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DBT Next Steps Skills Handouts: Building a Life Worth Living.
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CHAPTER 2

Structural Differences between Standard DBT and DBT Next Steps

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The goal of the Next Steps is to keep the clients moving as they come out of Stage 1 behavioral dyscontrol (i.e., moving farther from their life worth living goals) to Stage "1a," where avoidance or lack of skill prevents them from moving toward their life worth living goals, as shown in Figure 2.1.

The principle of DBT Next Steps across the board is that to move from tearing their life down to building it up, clients must become more competent in skills emphasizing self-sufficiency, be exposed to feared cues, and create strong environmental contingencies that reinforce taking action toward their goals as well as emotional and financial independence. Yet navigating this process will require the DBT therapist to address systemic hardships and other aspects of multicultural identity that might pose critical challenges for the individual as they pursue school, work, a strong social network, and self-sufficiency goals. The challenges experienced by the clients might be unknown or hidden to the therapist who possesses more privilege. Some DBT therapists treating the client labeled as "failure to launch" might employ a more

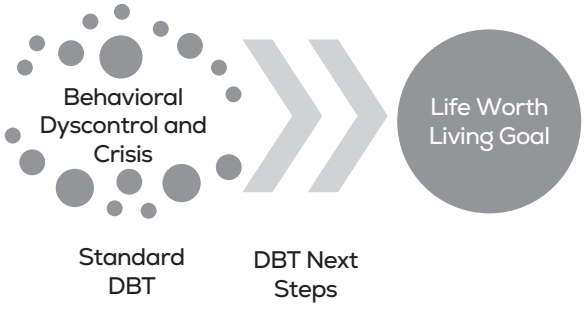

FIGURE 2.1. Progression out of Stage 1 to Stage 1a.

nuanced assessment of the disincentives for working and consider environmental reinforcement of emotion dysregulation or dependency behavior. They might consider, for example, that the client exists within invalidating environments where other family members thrive and succeed and the client doesn't; where there is an oversimplification of the ease of developing and excelling in one's career.

On the flip side, for those living on a lower income or in more communal cultures, self-sufficiency needs to be considered in context. Counting on others for financial, housing, transportation, child care, and other resources may not only be expected but also valued, with the goal being interdependence. This is consistent with the Principle of Interrelatedness and Wholeness articulated by Linehan (1993) in the core text of DBT. In this spirit, a dialectical look at self-sufficiency highlights that one cannot (and probably should not) strive for full independence—not needing anyone else to get along. This standard is perfectionistic and inconsistent with many cultures and community values. On the other hand, we can observe many cases of dependency that are problematic across cultures and contexts—this is often seen in the secondary target of active passivity and when family or friends offer opportunities or supports and the client's avoidance prevents them from taking action. This leaves both the client and their community—as well as their therapist—frustrated and stuck. DBT Next Steps uses the term "self-sufficiency" with this dialectic in mind: What does the client need to be able to do for themself to be effective in and a valued member of their community or subculture?

DBT Next Steps achieves this through targeted skills training with a new skills curriculum as well as unique contingency management and *in vivo* exposure-based strategies that function to initiate and maintain self-sufficiency and achieve goals—as well as to proactively structure one's environment to facilitate these behaviors. The following section provides a reminder of SDBT targets, strategies, and functions before illustrating the adapted approach of DBT Next Steps to address these challenges.

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Summary of SDBT

DBT is defined by its philosophical base (dialectics), treatment strategies, and treatment targets. The term "dialectical" is meant to convey both the multiple tensions that co-occur in therapy with emotionally dysregulated clients as well as the emphasis in DBT of enhancing dialectical thinking patterns to replace rigid, dichotomous thinking (Linehan, 1993). The overriding dialectic is the acceptance of clients as they are within the context of helping them change. DBT requires that each therapist working with the client balance the use of strategies, from the rapid juxtaposition of change and acceptance foci to the use of both irreverent and warmly responsive communication styles. Strategy changes in DBT are required to maintain therapeutic progress in the face of a client who, at various moments, may oscillate between suicidal crises, rigid refusal to collaborate, rapid emotional escalation, and collaborative effort.

