Dialectical Behavior Therapy for Borderline Personality Disorder

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This chapter presents one of the more remarkable developments in all of psychotherapy. Few therapists are willing to undertake the overwhelmingly difficult and wrenching task of treating individuals with “borderline” characteristics, yet these people are among the neediest encountered in any therapeutic setting. They also impose an enormous burden on the health care system. Over the past two decades, Linehan and her colleagues have developed a psychological treatment for individuals with borderline personality disorder (BPD). Importantly, data indicate that this treatment is effective when compared to alternative interventions. If results from the initial trials continue to hold up in future clinical trials, then this treatment will constitute one of the most substantial contributions to the armamentarium of the psychotherapist in recent times. What is even more interesting is that this approach blends emotion regulation, interpersonal systems, and cognitive-behavioral approaches into a coherent whole. To this mix Linehan adds her personal experience with Eastern philosophies and religions. Among the more intriguing strategies incorporated into this approach are “entering the paradox” and “extending” borrowed from aikido, a Japanese form of self-defense. Yet the authors remain true to the empirical foundations of their approach. The fascinating case study presented in this chapter illustrates Linehan’s therapeutic expertise and strategic timing in a way that will be invaluable to all therapists who deal with personality disorders. The surprising and tragic outcome illustrates the enormous burden of clinical responsibility inherent in any treatment setting, as well as the practical issues that arise when treatment ultimately fails.—D. H. B.

Clinicians generally agree that clients with a diagnosis of borderline personality disorder (BPD) are challenging and difficult to treat. As a result, BPD has become a stigmatized disorder resulting in negative attitudes, trepidation, and concern with regard to providing treatment (Aviram, Brodsky, & Stanley, 2006; Lequesne & Hersh, 2004; Paris, 2005). Perhaps of greatest concern is the generally high incidence of suicidal behavior among this population. Approximately 75% of clients who meet criteria for BPD have a history of suicide attempts, with an average of 3.4 attempts per individual (Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994). Suicide threats and crises are frequent, even among those who never engage in any suicidal or nonsuicidal self-injurious behavior (NSSI). Although much of this behavior is without lethal consequence, follow-up studies of individuals with BPD have found suicide rates of about 7–8%, and the percentage who eventually commit suicide is estimated at 10% (for a review, see Linehan, Rizvi, Shaw-Welch, & Page, 2000). Among all individuals
who have committed suicide, from 7 to 38% meet criteria for BPD when personality disorders are assessed via a psychological autopsy, with the higher incidence occurring primarily among young adults with the disorder (Brent et al., 1994; Isometsa et al., 1994, 1997; Lesage et al., 1994; Rich & Runeson, 1992). Individuals with BPD also have difficulties with anger and anger expression. Not infrequently, intense anger is directed at their therapists. The frequent coexistence of BPD with both Axis I conditions (e.g., mood or anxiety disorders) and other personality disorders clearly complicates treatment further.

The criteria for BPD, as defined within the text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) and the Revised Diagnostic Interview for Borderlines (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989), the most commonly used research assessment instrument, reflect a pervasive pattern of instability and dysregulation across all domains of functioning. Other assessment measures used to diagnose BPD include the International Personality Disorders Examination (IPDE; Loranger, 1995) and the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV; Zanarini, Frankenburg, Sickel, & Yong, 1996). The Borderline Symptom List (BSL; Bohus et al., 2001) and the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD; Zanarini et al., 2003) are both screening measures for BPD.

Linehan (1993a) has reorganized and summarized the diagnostic criteria of BPD into five domains. First, individuals with BPD generally experience emotional dysregulation and instability. Emotional responses are reactive, and the individuals generally have difficulties with episodic depression, anxiety, and irritability, as well as problems with anger and anger expression. Second, individuals with BPD have patterns of behavioral dysregulation, as evidenced by extreme and problematic impulsive behavior. As noted earlier, an important characteristic of these individuals is their tendency to direct apparently destructive behaviors toward themselves. Attempts to injure, mutilate, or kill themselves, as well as actual suicides, occur frequently in this population. Third, individuals with BPD sometimes experience cognitive dysregulation. Brief, nonpsychotic forms of thought and sensory dysregulation, such as de-
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Seizer, Koenigsberg, Carr, & Appelbaum,
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1983, 1993; Buie & Adler, 1982), and Bateman
and Fonagy (2004). Among these, Kernberg’s
(1975, 1984) theoretical contributions
are clearly prominent. His object relations model
is comprehensive as to theory and technique, and
has had considerable influence on the
psychodynamic literature. His expressive psycho-
otherapy for clients with “borderline personality
organization” (BPO) or BPD, transference-
focused therapy (TFT), emphasizes three
primary factors: interpretation, maintenance
of technical neutrality, and transference analysis.
The focus of the therapy is on exposure and
resolution of intrapsychic conflict. Treatment
goals include increased impulse control and
anxiety tolerance, ability to modulate affect,
and development of stable interpersonal
relationships. TFT also uses a target hierarchy
approach to the first year of treatment. The tar-
gets are (1) containment of suicidal and self-
destructive behaviors, (2) therapy-destroying
behaviors, and (3) identification and recapitula-
tion of dominant object relational patterns,
as experienced in the transference relationship
(Clarkin et al., 2001). Kernberg has also distin-
guished a supportive psychotherapy for more
severely disturbed clients with BPO or BPD.
Like expressive psychotherapy, supportive psy-
chotherapy also places great emphasis on the
importance of the interpersonal relationship in
therapy (transference); however, interpreta-
tions are less likely to be made early in treat-
ment, and only the negative responses to the
therapist and to therapy (negative transference)
are explored. Both expressive and supportive
psychotherapy are expected to last several
years, with primary foci on suicidal behaviors
and therapy-interfering behaviors. The data
supporting the use of TFT are not extensive.
Clarkin and colleagues have published results
from a preliminary study of TFT. Additionally,
one completed randomized clinical trial has
compared TFT to schema-focused therapy
(SFT; Giesen-Bloo et al., 2006). The results of
this study are described in the section on
cognitive-behavioral treatments.

The preliminary study of TFT assessed pre-
and posttreatment changes over the course of a
1-year treatment for adult women with BPD (N
= 23). Of the 23 clients who were considered in-
tent-to-treat (ITT), 17 completed the treatment.
Both the ITT sample and the completer sample
were analyzed. There were no significant reduc-
tions in number of suicide attempts, number of
NSSI behaviors (referred to as “parasuicide” in
the article), medical risk of either type of self-
injury, or physical condition after either type of
self-injury in the ITT sample. However, signifi-
cant decreases in medical risk and physical con-
dition after NSSI behaviors occurred in the com-
pleter sample. Furthermore, the number of
hospitalizations over the course of the treatment
year compared to the year prior to treatment
reduced significantly for both groups. Given the
lack of a control group in this study and the small
sample size, these findings should be reviewed
with caution (Clarkin et al., 2001).

Mentalization therapy, developed by Bat-
eman and Fonagy (2004), is an intensive therapy
grounded in attachment theory (i.e., BPD is
viewed as an attachment disorder), with a focus
on relationship patterns and unconscious
factors inhibiting change. “Mentalization” re-
fers to one’s perception or interpretation of the
actions of others and oneself as intentional.
The treatment is based on the theory that indi-
viduals with BPD have an inadequate capacity
for mentalization. Treatment, therefore, is
focused on bringing the client’s mental experi-
ences to conscious awareness, facilitating a
more complete, integrated sense of mental
agency. The goal is to increase the client’s ca-
pacity for recognizing the existence of the
thoughts and feelings he or she is experiencing.

A randomized trial of mentalization therapy
offered in a partial hospitalization setting pro-
vides additional supporting data for psychoan-
alytic treatment of BPD. This study by Bat-
eman and Fonagy (1999) consisted of random
assignment of clients to either standard psychi-
atriatric care constrained only by the requirement
that individual psychotherapy was not allowed
(control condition) or to partial hospitaliza-
tion, a treatment program with the following
goals of therapy: (1) psychoanalytically in-
formed engagement of clients in treatment; (2)
reduction of psychopathology, including de-
pression and anxiety; (3) reduction of suicidal
behavior; (4) improvement in social com-
petence; and (5) reduction in lengthy hospitaliza-
tions. The experimental treatment group re-
ceived once-weekly individual psychotherapy
provided by psychiatric nurses, once-weekly
psychodrama-based expressive therapy, threc-
weekly group therapy, a weekly community
meeting, a monthly meeting with a case admin-
istrator, and a monthly medications review. At
the end of the 18-month treatment, the group receiving mentalization therapy showed significant reductions in suicidal behavior (suicide attempts and self-mutilation), inpatient hospitalization stays, measures of psychopathology (including depression and anxiety), and social functioning relative to the control group. These gains were maintained and increased during an 18-month follow-up period consisting of twice-weekly group therapy (Bateman & Fonagy, 2001). The researchers note that their program contained three characteristics that they hypothesize to be related to treatment effectiveness: a consistent theoretical rationale for treatment, a relationship focus, and consistent treatment over time.

Psychopharmacological

Reviews of the literature regarding drug treatments for BPD highlight a dilemma for the prescribing pharmacotherapist: BPD involves dysregulation in too many domains for a single drug to serve as a panacea (Dimeff, McDavid, & Linehan, 1999; Lieb, Zanarini, Linehan, & Bohus, 2004; Nose, Cipriani, Biancosino, Grassi, & Barbui, 2006). In general, results indicate that several agents may be useful for improving global functioning, cognitive perceptual symptoms (e.g., suspiciousness, ideas of reference, transitory hallucinations), emotion dysregulation, or impulsive–behavioral dyscontrol (for reviews, see Lieb et al., 2004; Nose et al., 2006). Nose and colleagues (2006) conducted a meta-analysis of 22 randomized, placebo-controlled clinical trials, published between 1986 and 2006, examining the effects of pharmacotherapy for individuals with BPD. Organization of results was based on five primary outcome measures: affective instability and anger, impulsivity and aggression, interpersonal relationships, suicidality, and global functioning. First, no medication had a more positive effect than placebo on suicidality. Overall, across the studies, fluoxetine, an antidepressant, and topiramate and lamotrigine, mood stabilizers, showed more positive effects than placebo for affective instability and anger. Additionally, valproate, an anticonvulsant and mood stabilizer, has effectively treated behavioral dysregulation in clients with BPD, including those with aggressive and impulsive behavior (Stein, Simeon, Frenkel, Islam, & Hollander, 1995). As a class, antipsychotics were more effective than placebo for impulsivity, interpersonal relationships, and global functioning, and specifically, olanzapine was better than placebo relative to global functioning (Nose et al., 2006) and has been shown to decrease impulsive aggression and chronic dysphoria more effectively compared to fluoxetine (Zanarini, Frankenburg, & Parachini, 2004). In summary, although some drug treatments may be effective, caution is in order when considering pharmacotherapy for this particular client population. Clients with BPD are notoriously noncompliant with treatment regimens, may abuse the prescribed drugs or overdose, and may experience unintended effects of the drugs. With these caveats in mind, carefully monitored pharmacotherapy may be a useful and important adjunct to psychotherapy in the treatment of BPD.

Cognitive-Behavioral

Treatment of BPD has received increasing attention from cognitive theorists. The cognitive approach views the problems of the client with BPD as residing within both the content and the process of the individual's thoughts. Beck's approach to treating BPD (Beck & Freeman, 1990) is representative of cognitive psychotherapy generally, with the focus of treatment on restructuring thoughts and on developing a collaborative relationship through which more adaptive ways of viewing the world are developed. More specifically it focuses on decreasing negative and polarized beliefs that result in unstable affect and destructive behaviors (Brown, Newman, Charlesworth, Crits-Christoph, & Beck, 2004). In an open clinical trial of cognitive therapy for clients with BPD, Brown and colleagues found decreases in clients meeting BPD criteria, depression, hopelessness, and suicide ideation at the end of the 12-month treatment and 6-month follow-up posttreatment. The cognitive-behavioral therapies of Young, Klosko, and Weishaar (Kellog & Young, 2006; Young, 2000; Young, Klosko, & Weishaar, 2003; Pretzer, 1990); Blum and colleagues (Blum, Pfahl, St. John, Monahan, & Black, 2002) and Schmidt and Davidson (as cited in Weinberg, Gunderson, Hennen, & Custer, 2006) attempt to address some of the difficulties experienced in applying traditional cognitive approaches to the treatment of BPD. Pretzer's (1990) approach emphasizes modifying standard cognitive therapy to address difficulties often encountered in treating clients
with BPD, such as establishing a collaborative relationship between therapist and client, maintaining a directed treatment, and improving homework compliance. Blum and colleagues (2002) developed a twice-weekly outpatient group treatment that uses a psychoeducational approach to teaching skills to clients with BPD and to their support systems (e.g., family, friends, other care providers). The treatment focuses on destigmatization of BPD, emotional control, and behavioral control. At present, outcome data are limited for Pretzer’s approach. A pilot study has shown potential for the group treatment developed by Blum and colleagues and a randomized control trial is currently being conducted (Van Wel et al., 2006).

Young’s schema-focused therapy (SFT) (Young et al., 2003) postulates that stable patterns of thinking (“early maladaptive schemas”) can develop during childhood and result in maladaptive behavior that reinforces the schemas. SFT includes a variety of interventions aimed at challenging and changing these early schemas through the identification of a set of dysfunctional schema modes that control the individual’s thoughts, emotions, and behaviors (i.e., detached protector, punitive parent, abandoned/abused child, angry/impulsive child). Giesen-Bloo and colleagues (2006) completed the first randomized clinical trial of TFT and SFT. Transference focused therapy was compared to schema focused therapy in a study where 88 participants received three years of twice per week individual sessions of either schema focused therapy or transference based therapy. Study results indicated an overall decrease in BPD symptoms for both treatments, however, participants who received SFT had significantly greater improvements overall and a lower attrition rate. Suicide and NSSI behaviors were not assessed as an outcome measure in this study.

Weinberg and colleagues (2006) completed a randomized, controlled trial of Schmidt and Davidson’s manual-assisted cognitive treatment (MACT) and treatment as usual (TAU). MACT is a brief cognitive-behavioral treatment that incorporates strategies from DBT, cognitive therapy, and bibliotherapy. The treatment targets NSSI behaviors occurring in individuals with BPD. MACT was provided as an adjunctive treatment to TAU for study participants (N = 30). Participants were 30 women diagnosed with BPD, with a history of NSSI behaviors and at least one in the last month; however, suicide was considered one of the exclusionary criteria for study participation. Participants were randomly assigned to MACT plus TAU or to TAU-alone conditions. Upon completion of the 6-week treatment and at the 6-month follow-up, individuals who received MACT had significantly fewer and less severe NSSI behaviors than those in the TAU-alone condition. The authors state that these results should be interpreted with caution due to small sample size and the use of self-report measures only in assessment of NSSI behaviors.

DIALECTICAL BEHAVIOR THERAPY

DBT evolved from standard cognitive-behavioral therapy as a treatment for BPD, particularly for recurrently suicidal, severely dysfunctional individuals. The theoretical orientation to treatment is a blend of three theoretical positions: behavioral science, dialectical philosophy, and Zen practice. Behavioral science, the principles of behavior change, is countered by acceptance of the client (with techniques drawn both from Zen and from Western contemplative practice); these poles are balanced within the dialectical framework. Although dialectics was first adopted as a description of this emphasis on balance, dialectics soon took on the status of guiding principles that have advanced the therapy in directions not originally anticipated. DBT is based within a consistent behaviorist theoretical position. However, the actual procedures and strategies overlap considerably with those of various alternative therapy orientations, including psychodynamic, client-centered, strategic, and cognitive therapies.

Efficacy

Although several treatments (Bateman & Fonagy, 1999, 2001; Giesen-Bloo et al., 2006; Marziali & Munroe-Blum, 1994) have shown efficacy in the treatment of individuals with BPD, DBT has the most empirical support at present and is generally considered the frontline treatment for the disorder. DBT has been evaluated in six randomized controlled trials (RCTs) conducted across three independent research teams (Koons et al., 2001; Linehan et al., 1991, 1999, 2002, 2006; Linchen, Heard, & Armstrong, 1993; Linehan,
Tutek, Heard, & Armstrong, 1994; Verheul et al., 2003). Two of the RCTs specifically recruited clients with suicidal behaviors (Linehan et al., 1991, 1993, 1994, 1999). The results in general have shown DBT to be an effective evidenced-based treatment for the disorder. In four of the six studies participants treated with DBT demonstrated significantly greater reductions in suicide attempts, intentional self-injury, and suicidal ideation (Koons et al., 2001; Linehan et al., 1991, 1999, 2002; Verheul et al., 2003). Treatment superiority was maintained when DBT was compared to only those control subjects who received stable individual psychotherapy during the treatment year, and even after researchers controlled for number of hours of psychotherapy and of telephone contacts (Linehan & Heard, 1993; Linehan et al., 1999). Two studies with participants with substance dependence and BPD found DBT to be more effective than control treatments in reducing substance use, and increasing global and social adjustment (Linehan et al., 1999, 2002). In the original study of recurrently suicidal patients with BPD, participants treated with DBT were significantly less likely than TAU participants to attempt suicide or NSSI behaviors during the treatment year, had less medically severe NSSI behaviors, were less likely to drop out of treatment, had fewer inpatient psychiatric days per participant, and improved more on scores of both global and social adjustment. More specifically, Linehan and colleagues' (2006) study showed that participants treated with DBT were half as likely to engage in suicidal behaviors compared to participants in the treatment by community experts (TBCE) condition, further indicating that DBT is an effective treatment for reducing suicidal behavior. This study suggests that the efficacy of DBT is due to specific treatment factors, and not general factors or the expertise of the treating psychotherapists. In two studies to date, DBT has been shown to be effective in reducing substance use disorders (Linehan et al., 1999, 2002).

