, requires that treatment accomplish five functions that follow from the impact of pervasive emotional dysregulation described earlier. These are:

1. Enhance client capabilities. People with pervasive emotion dysregulation usually lack capabilities for effectively regulating emotion; they need to learn new skills and sometimes receive pharmacotherapy to enhance their capabilities.
2. Improve client motivation to change. As discussed earlier, clients often feel hopeless about change and have learned to be passive in the face of problems; they need help in becoming motivated to learn and then use new responses.
3. Ensure that new client capabilities generalize to the natural environment. Because emotion dysregulation keeps newly learned responses from readily generalizing, generalization to different settings and circumstances must be directly addressed.
4. Enhance therapist capabilities and motivation to treat clients effectively. Client emotion dysregulation, unrelenting crises, and suicidal behaviors wear down therapists' motivation and often stretch their skills to the limit. Therefore, therapists need support, motivation, and ways to increase their own skills.
5. Structure the environment in the ways essential to support client and therapist capabilities (Linehan, 1996, 1997a; Linehan et al., 1999). Particularly when emotional intensity and crises are an expected part of the work, everyone must know their role and what to do and what not to do to provide a clear, coherent, and well-organized approach. When treatment fails, it is often because it has failed to function in one or more of these ways; as a result, client and/or therapist needs were not met.

In standard comprehensive DBT, the above functions are spread among various modes of service delivery. Table 1.2 summarizes the above treatment functions along with examples of service modes. For example, clients in comprehensive treatment may receive weekly individual psychotherapy, weekly group skills training, telephone coaching of skills, and therapists participate in weekly or biweekly meetings of a DBT peer consultation team. The client and the individual therapist form the core of the treatment team, and they then engage other providers and loved ones

TABLE 1.2. Functions and Treatment Modes of Comprehensive DBT

Functions	Modes
Enhancing clients' capabilities: Helping clients acquire responses for effective performance	Skills training (individual or group), pharmacotherapy, psychoeducation
Improving motivation: Strengthening clinical progress and helping reduce factors that inhibit and/or interfere with progress (e.g., emotions, cognitions, overt behavior, environmental factors)	Individual psychotherapy, milieu treatment
Ensuring generalization: Transferring skillful response repertoire from therapy to clients' natural environment and helping integrate skillful responses within the changing natural environment	Skills coaching, milieu treatment, therapeutic communities, *in vivo* interventions, review of session tapes, involvement of family/friends
Enhancing therapists' skills and motivations: Acquiring, integrating, and generalizing the cognitive, emotional, and overt behavioral and verbal repertoires necessary for effective application of treatment—including the strengthening of therapeutic responses and the reduction of responses that inhibit and/or interfere with effective application of treatment	Supervision, therapist consultation meeting, continuing education, treatment manuals, adherence and competency monitoring, and staff incentives
Structuring the environment through contingency management within the treatment program as a whole as well as through contingency management within the client's community	Clinic director or via administrative interactions, case management, and family and couples interventions

to play needed roles on the team. All team members are asked to share DBT's basic philosophy. Therapy tasks are clearly delegated to different members of the treatment team with the individual therapist and client responsible for seeing that all treatment targets are adequately addressed by someone in the system.

The Role of Skills Training

Individual therapy sessions are typically crowded with high-priority tasks and crises making it difficult to sustain a step-by-step skills training focus. Consequently, skills training is taught in a group format as a class. Linehan (1993b) has taken various evidence-based protocols and distilled them into four categories of skills that clients can learn and practice:

mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. Table 1.3 offers a complete list of skills by category. The dialectic of acceptance and change discussed earlier runs through the skills taught to clients. Mindfulness and distress tolerance skills are acceptance oriented. By practicing mindfulness skills, clients become increasingly able to willingly and nonjudgmentally engage with their immediate experience. Mindfulness skills also help clients refrain from impulsive action and when they do act, to act from "wise mind," the intuitive blend of emotion and reason that radically accepts and responds to the moment just as it is. The distress tolerance skills include crisis survival skills which are stopgap measures used to tolerate distress without impulsively doing things that make the situation worse. They also include reality acceptance skills that are psychological and behavioral versions of meditation practices intended to develop a lifestyle of participating with awareness and wisdom.