SDBT Treatment Targets

DBT treatment targets for suicidal clients are organized in a hierarchy, with the top priority being life-threatening behaviors including suicidal behaviors, nonsuicidal self-injury, and

violence toward others. The second target is TIB, which includes clients' nonattendance, noncompliance, and noncollaborative behaviors or therapists being out of balance in their use of DBT strategies or being disrespectful. The third target is QOL-interfering behaviors including psychiatric disorders, substance abuse, unemployment, interpersonal conflicts, and so forth. The fourth target is to increase the client's mastery of DBT skills, and the fifth and final target focus is on any other client goals.

SDBT Strategies

DBT treatment strategies are divided into five sets: (1) dialectical strategies; (2) core strategies (validation and problem solving), including standard CBT procedures (behavioral assessment, didactic strategies, orienting to treatment rationale, contingency management, skills training, exposure, and cognitive modification strategies); (3) communication strategies (irreverent and reciprocal communication styles); (4) case management strategies (consultation to the client, environmental intervention, consultation to the therapists); and (5) structural strategies (targeting within sessions, starting and ending therapy). There are also a number of specific behavioral treatment protocols covering how to respond to suicidal behaviors and other crises states, TIBs and compliance issues, relationship problems and breakdowns, as well as ancillary treatment issues, including medication management.

SDBT Functions

SDBT serves five functions: (1) increasing behavioral capabilities; (2) improving motivation for more skillful responding, by modifying inhibitions and reinforcement contingencies; (3) assuring that treatment gains generalize to the natural environment; (4) structuring the treatment environment so that it reinforces functional rather than dysfunctional behaviors; and (5) enhancing therapist capabilities and motivation to treat clients effectively.

SDBT Modes of Treatment Delivery

These functions are divided among four modes of service delivery, each described in detail below.

1. **Weekly individual psychotherapy** (1 hour/week) functions primarily to improve client's motivation to reduce dysfunctional behaviors and replace them with functional and effective behaviors. It is designed to provide individualized behavioral assessment, treatment planning, and change strategies aimed at helping clients inhibit maladaptive behaviors and instead use behavioral skills, even if newly learned, in problematic situations. Session agendas are determined by treatment targets. If the client is at risk for imminent suicidal behavior or self-injury, crisis intervention takes priority. If maladaptive behaviors in the first three DBT target areas have occurred since the previous sessions (as indicated by reviewing the weekly Diary Card) or occur during the session, then those behaviors are the focus of the session. Generally, this involves an intensive analysis of the specific problem behavior in question (vulnerability and contextual factors, prompting events, behavioral links up to the problem behavior, consequences), and in-session interventions and out-of-session homework focus on what is needed

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for the client to avoid their problematic response in the future. If no problems in these areas have arisen, then problems or issues the client wants to work on determine the focus of the session. The primary focus is on analyzing and changing associations and contingencies to inhibit dysfunctional behaviors, particularly those associated with suicidality and BPD criteria, and to shape alternative skillful responses. Environmental intervention (e.g., interacting with other professionals or friends and family to manage services or circumstances for the client) occurs only when the immediate safety of the client outweighs the loss of opportunity for shaping new client behaviors (by teaching clients how to handle the problem themselves) or when the social power of the client is insufficient to effect necessary change (e.g., a letter from a clinician is required to get public housing).