In addition to these studies of DBT for individuals with BPD, three studies have examined its effectiveness with other disorders. First, Lynch, Morse, Mendelson, and Robins (2003) found that a DBT skills group plus antidepressant medication showed greater reductions in depressive symptoms in older (over 60-years-old) depressed individuals compared to TAU plus antidepressant medication group at the 6-month follow-up time point in a 28-week treatment program. DBT has also been adapted for use with individuals without BPD who are diagnosed with binge-eating disorder (BED). Telch, Agras, and Linehan (2001) compared women diagnosed with BED receiving an adapted 20-week group DBT treatment to waiting-list controls. Participants in the DBT condition had significantly fewer days of binge-eating episodes compared to those in the wait-list control condition and were more likely to abstain from bingeing at follow-up. Additionally, those in the wait-list control group who were offered the DBT treatment after the study had similar results. DBT continues to be examined in a variety of settings and for a variety of different diagnoses. However, it is important to highlight that when DBT is adapted for use with different populations, it may not be as effective, given that many adaptations have not been rigorously tested. We recommend that until it is tested in an RCT, adaptations should not be made to DBT. If using DBT with different populations, then the most important change should be in the examples used when teaching, not in the content itself.

Philosophical Basis: Dialectics

The term "dialectics" as applied to behavior therapy refers both to a fundamental nature of reality and to a method of persuasive dialogue and relationship. (See Wells [1972, cited in Kegan, 1982] for documentation of a shift toward dialectical approaches across all the sciences during the last 150 years; more recently, Peng & Nisbett [1999] discuss both Western and Eastern dialectical thought.) As a worldview or philosophical position, dialectics guide the clinician in developing theoretical hypotheses relevant to the client's problems and to the treatment. Alternatively, as dialogue and relationship, dialectics refers to the treatment approach or strategies used by the therapist to effect change. Thus, central to DBT are a number of therapeutic dialectical strategies. These are described later in this chapter.

Dialectics as a Worldview

DBT is based on a dialectical worldview that emphasizes wholeness, interrelatedness, and process (change) as fundamental characteristics of reality. The first characteristic, the Principle
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of Interrelatedness and Wholeness, provides a perspective of viewing the system as a whole and how individuals relate to the system, rather than seeing individuals as if they exist in isolation. Similar to contextual and systems theories, a dialectical view argues that analysis of parts of any system is of limited value unless the analysis clearly relates the part to the whole. The second characteristic is the Principle of Polarity. Although dialectics focuses on the whole, it also emphasizes the complexity of any whole. Thus dialectics asserts that reality is nonreducible; that is, within each single thing or system, no matter how small, there is polarity. For example, physicists are unable to reduce even the smallest of molecules to one thing. Where there is matter there is antimatter; even every atom is made up of both protons and electrons: A polar opposite is always present. The opposing forces are referred to as the thesis and antithesis, present in all existence. Dialectics suggests that the thesis and antithesis move toward a synthesis, and inherent in the synthesis will be a new set of opposing forces. It is from these opposing forces that the third characteristic is developed. This characteristic of the dialectical perspective refers to the Principle of Continuous Change. Change is produced through the constant synthesis of the thesis and the antithesis, and because new opposing forces are present within the synthesis, change is ongoing. These dialectical principles are inherent in every aspect of DBT and allow for continuous movement throughout the therapy process. A very important dialectical idea is that all propositions contain within them their own oppositions. Or, as Goldberg (1980, pp. 293–296) put it, “I assume that truth is paradoxical, that each article of wisdom contains within it its own contradictions, that truths stand side by side. Contradictory truths do not necessarily cancel each other out or dominate each other, but stand side by side, inviting participation and experimentation.”

One way that the client and therapist address this in therapy is by repeatedly asking each other or oneself the question: “What is being left out?” This simple question can assist in finding a synthesis and letting go of an absolute truth, a nondialectical stance.

Dialectics as Persuasion

From the point of view of dialogue and relationship, dialectics refers to change by persuasion and by making use of the oppositions inherent in the therapeutic relationship rather than by formal impersonal logic. Through the therapeutic opposition of contradictory positions, both client and therapist can arrive at new meanings within old meanings, moving closer to the essence of the subject under consideration. The spirit of a dialectical point of view is never to accept a proposition as a final truth or an undisputable fact. Thus, the question addressed by both client and therapist is “What is being left out of our understanding?” Dialectics as persuasion is represented in the specific dialectical strategies described later in this chapter. As readers will see, when we discuss the consultation strategies, dialectical dialogue is also very important in therapist consultation meetings. Perhaps more than any other factor, attention to dialectics can reduce the chances of what psychodynamic therapists have labeled “staff splitting,” that is, the frequent phenomenon of therapists’ disagreeing or arguing (sometimes vehemently) about how to treat and interact with an individual client who has BPD. This “splitting” among staff members is often due to one or more factions within the staff deciding that they (and sometimes they alone) know the truth about a particular client or clinical problem.

Dialectical Case Conceptualization

Dialectical assumptions influence case conceptualization in DBT in a number of ways. First, dialectics suggests that a psychological disorder is best conceptualized as a systemic dysfunction characterized by (1) defining the disorder with respect to normal functioning, (2) assuming continuity between health and the disorder, and (3) assuming that the disorder results from multiple rather than single causes (Hollander, 1990). Similarly, Linehan’s biosocial theory of BPD, presented below, assumes that BPD represents a breakdown in normal functioning, and that this disorder is best conceptualized as a systemic dysfunction of the emotion regulation system. The theory proposes that the pathogenesis of BPD results from numerous factors: Some are genetic–biological predispositions that create individual differences in susceptibility to emotion dysregulation, known as emotion vulnerability; others result from the individual’s interaction with the environment; referred to as the invalidating environment. Assuming a systemic view compels the theorist to
integrate work from a variety of fields and disciplines.

A second dialectical assumption that underlies Linehan's biosocial theory of BPD is that the relationship between the individual and the environment is a process of reciprocal influence, and that the outcome at any given moment is due to the transaction between the person and the environment. Within social learning theory, this is the principle of "reciprocal determinism." Besides focusing on reciprocal influence, a transactional view also highlights the constant state of flux and change of the individual–environment system. Therefore, BPD can occur in multiple environments and families, including chaotic, perfect, and even ordinary families. Millon (1987) made much the same point in discussing the etiology of BPD and the futility of locating the "cause" of the disorder in any single event or time period.

Both transactional and interactive models, such as the diathesis–stress model of psychopathology, call attention to the role of dysfunctional environments in bringing about disorder in the vulnerable individual. A transactional model, however, highlights a number of points that are easy to overlook in an interactive diathesis–stress model. For example, a person (Person A) may act in a manner stressful to an individual (Person B) only because of the stress Person B is putting on Person A. Take the child who, due to an accident, requires most of the parents' free time just to meet survival needs. Or consider the client who, due to the need for constant suicide precautions, uses up much of the inpatient nursing resources. Both of these environments are stretched in their ability to respond well to further stress. Both may inadvertently or temporarily blame the victim if any further demand on the system is made. Although the system (e.g., the family or the therapeutic milieu) may have been predisposed to respond dysfunctionally in any case, such responses may have been avoided in the absence of exposure to the stress of that particular individual. A transactional, or dialectical, account of psychopathology may allow greater compassion, because it is incompatible with the assignment of blame, by highlighting the reality of the situation rather than judgments about the individuals. This is particularly relevant with a label as stigmatized among mental health professionals as "borderline" (for examples of the misuse of the diagnosis, see Reiser & Levenson, 1984).

A final assumption in our discussion regards the definition of behavior and the implications of defining behavior broadly. Linehan's theory, and behaviorists in general, take "behavior" to mean anything an organism does involving action and responding to stimulation (Merriam-Webster's New Universal Unabridged Dictionary, 1983, p. 100). Conventionally, behaviorists categorize behavior as motor, cognitive/verbal, and physiological, all of which may be either public or private. There are several points to make here. First, dividing behavior into these three categories is arbitrary and is done for conceptual clarity rather than in response to evidence that these response modes actually are functionally separate systems. This point is especially relevant to understanding emotion regulation, given that basic research on emotions demonstrates that these response systems are sometimes overlapping, somewhat independent, but definitely not wholly independent, thus remaining consistent with the dialectical worldview. A related point here is that in contrast to biological and cognitive theories of BPD, biosocial theory suggests that there is no a priori reason for favoring explanations emphasizing one mode of behavior as intrinsically more important or compelling than others. Rather, from a biosocial perspective, the crucial questions are under what conditions a given behavior–behavior relationship or response system–response system relationship holds, and under what conditions these relationships enter causal pathways for the etiology and maintenance of BPD.

BIOSOCIAL THEORY

Emotion Dysregulation

Linehan's biosocial theory suggests that BPD is primarily a dysfunction of the emotion regulation system. Behavioral patterns in BPD are functionally related to or are unavoidable consequences of this fundamental dysregulation across several, perhaps all, emotions, including both positive and negative emotions. From Linehan's point of view, this dysfunction of the emotion regulation system is the core pathology; thus, it is neither simply symptomatic nor definitional. Emotion dysregulation is a product of the combination of emotional vulnerability and difficulties in modulating emotional reactions. Emotional vulnerability is conceptualized as high sensitivity to emotional stimuli,
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ntensive emotional responses, and a slow return to emotional baseline. Deficits in emotion modulation may be due to difficulties in (1) inhibiting mood-dependent behaviors; (2) organizing behavior in the service of goals, independently of current mood; (3) increasing or decreasing physiological arousal as needed; (4) distracting attention from emotionally evocative stimuli; and/or (5) experiencing emotion without either immediately withdrawing or producing an extreme secondary negative emotion (see Gottman & Katz, 1990, for a further discussion).

Conceptually, the deficit in the emotion regulation system leads to not only intense emotional suffering but also multiple behavioral problems in individuals with BPD. When clinician's ratings of characteristics associated with psychopathology are examined, tendencies toward being chronically anxious and unhappy, depressed, or disontent are the most highly descriptive of the BPD (Bradley, Zittel, & Westen, 2003). Dysfunction leads the individual to attempt to escape aversive emotions, often leading to further suffering. For example, a female client may be experiencing intense anger after a fight with her partner, and in an effort to escape the anger, she engages in cutting behaviors. She begins to feel relief from her anger for a short period of time. However, once her anger begins to subside, shame in response to the cutting behavior begins to increase and the cycle of emotion escape behavior continues. Although the mechanisms of the initial dysregulation remain unclear, it is likely that biological factors play a primary role. Siever and Davis (1991) hypothesized that deficits in emotion regulation for clients with BPD are related to both instability and hyperresponsiveness of catecholamine function. The etiology of this dysregulation may range from genetic influences to prenatal factors to traumatic childhood events affecting development of the brain and nervous system. Furthermore, adoption studies of monozygotic (MZ) twins (Davison & Neale, 1994) suggest a genetic vulnerability. However, researchers do not claim that genetic or biological factors accounted for all pathology. If pathology were solely determined by genetics, then 100% of the MZ twins would have been presumed to share the same pathology. Because this does not occur, we can explain the differences through the transactions between biology, as described earlier, and the environment.

Invalidating Environments

Most individuals with an initial temperamental vulnerability to emotion dysregulation do not develop BPD. Thus, the theory suggests further that particular developmental environments are necessary. The crucial developmental circumstance in Linehan's theory is the transaction between emotion vulnerability and the presence of the "invalidating environment" (Linehan, 1987a, 1987b, 1989, 1993a), which is defined by its tendency to negate, punish, and/or respond erratically and inappropriately to private experiences, independent of the validity of the actual behavior. Private experiences, and especially emotional experiences and interpretations of events, are not taken as valid responses to events by others; are punished, trivialized, dismissed, or disregarded; and/or are attributed to socially unacceptable characteristics, such as overactivity, inability to see things realistically, lack of motivation, motivation to harm or manipulate, lack of discipline, or failure to adopt a positive (or, conversely, discriminating) attitude. The invalidating environment can be any part of an individual's social environment, including immediate or extended family, school, work, or community. Within each of these environments are even more specific idiosyncrasies that may impact the environment, such as birth order, years between siblings, teachers and peers, and/ or coworkers. It is important to note that because two children grew up in the same home does not mean that they were raised in identical environments. Furthermore, individuals are often not aware of their invalidating behaviors and are not acting with a malicious intent.

There are three primary characteristics of the invalidating environment. First, the environment indiscriminately rejects communication of private experiences and self-generated behaviors. For example a person may be told, "You are so angry, but you won't admit it" or "You can't be hungry, you just ate." Second, the invalidating environment may punish emotional displays and intermittently reinforce emotional escalation. For example, a woman breaks up with her partner and is feeling depressed. Her friends and family begin telling her to "Get over it." "He wasn't worth it," "Don't feel sad." Over the course of the next week, she becomes more depressed and is beginning to withdraw from daily activities. Again, her environment responds in an invalid-
dating manner. Finally after another 3 days of high emotional arousal she makes a suicide attempt. At that moment the environment jumps in and provides support by taking care of her. Unfortunately, this type of pattern often results in inadvertent reinforcement of extreme dysfunctional behavior. Finally, the invalidating environment may oversimplify the ease of problem solving and meeting goals for an individual.

The high incidence of childhood sexual abuse reported among individuals with BPD (Bryer, Nelson, Miller, & Krol, 1987; Herman, 1986; Herman, Perry, & van der Kolk, 1989; Wagner, Linehan, & Wasson, 1989) suggests that sexual abuse may be a prototypic invalidating experience for children. The relationship of early sexual abuse to BPD, however, is quite controversial and is open to many interpretations. On the one hand, Silk, Lee, Hill, and Lohr (1995) reported that the number of criterion BPD behaviors met was correlated with severity of childhood sexual abuse in a group of clients with BPD. On the other hand, a review by Fossati, Maddeddu, and Maffei (1999) suggested that sexual abuse is not a major risk factor for BPD.

The overall results of this transactional pattern between the emotionally vulnerable individual and the invalidating environment are the emotional dysregulation and behavioral patterns exhibited by the borderline adult. Such an individual has never learned how to label and regulate emotional arousal, how to tolerate emotional distress, or when to trust his or her own emotional responses as reflections of valid interpretations of events resulting in self-invalidation (Linehan, 1993a). In more optimal environments, public validation of one’s private, internal experiences results in the development of a stable identity. In the family of a person with BPD, however, private experiences may be responded to erratically and with insensitivity. Thus, the individual learns to mistrust his or her internal states, and instead scans the environment for cues about how to act, think, or feel. This general reliance on others results in the individual’s failure to develop a coherent sense of self. Emotional dysfunction also interferes with the development and maintenance of stable interpersonal relationships, which depend on both a stable sense of self and a capacity to self-regulate emotions. The invalidating environment’s tendency to trivialize or ignore the expression of negative emotion also shapes an expressive style later seen in the adult with BPD—a style that vacillates from inhibition and suppression of emotional experience to extreme behavioral displays. Behaviors such as overdosing, cutting, and burning have important affect-regulating properties and are additionally quite effective in eliciting helping behaviors from an environment that otherwise ignores efforts to ameliorate intense emotional pain. From this perspective, the dysfunctional behaviors characteristic of BPD may be viewed as maladaptive solutions to overwhelming, intensely painful negative affect.

**DIALECTICAL DILEMMAS**

Linehan (1993a) describes “dialectical dilemmas” as behavioral patterns of the client that often interfere with therapy. These behavioral patterns, also referred to as “secondary targets” in treatment (compared to other targets that we describe later) represent six behaviors that are dichotomized into a set of three dimensions of behavior defined by their opposite poles (see Figure 9.1). At one end of each dimension is the behavior that theoretically is most directly influenced biologically via deficits in emotion regulation. At the other end is behavior that has been socially reinforced in the invalidating environment. These secondary targets are characteristics of individuals with BPD that often interfere with change, thus interfering with therapy.

![FIGURE 9.1. Dialectical dilemmas in DBT.](image-url)
Emotion Vulnerability/Self-Invalidation

One dialectical dilemma is represented by biologically influenced emotional vulnerability on the one hand (e.g., the sense of being out of control or falling into the abyss) and by socially influenced self-invalidation on the other (e.g., hate and contempt directed toward the self, dismissal of one's accomplishments). Along this dimension of behavior, clients with BPD often vacillate between acute awareness of their own intense, unbearable, and uncontrollable emotional suffering on the one hand, and dismissal, judgment, and invalidation of their own suffering and helplessness on the other.

Emotion vulnerability here refers to the client's acute experience and communication of emotional vulnerability and excruciating emotional pain. "Vulnerability" here means the acute experience of vulnerability rather than the sensitivity to emotional cues that defines the term when discussing the emotion dysregulation difficulties of the BPD person. In the case here, vulnerability is experienced; in the latter case, the vulnerability may not be experienced.

Three reactions to emotional vulnerability are common in BPD: (1) freezing or dissociating in the face of intense emotion; (2) rage, often directed at society in general or at individuals who are experienced as invalidating; and (3) intense despair. Suicide here can function to communicate to others the depth of one's suffering ("I'll show you") and/or as an escape from an unendurable life.

On the other side of this polarity is self- invalidation. What is invalidated, in essence, is one's own emotional experiencing and dysregulated responses. The most typical pattern here is a reaction to emotional pain with intense self-blame and self-hate. These individuals identify themselves as perpetrators, which results in intense levels of shame and contempt toward the self ("There is nothing wrong with me, I'm just a bad person"). Mood-dependent perfectionism is also common. Here, the individual belittles, ignores, or discounts the difficulty of his or her own life or may overestimate the ease of solving current problems. Unfortunately, this may initiate the start of a cycle that may eventually end in death. Extreme perfectionism often ultimately leads to failure, especially in individuals who overestimate their abilities; the failure then results in self-hatred, which cues suicidal behaviors in these individuals. Finally, self-invalidation can also be expressed through willful suppression, meaning that the individual actively denies the experience of all emotion. Often clients who come into our offices simply state, "I don't do emotions." As with emotion vulnerability, self-invalidation needs to be attended to actively and directly with individuals with BPD, due to the lethal consequences of these behaviors.

Active Passivity/Apparent Competence

A second dimension of behavior is a tendency toward active passivity versus the socially mediated behavior of apparent competence. Either pole of this dimension can lead to anger, guilt, or shame on the part of the client, and a tendency for the therapist to either under- or overestimate the client's capabilities.