Emotion regulation and interpersonal effectiveness, on the other hand, are change-oriented skills. Clients learn the natural and adaptive functions of the major emotions and learn practical techniques for preventing emotion dysregulation, for changing or reducing negative emotions, and for increasing positive emotions. They learn how to manage interpersonal conflict, asking for what they want and saying no, in ways that can obtain their objectives while maintaining good relationships and keeping self-respect.

Whenever possible, in session and during coaching calls, the therapist encourages the client to practice replacing dysfunctional responses with appropriate DBT skills. The individual therapist in DBT learns the skills from the inside out, so that from practicing extensively in her own life she can explain how to use the skill in tough circumstances.

The Individual Therapist and the Consultation Team

In comprehensive DBT, each individual therapist participates in a peer-consultation team. The team's role is to help the therapist have the motivation and skills needed to conduct effective therapy. The team helps the therapist clearly conceptualize difficulties in the therapy and remedy these be they the therapist's skills deficits, or his or her own problematic emotions, cognitions, or contingencies that interfere with conducting therapy. This process of peer consultation is a required component of DBT and is described in depth in Chapter 7.

The individual therapist and other members of a DBT consultation team agree to a set of specific assumptions about clients, therapists, and therapy listed in Table 1.4. These are *assumptions*, that is, not statements of fact. They are our agreed-upon default settings for how we'll operate,

TABLE 1.3. DBT Skills

Acceptance-oriented skills

Core mindfulness

Taking hold of your mind
- Reasonable mind (logical analysis)
- Emotion mind (emotional experience)
- Wise mind (adding intuitive knowledge to reason and emotion)

"What" skills
- Observe
- Describe
- Participate; allowing experience

"How" skills
- Nonjudgmentally
- One-mindfully
- Effectively

Distress tolerance and acceptance

Crisis survival
- TIP your body chemistry
  - Temperature (ice) of your face
  - Intensely exercise
  - Progressively relax your muscles
- Distract with wise mind: ACCEPTS
  - Activities
  - Contributing
  - Comparisons
  - Emotions (use opposite emotions)
  - Pushing away
  - Thoughts
  - Sensations
- Self-soothe with five senses
  - Taste
  - Smell
  - See
  - Hear
  - Touch
- IMPROVE the moment
  - Imagery
  - Meaning
  - Prayer
  - Relaxation
  - One thing at a time
  - Vacation
  - Encouragement
- Pros and cons
  - Accepting reality
  - Willingness
  - Turning your mind
  - Radical acceptance
  - Mindfulness of current thoughts

Change-oriented skills

Emotion regulation

Changing emotional responses
- Check the facts
- Opposite action (to the emotion)
- Problem solving

Reduce vulnerability: ABC PLEASE
- Accumulate positives
- Build mastery
- Cope ahead of time
- Treat PhysicaL illness
- Balanced Eating
- Avoid mood-altering drugs (unless prescribed by your doctor)
- Balanced Sleep
- Exercise

Interpersonal effectiveness

Objective effectiveness: DEARMAN
- Describe
- Express
- Assert
- Reinforce
- Mindfully
- Appear confident
- Negotiate

Relationship effectiveness: GIVE
- Gentle
- Interested
- Validate
- Easy manner

Self-respect effectiveness: FAST
- Fair
- Avoid apologies
- Stick to values
- Truthful

TABLE 1.4. DBT Assumptions about Clients, Therapy, and Therapists

Assumptions about clients

- Clients are doing the best they can.
- Clients want to improve.
- Clients cannot fail in DBT.
- The lives of suicidal individuals are unbearable as they are currently being lived.
- Clients must learn new behaviors in all relevant contexts.
- Clients may not have caused all of their own problems, but they have to resolve them anyway.
- Clients need to do better, try harder, and/or be more motivated to change.

