

## Orienting Adolescents and Families to Treatment and Obtaining Commitment

The pretreatment stage of orientation and commitment to DBT begins once suicide risk and diagnostic assessments are complete and the adolescent has been found to meet the inclusion criteria for the DBT program (see Chapter 6). As discussed in Chapter 3, the key goals of this stage are for the client and therapist to arrive at a mutually informed decision to work together and to make explicit their agreed-on expectations about that work. The process involves the primary therapist's helping the adolescent identify his or her long-term goals, orienting him or her to the treatment, and obtaining the teen's commitment to treatment. These therapeutic actions are considered "pretreatment targets." This chapter presents a set of strategies to use with adolescents and families to orient them and obtain their commitment. These are outlined in Table 7.1. In outpatient adolescent programs, an additional orientation to DBT often occurs in a multifamily skills training group format. (See Chapter 10 for orientation to skills training.)

Orientation and commitment to DBT begin with the adolescent alone first. Once the process has been initiated with the adolescent, the therapist can bring in the parents and/or other participating family members and repeat some of the key elements (this can occur late in the first session or in the second session). Even in more restrictive treatment settings (e.g., inpatient, forensic, and residential), we suggest following this same format, despite the fact that the adolescent may not have any choice whether to participate in the DBT program or not. It is important to foster some sense of control over the teen's participation. For example, the therapist might say,

"We know right now that you do not want to be here. So you can remain miserable, stay in your room, not participate in DBT group or individual sessions, and keep talking to your friend—or you can try to get to know some new people, participate in the treatment, and maybe figure out what you need to do to build a life worth living outside of this place and we'll help you do it."

The development and maintenance of a therapeutic alliance with the adolescent are of critical importance in this initial stage and throughout treatment. Other key orientation tasks are (1) to introduce the treatment in terms of how it fits, and can help solve, the individual teen's problems; (2) to link work on Stage 1 treatment targets with the adolescent's long-term goals; and (3) to present an overview of the treatment and its requirements. Orientation is not simply a description of the treatment; rather, it aims to build motivation. It is a discussion of

**TABLE 7.1. Orientation and Commitment Strategies for Adolescents and Families**

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1. Begin to establish a therapeutic alliance:
    - a. Use friendly, egalitarian, down-to-earth, and open demeanor, while simultaneously earning respect and conveying credibility.
    - b. Convey realistic degree of confidence in oneself as therapist, the client, and the treatment.
    - c. Establish active stance while collaboratively setting the agenda.
  2. Fold adolescent's specific problems into areas of dysregulation (and explain corresponding skills developed to address each problem area):
    - a. Confusion about self
    - b. Impulsivity
    - c. Emotional instability
    - d. Interpersonal problems
    - e. Adolescent–family dilemmas
  3. Define adolescent's specific problems as primary target behaviors:
    - a. Life-threatening behaviors
    - b. Treatment-interfering behaviors (based on prior treatment history)
    - c. Quality-of-life-interfering behaviors
    - d. Skills capabilities and deficits
  4. Elicit client's long-term goals, and link these to work on Stage 1 targets.
  5. Introduce the biosocial theory.
  6. Introduce the treatment's format and characteristics.
  7. Introduce DBT diary cards.
  8. Review treatment agreements:
    - a. Client agreements
    - b. Therapist agreements
    - c. Client–therapist relationship agreement
    - d. Family agreements
  9. Use commitment strategies with adolescent to obtain and strengthen commitment.
  10. Use commitment strategies with family members to obtain and strengthen commitment.
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what the particular teen can (and can't) realistically hope to get out of the treatment, and of how the treatment works to fulfill those hopes. The process clarifies the adolescent's specific goals and the specific DBT procedures used for reaching those goals. This becomes the basis for an explicit treatment agreement to which all parties are asked to commit themselves. Strategies for obtaining client commitment are discussed later in this chapter.