2. **Group skills training** (2.5 hours/week) functions to enhance the acquisition of new behavioral skills. It is didactically focused and emphasizes modeling, instructions, structured behavioral rehearsal exercises, feedback, and assignments to practice new skills. In contrast to individual therapy, the session agenda is determined by the skills to be taught, rather than by maladaptive behaviors of the clients. Assignments are reviewed during the first half of the session and new material (with handouts) is taught during the second half. The structured skills manual gives session-by-session guidelines for content and format (Linehan, 2025b). There are four group skill modules targeting (a) mindfulness, (b) interpersonal effectiveness, (c) emotion regulation, and (d) distress tolerance skills. The latter three modules are given once over the course of 6 months, and mindfulness is taught for 2 weeks before each module. Problems not specifically related to skills, such as suicide threats or complex difficulties applying skills to individual situations, are referred to the individual therapist. In SDBT, the skills trainer meets with the individual DBT therapist in weekly team consultation.

3. **Out-of-session coaching** (as needed within the therapist's limits)—usually by phone but increasingly by text or other messaging platforms—functions to enhance the strength and generalization of learning to the client's everyday environment. Brief telephone contact between sessions, within the personal limits of each individual therapist and their client, is used for (a) problem solving and coaching in generalization of skills, (b) crisis intervention, (c) reinforcement of effective behavior, and (d) relationship repair.

4. **Therapists' team consultation** (weekly) functions to enhance and maintain therapists' motivation and skill. All therapists attend a structured weekly meeting to assist each other in the implementation of the treatment. The goal is dialectical—to help therapists to accept themselves, each other, and the clients and to mobilize themselves, each other, and the clients to change.

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DBT Next Steps Modes of Treatment Delivery

DBT Next Steps is structurally and fundamentally DBT. It has the same functions as DBT and uses all the principles, assumptions, agreements, and treatment strategies. The balance of acceptance-based and change-based strategies is done in the effort to help clients accept the challenges of increasing self-sufficiency and taking action toward life worth living goals while providing the tools necessary to do so. Secondary targets in DBT Next Steps are identical

to secondary targets in SDBT. The following sections outline each treatment mode, highlight changes, and address pitfalls that can arise when doing DBT Next Steps.

Individual DBT

Individual therapy is fundamentally identical to individual therapy in SDBT. As in SDBT, the weekly individual therapy sessions are the mode around which all other treatment modes revolve. The individual therapist is responsible for identifying client goals, behavioral assessment, and implementing the core validation, problem-solving, and dialectical strategies, and for applying the primary contingency, skills training, exposure and cognitive modification change procedures, and all other DBT strategies.

The differences in DBT Next Steps individual sessions stem from the higher functioning and enhanced skillfulness of the clients, which are critical to reinforce. There is relatively more emphasis on cueing client's effective behavior than blocking dysfunctional behavior or teaching new behavior. Also, though the primary SDBT targets of (1) life-threatening behavior, (2) TIB, and (3) dangerous and out-of-control QOL-interfering behaviors remain as primary targets and are monitored each week, they are expected to be infrequent so rarely take up individual session time. Instead, the targeting is focused on the QOL-interfering behaviors characterized by avoidance—situations where the client is not taking action or building something new. Such behaviors lend themselves to a full range of exposure strategies and manualized behavioral treatments for other psychiatric disorders (e.g., activation treatment for depression or CBT for social phobia), and it is more likely that a client can see such therapy protocols through to the end than is typical with beginning SDBT clients. Thus, a major difference is that the therapist exercises more cueing strategies than skills-training strategies, thereby relying more on the client to manage the agenda and the basic steps of the session, and to identify and apply appropriate skills.

Two main pitfalls when moving from targeting behavioral dyscontrol to targeting avoidance of self-sufficiency, employment, and the like in individual sessions are (1) escalation of self-harm, crisis-generating, or therapy-interfering behaviors and (2) loss of client or therapist motivation (urgency) prior to reaching life worth living goal milestones.

When focusing on Next Steps in individual sessions, any escalation of self-harm, crisis-generating, or therapy-interfering behavior requires the same set of acceptance and change strategies on the part of the therapist as in SDBT. Often such an escalation occurs when goals have been set too high; however, such escalation can also function as avoidance for the client. Such "bursts" of previous dysfunctional behavior are common in SDBT and can be more demoralizing to the client and therapist when moving on to DBT Next Steps. However, the principles for responding are identical in the two treatments and comparable to those of DBT trauma interventions such as the DBT Prolonged Exposure protocol (DBT PE; Carmel et al., 2016).