Assumptions about therapy and therapists

- The most caring thing therapists can do is to help clients change.
- Clarity, precision, and compassion are of the utmost importance in the conduct of DBT.
- The relationship between therapists and clients is a real relationship between equals.
- Therapists can fail to apply the treatment effectively. Even when applied effectively, DBT can fail to achieve the desired outcome.
- Therapists who treat individuals with pervasive emotion dysregulation and Stage 1 behaviors need support.

especially when the chips are down. These assumptions function like a guide rope in a dark twisty cavern, leading the therapist back to empathy for what it is truly like to live in our clients' skins. The assumptions begin with the idea that clients, as with all people, are at any given time doing the best they can and, further, that clients want to improve. Yet, amid setbacks and excruciatingly slow progress it can be easy for us as therapists to communicate frustration, and to act as if the problem is the client's lack of willpower—he or she simply does not want to change badly enough.

But imagine a kid who has practiced indoors all spring to do his first dive off the 10-meter platform. Then on the first beautiful summer day he competes. His family all sit in the audience as he climbs the diving platform. He walks out to the edge, and looks down. A huge wave of fear and vertigo sweep through him. He retreats to the stairs to climb down. He makes eye contact with his dad; the power of his dad's encouraging smile turns him around and moves him back to the edge of the platform. At the edge, he freezes. This is not at all like spring practice: no buddies joking around on the platform with him and no coach talking him through. Just silence as he feels fearful and humiliated. He steps away from the edge. Now, does that kid want to dive? Yes! More than anything. But fear is in the way. The needed behavior has not been practiced in all relevant contexts.

It's like this with our clients. The DBT assumptions, that our clients want to improve and at any given moment are doing the best they can,

lead us back to examine factors that interfere with needed behaviors. We assume that new behaviors must be learned in all relevant contexts: what is possible in session in the context of a supportive therapy relationship is different from that which is possible when alone in the middle of the night. Few of us would change places with our most distressed clients—their lives are truly unbearable without change. Yet while clients want to improve and are doing the best they can, often that is not sufficient. He or she in fact must try harder and be more motivated. In essence the boy on the diving board is exactly where he should be: all factors required to create the current circumstance, to have him freeze, trapped between diving or retreating down the stairs, have occurred. Something, somewhere along the way, must go differently for him to dive.

And so we assume it is with our clients: therapy must identify what needs to change in order to have needed behavior occur. The assumption is that even though the client may not have caused all of his or her own problems, he or she must solve them anyway. Here the therapist assumes that the client can't fail but instead views it as the therapist's job and the job of therapy to motivate and enable change. The analogy here is much like chemotherapy: when the patient dies, we don't blame the patient. Rather the assumption is that "treatment fails" because the practitioner failed to follow the protocol or it could be that the treatment itself is inadequate and must be improved. By explicitly agreeing to these assumptions and returning to them the therapist and team avoid unproductive polarization and more rapidly resume a useful stance of phenomenological empathy.

A dialectical stance informs conversations between the therapist and consultation team. This means that polarization is an expected phenomenon, something to be explored rather than avoided. At each point in time, the assumption is that any understanding is partial and likely to leave out something important. For example, a therapist asks for consultation on his work with a client. The team immediately remembers her—she's the one who habitually expresses distress with her husband and her health in an overly dramatic, helpless style that has burnt out all her supportive people. The therapist hasn't talked about this client in weeks. What the team hadn't realized is that, for the last 6 weeks, the client has only sporadically attended individual therapy sessions. The therapist is seeking help now because the client left a message that morning casually informing the therapist that she attempted suicide. The client took a minor overdose of Advil, went to the emergency department, and somehow finagled placement to the city's most plush, supportive day treatment program. The individual therapist flips out in exasperation. While his teammates commiserate and help plan the therapist's next move, somebody on a dialectically informed team will wonder aloud: Has the individual therapist inadvertently shaped the client to communicate distress in this

dysfunctional manner because he was not responding to lower-level communications? Has he too burnt out as others have? Someone else on the team will wonder if perhaps the *team* has played a role by shaping the *therapist:* Did the team's impatience with slow progress make the therapist hesitate to ask for help with the client's sporadic attendance and his own sense of burnout? On a dialectically informed team, such dialogues are valued, not viewed as splitting and part of the client's pathology.