Jessica, the 15-year-old introduced in Chapter 6, is typical of adolescents in our outpatient clinic. When her assessments were complete, she met the criteria for the DBT program. She then met alone with the person who was to become her primary (individual) therapist. This began the orientation process.

## ORIENTING ADOLESCENTS TO DBT

### Beginning to Establish a Therapeutic Alliance

The primary task at the start of DBT is beginning to develop a collaborative relationship with the adolescent. This is crucial as well as difficult. Many adolescents presenting for treatment initially believe that they do not need it. Even those who have made a recent

suicide attempt often minimize it as an impulsive act and state that they “feel better now.” These adolescents often have had conflictual relationships with their parents as well as other adults. Being told that they must talk to a therapist, a stranger, because “something is wrong” makes many teenagers angry, resistant, and noncompliant. Given that up to 77% of suicidal adolescents either do not attend follow-up therapy appointments or drop out of treatment prematurely, it becomes important for therapists to equip themselves with a variety of techniques and strategies to engage such adolescents (Trautman et al., 1993).

A key strategy to working with adolescents involves conveying a down-to-earth, friendly, egalitarian, and open demeanor, while maintaining an understated degree of expertise and credibility. The challenge for therapists entails getting teens both to like and to respect them. In our experience, therapists who have had more experience with adult clients at times approach teenagers with an authoritarian, doctor-like, “one-up–one-down” stance. This approach consistently alienates adolescents. In working with an adolescent, it is also important to communicate a high level of confidence in one’s own ability as a therapist, in the client’s ability to improve, and in the efficacy of the treatment. Feigning confidence in oneself, in the client, or in the treatment will inevitably prove ineffective; a teenager will see through the act and disengage from the treatment. This may pose a challenge for a therapist who is new to the treatment and feels less competent. Thus the therapist should strive for a balance between genuinely communicating confidence in all three domains (self, client, and treatment) and not overpromoting them.

It is important to take an active stance in work with adolescents, especially early in treatment. Therapists who work within other treatment orientations often take a less active stance at the beginning of treatment and allow clients to choose freely what to discuss. In standard DBT, as well as in DBT with adolescents, the therapist uses these early sessions to get to know the client and to allow the client to get to know the therapist. This active stance is part of a dialectic, however, since one of the biggest mistakes that a novice DBT individual therapists tends to make is forcing an agenda on the client instead of letting the session unfold and skillfully weaving in the necessary components identified below. Thus taking an active stance involves the therapist’s developing a plan for the session content with the client and then guiding the client through this content, as well as adhering to DBT principles. Setting an agenda at the beginning of the session is a customary part of most forms of CBT. Although DBT does not require agendas, it can often be helpful to lay out at the beginning of a session which tasks and topics need to be covered. It also gives the adolescent a chance to say what topics he or she wants to cover. In the first or second session, which may include assessment, orientation, and commitment, the therapist will set the agenda by stating, “Jessica, I want to get some history and hear what problems you may currently be having before we decide what is the appropriate treatment for you.” Some beginning therapists feel compelled to tell clients everything they are supposed to cover in the first session, as opposed to skillfully weaving the material into the first couple of sessions.

One stylistic strategy in DBT is the use of irreverence—a style characterized by calling a spade a spade, as well as by using humor, sarcasm, or confrontation. Whereas some therapists are wary that being “too” irreverent early in therapy might alienate teens, we believe exactly the opposite. We recommend weaving irreverence into treatment immediately, since it functions to get adolescents’ attention in a manner different from most others with whom they discuss their problems. For example, when Jessica nonchalantly discussed her suicidal behaviors and her ambivalence about discontinuing them, the therapist stated, “Jessica, you realize that this treatment will not work if you are dead.” Irreverent communication strategies are discussed further in Chapters 3 and 8 as well as in Linehan’s (1993a) text.