During DBT Next Steps individual sessions, the client or therapist may experience reduced motivation, resulting in an inclination to settle for less than the original goals. While this sense of complacency is certainly understandable, it is exactly the opposite of what is needed. When this happens to the therapist, the same disciplined self-monitoring and consultation team intervention is required as in SDBT. Similarly, when this occurs in the client, the therapist applies the same validation, commitment, dialectical and contingency highlighting, and management strategies as in SDBT.

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Group Skills Training

The DBT Next Steps skills-training six-module curriculum is taught in one 2-hour group per week. Each of the Next Steps modules lasts 1 month, so completing the entire curriculum of six modules takes 6 months. These skills build on SDBT skills but are distinct. DBT Next Steps skills handouts and assignments can be found in our companion book for clients, *DBT Next Steps Skills Handouts*, and detailed lesson plans for skills group leaders can be found in Part IV of this volume. The same clinical and didactic strategies are used in SDBT and Next Steps groups. Similar to SDBT skills modules, the Next Steps skills modules include both acceptance-oriented and change-oriented skills.

Out-of-Session Coaching

Out-of-session coaching via telephone, text, or other messaging platforms is provided as in SDBT, except the focus is on coaching self-sufficiency as opposed to generating solutions for the clients. In SDBT, out-of-session coaching in which the client contacts the therapist for *in vivo* coaching can be utilized as both a crisis management intervention and an opportunity to focus on cueing and reinforcing early skill acquisition as well as generalization. In DBT Next Steps, telephone consultations differ in that they emphasize consultation-to-patient strategies aimed primarily at skills generalization, although there is also ample opportunity to cue and reinforce early acquisition of DBT Next Steps skills. There is less need for the crisis management function as clients should already have distress tolerance solidly in their skills repertoire.

The pitfalls of coaching when working on Next Steps are that (1) coaching may be underutilized due to its association in SDBT with crisis behavior, and (2) coaching can interfere with "self-sufficiency" targets by inadvertently reinforcing reliance on cueing from the therapist.

The association with "crisis management" in SDBT treatment makes it a challenge for clients and clinicians to adapt to a more developmentally appropriate use of out-of-session coaching. For clinicians, this is dealt with in a consultation team, with regular reminders to assess the utility of coaching sessions and any possible unwitting reinforcement of avoidance behavior on the part of the client. When focused on DBT Next Steps, clinicians also use coaching as a vehicle for clients to report their use of skills and effective behavior, rather than reaching out only when they need help. Reinforcement of adaptive behavior is extremely important as clients overcome their anxiety and shame, and re-approach the workforce, social community, and so forth. It is typical to have planned contact after clients take action for themselves, or to have a general expectation of update messages to which the therapist can send congratulatory memes or emojis. Similar to contingency management in addiction treatment, these communications provide extra reinforcement during the period when natural reinforcements are not present and can be tapered once natural reinforcers begin to surface. There are many more reinforcers to working or attending school versus filling out applications, being in relationships versus dating or finding friends, and being settled in one's own place versus saving up and moving. For clients, getting oriented to the differences in how telephone coaching is used is a key part of becoming oriented to DBT Next Steps. The clinician must communicate the challenges of adapting, while holding to the rationale of adapting—that these changes promote more self-generated skills practice so that clients are able to reach their life worth living goals. Once the client has

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overcome the initial hurdles and is working, in school, living on their own, and the like, coaching as an outside support can be tapered prior to the end of treatment.