The role of the individual therapist—the focus of this book—is to provide psychotherapy and work with the client to make progress toward all treatment goals. While others have input, the individual therapist does the lion's share of treatment planning and crisis management. Next, I outline the framework of treatment priorities that structures the conduct of individual therapy. In DBT, the individual therapist structures therapy based on the extent of client disorder. With highly disordered clients, the therapy environment is highly structured.

Hierarchy of Treatment Goals and Targets for Individual Therapy

The key tool that individual therapists use to structure and prioritize their many therapy tasks is the stage-based hierarchy of treatment goals and targets. *Treatment goals* are the overarching desired end point for a stage of work. *Targets* in DBT are behaviors identified as needing change, whether to be increased or decreased. DBT stages treatment using a commonsense notion: Prioritize problems according to the threat they pose to a reasonable quality of life. Therapy tasks are organized hierarchically so that the most important tasks take priority over the less important. Linehan (1996) has described DBT as a treatment with five stages. Table 1.5 shows the hierarchy of primary targets for pretreatment, Stage 1, and Stage 2 in individual therapy. In addition, there are secondary treatment targets. These address the behavior patterns, the dialectical dilemmas, described earlier. Little has been written and less researched about Stage 3 and Stage 4 of DBT. Linehan says that in Stage 3, the therapist helps the client synthesize what was learned in earlier stages, increase his or her self-respect and the sense of abiding connection, and work toward resolving problems in living. In Stage 4, the therapist focuses on the sense of incompleteness that many individuals experience, even after problems in living are essentially resolved. The task is to give up "ego" and participate fully in the moment with the goal of becoming free of the need for reality to be different from it is at the moment. Although the stages of therapy are presented linearly, progress is often not linear and the stages overlap. When problems arise it is not uncommon to return to discussions like those of pretreatment to regain commitment to the treatment goals or methods. At termination or

TABLE 1.5. Hierarchy of Primary and Secondary Targets, by Stage of Individual Psychotherapy

Primary behavioral targets

Pretreatment: Agreement and commitment
- Agreement on goals and methods
- Commitment to complete agreed-upon plan

Stage 1: Severe behavioral dyscontrol → behavioral control

1. Decrease life-threatening behaviors
   - Suicidal or homicidal crisis behaviors
   - Nonsuicidal self-injurious behaviors
   - Suicidal ideation and communications
   - Suicide-related expectancies and beliefs
   - Suicide-related affect
2. Decrease therapy-interfering behaviors
3. Decrease quality-of-life-interfering behaviors
4. Increase behavioral skills
   - Core mindfulness
   - Distress tolerance
   - Interpersonal effectiveness
   - Emotion regulation
   - Self-management

Stage 2: Quiet desperation → emotional experiencing

No a priori hierarchy; instead, prioritized based on individual case formulation

Decrease:
- Intrusive symptoms (e.g., PTSD intrusive symptoms)
- Avoidance of emotions (and behaviors that function as avoidance)
- Avoidance of situations and experiences (i.e., avoidance that includes what is seen in PTSD but that is not specifically limited to avoidance of trauma-related cues)
- Emotion dysregulation (both heightened and inhibited emotional experiencing, specifically related to anxiety/fear, anger, sadness, or shame/guilt)
- Self-invalidation

Secondary behavioral targets (relevant across all stages)

Increase emotion modulation
Decrease emotional reactivity

Increase self-validation
Decrease self-invalidation

Increase realistic decision making and judgment
Decrease crisis-generating behaviors

Increase emotional experiencing
Decrease inhibited grieving

Increase active problem solving
Decrease active passivity

Increase accurate communication of emotions and competencies
Decrease mood dependency of behavior

before breaks, especially if not well prepared, the client may resume Stage 1 behaviors. The transition from Stage 1 to 2 is also difficult for many, because exposure work can lead to intense painful emotions and consequent behavioral dyscontrol. Only pretreatment, Stage 1, and Stage 2 have been well articulated to date and therefore I only cover these three stages in this book.