"Active passivity" may be defined as passivity in solving one's own problems, while actively engaging others to solve one's problems. It can also be described as passivity that appears to be an active process of shutting down in the face of seeing problems coming in the future. In a sense, individuals with BPD do not appear to have the ability to regulate themselves internally, particularly when the regulation required is non-mood-dependent behaviors. Individuals with BPD appear to be "relational selves" rather than "autonomous selves"; that is, they are more highly regulated by their environment than by internal dialogues, choices and decisions. Their best form of self-regulation is to regulate their environment, such that it then provides the regulation they need. The problem here is that managing one's environment and getting the support one needs requires a good deal of emotional consistency and regulation, characteristics that ordinarily are difficult for individuals with BPD. Lorna Benjamin has described this characteristic as "My misery is your command" (1996, p. 192).

On the opposite side of the polarity is apparent competence. "Apparent competence" refers to the tendency of other individuals to overestimate the capabilities of the individual with BPD. Thus, this characteristic is defined by the behavior of the observer rather than the behavior of the individual with BPD. This failure to accurately perceive their difficulties and "disability" has serious effects on individuals with BPD. Not only do they not get the help they need, but also their emotional pain and difficulties may easily be invalidated, leading to a
further sense of being misunderstood. A number of behavioral patterns can precipitate this overestimation of the competence of the individual with BPD. Often, a significant discrepancy between the individual’s verbal and nonverbal presentations results in the individual with BPD believing that he or she has sufficiently communicated his or her level of distress, when in fact the observer interprets the individual as effectively managing a difficult situation. An example would be a woman speaking nonchalantly and without emotion about urges toward suicide after a fight with her husband. Individuals with BPD also frequently have difficulty generalizing behaviors across situations, especially in relationships. For example, the person may be able to cope well in the presence of one person, such as a therapist, but be unable to cope when he or she is alone or with someone other than the therapist. The therapist, understandably, may then fail to predict the dysregulation that occurs as the client walks away from the therapy session. Additionally, there may be a difficulty in generalizing coping behaviors across different moods. In one mood, a problem is solvable; in another, it is not. This may not be as difficult for the observer to figure out if mood changes are readily apparent to the observer, but often they are not. Thus, accurate estimates of the person’s competence actually require the observer, such as the therapist, constantly to anticipate mood changes that might occur to be able to predict what a client might or might not do. It is this characteristic, more than any other, that leads so often to a client walking out of a session, with the therapist believing all is well, only to end up in the emergency department with a suicide attempt 2 hours later. At times, client failures are nothing more than failures of the therapist (and often the client, also) to predict future behavior accurately.

Unrelenting Crisis/Inhibited Grieving
The third dimension of behavior is the tendency of the client with BPD to experience life as a series of unrelenting crises as opposed to the behavior of “inhibited grieving” (i.e., an inability to experience emotions associated with significant trauma or loss). The client experiences each of these extremes in a way that facilitates movement to the other extreme; for example, attempting to inhibit emotional experiences related to current crises may result in problem behaviors that add to existing crises. As with all of these dialectical dilemmas, the solution is for therapist and client to work toward a more balanced position that represents a synthesis of the opposing poles.

Individuals with BPD who experience unrelenting crises have lives that are often characterized as chaotic and in crisis. “Crisis” is defined as the occurrence of problems that are extreme, with significant pressure to resolve them quickly. The consequence of the unrelenting crisis is that the individual with BPD, as well as the person’s environmental resources, such as family, friends, coworkers, and even the therapist, slowly wear down. There are three typical scenarios that result in a pattern of unrelenting crisis. First, individuals with extreme impulsivity and emotion dysregulation engage in behaviors that result in crisis situations. Poor judgment is a key element to assess when analyzing the impulsive behaviors of individuals with BPD. Second, situations that do not start out as crises can quickly become critical due to the lack of resources available to many individuals with BPD. This may be due to socioeconomic status, or to lack of family or peer support. Finally, unrelenting crises can be due simply to fate or bad luck at a given moment, a phenomenon that is out of the person’s control.

For example, an unexpected disaster in a client’s apartment due to the neighbors running the water in their sink for an extended period of time, might occur. The floors in the client’s apartment are damaged by the water and he or she does not have the financial resources to pay for renter’s insurance or to replace the carpet in the apartment. His or her apartment is now uninhabitable but he or she does not have any place else to stay. This problem is out of the person’s control, but it is still that person’s responsibility to solve.

At the other extreme, and often precipitated by a crisis, is the phenomenon of “inhibited grieving.” In this context, “grief” refers to the process of grieving, including experiencing multiple painful emotions associated with loss, particularly traumatic loss, not just the one emotion of deep sadness or grief. Individuals with BPD may not be able to experience or process the grief related to the loss of the life they had expected for themselves, and ordinarily do not believe they will recover from the grief if they actually try to experience or to cope with it on their own.
As one client said to us, "I don't do sadness." Another said, "I feel sad, I die." Individuals with BPD may not recognize their own emotional avoidance and shutdown. Thus, it is crucial that the therapist attend to emotional avoidance, particularly of sadness and grief, and assist clients through the grief process. Areas that must be confronted, grieved, and finally accepted include an insurmountably painful childhood, a biological makeup that makes life harder rather than easier, inability to "fit in" in many environments, absence of loving people in the current environment, or loss of hope for a particular future for which one had ardently hoped. What must be confronted by the therapist is that egregious losses can be real and clients might be right: They really cannot get out of the abyss if they fall into it. Regardless of the situation to be grieved, avoidance of these situations may lead to increased shame. The shame is a result of believing that one is unloved, being alone, or fearing that one will not be able to cope in the face of emotional situations. Many of our clients believe that if they begin to address any of these areas, they will not be able to function in their lives, and often this is true. They do not have the skills or resources to assist them with the process of experiencing emotions. We often tell clients that managing grief or processing emotions requires going to the cemetery to pay tribute to what is lost, but building a house at the cemetery and living there is not a good idea. It is a place to visit, experience the sadness of the loss, and then leave. The use of this metaphor has helped many of our clients to experience emotion without falling into the abyss.

STAGES OF THERAPY AND TREATMENT GOALS

In theory, treatment of all clients with BPD can be organized and determined based on their levels of disorder, and is conceptualized as occurring in stages. "Level of disorder" is defined by the current severity, pervasiveness, complexity, disability, and imminent threat presented by the client. Clients can enter into five stages of treatment based on their current level of disorder. First, a pretreatment stage prepares the client for therapy and elicits a commitment to work toward the various treatment goals. Orientation to specific goals and treatment strategies, and commitment to work toward goals addressed during this stage, are likely to be important throughout all stages of treatment. In Stage 1 of therapy, the primary focus is on stabilizing the client and achieving behavioral control. Out-of-control behaviors constitute those that are disordered due to the severity of the disorder (e.g., as seen in an actively psychotic client) or due to severity combined with complexity of multiple diagnoses (e.g., as seen in a suicidal client who has BPD with comorbid panic disorder and depression). Generally, the criteria for putting a client in Stage 1 are based on level of current functioning, together with the inability of the client to work on any other goals before behavior and functioning come under better control. As Mintz (1968) suggested in discussing treatment of the suicidal client, all forms of psychotherapy are ineffective with a dead client. In the subsequent stages (2–4), the treatment goals are to replace "quiet desperation" with nontraumatic emotional experiencing (Stage 2); to achieve "ordinary" happiness and unhappiness, and to reduce on-going disorders and problems in living (Stage 3); and to resolve a sense of incompleteness and to achieve freedom (Stage 4). In summary, the orientation of the treatment is first to get action under control, then to help the client to feel better, to resolve problems in living and residual disorder, and to find freedom (and, for some, a sense of transcendence). All research to date has focused on the severely or multiply disordered clients who enter treatment at Stage 1. Understanding a client's severity of disorder and level of treatment through accurate and thorough assessment can assist a therapist in two ways. First, it aids in treatment planning and conceptualization with the client, and in identifying the appropriate level of care needed. Second, it can assist a therapist in determining whether to accept the client into care based on the level of severity. For example, if a therapist has multiple Stage 1 clients, he or she may not want to take on one more Stage 1 client, until treatment is either completed with the others or far enough along that the therapist does not have multiple clients in crisis at one time. Furthermore, some therapists may also use level of severity to determine that a client's condition is not severe enough for the type of treatment the therapist provides; for example, DBT may be too intensive a treatment for someone with a single diagnosis of major depressive disorder.
Pretreatment: Orienting and Commitment

Specific tasks of orientation are twofold. First, client and therapist must arrive at a mutually informed decision to work together. Typically, the first one to four sessions are presented to the client as opportunities for client and therapist to explore this possibility. Diagnostic interviewing, history taking, and formal behavioral analyses of high-priority, targeted behaviors can be woven into initial therapy sessions or be conducted separately. Second, client and therapist must negotiate a common set of expectations to guide the initial steps of therapy. Agreements outlining specifically what the client and therapist can expect from each other are discussed and agreed to. When necessary, the therapist attempts to modify the client’s dysfunctional beliefs regarding the process of therapy. Issues addressed include the rate and magnitude of change that can reasonably be expected, the goals of treatment and general treatment procedures, and various myths the client may have about the process of therapy in general. The dialectical/biosocial view of BPD is also presented. Orientation covers several additional points. First, DBT is presented as a supportive therapy requiring a strong collaborative relationship between client and therapist. DBT is not a suicide prevention program, but a life enhancement program in which client and therapist function as a team to create a life worth living. Second, DBT is described as a cognitive-behavioral therapy with a primary emphasis on analyzing problematic behaviors and replacing them with skillful behaviors, and on changing ineffective beliefs and rigid thinking patterns. Third, the client is told that DBT is a skills-oriented therapy, with special emphasis on behavioral skills training. The commitment and orienting strategies, balanced by validation strategies described later, are the most important strategies during this phase of treatment. The therapist places a strong effort into getting the client to commit to not engaging in suicidal or NSSI behaviors for some specified period of time before allowing the client to leave the session; it can be for 1 year, 6 months, until the next session, or until tomorrow.

Stage 1: Attaining Basic Capacities

The primary focus of the first stage of therapy is attaining behavioral control in order to build a life pattern that is reasonably functional and stable. Furthermore, DBT does not promote itself as a suicide prevention program; instead, it focuses on life improvement. Therefore, the primary treatment goal in DBT and in Stage 1 specifically is to assist clients in building a life worth living. DBT attains this goal by focusing the treatment on specific behavioral targets agreed upon by both therapist and client. Specific targets in order of importance are to reduce life-threatening behaviors (e.g., suicide attempts, increase in suicide ideation, NSSI behaviors, homicidal threats and behaviors), therapy-interfering behaviors (e.g., late to session, missing sessions, not following treatment plan, hostile attacks on the therapist), and quality-of-life-interfering behaviors (e.g., substance abuse, eating disorder, homelessness, serious Axis I disorders), and to increase behavioral skills. These targets are approached hierarchically and recursively as higher-priority behaviors reappear in each session. However, this does not mean that these behaviors must be addressed in this specific order during a session; it means that based on the hierarchy, all relevant behavior must be addressed at some point within the session. For example, if a client is 10 minutes late to session (therapy-interfering behavior) and has cut within the last week (life-threatening behavior), the therapist may choose to address the therapy-interfering behavior first, then move on to address the life-threatening behaviors.

With severely dysfunctional and suicidal clients, significant progress on first stage targets may take up to 1 year or more. In addition to these therapy targets, the goal of increasing dialectical behaviors is universal to all modes of treatment. Dialectical thinking encourages clients to see reality as complex and multifaceted, to hold contradictory thoughts simultaneously and learn to integrate them, and to be comfortable with inconsistency and contradictions. For individuals with BPD, who are extreme and dichotomous in their thinking and behavior, this is a formidable task indeed. A dialectical emphasis applies equally to a client’s patterns of behavior, because the client is encouraged to integrate and balance emotional and overt behavioral responses. In particular, dialectical tensions arise in the areas of skills enhancement versus self-acceptance, problem solving versus problem acceptance, and affect regulation versus affect tolerance. Behavioral extremes, whether emotional, cognitive, or overt re-
DBT does not envision profound improvement. Its goal in DBT is to assist clients. DBT attains its goals on specific by both therapeutic means and by maintaining behaviors. Suicide, self-harm, and violent behaviors can be adequately treated by novel treatments. However, not all attacks on the interfering behaviors (disorders), and new targets are recursively as per in each of a mean that is in this specific mean that want behavior int within the is 10 minutes (treatment behavior) week (living therapist may spy-interfering to address the suicidal client's stage targets). In addition to increasing di- o all modes of encouragement client-multifaceted, simultaneously to be comfort- radications. For extreme and di- behavior, this dialectical em- ployed patterns of encouragement can be coaxed from their overt, dialectical enhancement and solving verbal perfection of verbal extremes or overt re- sponses, are constantly confronted while more balanced responses are taught.

Life-Threatening Behaviors
Keeping a client alive must, of course, be the first priority in any psychotherapy. Thus, reducing suicide crisis behaviors (any behaviors that place the client at high and imminent risk for suicide or threaten to do so, including credible suicide threats, planning, preparations, obtaining lethal means, and high suicide intent) is the highest priority in DBT. The target and its priority are made explicit in DBT during orientation and throughout treatment, simply because suicidal behavior and the risk of suicide are of paramount concern for clients with BPD. Similarly, any acute, intentional NSSI behaviors share the top priority. The priority here is due both to the risk of suicidal and NSSI behavior as the single best predictor of subsequent suicide. Similarly, DBT also targets suicide ideation and client expectations about the value and long-term consequences of suicidal behavior, although these behaviors may not necessarily be targeted directly.

Therapy-Interfering Behaviors
Keeping clients and therapists working together collaboratively is the second explicitly targeted priority in DBT. The chronic nature of most problems among clients with BPD, including their high tendency to end therapy prematurely, and the likelihood of therapist burnout and iatrogenic behaviors when treating BPD require such explicit attention. Both client and therapist behaviors that threaten the relationship or therapeutic progress are addressed directly, immediately, consistently, and constantly—and most importantly, before rather than after the intervention or the client no longer wants to continue. Interfering behaviors of the client, including those that actually interfere with receiving the therapy (e.g., lateness to sessions, missed sessions, lack of transportation to sessions, dissociation in sessions) or with other clients benefiting from therapy (in group or milieu settings; e.g., selling drugs to other clients in the program), and those that turn off or cross the personal limits of the therapist (e.g., repeated crisis calls at three in the morning, repeated verbal attacks on the therapist) are treated within therapy sessions. Behaviors of the therapist include any that are iatrogenic (e.g., inadvertently reinforcing dysfunctional behaviors), as well as any that cause the client unnecessary distress or make progress difficult (e.g., therapist arriving late to sessions, missing sessions, not returning phone calls within a reasonable time frame). These behaviors are dealt with in therapy sessions, if brought up by either the client or the therapist, and are also discussed during the consultation/supervision meeting.

Quality-of-Life-Interfering Behaviors
The third target of Stage 1 addresses all other behaviors that interfere with the client having a reasonable quality of life. Typical behaviors in this category include serious substance abuse, severe major depressive episodes, severe eating disorders, high-risk and out-of-control sexual behaviors, extreme financial difficulties (uncontrollable spending or gambling, inability to handle finances), criminal behaviors that are likely to lead to incarcera- tion, employment- or school-related dysfunctional behaviors (a pattern of quitting jobs or school prematurely, getting fired or failing in school, not engaging in any productive activities), housing-related dysfunctional behaviors (living with abusive people, not finding stable housing), mental health-related patterns (going in and out of hospitals, failure to take or abuse of necessary medications), and health-related problems (failure to treat serious medical disorders). The goal here is for the client to achieve a stable lifestyle that meets reasonable standards for safety and adequate functioning.

Behavioral Skills
The fourth target of Stage 1 is for the client to achieve a reasonable capacity for acquiring and applying skillful behaviors in the areas of distress tolerance, emotion regulation, interpersonal effectiveness, self-management, and the capacity to respond with awareness without being judgmental ("mindfulness" skills). In our outpatient program, the primary responsibility for skills training lies with the weekly DBT skills group. The individual therapist monitors the acquisition and use of skills over time, and aids the client in applying skills to specific problem situations in his or her own life. Additionally, it is the role of the individual therapist, not the skills group leader, to provide skills
coaching to the client as needed when problems arise.

Stage 2: Posttraumatic Stress Reduction

Stage 1 of DBT takes a direct approach to managing dysfunctional behavioral and regulating emotional patterns. Although the connection between current behavior and previous traumatic events (including those from childhood) may be explored and noted, the focus of the treatment is distinctly on analyzing the relationship among current thoughts, feelings, and behaviors, and on accepting and changing current patterns. The aim of Stage 2 DBT is to reduce “quiet desperation,” which can be defined as extreme emotional pain in the presence of control of action (Linehan et al., 1999). A wide range of emotional experiencing difficulties (e.g., avoidance of emotions and emotion-related cues) are targeted in this stage, with the goal of increasing the capacity for normative emotional experiencing (i.e., the ability to experience a full range of emotions without either severe emotional escalation or behavioral dyscontrol). Because many individuals with BPD have histories of severe and chronic traumatic experiences, these problems frequently take the form of posttraumatic stress disorder (PTSD) and related behaviors and are treated through exposure therapy (formal and informal). Stage 2 addresses four goals: remembering and accepting the facts of earlier traumatic events; reducing stigmatization and self-blame commonly associated with some types of trauma; reducing the oscillating denial and intrusive response syndromes common among individuals who have suffered severe trauma; and resolving dialectical tensions regarding placement of blame for the trauma.