### Folding Adolescent's Specific Problems into Areas of Dysregulation

The orientation session begins with asking for a recap of the client's problems. Hence it is important to validate the client's potential frustration at having to repeat his or her story to yet another mental healthcare provider. This is relevant only if the primary therapist is different from the initial evaluator. For example, the therapist might say,

“Jessica, I know you already told a lot of this information to Liz, who spent 3 hours with you last week during the diagnostic evaluation. She did share much of that information with me; however, if I am going to be your individual therapist, I want to get to know you, your strengths, and your weaknesses, and I will probably be asking at least some of the same questions. So bear with me.”

As the session proceeds, the therapist folds the client's problems into the five major problem areas identified on Figure 7.1. These problem areas correspond directly to the areas of dysregulation associated with BPD (i.e., emotional, behavioral, cognitive, interpersonal, and self; see Chapter 3). We describe the five problem areas as follows: (1) confusion about self, (2) impulsivity, (3) emotional instability, (4) interpersonal problems, and (5) teenager–family dilemmas. For example, if a teen identifies sudden and apparently baseless anger as a problem, the therapist might say,

“Jessica, when you are feeling OK one minute and then angry for seemingly no reason, DBT therapists call that a ‘problem with regulating emotion’ or ‘emotional instability’ (Problem 3 on the handout). Since you don't know why your emotions shift sometimes, you probably experience some confusion about yourself (Problem 1 on the handout). If you then start cutting yourself or purging without thinking about the consequences, we consider that impulsive behavior (Problem 2 on the handout).”

The therapist will review the other problem domains if the adolescent does not raise them naturally during the first session. Typically, adolescents referred to our program endorse at least four out of the five problem areas.

“Jessica, do you find that your relationships—with your boyfriend, your parents, your sister, your friends—run hot and cold? That is, even though you have friendships, do you find it hard to keep these relationships stable? Is it hard to get what you want from these relationships? If so, that would be Problem 4—interpersonal problems. And Problem 5 relates to teenagers who feel that they don't see eye to eye with their family members. Do you feel you're on one side of the Grand Canyon and your family members are on the other side, and it is difficult to understand one another and come to an agreement on issues, such as curfew, dating, homework, or body piercing?”

The DBT therapist then tells the teen that although having these problems may feel overwhelming, there is some good news:

“For each of these problems, the skills group will teach you specific skills that will target and reduce your specific problems. For example, in regard to impulsivity, we are going to teach you distress tolerance skills so that you will learn how to distract and soothe yourself when you have urges to kill yourself, cut yourself, overdose, drink alcohol, or purge. When you say you have interpersonal problems, we are going to teach you a set of inter-

## **Dialectical Behavior Therapy**

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### **PROBLEMS (What to decrease)**

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- I. Confusion about yourself  
(Not always knowing what you feel or why you get upset; dissociation)
  
- II. Impulsivity  
(Acting without thinking it all through)
  
- III. Emotional instability  
(Fast, intense mood changes with little control; or, steady negative emotional state)
  
- IV. Interpersonal problems  
(Pattern of difficulty keeping relationships steady, getting what you want, or keeping your self-respect; frantic efforts to avoid abandonment)
  
- V. Teenager–family dilemmas  
(Polarized thinking, feeling, and acting—e.g., all-or-nothing thinking)

### **SKILLS (What to increase)**

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- I. Mindfulness
  
- II. Distress tolerance
  
- III. Emotion regulation
  
- IV. Interpersonal effectiveness
  
- V. Walking the middle path

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**FIGURE 7.1.** *Handout on DBT for adolescents and family members.*

personal effectiveness skills in order to help you keep your self-respect; you're your relationships stable; and get what you want from your boyfriend, your girlfriends, and your parents. Do those skills sound helpful?"

In addition to what takes place in individual therapy, the skills trainer briefly reviews each problem area as it relates to each individual client and then describes the corresponding skills module, one by one. This review typically instills hope in the adolescent and family.