Pretreatment Stage: Orientation and Commitment

All DBT clients begin in pretreatment. The individual therapist and client use this structured pretreatment phase to formulate the problems the client experiences and tailor a treatment plan. The goals are to learn enough about each other to determine whether they can work together well as a team, agree to the essential goals and methods of treatment, and then to mutually commit to complete the agreed-upon plan of therapy.

Because DBT requires voluntary rather than coerced consent, both the client and the therapist must have the choice of committing to DBT over another non-DBT option. For example, in a forensic unit or when a client is legally mandated to treatment, he or she is not considered to have entered DBT until a considered verbal commitment is obtained. While it is not important to have a written contract, it is important to have a mutual verbal commitment to treatment agreements. Specific agreements may vary by setting and the client's problems. For example, the client might agree to work on identified treatment targets for a specified length of time and to attend all scheduled sessions, pay fees and the like. The therapist might agree to provide the best treatment possible (including increasing their own skills as needed), to abide by ethical principles, and to participate in consultation. In the same manner, therapists on the consultation team undergo a pretreatment process as they consider and agree to consultation team agreements prior to joining the consultation team (described in Chapter 7). All such agreements are in place before beginning formal treatment.

As in any CBT package, orienting strategies (change-oriented) are used to vividly link treatment methods to the client's ultimate goals so that the client understands what is proposed, why it is proposed, and how to do it. Orienting is particularly emphasized in DBT, not only at the beginning of treatment but throughout, because emotion dysregulation may disrupt collaboration with therapy tasks. Even well-considered, gently offered therapist interventions can be experienced as highly invalidating. Consequently, you must frequently explain why a particular treatment task is necessary to reach the client's goals and further, you will need to instruct the client specifically how to do the therapy task despite or in the face of emotion dysregulation. Additionally, many clients enter

therapy with implicit expectations about how therapy will proceed based on past therapy experiences. Explicit orientation and socialization about client and therapist roles, responsibilities and expectations can head off misunderstandings and disappointment allowing for well-informed consent before beginning therapy.

Clients often enter the pretreatment stage understandably ambivalent and suspicious about what help therapy can offer given their past treatment failures. Therefore, the client and therapist need to thoroughly discuss concerns and reservations to reach a therapeutic agreement that genuinely works for both parties. The therapist views it as his job to actively assess and enhance the client's motivation starting in pretreatment and throughout therapy whenever needed—this is one of the most important targets of DBT. A number of specific commitment strategies are used in DBT. These are listed in Table 1.1 with other change-oriented strategies. A client is ready to begin Stage 1 if he or she is at least minimally committed to treatment—DBT therapists typically get what they can take, and take what they can get. They work toward gradually shaping greater commitment and motivation throughout the treatment process as I illustrate repeatedly throughout the book.

Stage 1: Attaining Basic Capacities (Reducing Behavioral Dyscontrol)

Stage 1 clients are those with the most severe level of disorder, whose problems and dyscontrol of behavior are so pervasive that they significantly impair quality of life, interfere with therapy, and pose a threat to life. These are the clients that require comprehensive DBT. The primary treatment goals for Stage 1 are to help the client attain the basic capacities he or she needs to stay alive and engaged in treatment, followed by those needed to improve the client's quality of life. The individual therapist allocates treatment time in sessions according to the following priorities: (1) life-threatening behaviors; (2) therapy-interfering behaviors of the therapist or client; (3) behaviors that seriously compromise the client's quality of life; and (4) deficits in behavioral capabilities needed to make life changes.

Within the highest priority category, life-threatening behaviors, priority is further assigned (in descending order of priority) to: suicide or homicide crisis behaviors; nonsuicidal self-injurious behavior; suicidal ideation and communications; suicide-related expectancies and beliefs; and suicide-related affect. These are also listed in Table 1.5. Therapy-interfering behavior is any behavior of either the client or the therapist that negatively affects the therapeutic relationship or that compromises the effectiveness of treatment. For clients this may include missing

sessions, excessive psychiatric hospitalization, inability or refusal to work in therapy, and excessive demands on the therapist. For therapists this may include forgetting appointments or being late to them, failing to return phone calls, being inattentive, arbitrarily changing policies, and feeling unmotivated or demoralized about therapy. Quality-of-life targets include any serious mental health problems such as mood or anxiety disorders, substance abuse or eating disorders, psychotic and dissociative phenomena, as well as life problems such as an inability to maintain stable housing, inattention to medical problems, domestic violence, and so on.