Stage 3: Resolving Problems in Living and Increasing Respect for Self

In the third stage, DBT targets the client’s unacceptable unhappiness and problems in living. At this stage, the client with BPD has either done the work necessary to resolve problems in the prior two stages or was never severely disordered enough to need it. Although problems at this stage may still be serious, the individual is functional in major domains of living. The goal here is for the client to achieve a level of ordinary happiness and unhappiness, as well as independent self-respect. To this end, the client is helped to value, believe in, trust, and validate him- or herself. The targets here are the abilities to evaluate one’s own behavior nondefensively, to trust one’s own responses, and to hold on to self-evaluations, independent of the opinions of others. Ultimately, the therapist must pull back and persistently reinforce the client’s independent attempts at self-validation, self-care, and problem solving. Although the goal is not for clients to become independent of all people, it is important that they achieve sufficient self-reliance to relate to and depend on others without self-invalidating.

Stage 4: Attaining the Capacity for Freedom and Sustained Contentment

The final stage of treatment in DBT targets the resolution of a sense of incompleteness and the development of a capacity for sustained contentment. The focus on freedom encompasses the goal of freedom from the need to have one’s wishes fulfilled, or one’s current life or behavioral and emotional responses changed. Here the goals are expanded awareness, spiritual fulfillment, and the movement into experiencing flow. For individuals at Stage 4, long-term insight-oriented psychotherapy, spiritual direction or practices, or other organized experiential treatments and/or life experiences may be of most benefit.

STRUCTURING TREATMENT: FUNCTIONS AND MODES

Functions of Treatment

Treatment in DBT is structured around the five essential functions it serves. Treatment functions to: (1) enhance behavioral capabilities by expanding the individual’s repertoire of skillful behavioral patterns; (2) improve the client’s motivation to change by reducing reinforcement for dysfunctional behaviors and high-probability responses (cognitions, emotions, actions) that interfere with effective behaviors; (3) ensure that new behaviors generalize from the therapeutic to the natural environment; (4) enhance the motivation and capabilities of the therapist so that effective treatment is rendered; and (5) structure the environment so that effective behaviors, rather than dysfunctional behaviors, are reinforced.
Modes of Treatment:
Who Does What and When

Responsibility for performing functions and meeting target goals of treatment in DBT is spread across the various modes of treatment, with focus and attention varying according to the mode of therapy. The individual therapist (who is always the primary therapist in DBT) attends to one order of targets and is also, with the client, responsible for organizing the treatment so that all goals are met. In skills training, a different set of goals is targeted; during phone calls, yet another hierarchy of targets takes precedence. In the consultation/supervision mode, therapists’ behaviors are the targets. Therapists engaging in more than one mode of therapy (e.g., individual, group, and telephone coaching) must stay cognizant of the functions and order of targets specific to each mode, and switch smoothly from one hierarchy to another as the modes of treatment change.

Individual Therapy

DBT assumes that effective treatment must attend to both client capabilities and behavioral skills deficits, and to motivational and behavioral performance issues that interfere with use of skillful responses (function 2). Although there are many ways to effect these principles, in DBT the individual therapist is responsible for the assessment and problem solving of skill deficits and motivational problems, and for organizing other modes to address problems in each area.

Individual outpatient therapy sessions are scheduled on a once-a-week basis for 50-90 minutes, although twice-weekly sessions may be held as needed during crisis periods or at the beginning of therapy. The priorities of specific targets within individual therapy are the same as the overall priorities of DBT discussed earlier. Therapeutic focus within individual therapy sessions is determined by the highest-priority treatment target relevant at the moment. This ordering does not change over the course of therapy; however, the relevance of a target does change. Relevance is determined by either the client’s most recent, day-to-day behavior (since the last session) or by current behavior during the therapy session. If satisfactory progress on one target goal has been achieved or the behavior has never been a problem, or if the behavior is currently not evident, then the therapist shifts attention to another treatment target according to the hierarchy. The consequence of this priority allocation is that when high-risk suicidal behaviors or intentional self-injury, therapy-interfering behaviors, or serious quality-of-life-interfering behaviors are occurring, at least part of the session agenda must be devoted to each of these topics. If these behaviors are not occurring at the moment, then the topics to be discussed during Stages 1, 3, and 4 are set by the client. The therapeutic focus (within any topic area discussed) depends on the stage of treatment, the skills targeted for improvement, and any secondary targets. During Stage 1, for example, any problem or topic area can be conceptualized in terms of interpersonal issues and skills needed, opportunities for emotion regulation, and/or a necessity for distress tolerance. During Stage 3, regardless of the topic, the therapist focuses on helping the client decrease problems in living and achieve independent self-respect, self-validation, and self-acceptance both within the session and within everyday life. (These are, of course, targets all through the treatment, but the therapist pulls back further during Stage 3 and does less work for the client than during the two preceding stages.) During Stage 2, the major focus is on reducing pervasive “quiet desperation,” as well as changing the extreme emotions and psychological meanings associated with traumatizing cues.

For highly dysfunctional clients, it is likely that early treatment will necessarily focus on the upper part of the hierarchy. For example, if suicidal or NSSI behavior has occurred during the previous week, attention to it takes precedence over attention to therapy-interfering behavior. In turn, focusing on therapy-interfering behaviors takes precedence over working on quality-of-life-interfering behaviors. Although it is often possible to work on more than one target (including those generated by the client) in a given session, higher-priority targets always take precedence, but all relevant targets must be addressed adequately during the session. Again, targets do not need to be addressed in sequential order, they just have to be addressed during the session. Determining the relevance of targeted behaviors is assisted by the use of diary cards. These cards are filled out by the client during at least the first two stages of therapy and are brought to weekly sessions.
Failure to complete or to bring in a card is considered a therapy-interfering behavior and should be openly addressed as such. Diary cards record daily instances of suicidal and NSSI behavior, urges to self-harm or to engage in suicide behaviors (on a 0- to 5-point scale), “misery,” use of substances (licit and illicit), and use of behavioral skills. Other targeted behaviors (bulimic episodes, daily productive activities, flashbacks, etc.) may also be recorded on the blank area of the card. The therapist doing DBT must develop the pattern of routinely reviewing the card at the beginning of each session. The card acts as a road map for each session; therefore, a session cannot begin until a diary card has been completed. If the card indicates that a life-threatening behavior has occurred, it is noted and discussed. If high suicide or self-harm urges are recorded, or there is a significant increase (e.g., an increase of 3 points or higher on the 0- to 5-point scale for urges) over the course of the week, they are assessed to determine whether the client is at risk for suicide. If a pattern of substance abuse or dependence appears, it is treated as a quality-of-life-interfering behavior.

Work on targeted behaviors involves a coordinated array of treatment strategies, described later in this chapter. Essentially, each session is a balance between structured, as well as unstructured, problem solving (including simple interpretive activities by the therapist) and unstructured validation. The amount of the therapist’s time allocated to each—problem solving and validating—depends on (1) the urgency of the behaviors needing change or problems to be solved, and (2) the urgency of the client’s needs for validation, understanding, and acceptance without any intimation of change being needed. However, there should be an overall balance in the session between change (problem solving) and acceptance (validation) strategies. Unbalanced attention to either side may result in a nondialectical session, in addition to impeding client progress.

Skills Training

The necessity of crisis intervention and attention to other primary targets makes skills acquisition within individual psychotherapy very difficult. Thus, a separate component of treatment directly targets the acquisition of behavioral skills (function 1). In DBT this usually takes the form of separate, weekly, 2- to 2½-hour group skills training sessions that clients must attend, ordinarily for a minimum of 6 months and preferably for a year. Skills training can also be done individually, although it is often more difficult to stay focused on teaching new skills in individual than in group therapy. After a client has gone through all skills modules twice (i.e., for 1 year), remaining in skills training is a matter of personal preference and need. Some DBT programs have developed graduate groups for individuals who have acquired the skills but still need weekly consultation in applying the skills effectively to everyday difficulties. It is important to note that there is no research to date on the effectiveness of graduate groups. In adolescent programs, family members are usually invited. Some programs include a separate friends and families skills training group as well.

Each group typically has a leader and a coleader. Whereas the primary role of the leader is to teach the skills, the coleader focuses on managing group process by keeping members both focused and attending to the material being taught, as well as processing the information (e.g., ensuring everyone is on the correct page, noticing when the leader’s invalidation has led to a member shutting down, waking someone up, sitting next to a member who is crying during group). We have found that it is difficult to keep the group focused and the leader on schedule for teaching the skills if the leader attempts to manage both roles on his or her own. Oftentimes, the coleader role is the more difficult position to learn.

Skills training in DBT follows a psychoeducational format. In contrast to individual therapy, in which the agenda is determined primarily by the problem to be solved, the skills training agenda is set by the skill to be taught. As mentioned earlier, skills training also has a hierarchy of treatment targets that are used to keep the group focused: (1) therapy-destroying behaviors (e.g., using drugs on premises, which could lead to the clinic being shut down; property damage; threatening imminent suicide or homicidal behavior to a fellow group member or therapist); (2) increasing skills acquisition and strengthening; and (3) decreasing therapy-interfering behaviors (e.g., refusing to talk in a group setting, restless pacing in the middle of sessions, attacking the therapist and/or the therapy). However, therapy-interfering behaviors are not given the attention in skills training that they are given in the individual psycho-
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ization in skills
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adequately con-
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fering behav-
ual psycho-
therapy mode. If such behaviors were a pri-
ary focus, there would never be time for
aching behavioral skills. Generally, therapy-
fering behaviors are put on an extinction
ble, while a client is “dragged” through
in skills training and simultaneously soothed.
M, all skills training clients are required to be
in concurrent individual psychotherapy.
throughout group or individual skills training,
each client is urged to address other problem-
grades with his or her primary ther-
risks of suicide develops, the
therapist refers the problem to the
primary therapist.
Although all of the strategies described be-
low are used in both individual psychotherapy
and skills training, the mix is decidedly dif-
rent. Skills acquisition, strengthening, and
generalization strategies are the predominant
change strategies in skills training. In addition,
skills training is highly structured, much more
so than the individual psychotherapy com-
ponent. Half of each skills training session is de-
voted to reviewing homework practice of the
skills currently being taught, and the other half
is devoted to presenting and practicing new
skills. Except when interpersonal process issues
seriously threaten progress, the agenda and
topics for discussion in skills training are usu-
ally set by the group leader.
Four skills modules are taught on a rotating
basis over the course of 6 months. In standard
DBT, mindfulness skills are taught in 2 consec-
utive weeks at the beginning of each of the sub-
sequent modules. New members are able to
join a group during either the 2 weeks of mind-
fulness or the first 2 weeks of the subsequent
module. If a new member is not ready to join
after this point, he or she must wait until the
start of the next mindfulness module.
Mindfulness skills are viewed as central in
DBT; thus, they are labeled the “core” skills.
These skills represent a behavioral translation
of meditation (including Zen and contempla-
tive prayer) practice and include observing,
describing, spontaneous participating, being
nonjudgmental, focusing awareness, and focus-
ing on effectiveness. Unlike standard behavior
and cognitive therapies, which ordinarily focus
on changing distressing emotions and events, a
major emphasis of DBT is on learning to man-
age pain skillfully. Mindfulness skills reflect
the ability to experience and to observe one’s
thoughts, emotions, and behaviors without
valuation, and without attempting to change
or control them. Distress tolerance skills com-
prise two types of skills. First, crisis survival
skills are used to regulate behavior in order to
manage painful situations without making
them worse (e.g., without engaging in life-
threatening behavior) until the problem can be
solved. Second, accepting reality skills are used
to tolerate the pain of problems that cannot be
solved in either the short-term future or that
may have occurred in the past and, therefore,
cannot be changed ever. Emotion regulation
skills target the reduction of emotional distress
through exposure to the primary emotion in a
nonjudgmental atmosphere. Emotion regula-
tion skills include affect identification and la-
beling, mindfulness to the current emotions
(i.e., experiencing nonjudgmentally), identify-
ing obstacles to changing emotions, increasing
positive emotional events, and behavioral ex-
pressiveness opposite to the emotion. Interper-
sonal effectiveness skills teach effective meth-
ods for deciding on objectives within conflict
situations (either asking for something or say-
ing “no” to a request) and teach strategies that
maximize the chances of obtaining those objec-
tives without harming the relationship or sacri-
ficing self-respect. Self-management skills are
taught in conjunction with the other behavioral
skills; however, there is not a specific module
allocated to these skills, because behavioral
principles are inherent in all of DBT. Self-
management skills include knowledge of the
fundamental principles of learning and behav-
ior change, and the ability to set realistic goals,
to conduct one’s own behavioral analysis, and
to implement contingency management plans.

Telephone Consultation

tical calls between sessions (or other
extratherapeutic contact when DBT is con-
ducted in other settings, e.g., inpatient units)
are an integral part of DBT. Telephone consul-
tation calls also follow a target hierarchy: (1)
to provide emergency crisis intervention and si-
multaneously break the link between suicidal
behaviors and therapist attention; (2) to pro-
vide coaching in skills and promote skills gen-
eralization (function 3); and (3) to provide a
context for repairing the therapeutic relation-
ship, without requiring the client to wait until
the next session. With respect to calls for skills
coaching, the focus of a phone call varies de-
pending on the complexity and severity of the
problem to be solved and the amount of time
the therapist is willing to spend on the phone. It is important to note that these calls are not considered therapy sessions and should not be used as such. Therapists must keep the function of the call in mind so that they do not begin conducting sessions over the phone; this behavior could easily lead to therapist burnout with the client. With easy or already clear situations, in which it is reasonably easy to determine what the client can or should do in the situation, the focus is on helping the client use behavioral skills (rather than dysfunctional behaviors) to address the problem. Alternatively, with complex problems, or with problems too severe for the client to resolve soon, the focus is on ameliorating and tolerating distress, and inhibiting dysfunctional problem-solving behaviors until the next therapy session. In the latter case, resolving the problem that set off the crisis is not the target of telephone coaching calls.

With the exception of taking necessary steps to protect the client’s life when he or she has threatened suicide, all calls for help are handled as much alike as possible. This is done to break the contingency between suicidal and NSSI behaviors, and increased phone contact. To do this, the therapist can do one of two things: refuse to accept any calls (including suicide crisis calls), or insist that the client who calls during suicidal crises also call during other crises and problem situations. As Linehan (1993b) notes, experts on suicidal behaviors uniformly say that therapist availability is necessary with suicidal clients. Thus, DBT chooses the latter course and encourages (and at times insists) on calls during nonsuicidal crisis periods. In DBT, calling the therapist too infrequently, as well as too frequently, is considered therapy-interfering behavior. Through orientation to coaching calls during pretreatment the client learns what to expect during the calls. For example, a therapist may communicate to the client in session what the therapist will ask during the call, “What's the problem? What skills have you used? Where is your skills book? Go get it, and let's figure out what other skills you can use to get through this situation.” It is important to highlight that clients and therapists can easily fall into the trap of considering the act of calling for phone consultation a skill. Although asking for help may be a current target of treatment, it is not considered a skill to be used when the client is in distress. Therapists want to reinforce the client for effectively reaching out; however, they do not want to reinforce the client who does not try using actual skills to manage the problem at hand prior to calling the therapist.

Additionally, the therapist is balancing the change-focused strategies with validation throughout the call. It is important that the therapist be aware of the contingency management principles that may be occurring during the phone calls to avoid inadvertently reinforcing crisis behaviors and to increase therapist-client contact between sessions.

A skills trainer uses phone calls for only one reason: to keep a client in the therapy (including, of course, when necessary, keeping the client alive). All other problems are handled by the primary therapist, and suicidal crises are turned over to the primary therapist as soon as possible. We have learned that this can be one of the most difficult distinctions for group leaders to uphold. Clients may call group leaders for a variety of reasons, and it is the role of the group leader consistently to refer the client back to the individual therapist. For example, a client may call a group leader to ask for assistance with the homework assigned the previous week. Although this may seem appropriate for the skills trainer to address, it should be referred back to the individual therapist. At most, the group leader may repeat what the assignment was but should not provide any coaching in how to complete the assignment.

The final priority for phone calls to individual therapists is relationship repair. Clients with BPD often experience delayed emotional reactions to interactions that have occurred during therapy sessions. From a DBT perspective, it is not reasonable to require clients to wait up to a whole week before dealing with these emotions, and it is appropriate for a client to call for a brief “heart-to-heart” talk. In these situations, the role of the therapist is to soothe and to reassure. In-depth analyses should wait until the next session.

Consultation Team

DBT assumes that effective treatment of BPD must pay as much attention to the therapist's behavior and experience in therapy as it does to the client's. Treating clients with BPD is enormously stressful, and staying within the DBT therapeutic frame can be tremendously difficult (function 4). Thus, an integral part of the therapy is the treatment of the therapist. Every therapist is required to be on a consultation
actual skills to
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balancing the
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tly reinforcing
are necessary
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PBD is enor-
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erapist. Every

consultation

team either with one other person or with a
group. DBT consultation meetings are held
weekly and are attended by therapists currently
providing DBT to clients. At times, the clinical
setting may require that the team be part of an
administrative meeting due to time and space
constraints. When this occurs, it is important to
set a specific agenda and time limitations on
each part of the meeting (administration, DBT)
to ensure that therapist consultation issues are
addressed. The roles of consultation are to hold
the therapist within the therapeutic frame and
to address problems that arise in the course of
treatment delivery. Thus, the fundamental tar-
get is increasing adherence to DBT principles
for each member of the consultation group.
The DBT consultation team is viewed as an
integral component of DBT; that is, it is consid-
ered peer group therapy for the therapists, in
which each member is simultaneously a ther-
apist to other members and a client. The focus is
on applying DBT strategies to increase DBT-
 adherent behaviors and decrease non-DBT be-
aviors.

There are three primary functions of consul-
tation to the therapist in DBT. First, a consulta-
tion team helps to keep each individual ther-
apist in the therapeutic relationship. The role
here is to cheerlead and to support the ther-
apist. Second, the supervisor or consultation
team balances the therapist in his or her inter-
actions with the client. In providing balance,
consultants may move close to the therapist,
helping him/her maintain a strong position.
Consultants may move back from the therapist,
requiring the therapist to move closer to the cli-
ent to maintain balance. Third, within pro-
grammatic applications of DBT, the team pro-
vides the context for the treatment.