### Defining Adolescent's Specific Problems as Primary Target Behaviors

The individual therapist (who may or may not be the same clinician as the diagnostic interviewer, as noted earlier) is responsible for eliciting the information relevant to the DBT Stage 1 targets. Much of this information may have already been gathered during the diagnostic evaluation. The therapist connects the client's specific problems with DBT's primary target behaviors. The therapist might say, "So those overdoses are considered life-threatening behaviors, and your depression, your bingeing and purging, your school problems, and your intense conflicts with your parents are what we call 'quality-of-life-interfering behaviors.' Is it your belief that these problems interfere in the quality of your life?" Reframing these problems in DBT language enables the therapist to explain how DBT will be able to target these problems, while also beginning (unobtrusively) to teach the client this language.

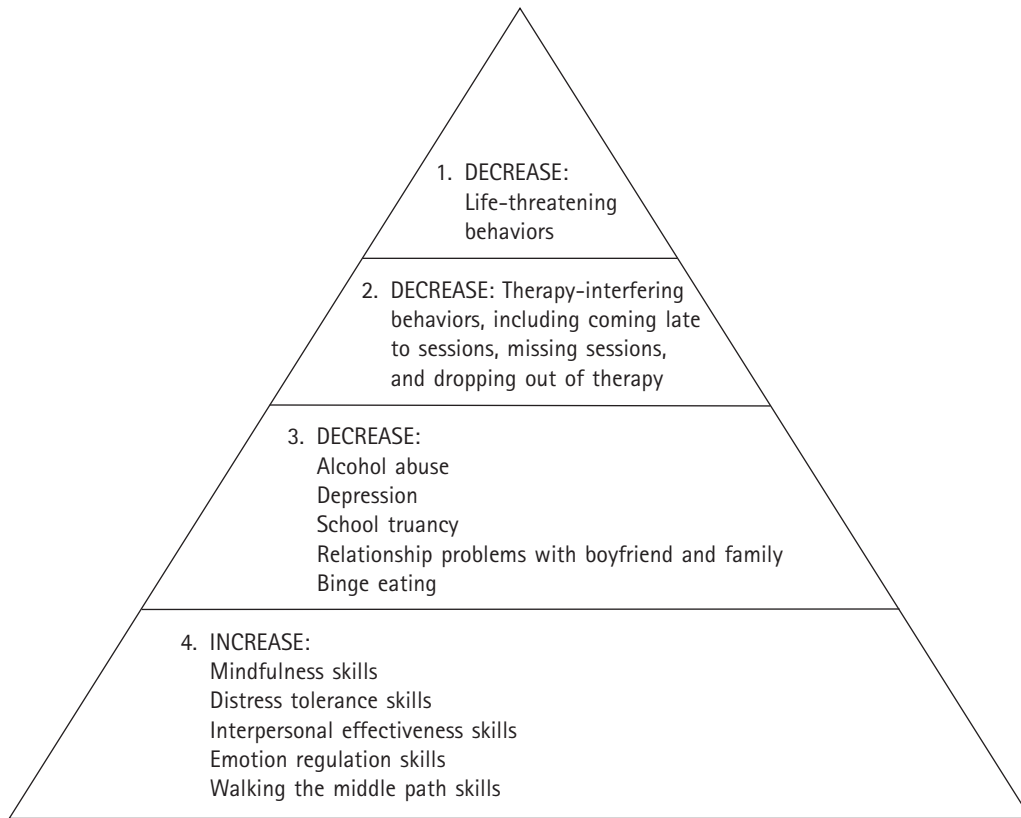
Once the primary target behaviors are identified, the DBT therapist is then able to review the Stage 1 treatment target hierarchy and informs the client that individual sessions will be organized accordingly from that day forward. To make this point clear, the therapist may draw a pyramid and list the client's problem behaviors from top to bottom in a fashion corresponding to the Stage 1 hierarchy (see Figure 7.2). It is explained to the adolescent that if in the past week there have been any self-injurious behaviors or increases in suicidal ideation, those behaviors will need to be analyzed first. The therapist goes on to explain that it does no one any good if the therapist and client spend the session talking about issues unrelated to the self-injury, since the client may intentionally or accidentally kill him- or herself by the next visit if they do not understand what is going on and how to deal with it differently. The remaining targets are then discussed, in hierarchical order.