The Diary Card

The individual therapist monitors these and other key behaviors through the client's daily completion of a diary card. Review of the card at the start of every session helps the therapist determine what targets may need attention in that session. If the client fails to fill out the card or bring it to the session, it is treated as therapy-interfering behavior. The therapist then works on targets in order of priority by weaving together the core treatment strategies (change, validation, and dialectics). The priority of a target need not always equate with the amount of session time spent on it. The therapist's aim is to get the most progress in each clinical interaction, balancing what is most important with the client's capability and the time available. This is described in detail in Chapter 6.

Priorities for Phone Consultation

The individual therapist is also the main person responsible for seeing that new behaviors are generalized to all relevant environments. The therapist not only uses the therapeutic relationship as a key place for clients to learn and apply new responses but also deliberately structures therapy to ensure what is learned generalizes to all needed contexts. To do this, the therapist uses phone consultation and *in vivo* therapy (i.e., therapy outside the office), which in standard DBT with highly suicidal and emotionally dysregulated clients, is considered essential. There are different priorities for phone calls than for individual therapy sessions. In phone calls, the therapist priorities are (1) decreasing suicide crises behaviors, (2) increasing generalization of skills, and (3) decreasing the sense of conflict, alienation, and distance from the therapist. These coaching calls are brief, typically 5–10 minutes in duration. In addition to phone coaching, the therapist might use milieu skills coaching and treatments, therapeutic communities, *in vivo* interventions (case management), review of session tapes, and systems interventions. This function of generalization can also include family and others in the client's social network (Miller, Rathus,

DuBose, Dexter-Mazza, & Goldberg, 2007; Fruzzetti, Santisteban, & Hoffman, 2007; Porr, 2010). The therapist does what is needed to help the client transfer what is learned in therapy to the client's daily life.

Stage 2: Nontraumatizing Emotional Experience (Decreasing Behaviors Related to Posttraumatic Stress)

As clients stabilize, gain behavioral control, and become more functional, they may enter Stage 2 of treatment (Wagner & Linehan, 2006). In Stage 2, the client works on posttraumatic stress disorder (PTSD) responses and traumatizing emotional experiences. Here the targets may include decreasing intrusive symptoms (e.g., PTSD-intrusive symptoms); avoidance of emotions (and behaviors that function as avoidance) and avoidance of situations and experiences (i.e., avoidance that includes what is seen in PTSD, but that is not specifically limited to avoidance of trauma-related cues); emotion dysregulation (both heightened and inhibited emotional experiencing, specifically related to anxiety/fear, anger, sadness, shame/guilt); and self-invalidation. In contrast to Stage 1 targets, Stage 2 targets are not thought of hierarchically but instead the prioritization of targets is determined by the level of severity and life disruption caused by the problems, the clients' goals, and the functional relationship between targets. For example, if intrusive images provoked an increase in suicidal ideation, they might be prioritized. If, instead, intense self-invalidation and self-loathing were most related to increases in suicidal ideation, that would be prioritized.

Because of the lifetime prevalence of PTSD among treatment-seeking individuals with BPD (36–58%; Linehan, Comtois, Murray, et al., 2006; Zanarini et al., 1998; Zanarini, Frankenburg, Hennen, & Silk, 2004; Zimmerman & Mattia, 1999) and the high incidence of reported new experiences of adult abuse (Zanarini, Frankenburg, Reich, Hennen, & Silk, 2005; Golier et al., 2003), exposure-based CBT protocols such as prolonged exposure should be considered (e.g., Foa et al., 2005; Foa, Rothbaum, Riggs, & Murdock, 1991). However, behaviors common to people with emotion dysregulation are associated unfortunately with poorer outcome in prolonged exposure (e.g., avoidance, severe depression, overwhelming anxiety, guilt, shame, anger, excessive physical tension, numbing, and dissociation; Foa & Kozak, 1986; Foa, Riggs, Massie, & Yarczower, 1995; Jaycox & Foa, 1996; Meadows & Foa, 1998; Feeny, Zoellner, & Foa, 2002; Hembree, Cahill, & Foa, 2004; McDonagh et al., 2005; Zayfert et al., 2005).