JOINING THE CONSULTATION TEAM

Each team comprises therapists who are cur-
rently treating a DBT client or are available to
take on a DBT client. Prior to joining the team, it
is important that the therapist be completely
aware of his or her commitment. As with clients
during the pretreatment phase of DBT, ther-
pists must make a commitment to the team (see
Table 9.1). A commitment session between the
new member and either the team leader, a team
member, or, in some cases, the entire team can be
extraordinarily helpful here. The team member
conducting the commitment session will use the
same strategies and techniques used in a first

<table>
<thead>
<tr>
<th>TABLE 9.1. DBT Consultation Team Commitment Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To keep the agreements of the team, especially</td>
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<tr>
<td>remaining compassionate, mindful, and</td>
</tr>
<tr>
<td>dialectical.</td>
</tr>
<tr>
<td>2. To be available to see a client in whatever role</td>
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<tr>
<td>one has joined the team for (e.g., individual</td>
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<tr>
<td>therapist, group skills trainer, clinical</td>
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<tr>
<td>supervisor, pharma therapist).</td>
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<tr>
<td>3. To function as a therapist in the group (to the</td>
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<tr>
<td>group) and not just be a silent observer or a</td>
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<tr>
<td>person that only speaks about his or her own</td>
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<tr>
<td>problems.</td>
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<tr>
<td>4. To treat team meetings in the same way one</td>
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<tr>
<td>treats any other group therapy session (i.e.,</td>
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<tr>
<td>attending the weekly meetings [not double</td>
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<tr>
<td>scheduling other events or clients], on time,</td>
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<tr>
<td>until the end, with papers, PDAs, and phones</td>
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<tr>
<td>out of sight and off or, if necessarily on, on</td>
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<tr>
<td>silent).</td>
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<tr>
<td>5. To come to team meetings adequately</td>
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<tr>
<td>prepared.</td>
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<td>6. To be willing to give clinical advice to people</td>
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<tr>
<td>who have more experience (especially when it’s hard</td>
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<tr>
<td>to imagine yourself as being able to offer anything</td>
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<tr>
<td>useful).</td>
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<tr>
<td>7. To have the humility to admit your mistakes/</td>
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<tr>
<td>difficulties and the willingness to have the group</td>
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<tr>
<td>help you solve them.</td>
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<tr>
<td>8. To be nonjudgmental and compassionate of your</td>
</tr>
<tr>
<td>fellow clinicians and clients. To ring the bell of</td>
</tr>
<tr>
<td>nonjudgmentaleness to remind yourself not to be</td>
</tr>
<tr>
<td>judgmental or unmindful, but not to ring it as a</td>
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<tr>
<td>proxy for criticizing someone. The bell is a</td>
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<tr>
<td>reminder, not a censor.</td>
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<tr>
<td>9. To properly assess the problem before giving</td>
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<tr>
<td>solutions (do unto others as you wish they would</td>
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<tr>
<td>more often do unto you).</td>
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<tr>
<td>10. To call out “Elephant in the room” when others</td>
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<tr>
<td>are ignoring or not seeing the elephant.</td>
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<tr>
<td>11. To be willing to go through a chain analysis</td>
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<tr>
<td>even though you were only 31 seconds late and you</td>
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<tr>
<td>would have been there on time if it were not for that</td>
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<tr>
<td>traffic light that always takes all day to change.</td>
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<tr>
<td>12. To participate in team by sharing the roles of</td>
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<tr>
<td>Leader, Observer, Note Taker or other tasks</td>
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<tr>
<td>critical to team functioning.</td>
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<tr>
<td>13. If you feel that the consult team is not being</td>
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<tr>
<td>useful or don’t like the way it is being run, then</td>
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<tr>
<td>say something about it rather than silently</td>
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<tr>
<td>stewing in frustration.</td>
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<tr>
<td>14. To repair with the team in some way when</td>
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<tr>
<td>team meetings are missed, because the team is</td>
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<td>only as strong as the weakest link. Therefore,</td>
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<tr>
<td>the absence of any team member is felt.</td>
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<tr>
<td>15. To carry on even when feeling burnt out,</td>
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<tr>
<td>frustrated, tired, overworked, undervalued,</td>
</tr>
<tr>
<td>hopeless, ineffective (easier committed to than</td>
</tr>
<tr>
<td>done, of course).</td>
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</tbody>
</table>
session with a DBT client (e.g., devil’s advocate, pros and cons, troubleshooting). In addition to the commitment items listed in Table 9.1, two fundamental commitments must be agreed to by each member of the team. First, as mentioned previously, the primary function of the team is to increase therapists’ motivation and capability in providing DBT. Therefore, each member agrees to work actively toward increasing the team member’s effectiveness and adherence when applying DBT principles and strategies to clients and to other team members. Second, the consultation team is a community of therapists treating a community of clients. Thus, each team member agrees to be responsible for treatment and outcomes of all clients treated by the team. For example, members of the team are agreeing that if a client being treated by any member of the team commits suicide, then all members will say “Yes” when asked if they have ever had a client commit suicide.

**CONSULTATION MEETING FORMAT**

There are multiple ways to run a DBT team meeting. The following is the way we conduct our meetings at the University of Washington (although it is important to note that even this format could change as needs of members change). Each of our DBT teams has an identified team leader. This person is typically the most experienced DBT therapist on the team, and his or her role is to articulate the DBT principles when necessary for overseeing the fidelity of the treatment provided. Additionally, a team may have an observer who rings a bell whenever team members make judgmental comments (in content or tone) about themselves, each other, or a client; stay polarized without seeking synthesis; fall out of mindfulness by doing two things at once; or jump in to solve a problem before assessing the problem. The point of these observations is not to lay blame, but to focus the team’s awareness on the behavior and move past it.

A team may begin with a mindfulness practice. There are several functions of mindfulness on a team. First, it helps members transition into the team by participating fully and focusing on only one thing in the moment, using a DBT mindset. Second, it can provide an opportunity for team members to enhance their skills in leading and providing feedback about the practice with other team members. Consultation team agreements (see Table 9.2) have been developed to facilitate a DBT frame and help to create a supportive environment for managing client-therapist and therapist-therapist difficulties. Therefore, a team may elect to read one or all of the team agreements during the team meeting. Most importantly, an agenda is set by the team following the DBT hierarchy of targets, with a specific focus on the needs of the therapist rather than the problems of the clients. Our agenda at the University of Washington uses the following format; however, the following items can be prioritized differently based on the needs of an individual team: (1) the therapists’ need for consultation around clients’ suicidal crises or other life-threatening behaviors; (2) therapy-interfering behaviors (including client absences and dropouts, as well as therapist therapy-interfering behaviors); (3) therapist team-interfering behaviors and burnout; (4) severe or escalating deterioration in quality-of-life behaviors; (5) reportage of good news and therapists’ effective behaviors; (6) a summary of the work of the previous skills group and graduate group by group leaders; and (7) discussion of administrative issues (requests to miss team or be out of town, new client contacts; changes in skills trainers or group time, format of consultation group, etc.). This agenda spans the 1-hour consultation meeting. Although the agenda may look impossibly long, therapists ordinarily manage the time by being explicit about their need for help and consultation from the team.

**Ancillary Care**

When problems in the client’s environment interfere with the client’s functioning or progress, the therapist moves to the case management strategies. Although not new, case management strategies direct the application of core strategies (discussed later) to case management problems. There are three case management strategies: the consultant-to-the-client strategy, environmental intervention, and the consultation/ supervision team meeting (described above). Because DBT is grounded in dialectics and avoids becoming rigid, a therapist intervenes in the client’s environment only under very specific conditions: (1) The client is unable to act on his own behalf and outcome is extremely important; (2) the environment will only speak with someone who is in high power
TABLE 9.2. DBT Consultation
Team Agreements

1. **Dialectical agreement:** We agree to accept a dialectical philosophy: There is no absolute truth. When caught between two conflicting opinions, we agree to look for the truth in both positions and to search for a synthesis by asking questions such as "What is being left out?"

2. **Consultation to the client agreement:** We agree that the primary goal of this group is to improve our own skills as DBT therapists, and not serve as a go-between for clients to each other. We agree to not treat clients or each other as fragile. We agree to treat other group members with the belief that others can speak on their own behalf.

3. **Consistency agreement:** Because change is a natural life occurrence, we agree to accept diversity and change as they naturally come about. This means that we do not have to agree with each others' positions about how to respond to specific clients, nor do we have to tailor our own behavior to be consistent with everyone else's.

4. **Observing limits agreement:** We agree to observe our own limits. As therapists and group members, we agree to not judge or criticize other members for having different limits from our own (e.g., too broad, too narrow, "just right").

5. **Phenomenological empathy agreement:** All things being equal, we agree to search for nonpejorative or phenomenologically empathic interpretations of our clients', our own, and other members' behavior. We agree to assume that we and our clients are trying our best and want to improve. We agree to strive to see the world through our clients' eyes and through one another's eyes. We agree to practice a nonjudgmental stance with our clients and with one another.

6. **Fallibility agreement:** We agree ahead of time that we are each fallible and make mistakes. We agree that we have probably already done whatever problematic things we're being accused of, or some part of it, so that we can let go of assuming a defensive stance to prove our virtue or competence. Because we are fallible, it is agreed that we will inevitably violate all of these agreements, and when this is done, we will rely on each other to point out the polarity and move to a synthesis.

(e.g., the therapist instead of the client); (3) when the client's or others' lives are in imminent danger; (4) when it is the humane thing to do and will cause no harm; and (5) when the client is a minor.

CONSULTATION TO THE CLIENT STRATEGY

The consultation-to-the-client strategy was developed with three objectives in mind. First, clients must learn how to manage their own lives and care for themselves by interacting effectively with other individuals in the environment, including health care professionals. The consultation-to-the-client strategy emphasizes clients' capacities and targets their ability to take care of themselves. Second, this strategy was designed to decrease instances of "splitting" between DBT therapists and other individuals interacting with clients. Splitting occurs when different individuals in a client's network hold differing opinions on how to treat the client. A fundamental tenet of this strategy is that therapists do not tell others, including other health care professionals, how to treat the client. The therapist may suggest, but may not demand. What this means in practice is that the therapist is not attached to others treating a client in a specific way. By remaining in the role of a consultant to the client, the therapist stays out of such arguments. Finally, the consultation-to-the-client strategy promotes respect for clients by imparting the message that they are credible and capable of performing interventions on their own behalf.

As mentioned previously, it is the responsibility of the individual DBT therapist to coordinate and organize care with ancillary treatment providers (function 5; e.g., case managers, pharmacotherapists). The consultation-to-the-client strategy balances the consultation-to-the-therapist strategy described earlier, primarily by providing direct consultation to the client in how to interact with other providers, rather than consulting with the environment on how to interact with the client. Except for special circumstances listed earlier, DBT therapists do not discuss clients with ancillary providers, or other individuals in the client's environment, without the client present. The therapist works with the client to problem-solve difficulties he or she has with his or her network, leaving the client to act as the intermediary between the therapist and other professionals.
ENVIRONMENTAL INTERVENTION

As outlined earlier, the bias in DBT is toward teaching the client how to interact effectively with his or her environment. The consultation-to-the-client strategy is thus the dominant case management strategy and is used whenever possible. There are times, however, when intervention by the therapist is needed. In general, the environmental intervention strategy is used over the consultation-to-the-client strategy when substantial harm may befall the client if the therapist does not intervene. The general rule for environmental intervention is that when clients lack abilities that they need to learn or that are impossible to obtain, or are not reasonable or necessary, the therapist may intervene.

Client Variables

DBT was developed to treat the multidagnostic, difficult-to-treat individuals. Therefore, there are a number of requisite client characteristics for Stage 1 DBT. Of these, voluntary participation and a commitment to a specified time period (e.g., 16 weeks, 6 months to 1 year) are critical. The effective application of DBT requires a strong interpersonal relationship between therapist and client. The therapist must first work to become a major reinforcer in the life of the client, then use the relationship to promote change in the client. Continuing the relationship can only be used as a positive contingency when a client wants to be in treatment; thus, contingency management is seriously compromised with involuntary clients. Court-ordered treatment is acceptable, if clients agree to remain in therapy even if the order is rescinded. A client characteristic necessary for group therapy is the ability to control overtly aggressive behavior toward others. DBT was developed and evaluated with perhaps the most severely disturbed portion of the population with BPD; all clients accepted into treatment had histories of multiple suicidal and NSSI behaviors. However, the treatment has been designed flexibly and is likely to be effective with less severely disturbed individuals.

Therapist Variables

In comparison to other aspects of therapy, the therapist characteristics that facilitate DBT have received comparatively little attention.

However, evidence supports the assumption that effective therapy for clients with BPD requires the proficient balancing of acceptance and change strategies (Shearin & Linehan, 1992). This research also found that therapists’ nonpejorative perceptions of clients were associated with less suicidal behavior.

Linehan (1993b) describes requisite therapist characteristics in terms of three bipolar dimensions that must be balanced in the conduct of therapy. The first dimension represents the balance of an orientation of acceptance with an orientation of change. The therapist must be able to inhibit judgmental attitudes (often under very trying circumstances) and to practice acceptance of the client, of him- or herself, and of the therapeutic relationship and process exactly as these are in the current moment. Nevertheless, the therapist remains cognizant that the therapeutic relationship has originated in the necessity of change, and he or she assumes responsibility for directing the therapeutic influence. Second, the therapist must balance unswerving centeredness with compassionate flexibility. “Unswerving centeredness” is the quality of believing in oneself, the therapy, and the client. “Compassionate flexibility” is the ability to take in relevant information about the client and to modify one’s position accordingly by letting go of a previously held position. In balancing these two dimensions, the therapist must be able to observe his or her own limits without becoming overly rigid, especially in the face of attempts by the client to control the therapist’s behaviors. Finally, the DBT therapist must be able to balance a high degree of nurturing with benevolent demanding. “Nurturing” refers to teaching, coaching, assisting, and strengthening the client, whereas “benevolent demanding” requires the therapist to recognize existing capabilities, to reinforce adaptive behavior, and to refuse to “do” for the client when the client can “do” for him- or herself. Above all, the ability to demand requires a concomitant willingness to believe in the client’s ability to change; the effective DBT therapist must see his or her client as empowered.

TREATMENT STRATEGIES

“Treatment strategies” in DBT refer to the role and focus of the therapist, as well as to a coordinated set of procedures that function to achieve specific treatment goals. Although DBT strategies usually consist of a number of
the assumption is with BPD re- of acceptance & Linehan, that therapists’ ments were associat- sites bipolar disorder the conduct of represents the balance an one must be able to ten under very nice acceptance and of the therapy. As a result, the necessity of responsibility for ce. Second, the center is:

"Unwavering belligerence in one's compassionate role: relevant for identifying one's position or role in a previously established structure, observing his or her overly rigid, by the client to the patient's role. Finally, the balance a high demand on the therapist, whereas "being a therapist to the patient" requires a role in the client's DBT therapy.

According to the role of the therapist as to a coordinating function to consult the patient. Although a number of steps, use of a strategy does not necessarily require the application of every step. It is considerably more important that the therapist apply the intent of the strategy than that he or she should inflexibly lead the client through a series of prescribed maneuvers.

DBT employs five sets of treatment strategies to achieve the previously described behavioral targets: (1) dialectical strategies, (2) core strategies, (3) stylistic strategies, (4) case management strategies (discussed earlier), and (5) integrated strategies. DBT strategies are illustrated in Figure 9.2. Within an individual session and with a given client, certain strategies may be used more than others, and all strategies may be necessary or appropriate. An abbreviated discussion of the first three types of DBT treatment strategies follows. For greater detail, the reader is referred to the treatment manual (Linehan, 1993a).

Dialectical Strategies

Dialectical strategies permeate the entire therapy, and their use provides the rationale for adding the term "dialectical" to the title of the therapy. There are three types of dialectical strategies: those having to do with how the therapist structures interactions; those pertaining to how the therapist defines and teaches skillful behaviors; and certain specific strategies used during the conduct of treatment.

Dialectics of the Relationship: Balancing Treatment Strategies

"Dialectical strategies" in the most general sense of the term have to do with how the therapist balances the dialectical tensions within the therapy relationship. As noted earlier, the fundamental dialectic within any psychotherapy, including that with a client who has BPD, is that between acceptance of what is and efforts to change what is. A dialectical therapeutic position is one of constant attention to combining acceptance and change, flexibility and stability, nurturing and challenging, and a focus on capabilities and a focus on limitations and deficits. The goals are to bring out the opposites, both in therapy and in the client's life, and to provide conditions for synthesizes. The presumption is that change may be facilitated by emphasizing acceptance, and acceptance by emphasizing change. The emphasis upon opposites sometimes takes place over time (i.e., over the course of an interaction), rather than simultaneously or in each part of an interaction. Although many, if not all, psychotherapies, including cognitive and behavioral treatments, attend to these issues of balance, placing the

![Diagram](attachment://dialectical-strategies.png)

concept of balance at the center of the treatment ensures that the therapist remains attentive to its importance.

Three primary characteristics are needed to maintain a dialectical stance in the therapeutic relationship: movement, speed, and flow. Movement refers to acting with certainty, strength, and total commitment on the part of the therapist. If the therapist only moves halfheartedly, the client will only move halfheartedly. Speed is of the essence and entails keeping the therapy moving, so that it does not become rigid or stuck. Finally, flow refers to being mindful to the moment-to-moment unfolding of a session and responding smoothly, and with apparent effortlessness.

Teaching Dialectical Behavior Patterns

Dialectical thinking is emphasized throughout the entire treatment. Not only does the therapist maintain a dialectical stance in his or her treatment of the client but he or she also focuses on teaching and modeling dialectical thinking to the client. The therapist helps the client move from an “either–or” position to a “both–and” position, without invalidating the first idea or its polarity when asserting the second. Behavioral extremes and rigidity—whether cognitive, emotional, or overtly behavioral—are signals that synthesis has not been achieved; thus, they can be considered nondialectical. Instead, a “middle path” similar to that advocated in Buddhism is advocated and modeled. The important thing in following the path to Enlightenment is to avoid being caught and entangled in any extreme and always follow the Middle Way (Kyokai, 1966). This emphasis on balance is similar to the approach advocated in relapse prevention models proposed by Marlatt and his colleagues (e.g., Marlatt & Gordon, 1985) for treating addictive behaviors.