Therapist Consultation Team

As in SDBT, the weekly consultation team meetings include all individual and group therapists and serve to assure treatment fidelity by providing therapists with skills, support, and re-moralization as they implement the treatment strategies. The same elements are required for DBT consultation to be effective for Next Steps as well as for treating behavioral dyscontrol. All therapists must make and keep the supervision/consultation agreements, cheerlead other therapists, maintain a balance of acceptance and change strategies, and maintain the integrity of the "team" as an active agent in the therapy. In both treatments, the consultation team is also where the team devises and authorizes the application of specific contingencies, such as individually tailored changes in behavioral expectations, requirements for collateral substance abuse treatment when it is necessary, or therapy suspensions (a.k.a. vacations).

The main pitfall of consultation team meetings for clinicians working with DBT Next Steps clients is that it is more challenging to observe and review incremental improvements in QOL-interfering behaviors, like the absence or avoidance of something, than behavioral dyscontrol (e.g., not submitting job applications vs. bingeing and purging). This can be addressed by giving a block of consultation team time each quarter (maybe 30–45 minutes depending on how many clients are working in DBT Next Steps) to focus on the current clients pursuing Next Steps and whether the individual therapists are targeting effectively. In our team, we have tied this to the Recovery Goals (discussed in Chapter 4), and we have found it helpful to tie these team discussions to when the clients conduct a reassessment of the Recovery Goals in their skills-training group (see the Self-Assessment of Recovery Goals form in *DBT Next Steps Skills Handouts*). Looking at the client's assessment of themself, the therapist can see how their targeting is doing compared to the client's view. The team can discuss changes that need to be made or do "therapy for the therapist" if the therapist knows what to do and isn't doing it.

DBT Next Steps Strategies

DBT integrates a range of treatment strategies that balance acceptance with change. The DBT therapist targeting a client's negative self-talk and self-invalidation, for example, might use acceptance-based strategies such as Mindfulness of Current Thoughts to coach the client to observe the thought arising and notice it passing. On the other hand, they might just as easily use change-based approaches such as Checking the Facts or highlighting the consequences of getting stuck in self-invalidating thoughts and consider alternative ways to respond.

There are four primary change procedures to draw from in SDBT: exposure strategies, contingency management, cognitive modification, and behavioral skills training. Just as in SDBT, DBT Next Steps uses change procedures to increase learning in all relevant contexts where new behaviors are needed. For example, a client might be coached to validate their therapist's perspective even though they adamantly disagree with it. While there might be more validation seen in session, what's ultimately needed for the client to thrive is the ability to generalize

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perspective taking and find validity in a vastly different point of view from their partner, teacher, or manager in a work setting. While change procedures are used by all SDBT therapists, DBT Next Steps emphasizes them in particular ways that block avoidance and reinforce courageous new behaviors required for the client's life worth living.

In order to accomplish this, the therapist keeps an eye out for the deficits or problems that arise in the client's life. What is needed in their job role and what are they demonstrating in session or other contexts? As in SDBT, the appropriate change procedure is selected to address the problem at hand. Consider the contexts where new behaviors are required in order for the client to meet their goals. Perhaps unwarranted shame or fear limits full participation or attendance. In this case, exposure might be the way to go. Are effective behaviors such as submitting job applications getting followed by neutral or punishing responses from others in their life, such as a parent questioning the client's readiness to pull it off? Contingency management is worth exploring. Consider if the client has a lack of awareness of the consequences following their avoidance behavior. Cognitive modification might be needed. Or does the client lack skills to manage time, build a sufficient sense of community to create a work/life balance, or get stuck in the rut of perfectionism? Then skills training addressing these specific skills deficits will be key to success.

In summary, the targets and balance of strategies in DBT for building a new life may be different than SDBT for behavioral dyscontrol, but the treatment is still fundamentally DBT. One key difference is the ability to see the avoidance behavior clearly and understand the internal and external contingencies that make sense of the client's avoidance behavior. The other is the strategic use of DBT principles and strategies to overcome this avoidance. To further illustrate these ideas, two case examples are presented in the next chapter and continue throughout this book.

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