Because of their difficulty regulating and tolerating intense emotions, some clients may be at increased risk of impulsive and self-destructive behaviors during exposure-based therapy. Therefore, in DBT, the client and therapist are encouraged to carefully assess readiness to engage in

exposure-based therapy (Stage 2). Tentatively, indicators of readiness include: the ability to control suicidal and nonsuicidal self-injurious behavior (e.g., abstinence from these behaviors for 2–4 months); a firm commitment not to engage in these behaviors in the future; and demonstrated ability to use skills to effectively manage urges to engage in these behaviors. The client and therapist might test whether the client is ready to begin Stage 2 work by choosing an item from the exposure hierarchy that is of low distress and see how he or she manages it. Exposure may be contraindicated when the client cannot be exposed to the trauma cues without dissociating or is currently experiencing crises or logistical issues that would block participation in treatment.

Many treatment development efforts are under way to adapt exposure-based procedures for individuals with pervasive emotion dysregulation and suicidal behaviors, including techniques designed to improve distress tolerance, further titrate anxiety and other emotions during exposure, and manage suicidality. For those with less severe disorder (e.g., those without suicidal and nonsuicidal self-injurious behavior) an abbreviated course of DBT skills training prior to exposure (e.g., Cloitre et al., 2002), a DBT-informed exposure treatment (e.g., Becker & Zayfert, 2001; Zayfert et al., 2005), or a standard exposure treatment without any priming intervention might work. Harned and Linehan's (2008) preliminary data suggest that clients quite early in Stage 1 DBT can in fact successfully participate in prolonged exposure for PTSD if they are well oriented, behavior is stabilized, and sufficient emotion regulation skills have been acquired. It's to be expected that clients may continue to experience low to moderate urges to self-injure or attempt suicide while undergoing exposure treatment. If these urges become too intense, exposure therapy may need to be temporarily postponed while the primary therapist helps the client regain or strengthen behavioral control. For this reason it may be helpful to have a different therapist conduct exposure therapy while the individual therapist continues his or her usual DBT sessions in tandem with the exposure work.

By staging treatment based on the extent of the client's disorder and prioritizing client behavioral problems, the therapist stays clear on the highest priorities, even in chaotic circumstances. Across all stages, DBT emphasizes learning to regulate emotion. While the amount of structure in the treatment environment depends on the extent of client disorder, the biosocial theory and core strategies remain steady. Applying the core strategies of DBT—change, validation, and dialectics—may initially appear straightforward, but the devil is in the details. In ever-changing, often high-risk and emotionally challenging clinical situations, applying even straightforward concepts becomes complicated. The nearly infinite if–then circumstances of clinical work mean that you often are working

from several sets of principles simultaneously. Any given moment is like hand-weaving an intricate tapestry. It's daunting, holding all the threads, working the tiny section that's immediately before you yet moving with the overall picture in mind. In fact, when Linehan first began to teach DBT, others who saw her clinical demonstrations often said to her, "you're a gifted therapist. You have an amazingly effective personal style and understanding of these patients, but no one else could pull that off." And yet hundreds of therapists, with training and practice, have indeed "pulled it off." As Malcolm Gladwell (2008) argues in his analysis of outstanding performers, while some innate talent is important, it's not talent that explains performance differences and good outcomes. It's practice. And the first thing to practice is how to conceptualize the client's problems using the principles of DBT. In Chapter 2, I'll describe how case formulation is used in DBT to structure the therapist's clinical decision making and treatment planning for an individual client. Whether you use the full comprehensive model of DBT or instead use its philosophy and strategies to inform your therapy, case formulation is the individual therapist's first step.

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