Specific Dialectical Strategies

There are eight specific dialectical treatment strategies: (1) entering and using paradox, (2) using metaphor, (3) playing the devil’s advocate, (4) extending, (5) activating the client’s “wise mind,” (6) making lemonade out of lemons (turning negatives into positives), (7) allowing natural change (and inconsistencies even within the therapeutic milieu), and (8) assessing dialectically by always asking the question “What is being left out here?” Due to space limitations, a selection of these strategies is included in the following sections. For a complete review, the interested reader is referred to the DBT treatment manual (Linehan, 1993a).

ENTERING THE PARADOX

Entering the paradox is a powerful technique because it contains the element of surprise. The therapist presents the paradox without explaining it and highlights the paradoxical contradictions within the behavior, the therapeutic process, and reality in general. The essence of the strategy is the therapist’s refusal to step in with rational explanation; the client’s attempts at logic are met with silence, a question, or a story designed to shed a small amount of light on the puzzle to be solved. The client is pushed to achieve understanding, to move toward synthesis of the polarities, and to resolve the dilemma himself or herself. Linehan (1993b) has highlighted a number of typical paradoxes and their corresponding dialectical tensions encountered over the course of therapy. Clients are free to choose their own behavior but cannot stay in therapy if they do not work at changing their behavior. They are taught to achieve greater independence by becoming more skilled at asking for help from others. Clients have a right to kill themselves, but if they ever convince the therapist that suicide is imminent, they may be locked up. Clients are not responsible for being the way they are, but they are responsible for what they become. In highlighting these paradoxical realities, both client and therapist struggle with confronting and letting go of rigid patterns of thought, emotion, and behavior, so that more spontaneous and flexible patterns may emerge.

USING METAPHOR: PARABLE, MYTH, ANALOGY, AND STORYTELLING

The use of metaphor, stories, parables, and myth is extremely important in DBT and provides an alternative means of teaching dialectical thinking. Stories are usually more interesting, are easier to remember, and encourage the search for other meanings of events under scrutiny. Additionally, metaphors allow clients to distance themselves from the problem being
 BORDERLINE PERSONALITY DISORDER

Speaking the questions? Due to these strategies, a reader is renewed (Linehan, 1993b). A useful technique of surprise. The without extra-ordinary conflict, the therapeutic relationship. The essence of usual to step in the client's attempts at question, or a mount of light: the client is pushed more toward synchronizing the client's (1993b) has paradoxes and tensions enter photography. Clientsavior but cannot not work at are taught to by becoming one with others. Clives, but if they suicide is imminent are not really are, but they come. In high-stakes, both clientouting and letting go, emotion, tantrum, and

PLAYING DEVIL'S ADVOCATE

The devil's advocate technique is quite similar to the argumentative approach used in rational-emotive and cognitive restructuring therapies as a method of addressing a client's dysfunctional beliefs or problematic rules. With this strategy, the therapist presents a propositional statement that is an extreme version of one of the client's own dysfunctional beliefs, then plays the role of devil's advocate to counter the client's attempts to disprove the extreme statement or rule. For example, a client may state, "Because I'm overweight, I'd be better off dead." The therapist argues in favor of the dysfunctional belief, perhaps by suggesting that because this is true for the client, it must be true for others as well; hence, all overweight people would be better off dead. The therapist may continue along these lines: "And since the definition of what constitutes being overweight varies so much among individuals, there must be an awful lot of people who

would be considered overweight by someone. That must mean they'd all be better off dead!" Or, "Gosh, I'm about 5 pounds overweight. I guess that means I'd be better off dead, too." Any reservations the client proposes can be countered by further exaggeration, until the self-defeating nature of the belief becomes apparent. The devil's advocate technique is often used in the first several sessions to elicit a strong commitment from the client and in commitment sessions with new therapists joining the DBT team. The therapist argues to the client that since the therapy will be painful and difficult, it is not clear how making such a commitment (and therefore being accepted into treatment) could possibly be a good idea. This usually has the effect of moving the client to take the opposite position in favor of therapeutic change. To employ this technique successfully, it is important that the therapist's argument seem reasonable enough to invite counterargument by the client, and that the delivery be made with a straight face, in a naive but offbeat manner.

EXTENDING

The term "extending" has been borrowed from aikido, a Japanese form of self-defense. In that context, extending occurs when the student of aikido waits for a challenger's movements to reach their natural completion, then extends a movement's endpoint slightly further than what would naturally occur, leaving the challenger vulnerable and off balance. In DBT, extending occurs when the therapist takes the severity or gravity of what the client is communicating more seriously than the client intends. This strategy is the emotional equivalent of the devil's advocate strategy. It is particularly effective when the client is threatening dire consequences of an event or problem to induce change in the environment. Take the interaction with the following client, who threatens suicide if an extra appointment time for the next day is not scheduled. The following interchange between therapist and client occurs after attempts to find a mutually acceptable time have failed.

CLIENT: I've got to see you tomorrow, or I'm sure I will end up killing myself. I just can't keep it together by myself any longer.

THERAPIST: Hmm, I didn't realize you were so
upset! We've got to do something immediately if you are so distressed that you might kill yourself. What about hospitalization? Maybe that is needed.

CLIENT: I'm not going to the hospital! Why won't you just give me an appointment?

THERAPIST: How can we discuss such a mundane topic as scheduling when your life is in danger? How are you planning to kill yourself?

CLIENT: You know how. Why can't you cancel someone or move an appointment around? You could put an appointment with one of your students off until another time. I can't stand it any more!

THERAPIST: I'm really concerned about you. Do you think I should call an aid car?

The aspect of the communication that the therapist takes seriously (suicide as a possible consequence of not getting an appointment) is not the aspect (needing an extra appointment the next day) that the client wants taken seriously. The therapist takes the consequences seriously and extends the seriousness even further. The client wants the problem taken seriously, and indeed is extending the seriousness of the problem.

MAKING LEMONADE OUT OF LEMONS

Making lemonade out of lemons is similar to the notion in psychodynamic therapy of utilizing a client's resistances; therapeutic problems are seen as opportunities for the therapist to help the client. The strategy involves taking something that is apparently problematic and turning it into an asset. Problems become opportunities to practice skills; suffering allows others to express empathy; weaknesses become one's strengths. To be effective, this strategy requires a strong therapeutic relationship between therapist and client; the client must believe that the therapist has a deep compassion for his or her suffering. The danger in using this strategy is that it is easily confused with the invalidating refrain repeatedly heard by clients with BPD. The therapist should avoid the tendency to oversimplify a client's problems, and refrain from implying that the lemons in the client's life are really lemonade. While recognizing that the cloud is indeed black, the therapist assists the client in finding the positive characteristics of a situation—thus, the silver lining.

Core Strategies

Validation

Validation and problem-solving strategies, together with dialectical strategies, make up the core of DBT and form the heart of the treatment. Validation strategies are the most obvious acceptance strategies, whereas problem-solving strategies are the most obvious change strategies. Both validation and problem-solving strategies are used in every interaction with the client, although the relative frequency of each depends on the particular client, the current situation, and the vulnerabilities of that client. However, throughout an entire session, there should be an overall balance between the acceptance and change strategies. Many treatment impasses are due to an imbalance of one type of strategy over the other. We discuss validation strategies in this section and problem-solving strategies in the next.

Clients with BPD present themselves clinically as individuals in extreme emotional pain. They plead, and at times demand, that their therapists do something to change this state of affairs. It is very tempting to focus the energy of therapy on changing the client by modifying irrational thoughts, assumptions, or schemas; critiquing interpersonal behaviors or motives contributing to interpersonal problems; giving medication to change abnormal biology; reducing emotional overreactivity and intensity; and so on. In many respects, this focus recapitulates the invalidating environment by confirming the client's worst fears: The client is the problem and indeed cannot trust his or her own reactions to events. Mistrust and invalidation of how one responds to events, however, are extremely aversive and can elicit intense fear, anger, and shame, or a combination of all three. Thus, the entire focus of change-based therapy can be aversive, because the focus by necessity contributes to and elicits self invalidation. However, an entire focus of acceptance-based therapy can also be invalidating when it appears to the client that the therapist does not take his or her problems seriously. Therefore, once again, a dialectical stance focuses on a balance between the two poles.

Validation (according to the Oxford English Dictionary; Simpson & Weiner, 1989) means "the action of validating or making valid . . . a strengthening, reinforcement, confirming; an establishing or ratifying." It also encompasses activities such as corroborating, substantiating,
verifying, and authenticating. The act of validating is "to support or corroborate on a sound or authoritative basis... to attest to the truth or validity of something" (Merriam-Webster, Inc., 2006). To communicate that a response is valid is to say that it is "well-grounded or justifiable; being at once relevant and meaningful... logically correct... appropriate to the end in view [or effective]... having such force as to compel serious attention and [usually] acceptance" (Webster’s Dictionary, 1991). Being "valid implies being supported by objective truth or generally accepted authority" (Webster’s Dictionary, 1991); "being well-founded on fact, or established on sound principles, and thoroughly applicable to the case or circumstances," and "soundness and strength," "value or worth," and "efficacy" (Simpson & Weiner, 1989). These are precisely the meanings associated with the term when used in the context of psychotherapy in DBT:

The essence of validation is this: The therapist communicates to the client that her [sic] responses make sense and are understandable within her [sic] current life context or situation. The therapist actively accepts the client and communicates this acceptance to the client. The therapist takes the client’s responses seriously and does not discount or trivialize them. Validation strategies require the therapist to search for, recognize, and reflect on the validity inherent in the client’s response to events. With unruly children, parents have to catch them while they’re good in order to reinforce their behavior; similarly, the therapist has to uncover the validity within the client’s response, sometimes amplify it, and then reinforce it. (Linehan, 1993b, pp. 222–223, original emphasis)

Two things are important to note here. First, validation means the acknowledgment of that which is valid. It does not mean “making” valid. Nor does it mean validating that which is invalid. The therapist observes, experiences, and affirms, but he or she does not create validity. Second, “valid” and “scientific” are not synonyms. Science may be one way to determine what is valid, logical, sound in principle, and/or generally accepted as authority or normative knowledge. However, an authentic experience or apprehension of private events (at least, when similar to the same experiences of others or when in accord with other, more observable events) is also a basis for claiming validity. Validation can be considered at any one of six levels. Each level is correspondingly more complete than the previous one, and each level depends on one or more of the previous levels. They are definitional of DBT and are required in every interaction with the client. These levels are described most fully in Linehan (1997), and the following definitions are taken from her discussion.

LISTENING AND OBSERVING (V1)

Level 1 validation requires listening to and observing what the client is saying, feeling, and doing, as well as a corresponding active effort to understand what is being said and observed. The essence of this step is that the therapist is staying awake and interested in the client, paying attention to what the client says and does in the current moment. The therapist notices the nuances in response in the interaction. Validation at Level 1 communicates that the client per se, as well as the client’s presence, words, and responses in the session have “such force as to compel serious attention and [usually] acceptance” (see earlier definitions of validation; pp. 360–361)

ACCURATE REFLECTION (V2)

The second level of validation is the accurate reflection back to the client of his or her own feelings, thoughts, assumptions, and behaviors. The therapist conveys an understanding of the client by hearing what the client has said and seeing what the client does, and how he or she responds. Validation at Level 2 sanctions, empowers, or authenticates that the individual is who he or she actually is (p. 362).

ARTICULATING THE UNVERBALIZED (V3)

In Level 3 of validation, the therapist communicates understanding of aspects of the client’s experience and response to events that have not been communicated directly by the client. The therapist “mind-reads” the reason for the client’s behavior and figures out how the client feels and what he or she is wishing for, thinking, or doing just by knowing what has happened to the client. The therapist can make the link between precipitating event and behavior without being given any information about the behavior itself. Emotions and meanings the client has not expressed are articulated by the therapist (p. 364).
VALIDATING IN TERMS OF PAST LEARNING OR BIOLOGICAL DYSFUNCTION (V4)

At Level 4, behavior is validated in terms of its causes. Validation here is based on the notion that all behavior is caused by events occurring in time; thus, in principle, it is understandable. The therapist justifies the client's behavior by showing that it is caused by past events. Even though information may not be available to determine all the relevant causes, the client's feelings, thoughts, and actions make perfect sense in the context of the client's current experience, physiology, and life to date. At a minimum, what "is" can always be justified in terms of sufficient causes; that is, what is "should be," in that whatever was necessary for it to occur had to have happened (p. 367).

VALIDATION IN TERMS OF PRESENT CONTEXT OR NORMATIVE FUNCTIONING (V5)

At Level 5, the therapist communicates that behavior is justifiable, reasonable, well-grounded, meaningful, and/or efficacious in terms of current events, normative biological functioning, and/or the client's ultimate life goals. The therapist looks for and reflects the wisdom or validity of the client's response and communicates that the response is understandable. The therapist finds the relevant facts in the current environment that support the client's behavior. The therapist is not blinded by the dysfunctional nature of some of the client's response patterns to those aspects of a response pattern that may be either reasonable or appropriate to the context. Thus, the therapist searches the client's responses for their inherent accuracy or appropriateness, or reasonableness (as well as commenting on the inherent dysfunctionality of much of the response, if necessary) (pp. 370–371).

RADICAL GENUINENESS (V6)

In Level 6, the task is to recognize the person as he or she is, seeing and responding to the strengths and capacities of the client, while keeping a firm empathic understanding of his or her actual difficulties and incapacities. The therapist believes in the client and his or her capacity to change and move toward ultimate life goals just as the therapist may believe in a friend or family member. The client is responded to as a person of equal status, due equal respect. Validation at the highest level is the validation of the individual as "is." The therapist sees more than the role, more than a "client" or "disorder." Level 6 validation is the opposite of treating the client in a condescending manner or as overly fragile. It is responding to the individual as capable of effective and reasonable behavior rather than assuming that he or she is an invalid. Whereas Levels 1–5 represent sequential steps in validation of a kind, Level 6 represents change in both level and kind (p. 377).

Cheerleading strategies constitute another form of validation and are the principal strategies for combating the active passivity and tendencies to hopelessness in clients with BPD. In cheerleading, therapists communicate the belief that clients are doing their best and validate clients' ability to eventually overcome their difficulties (a type of validation that, if not handled carefully, can simultaneously invalidate clients' perceptions of their helplessness). In addition, therapists express a belief in the therapy relationship, offer reassurance, and highlight any evidence of improvement. Within DBT, cheerleading is used in every therapeutic interaction. Although active cheerleading by therapists should be reduced as clients learn to trust and to validate themselves, cheerleading strategies always remain an essential ingredient of a strong therapeutic alliance.

Finally, functional validation, another form of validation that is used regularly in DBT, is a form of nonverbal or behavioral validation that at times may be more effective than verbal validation. For example, a therapist drops a 50-pound block on the client's foot. It would be considered invalidating for the therapist simply to respond verbally, saying, "Wow, I can see that really hurts! You must be in a lot of pain." Functional validation would entail the therapist removing the block from the client's foot.

Problem Solving

We have previously discussed how therapies with a primary focus on client change are typically experienced as invalidating by clients with BPD. However, therapies that focus exclusively on validation can prove equally problematic. Exhortations to accept one's current situation offer little solace to an individual who experiences life as painfully unendurable. Within DBT, problem-solving strategies are the core change strategies, designed to foster an active problem-solving style. For clients with BPD,
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validation of the sees more than or “disorder.” of treating the or as overly individual as cap- behavior he is an invalid. sequencial steps (6 represents (p. 377).
stitute another principal strate- sivity and ten- s with BPD. In nicate the belief ind validate ch- ome their diffi-, if not handled validate clients’). In addition, e therapy rela- highlight any in DT, chee- stic interaction, by therapists in to trust and iding strategies ingredient of a , another form- rly in DT, is a ra l validation ive than verbal rapist drops a ot. It would be therapist simply l, I can sec a lot of pain.” tail the ther- cient’s foot.

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current situation al who experi- erable. Within s are the core ceter an active nts with BPD,

however, the application of these strategies is fraught with difficulties. The therapist must keep in mind that with clients with BPD the process will be more difficult than with many other client populations. In work with clients who have BPD, the need for empathetic understanding and interventions aimed at enhancing current positive mood can be extremely important. The validation strategies just described, as well as the irreverent communication strategy described later, can be tremendously useful here. Within DBT, problem solving is a two-stage process that concentrates first on understanding and accepting a selected problem, then generating alternative solutions. The first stage involves (1) behavioral analysis; (2) insight into recurrent behavioral context patterns; and (3) giving the client didactic information about principles of behaviors, norms, and so on. The second stage specifically targets change through (4) analysis of possible solutions to problems; (5) orienting the client to therapeutic procedures likely to bring about desired changes; and (6) strategies designed to elicit and strengthen commitment to these procedures. The following sections specifically address behavioral analysis, solution analysis, and problem-solving procedures.

Behavioral Analysis

Behavioral analysis is one of the most important strategies in DBT. It is also the most difficult. The purpose of a behavioral analysis is first to select a problem, then to determine empirically what is causing it, what is preventing its resolution, and what aids are available for solving it. Behavioral analysis addresses four primary questions:

1. Are ineffective behaviors being reinforced, are effective behaviors followed by aversive outcomes, or are rewarding outcomes delayed?
2. Does the client have the requisite behavioral skills to regulate his or her emotions, respond skillfully to conflict, and manage his or her own behavior?
3. Are there patterns of avoidance, or are effective behaviors inhibited by unwarranted fears or guilt?
4. Is the client unaware of the contingencies operating in his or her environment, or are effective behaviors inhibited by faulty beliefs or assumptions?