### Eliciting Client's Long-Term Goals, and Linking These to Reducing Stage 1 Target Behaviors

In obtaining a commitment to reducing such Stage 1 target behaviors as suicide and self-injury, drug use, and truancy, as well as increasing behavioral skills, it is critical for the therapist to link them to the adolescent's long-term goals. Thus it is always important to elicit these goals. Jessica's goals included graduating from high school and starting college, continuing her cheerleading activities, joining a band as a singer, getting married, having kids, and finding a high-paying job. Jessica agreed not to kill herself, but was initially reluctant to reduce her self-cutting, since the behavior helped distract her from her intense anxiety and sadness. The therapist then queried Jessica as follows:

THERAPIST: You mentioned that you are self-conscious about the marks on your arms and legs. If we could figure out a way for you to reduce your anxiety and sadness without leaving cuts and scars on your body, would you choose another method?

JESSICA: I don't know . . . I know this works.



**FIGURE 7.2.** *Jessica's Stage 1 target pyramid drawn in session.*

**THERAPIST:** I get that . . . and if you want to continue your cheerleading next year, I imagine it may be hard to wear long sleeves and pants to cover those marks. And I also know that while you initially experience relief when you cut, you also often experience shame later. This becomes a vicious cycle for many people and makes them more vulnerable to cutting again . . . Does that happen to you?

**JESSICA:** Yes, I often feel worse. I know I have to work on this, but I am so scared to give it up.

**THERAPIST:** That makes perfect sense to me, given how effective this behavior has been for you in the short term at reducing certain negative emotions. I feel confident, though, that if I can teach you some new skills and we try them out, we'll find some of them will help you in similar ways to cutting, without leaving those marks or creating the negative emotions that perpetuate the problem as well.

### Introducing the Biosocial Theory

Referring back to the five problem areas listed on Figure 7.1, the therapist asks the adolescent rhetorically, "How do you think you developed these types of problems?" Typically, the adolescent is baffled and somewhat demoralized by the rhetorical question. To help answer this question, we explain that Marsha Linehan, the originator of DBT, developed a theory that

helps explain why some people have these types of problems (Linehan, 1993a; see Chapter 3 for a full discussion of the biosocial theory). Using visual aids such as a handout can help adolescents better understand this abstract theory. The therapist first reviews and defines the two components of the theory: “bio” and “social.” “Bio,” derived from the word “biology,” involves the biochemistry of one’s brain. The therapist might ask, “Jessica, have you ever experienced yourself as more emotionally sensitive, quicker to react, and slower in returning to your emotional baseline once you get upset than your siblings or friends?” Indeed, most of these adolescents admit that little things seem to “get under their skin easily” and affect them more than their peers. Moreover, they acknowledge that when they get upset, their emotional reactions are more intense and reactive (e.g., not just a little sad, but feeling very depressed; not mildly anxious, but having panic attacks; not merely irritated, but experiencing angry outbursts). The third characteristic—slow return to emotional baseline—is explained by drawing a graph on a piece of paper, with a line halfway up the bell curve to represent the adolescent’s moderate to high level of emotional arousal. Instead of returning back to 0, the line remains elevated at this level for an extended period (sometimes hours or even days). Many teens endorse this characteristic as true of themselves as well. Jessica reported, “Sometimes when I get really angry, it takes me almost a whole day to chill.”