Answers to these questions guide the therapist in the selection of appropriate treatment procedures, such as contingency management, behavioral skills training, exposure, or cognitive modification. Thus, the value of an analysis lies in helping the therapist assess and understand a problem fully enough to guide effective therapeutic response. The first step in conducting a behavioral analysis is to help the client identify the problem to be analyzed and describe it in behavioral terms. Identifying the problem can be the most difficult task for the therapist, and if not done accurately and specifically, can lead the therapist and client down a path of solving only a related problem, without getting to the true heart of the problem behavior at hand. Problem definition usually evolves from a discussion of the previous week’s events, often in the context of reviewing diary cards. The assumption of facts not in evidence is perhaps the most common mistake at this point. Defining the problem is followed by a chain analysis—an exhaustive, blow-by-blow description of the chain of events leading up to and following the behavior. In a chain analysis, the therapist constructs a general road map of how the client arrives at dysfunctional responses, including where the road actually starts (highlights vulnerability factors and prompting events), and notes possible alternative adaptive pathways or junctions along the way. Additional goals are to identify events that automatically elicit maladaptive behavior, behavioral deficits that are instrumental in maintaining problematic responses, and environmental and behavioral events that may be interfering with more appropriate behaviors. The overall goal is to determine the function of the behavior, or, from another perspective, the problem the behavior was instrumental in solving.

Chain analysis always begins with a specific environmental event. Pinpointing such an event may be difficult, because clients are frequently unable to identify anything in the environment that sets off the problematic response. Nevertheless, it is important to obtain a description of the events co-occurring with the onset of the problem. The therapist then attempts to identify both environmental and behavioral events for each subsequent link in the chain. Here the therapist must play the part of a very keen observer, thinking in terms of very small chunks of behavior, and repeatedly identifying what the client was thinking, feeling, and doing, and
what was occurring in the environment from moment to moment. The therapist asks the client, "What happened next?" or "How did you get from there to there?" Although, from the client's point of view, such links may be self-evident, the therapist must be careful not to make assumptions. For example, a client who had attempted suicide once stated that she decided to kill herself because her life was too painful for her to live any longer. From the client's point of view, this was an adequate explanation for her suicide attempt. For the therapist, however, taking one's life because life is too painful was only one solution. One could decide life is too painful, then decide to change one's life. Or one could believe that death might be even more painful and decide to tolerate life despite its pain. In this instance, careful questioning revealed that the client actually assumed she would be happier dead than alive. Challenging this assumption, then, became a key to ending her persistent suicide attempts. It is equally important to pinpoint exactly what consequences are maintaining the problematic response. Similarly, the therapist should also search for consequences that serve to weaken the problem behavior. As with antecedent events, the therapist probes for both environmental and behavioral consequences, obtaining detailed descriptions of the client's emotions, somatic sensations, actions, thoughts, and assumptions. A rudimentary knowledge of the rules of learning and principles of reinforcement is crucial.

The final step in behavioral analysis is to construct and test hypotheses about events that are relevant to generating and maintaining the problem behavior. The biosocial theory of BPD suggests several factors of primary importance. For example, DBT focuses most closely on intense or aversive emotional states; the amelioration of negative affect is always suspected as being among the primary motivational variables for dysfunctional behavior in BPD. The theory also suggests that typical behavioral patterns, such as deficits in dialectical thinking or behavioral skills, are likely to be instrumental in producing and maintaining problematic responses.

Solution Analysis

Once the problem has been identified and analyzed, problem solving proceeds with an active attempt at finding and identifying alternative solutions. DBT posits that there are five responses to any one problem: (1) Solve the problem; (2) change the emotional reaction to the problem; (3) tolerate the problem; or (4) stay miserable. An alert client suggested another response, which we have added: (5) Make things worse. These five options are presented to the client at pretreatment and throughout sessions prior to problem solving to ensure that therapist and client are working toward the same goal at any given point.

At times, solutions are discussed throughout the behavioral analysis, and pointing to these alternative solutions may be all that is required, rather than waiting until the behavioral analysis is completed. The therapist may ask, "What do you think you could have done differently here?" Throughout this process, the therapist is actively modeling effective problem solving and solution generation, with a heavier emphasis on modeling and guiding the client early on in treatment. At other times, a more complete solution analysis is necessary. Here the task is to "brainstorm" or generate as many alternative solutions as possible. Solutions should then be evaluated in terms of the various outcomes expected. The final step in solution analysis is to choose a solution that will somehow be effective. Throughout the evaluation, the therapist guides the client in choosing a particular behavioral solution. Here, it is preferable that the therapist pay particular attention to long-term over short-term gain, and that chosen solutions render maximum benefit to the client rather than benefit to others.

Problem-Solving Procedures

DBT employs four problem-solving procedures taken directly from the cognitive and behavioral treatment literature. These four—skills training, contingency procedures, exposure, and cognitive modification—are viewed as primary vehicles of change throughout DBT, since they influence the direction that client changes take from session to session. Although they are discussed as distinct procedures by Linehan (1993b), it is not clear that they can in fact be differentiated in every case in clinical practice. The same therapeutic sequence may be effective because it teaches the client new skills (skills training), provides a consequence that influences the probability of preceding client behaviors occurring again (contingency procedures), provides nonreinforced exposure to
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34 cue associated previously but not currently
35 with threat (exposure procedures), or changes
36 the client's dysfunctional assumptions or sche-
37 matic processing of events (cognitive modi-
38 cation). In contrast to many cognitive and behav-
39 ioral treatment programs in the literature, these
40 procedures (with some exceptions noted be-
41 ow) are employed in an unstructured manner,
42 interwoven throughout all therapeutic dia-
43 logue. Thus, the therapist must be well aware of
44 the principles governing the effectiveness of
45 each procedure in order to use each in imme-
46 diate response to events unfolding in a particu-
47 lar session. The exceptions are in skills training,
48 where skills training procedures predominate,
49 and Stage 2, where exposure procedures pre-
50 dominate.

Skills Training

An emphasis on skills building is pervasive
51 throughout DBT. In both individual and group
52 therapy, the therapist insists at every opportu-
53 nity that the client actively engage in the acquisi-
54 tion and practice of behavioral skills. The
55 term “skills” is used synonymously with “abil-
56 ity” and includes, in its broadest sense, cogni-
57 tive, emotional, and overt behavioral skills, as
58 well as their integration, which is necessary for
59 effective performance. Skills training is called
60 for when a solution requires skills not currently
61 in the individual's behavioral repertoire, or
62 when the individual has the component behav-
63 iors but cannot integrate and use them effecti-
64 vely. Skills training in DBT incorporates three
65 types of procedures: (1) skills acquisition (mod-
66 eling, instructing, advising); (2) skills strength-
67 ening (encouraging in vivo and within-session
68 practice, role playing, feedback); and (3) skills
69 generalization (phone calls to work on apply-
70 ing skills; tapering therapy sessions to listen to
71 between sessions; homework assignments).

Contingency Procedures

Every response within an interpersonal inter-
72 action is potentially a reinforcement, a punish-
73 ment, or a withholding or removal of rein-
74 forcement. Contingency management requires
75 therapists to organize their behavior strategi-
76 cally so that client behaviors that represent
77 progress are reinforced, while unskillful or
78 maladaptive behaviors are extinguished or lead
79 to aversive consequences. Natural conse-
80 quences should be used over arbitrary conse-
81 quences whenever possible. An important con-
82 tingency for most clients with BPD is the ther-
83 apist's interpersonal behavior with such clients.
84 The ability of the therapist to influence the cli-
85 ent's behavior is directly tied to the strength of
86 the relationship between the two. Thus, contin-
87 gency procedures based on the relationship are
88 less useful in the very early stages of treatment
89 (except, possibly, when the therapist is the
90 "only game in town").

A first requirement for effective contingency
91 management is that the therapist orient the cli-
92 ent to the principles of contingency manage-
93 ment and explain how learning takes place.
94 The therapist must attend to the client's behav-
95 iors and use the principles of shaping to rein-
96 force those behaviors that represent progress
97 toward DBT targets. Equally important is that
98 the therapist takes care not to reinforce behav-
99 iors targeted for extinction. In theory, this may
100 seem obvious, but in practice, it can be quite
difficult. The problematic behaviors of clients
101 with BPD are often quite effective in obtaining
102 reinforcing outcomes or in stopping painful
103 events. Indeed, the very behaviors targeted for
104 extinction have been intermittently reinforced
105 by mental health professionals, family mem-
106 bers, and friends. Contingency management at
107 times requires the use of aversive consequences,
108 similar to "setting limits" in other treatment
109 modalities. Three guidelines are important
110 when using aversive consequences. First, pun-
111 ishment should "fit the crime," and a client
112 should have some way of terminating its appli-
113 cation. For example, in DBT, a detailed behav-
114 ioral analysis follows a suicidal or NSSI act;
115 such an analysis is an aversive procedure for
116 most clients. Once it has been completed, how-
117 ever, a client's ability to pursue other topics is
118 restored. Second, it is crucial that therapists use
119 punishment with great care, in low doses, and
120 very briefly, and that a positive interpersonal
121 atmosphere be restored following any client
122 improvement. Third, punishment should be
123 just strong enough to work. Although the ul-
124 timate punishment is termination of therapy, a
125 preferable fallback strategy is putting clients on
126 "vacations from therapy." This approach is
127 considered when all other contingencies have
128 failed, or when a situation is so serious that a
129 therapist's therapeutic or personal limits have
130 been crossed. When utilizing this strategy, the
131 therapist clearly identifies what behaviors must
132 be changed and clarifies that once the condi-
133 tions have been met, the client can return. The
therapist maintains intermittent contact by phone or letter, and provides a referral or backup while the client is on vacation. (In colloquial terms, the therapist kicks the client out, then pines for his or her return.) Observing limits constitutes a special case of contingency management involving the application of problem-solving strategies to client behaviors that threaten or cross a therapist’s personal limits. Such behaviors interfere with the therapist’s ability or willingness to conduct the therapy, thus constituting a special type of therapy-interfering behavior. Therapists must take responsibility for monitoring their own personal limits and clearly communicate to their clients which behaviors are tolerable and which are not. Therapists who do not do this eventually burn out, terminate therapy, or otherwise harm their clients. DBT favors natural over arbitrary limits. Thus, limits vary among therapists, and with the same therapist over time and circumstance. Limits should also be presented as for the good of the therapist, not for the good of the client. The effect of this is that although clients may argue about what is in their own best interests, they do not have ultimate say over what is good for their therapists.

Cognitive Modification

The fundamental message given to clients in DBT is that cognitive distortions are just as likely to be caused by emotional arousal as to be the cause of the arousal in the first place. The overall message is that, for the most part, the source of a client’s distress is the extremely stressful events of his or her life rather than a distortion of events that are actually benign. Although direct cognitive restructuring procedures, such as those advocated by Beck and colleagues (Beck, Brown, Berchick, Stewart, & Steer, 1990; Beck, Rush, Shaw, & Emery, 1979) and by Ellis (1962, 1973), are used and taught as part of emotion regulation, they do not hold a dominant place in DBT. In contrast, contingency clarification strategies are used relentlessly, highlighting contingent relationships operating in the here and now. Emphasis is placed on highlighting immediate and long-term effects of clients’ behavior (both on themselves and on others), clarifying the effects of certain situations on clients’ own responses, and examining future contingencies that clients are likely to encounter. An example here is orienting a client to DBT as a whole and to treatment procedures as they are implemented.

Exposure

All of the change procedures in DBT can be conceptualized as exposure strategies. Many of the principles of exposure as applied to DBT have been developed by researchers in exposure techniques (see Foa & Kozak, 1986; Foa, Steketee, & Grayson, 1985). These strategies work by reconditioning dysfunctional associations that develop between stimuli (e.g., an aversive stimulus, hospitalization, may become associated with a positive stimulus, nurturing in the hospital; a client may later work to be hospitalized) or between a response and a stimulus (e.g., an adaptive response, healthy expression of emotions, is met with an aversive consequent stimulus, rejection by a loved one; a client may then try to suppress emotions). As noted earlier, the DBT therapist conducts a chain analysis of the eliciting cue, the problem behavior (including emotions), and the consequences of the behavior. Working within a behavioral therapy framework, the therapist operates according to three guidelines for exposure in DBT. First, exposure to the cue that precedes the problem behavior must be non-reinforced (e.g., if a client is fearful that discussing suicidal behavior will lead to his or her being rejected, the therapist must not reinforce the client’s shame by ostracizing him/her). Second, dysfunctional responses are blocked in the order of the primary and secondary targets of treatment (e.g., suicidal or NSSI behavior related to shame is blocked by getting the client’s cooperation in throwing away hoarded medications). Third, actions opposite to the dysfunctional behavior are reinforced (e.g., the therapist reinforces the client for talking about painful, shame-related suicidal behavior).

Therapeutic exposure procedures are used informally throughout the whole of therapy and formally during Stage 2, in which the client is systematically exposed to cues of previous traumatic events. Exposure procedures of the DBT therapist involve first orienting the client to the techniques and then the client to the techniques. Exposure to cues is often experienced as painful or frightening. Thus, the therapist does not remove the cue to emotional arousal, and at the same time he or she blocks both the action tendencies (including escape responses) and the expressive
tendencies associated with the problem emotion. In addition, the DBT therapist works to assist the client in achieving enhanced control over aversive events. A crucial step of exposure procedures is that the client be taught how to control the event. It is critical that the client have some means of titrating or ending exposure when emotions become unendurable. The therapist and client should collaborate in developing positive, adaptive ways for the client to end exposure voluntarily, preferably after some reduction in the problem emotion has occurred.

Stylistic Strategies

DBT balances two quite different styles of communication that refer to how the therapist executes other treatment strategies. The first, reciprocal communication, is similar to the communication style advocated in client-centered therapy. The second, irreverent communication, is quite similar to the style advocated by Whitaker (1973) in his writings on strategic therapy. Reciprocal communication strategies are designed to reduce a perceived power differential by making the therapist more vulnerable to the client. In addition, they serve as a model for appropriate but equal interactions within an important interpersonal relationship. Irreverent communication is usually riskier than reciprocity. However, it can facilitate problem solving or produce a breakthrough after long periods when progress has seemed thwarted. To be used effectively, irreverent communication must balance reciprocal communication, and the two must be woven into a single stylistic fabric. Without such balancing, neither strategy represents DBT.

Reciprocal Communication

Responsiveness, self-disclosure, warm engagement, and genuineness are the basic guidelines of reciprocal communication. Responsiveness requires attending to the client in a mindful (attentive) manner and taking the client’s agenda and wishes seriously. However, this does not mean that the therapist gives priority to the client’s agenda over the treatment hierarchy. It refers to the therapist validating the importance of the client’s agenda openly. It is a friendly, affectionate style reflecting warmth and engagement in the therapeutic interaction. Both self-involving and personal self-disclosure, used in the interests of the client, are encouraged to increase problem solving or to reinforce therapeutic activities. Self-involving self-disclosure is the therapist’s immediate, personal reactions to the client and his or her behavior. This strategy is used frequently throughout DBT. For example, a therapist whose client complained about his coolness said, “When you demand warmth from me, it pushes me away and makes it harder to be warm.” Similarly, when a client repeatedly failed to fill out diary cards but nevertheless pleaded with her therapist to help her, the therapist responded, “You keep asking me for help, but you won’t do the things I believe are necessary to help you. I feel frustrated because I want to help you, but I feel that you won’t let me.” Such statements serve both to validate and to challenge. They constitute both an instance of contingency management, because therapist statements about the client are typically experienced as either reinforcing or punishing, and an instance of contingency clarification, because the client’s attention is directed to the consequences of his or her interpersonal behavior. Self-disclosure of professional or personal information is used to validate and model coping and normative responses. The key point here is that a therapist should only use personal examples in which he or she has successfully mastered the problem at hand. This may seem like an obvious point, but it is very easy to fall into this pit by trying actively to validate the client’s dilemma. For example, when working with a client whose goal is to wake up early each morning to exercise but who is having difficulty getting out of bed, the therapist may attempt to validate the behavior as normative by stating, “Yeah, I struggle with getting up every morning, too, even though I tell myself every night that I am going to exercise in the morning.” However, this self-disclosure is only useful to the client if the therapist continues by stating what skillful behavior he or she uses to get up each morning and exercise successfully.

Irreverent Communication

Irreverent communication is used to push the client “off balance,” get the client’s attention, present an alternative viewpoint, or shift affective response. It is a highly useful strategy when the client is immovable, or when therapist and client are “stuck.” It has an “offbeat” flavor and uses logic to weave a web the client cannot
escape. Although it is responsive to the client, irreverent communication is almost never the response the client expects. For irreverence to be effective it must be both genuine (vs. sarcastic or judgmental) and come from a place of compassion and warmth toward the client. Otherwise, the client may become even more rigid. When using irreverence the therapist highlights some unintended aspect of the client’s communication or “reframes” it in an unorthodox manner. For example, if the client says, “I am going to kill myself,” the therapist might say, “I thought you agreed not to drop out of therapy.” Irreverent communication has a matter-of-fact, almost deadpan style that is in sharp contrast to the warm responsiveness of reciprocal communication. Humor, a certain naivety, and guilelessness are also characteristic of the style. A confrontational tone is also irreverent, communicating “bullshit” to responses other than the targeted adaptive response. For example, the therapist might say, “Are you out of your mind?” or “You weren’t for a minute actually believing I would think that was a good idea, were you?” The irreverent therapist also calls the client’s bluff. For the client who says, “I’m quitting therapy,” the therapist might respond, “Would you like a referral?” The trick here is to time the bluff carefully, with the simultaneous provision of a safety net; it is important to leave the client a way out.