The “social” part of the theory is described as the “invalidating environment.” Once “validation” and then “invalidation” are defined, an example is provided immediately to help illustrate the concept of invalidation. The therapist attempts to use examples offered by the adolescent during the first session if possible:

“Jessica, you told me that whenever you feel depressed and you feel you have less energy to do your chores in the house, your mother calls you a crybaby and tells you to snap out of it, or you’ll get a beating. You also told me that when you travel with your father to visit your relatives in Puerto Rico, your father insists that you put on a smile even if you are not in a smiling mood. These experiences are examples of ‘invalidation’—in other words, communications indicating that your thoughts, feelings, or actions are wrong, inappropriate, and invalid. . . . Who’s to say how you should feel and act and what you should think? Those are your thoughts and feelings, not theirs!”

Jessica responded, “I’m so used to it, I guess I never thought of it that way.” The therapist emphasizes that invalidation occurs frequently, to varying degrees, and can often be inadvertent. The therapist also explains the transactional nature of the biosocial theory (see Chapter 3), emphasizing a nonjudgmental and nonblaming attitude. For example, a mother and child may have different temperaments, as in the case of a quiet, shy, mellow toddler unmatched temperamentally with a gregarious, high-energy, demanding mother, or a highly emotional child with an emotionally controlled parent. Some teens tend to protect their parents in response to this explanation of an invalidating environment. The therapist can suggest that parents who invalidate often learned it as children from their own parents and do not know any way to communicate more effectively. If this is applicable, the therapist might state, “It makes perfect sense that your parents invalidate you, since that is what they learned growing up.” The therapist then has an opportunity to point out the intergenerational transmission of invalidation. Additionally, teens sometimes invalidate their family members as well.

Regardless of the intent, the therapist targets the invalidation experienced in the family, in order for the adolescent to feel better understood by the family and for the family members to feel better understood by the adolescent. (The biosocial theory review, like other aspects of orientation to treatment, typically occurs first with the adolescent alone and then is reported with the entire family.) The therapist then continues, “Here’s the good news: Now is the time



for you (and your family) to learn how to validate one another properly, and to put an end to the inadvertent invalidation that occurs in your household each day. You, Jessica, and each member of your family have to take responsibility for becoming more aware of this behavior and practicing the skill of validation.”

For many adolescents, hearing the biosocial theory explained is the first time they understand why they act and feel the way they do. Some adolescents are literally moved to tears by the experience.

### Introducing the Treatment's Format and Characteristics

The therapist reviews the treatment format next, consistently checking in with the client to ensure that he or she understands what is being said. Then the therapist attempts to obtain initial commitment to the various treatment modalities (see the later discussion of commitment strategies), using a conversational yet didactic style. A therapist would introduce the 16-week Montefiore program as follows:

“Jessica, our DBT program is two sessions per week for 16 weeks.<sup>1</sup> The treatment consists of one individual session (for 60 minutes) and one multifamily skills training group (for 2 hours) per week. So since you live with your mom, and you and she have a lot of conflicts, I think it makes sense to invite her as the family member who will attend the multifamily skills group with you. Don't you agree? Also, the individual session is periodically divided in half, so that we can have some time to address family issues with your mom, your dad, and even your sister. How does that sound to you? The bottom line is that you and your family will be treated by a team made up of your individual therapist, two skills trainers, your prescribing psychiatrist, and other DBT therapists in our program.

“The first phase of treatment lasts 16 weeks. When you finish that, you could be eligible for the graduate group, which involves a lot of fun activities and is only for people who graduate from the first phase. Another important component of the treatment is the telephone coaching. There are three reasons I would like you to call me. First, I want you to page me before you engage in a problem behavior, like cutting, overdosing, purging, or drinking. It doesn't help to call me afterwards, since you already decided how to handle that situation. Second, I want you to call me with good news. I love to hear good news—and you can leave a message on my machine and I will be thrilled to get it. Finally, I want you to call me if you feel that we have to repair our relationship [see Chapter 3 for further explanation]. Some teens have trouble with this pager idea . . . they say, ‘I didn't want to call you and bother you on the weekend.’ Jessica, let me be crystal-clear: I wouldn't be instructing you to call me if I thought it was a problem. If I am tied up with something else when you page me, I'll tell you so and let you know how soon I can call you back. Does that seem reasonable? Good. So I'd like to have you practice paging me this week, at some point when you're not in crisis, just to see how this whole thing works. Don't worry, I won't keep you on long—just to say hello. Can you we do a practice page on Tuesday night?”

The practice page helps the client add this new skill to his or her behavioral repertoire during an undistressed period, with the hope that he or she will be more likely to use it when actually faced with a stressor.

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<sup>1</sup>The most important issue is to set a treatment time period (e.g., 16 weeks, 6 months, 1 year) for the client to commit to. The therapist and client can then either renew the agreement at the “initial” endpoint for a specified period of time, or consider referring the client to a different therapist or therapy if sufficient progress is not being made.

The therapist then says to the client enthusiastically, “If we work together as a team, I can help you solve your problems. There are several key points you need to understand as we move ahead.” The therapist describes seven characteristics of DBT to the adolescent in the first or second individual therapy session. We list them below, with sample therapist descriptions for the client:

1. *DBT is not a suicide prevention program, but rather a life enhancement program.* Although the therapist acknowledges the client’s misery and concedes that suicide provides one way out of suffering, he or she emphasizes that the alternative is to make life more livable. “The bottom line is that I cannot keep you from killing yourself if you are intent on doing so, but I can help you create a life worth living.”

2. *DBT is supportive of clients’ attempts to improve the quality of their lives.* “Jessica, I want to support you to achieve your goals in any way I can.”

3. *DBT is behavioral.* “In order for you to change your life and achieve your goals, you are going to have to decrease some of your old problem behaviors, and begin to increase new skillful behaviors that you’re going to learn in DBT. Given your depression and anxiety, I think you will find it interesting to know that by changing your behavior, you can actually change your emotions.”

4. *DBT teaches skills.* “As you know from your cheerleading and piano lessons, it will take practice to get good at these new skills.”

5. *DBT is collaborative.* “We’re going to work as a team to help you achieve your goals. Clearly, you haven’t been able to get there yet without help, and I know that I will not be able to help you if you don’t pull some of the weight . . . so I feel confident that if we work together, we can do it.”

6. *DBT employs telephone consultation.* In the first session, the therapist gives the client his or her phone number or pager number and explains the three reasons for phone calls in DBT (see above). To emphasize this point, the therapist can use the metaphor of a basketball player and coach. “Jessica, you’re a basketball player [the therapist identifies Jessica’s favorite player and calls her by that name]. You’re dribbling down the court, your team is down by 1 point, and there are 20 seconds left. As you dribble past half-court, the other team sets up a defense, and you feel stuck. What do you do? You call a time out and check in with your coach to figure out how to get unstuck, instead of getting trapped and turning the ball over. Similarly, in life, when faced with a very tough or unfamiliar situation, I want you to call a ‘time out’ and call your coach—that’s me—so that I can help you get out of sticky situations without making things worse.”

7. *DBT is a team treatment.* “Here’s more good news: I am not treating you alone. I have a team I talk to every week. The team is made up of me, your individual therapist; the skills trainers; and other DBT therapists who work in this program. Their job is to make sure I deliver the best possible treatment to you. You’ve got me to help you, and I have the team to help me.”

### Introducing DBT Diary Cards

Introduction of the diary card (see Figure 7.3) typically occurs at the end of the first session or during the second session. (The two-page card can be photocopied and trimmed down to fit on one 8½ × 11 page.) The client is told that the diary card is a crucial component of the therapy, and that he or she is expected to complete it and return it to the therapist each week. The therapist explains the rationale for the diary card by explaining its several extremely important functions.