CASE STUDY

Background

At the initial meeting, “Cindy,” a 30-year-old, white, married woman with no children, was living in a middle-class suburban area with her husband. She had a college education and had successfully completed almost 2 years of medical school. Cindy was referred to one of us (M. M. L.) by her psychiatrist of 1½ years, who was no longer willing to provide more than psychotherapy following a recent hospitalization for a near-lethal suicide attempt. In the 2 years prior to referral, Cindy had been hospitalized at least 10 times (once for 6 months) for psychiatric treatment of suicidal ideation; had engaged in numerous instances of both NSSI behavior and suicide attempts, including at least 10 instances of drinking Clorox bleach, multiple deep cuts, and burns; and had had three medically severe or nearly lethal suicide attempts, including cutting an artery in her neck. At the time of referral, Cindy met DSM-III-R (American Psychiatric Association, 1987) as well as Gunderson’s (1984) criteria for BPD. She was also taking a variety of psychotropic drugs. Until age 27, Cindy was able to function well in work and school settings, and her marriage was reasonably satisfactory to both partners, although her husband complained about Cindy’s excessive anger. When Cindy was in the second year of medical school, a classmate she knew only slightly committed suicide. Cindy stated that when she heard about the suicide, she immediately decided to kill herself also, but had very little insight into what about the situation actually elicited her inclination to kill herself. Within weeks she left medical school and became severely depressed and actively suicidal. Although Cindy self-presented as a person with few psychological problems before the classmate’s suicide, further questioning revealed a history of severe anorexia nervosa, bulimia nervosa, and alcohol and prescription medication abuse, originating at the age of 14 years. Indeed, she had met her husband at an Alcoholics Anonymous (AA) meeting while attending college. Nevertheless, until the student’s suicide in medical school, Cindy had been successful at maintaining an overall appearance of relative competence.

Treatment

At the initial meeting, Cindy was accompanied by her husband, who stated that he and Cindy’s family considered his wife too lethally suicidal to be out of a hospital setting. Consequently, he and Cindy’s family were seriously contemplating the viability of finding long-term outpatient care. However, Cindy stated a strong preference for inpatient treatment, although no therapist in the local area other than M. M. L. appeared willing to take her into outpatient treatment. The therapist agreed to accept Cindy into therapy, contingent on the client’s stated commitment to work toward behavioral change and to stay in treatment for at least 1 year. (It was later pointed out repeatedly that this also meant the client had agreed not to commit suicide.) Thus, the therapist began the crucial first step of establishing a strong therapeutic alliance by agreeing to accept the client despite the fact that no one else was willing to do so. She pointed out, however, that acceptance into therapy did not come without a cost.
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In this manner, the therapist communicated ac-
ceptance of the client exactly as she was in the
current moment, while concomitantly making
clear that Cindy's commitment toward change
was the foundation of the therapeutic alliance.
At the fourth therapy session, Cindy reported
that she felt she could no longer keep herself
alive. When reminded of her previous commit-
ment to stay alive for 1 year of therapy, Cindy
replied that things had changed and she could
not help herself. Subsequent to this session, al-
most every individual session for the next 6
months revolved around the topic of whether
(and how) to stay alive versus committing su-
icide. Cindy began coming to sessions wearing
mirrored sunglasses and would slump in her
chair or ask to sit on the floor. Questions from
the therapist were often met with a minimal
comment or long silences. In response to the
therapist's attempts to discuss prior self-
injurious behavior, Cindy would become angry
and withdraw (slowing down the pace of ther-
apy considerably). The client also presented
with marked dissociative reactions, which
would often occur during therapy sessions.
During these reactions, Cindy would appear
unable to concentrate or hear much of what
was being said. When queried by the therapist,
Cindy would describe her experience as feeling
"spacey" and distant. The client stated that she
felt she could no longer engage in many activi-
ties, such as driving, working, or attending
school. Overall, the client viewed herself as in-
competent in all areas.

The use of diary cards, which Cindy filled
out weekly (or at the beginning of the session,
if she forgot), assisted the therapist in carefully
monitoring Cindy's daily experiences of suici-
dal ideation, misery, and urges to harm her-
self, as well as actual suicide attempts and NSSI
behaviors. Behavioral analyses that attempted
to identify the sequence of events leading up to
and following Cindy's suicidal behavior soon
became an important focus of therapy. At every
point the therapist presented self-injurious
behavior as to be expected, given the strength
of the urge (but considered it ultimately
beatable), and pointed out repeatedly that if
the client committed suicide, therapy would be
over, so they had better work really hard now,
while Cindy was alive.

Over the course of several months, the
behavioral analyses began to identify a fre-
quently recurring behavioral pattern that pre-
ceded suicidal behaviors. For Cindy, the chain
of events would often begin with an interper-
sonal encounter (almost always with her
husband), which culminated in her feeling
threatened, criticized, or unloved. These feel-
ings were often followed by urges either to self-
mutilate or to kill herself, depending somewhat
on the covarying levels of hopelessness, anger,
and sadness. Decisions to self-mutilate and/or
to attempt suicide were often accompanied by
the thought, "I'll show you." At other times,
hopelessness and a desire to end the pain per-
nanently seemed predominant. Both are ex-
pamples of emotional vulnerability. Following
the conscious decision to self-mutilate or to at-
tempt suicide, Cindy would then immediately
dissociate and at some later point cut or burn
herself, usually while in a state of "automatic
pilot." Consequently, Cindy often had diffi-
culty remembering specifics of the actual acts.
At one point, Cindy burned her leg so badly
(and then injected it with dirt to convince the
doctor that she should give her more attention)
that reconstructive surgery was required.
Behavioral analyses also revealed that disso-
ciation during sessions usually occurred following
Cindy's perception of the therapist's disap-
proval or invalidation, especially when the
therapist appeared to suggest that change was
possible. The therapist targeted in-session dis-
sociation by immediately addressing it as it oc-
curred.

By several months into therapy, an appar-
ently long-standing pattern of suicidal behav-
iors leading to inpatient admission was ap-
parent. Cindy would report intense suicidal
ideation, express doubts that she could resist
the urge to kill herself, and request admission
to her preferred hospital; or, without warning,
she would cut or burn herself severely and re-
quire hospitalization for medical treatment.
Attempts to induce Cindy to stay out of the hospi-
tal or to leave the hospital before she was ready
typically resulted in an escalation of suicidality,
followed by her pharmacotherapist's (a psychi-
atrists) insistence on her admission or the hospi-
tal's agreement to extend her stay. Observation
of this behavioral pattern led the therapist to
hypothesize that the hospitalization itself was
reinforcing suicidal behavior; consequently,
she attempted to change the contingencies for
suicidal behaviors. Using didactic and con-
tingency clarification strategies, the therapist
attempted to help Cindy understand how hos-
pitalization might be strengthening the very
behavior they were working to eliminate. This
issue became a focal point of disagreement within the therapy, with Cindy viewing the therapist's position as unsympathetic and lacking understanding of her phenomenal experience. In Cindy's opinion, the intensity of her emotional pain rendered the probability of suicide so high that hospitalization was necessary to guarantee her safety. She would buttress her position by citing frequently her difficulties with dissociative reactions, which she reported as extremely aversive and which, in her opinion, made her unable to function much of the time. From the therapist's perspective, the deleterious long-term risk of suicide created by repeated hospitalization in response to suicidal behavior was greater than the short-term risk of suicide if hospitalization stays were reduced. These differences in opinion led to frequent disagreements within sessions. It gradually became clear that Cindy viewed any explanations of her behavior as influenced by reinforcement as a direct attack; she implied that if hospitalization was reinforcing her suicidal behavior, then the therapist must believe that the purpose of her suicidality was for admission into the hospital. This was obviously not the case (at least some of the time), but all attempts to explain reinforcement theory in any other terms failed. The therapist compensated somewhat for insisting on the possibility that she (the therapist) was correct by doing three things. First, she repeatedly validated the client's experience of almost unendurable pain. Second, she made certain to address the client's dissociative behavior repeatedly, explaining it as an automatic reaction to intensely painful affect (or the threat of it). Third, she frequently addressed the quality of the relationship between Cindy and herself to strengthen the relationship and maintain Cindy in therapy, even though to do so was a source of even more emotional pain.

By the fifth month, the therapist became concerned that the current treatment regimen was going to have the unintended consequence of killing the client (via suicide). At this point, the therapist's limits for effective treatment were crossed; therefore, she decided to employ the consultation-to-the-client strategy to address Cindy's hospitalizations. The first-choice strategy would have been to get Cindy to negotiate a new treatment plan with her preferred hospital and admitting psychiatrist. Cindy refused to go along, however, because she disagreed with the wisdom of changing her current unlimited access to the inpatient unit. The therapist was able to get her to agree to a consultation meeting with all of her treatment providers, and, with some tenacity, the therapist actually got Cindy to make all the calls to set up the meeting (including inviting her insurance monitor, who was coordinating payment for treatment).

At the case conference, the therapist presented her hypothesis that contingent hospitalization was reinforcing Cindy's suicidal behavior. She also assisted Cindy in making the case that she (the therapist) was wrong. Using reciprocal communication and contingency management, the therapist stated that she simply could not conduct a therapy she thought might kill the client (and she had to go along with what she thought was best even if she were wrong—"to do otherwise would be unethical"), and she requested that a new system of contingencies be agreed upon to disrupt the functional relationship between Cindy's suicidal behavior and hospitalization. Therefore, a plan was developed wherein the client was not required to be suicidal to gain hospital admittance. Under this new set of contingencies, Cindy could elect, at will, to enter the hospital for a stay of up to 3 days, at the end of which time she would always be discharged. If she convinced people that she was too suicidal for discharge, she would be transferred to her least-preferred hospital for safety. Suicidal and NSSI behaviors would no longer be grounds for admission except to a medical unit, when required. Although there was some disagreement as to the functional relationship between suicidal behavior and hospitalization, this system was agreed upon. Following this meeting, Cindy's husband announced that he was no longer able to live with or tolerate his wife's suicidal behavior, and that the constant threat of finding her dead had led to his decision to file for divorce. The focus of therapy then shifted to helping Cindy grieve over this event and find a suitable living arrangement. Cindy alternated between fury that her husband would desert her in her hour of need (or "illness," as she put it) and despair that she could ever cope alone. She decided that "getting her feelings out" was the only useful therapy. This led to many tearful sessions, with the therapist simultaneously validating the pain; focusing on Cindy's experiencing the affect in the moment, without escalating or blocking it; and cheering leading Cindy's ability to manage without going back into the hospital. Due to Cindy's high
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level of dysfunctionality, she and her therapist
decided that she would enter a residential treat-
ment facility for a 3-month period. The facility
had a coping skills orientation and provided
group but not individual therapy. Cindy saw
her therapist once a week and talked to her sev-
eral times a week during this period. With some
coaching, Cindy looked for and found a room-
mate to live with and returned to her own
home at the end of 3 months (the ninth month
of therapy). Over the course of treatment, the
therapist used a number of strategies to treat
Cindy's suicidal, NSSI, and therapy-interfering
behaviors. In-depth behavioral chain and solu-
tion analysis helped the therapist (and some-
times the client) gain insight into the factors in-
fluencing current suicidal behavior. For Cindy,
as for most clients, performing these analyses
was quite difficult, because the process usually
generated intense feelings of shame, guilt, or
anger. Thus, behavioral analysis also func-
tioned as an exposure strategy, encouraging the
client to observe and experience painful affect.
It additionally served as a cognitive strategy in
helping to change Cindy's expectations con-
cerning the advantages and disadvantages of
suicidal behavior, especially as the therapist re-
peatedly made statements such as "How do
you think you would feel if I got angry at you
and then threatened suicide if you didn't
change?" Finally, behavioral analysis served as
contingency management, in that the client's
ability to pursue topics of interest in therapy
sessions was made contingent on the successful
completion of chain and solution analysis.

Cindy presented early in therapy with ex-
ceedingly strong perceptions as to her needs
and desires, and with a comcomitant willing-
ness to engage in extremely lethal suicidal
behavior. As previously mentioned, several of
these acts were serious attempts to end her life,
whereas others functioned as attempts to gain
attention and care from significant others. This
client also presented with an extreme sensitiv-
ity to any attempts at obvious change pro-
cedures, which she typically interpreted as com-
municating a message about her incompetence
and unworthiness. Although Cindy initially
committed herself to attending weekly group
skills training for the first year of therapy, her
attendance at group meetings was quite erratic,
and she generally tended either to miss entire
sessions (but never more than three in a row) or
to leave during the break. Cindy answered the
therapist's attempts to address this issue by
stating that she could not drive at night due to
night blindness. Although considered a
therapy-interfering behavior and frequently ad-
ressed over the course of therapy, missing
skills training was not a major focus of treat-
ment, due to the continuing presence of higher-
priority suicidal behavior. The therapist's
efforts to engage the client in active skills ac-
quision during individual therapy sessions
were also somewhat limited and were always
preceded by obtaining Cindy's verbal commit-
tment to problem solving. The stylistic strategy
of irreverent communication was of value to
the therapeutic process. The therapist's irrever-
ence often served to "shake up" the client, re-
sulting in a loosening of dichotomous thinking
and maladaptive cognitions. The result of this
was Cindy's increased willingness to explore
new and adaptive behavioral solutions. Finally,
relationship strategies were heavily employed
as tools to strengthen the therapeutic alliance
and to keep it noncontingent on suicidal and/or
dissociative behaviors. Included here were
between-session therapist-initiated telephone
calls to see how Cindy was doing, the therapist
routinely giving out phone numbers when she
was traveling, and sending the client postcards
when she was out of town.

By the 12th month of therapy, Cindy's sui-
cidal and self-injurious behavior, as well as
urges to engage in such behavior, receded. In
addition, her hospital stays were reduced
markedly, with none occurring after the eighth
month. While living at home with a roommate,
Cindy was readmitted to medical school. Part
of the reason for returning to school was to
turn her life around, so that she could try to re-
gain her husband's love and attention, or at
least his friendship. As the therapy continued
to focus on changing the contingencies of su-
icidal behavior, reducing both emotional pain
and inhibition, and tolerating distress, a further
focus on maintaining sobriety and reasonable
food intake was added. During the first months
of living in her home without her husband,
Cindy had several alcoholic binges, and her
food intake dropped precipitously. These be-
haviors became immediate targets. The ther-
apist's strong attention to these behaviors also
communicated to Cindy that the therapist
would take her problems seriously even if she
were not suicidal. Therapy focused as well on
expanding her social network. As with suicidal
behaviors, attention to these targets served as a
pathway to treating associated problems. As
crisis situations decreased in frequency, much greater attention was paid to analyzing family patterns, including experiences of neglect and invalidation, that might have led to Cindy's problems in later life. Cindy did not report a history of sexual or physical abuse. Thus, the explicit goal of Stage 2 (which was being cautiously entered as an overlap to Stage 1) was to understand Cindy's history and its relationship to her current problems.

In other cases, especially when there has been sexual and/or physical abuse in childhood, movement to Stage 2 before Stage 1 targets have been mastered is likely to result in retrogression to previously problematic behaviors. For example, another client treated by the same therapist (M. M. L.), Terry, had been quite seriously abused physically by her mother throughout childhood and sexually abused by her father, beginning at age 5. The sexual advances were nonviolent at first but became physically abusive at approximately age 12. Prior to this therapy, Terry had not disclosed the incidents of abuse to anyone.

After successful negotiation of Stage 1 targets, the therapist proceeded to expose Terry to trauma-related cues by simply having her begin to disclose details of the abuse. These exposure sessions were intertwined with work on current problems in Terry's life. Following one exposure session focused on the sexual abuse, Terry reverted to some of her previously problematic behaviors, evidenced by withdrawal and silence in sessions, suicidal ideation, and medication noncompliance. The appearance of such behavior marked the necessity of stopping Stage 2 discussions of previous sexual abuse to address Stage 1 targets recursively. Three sessions were devoted to a behavioral analysis of Terry's current suicidal, therapy-interfering, and quality-of-life-interfering behaviors; these were eventually linked to fears about how the therapist would view her childhood emotional responses to her father, and to holiday visits with her father that precipitated conflicts over how Terry should be feeling about him in the present. This two-steps-forward, one-step-back approach is common to therapy for clients with BPD, and in particular may mark the transition between Stage 1 and Stage 2.

As previously mentioned, Stage 3 targets the client's self-respect, regardless of the opinions of others. Betty, who was also in treatment with the same therapist (M. M. L.), had successfully negotiated Stages 1 and 2, and had become a highly competent nurse with training and supervisory responsibilities. Therapy with Betty was then focused on maintaining her self-esteem in the face of very powerful significant others (e.g., her supervisor) who constantly invalidated her. Components of the treatment included the therapist's noting and highlighting for Betty her tendency to modify her self-opinion in accordance with that of others, persistent attempts to extract from Betty self-validation and self-soothing, and imagery exercises wherein the client imagined and verbalized herself standing up to powerful others. Much of the therapy focus was on Betty's interpersonal behavior within the therapy session, with attention to relating this behavior to her interactions with other important people. Thus, treatment at that point was very similar to the functional-analytic psychotherapy regimen developed by Kohlenberg and Tsai (1991). Overall, this third stage of therapy involved the movement to a more egalitarian relationship between the client and the therapist, in which emphasis was placed on the client's standing up for her own opinions and defending her own actions. This approach required that the therapist both reinforce the client's assertions, and step back and refrain from validating and nurturing the client in the manner characteristic of Stages 1 and 2. In addition, therapy sessions were reduced to every other week, and issues surrounding eventual termination were periodically discussed.

Stage 4 of DBT targets the sense of incompleteness that can preclude the experience of joy and freedom. Sally started Stage 1 treatment with the same therapist (M. M. L.) 15 years ago. Stage 1 lasted 2 years; this was followed by a break of 1 year, after which treatment resumed for several years of bimonthly sessions leading to monthly sessions, and currently consists of four or five sessions a year. Sally has been married for 30 years to an irregularly employed husband who, though devoted and loyal, is quite invalidating of her. Although apparently brilliant, he is usually dismissed from jobs for his interpersonal insensitivity. She has been employed full-time at the same place for years, working with children. The son she felt closest to died in a plane accident 2 years ago; her mother died last year, and her father is very ill. Despite having a stable marriage, working in a stable and quite fulfilling job, having raised two well-adjusted sons, and still being athletic, life feels meaningless to Sally. In the past she was very active in spiritual activi-
and supervisory etty in the face
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less to Sally. In

THERAPIST: How so?
CLIENT: Umm, I don't know. I just can't even
cope with everyday life right now. And I
can't even . . . I'm just a mess. I don't know
how to deal with anything.
THERAPIST: So what does that mean exactly?
CLIENT: Umm, well, everything I try these days
just seems overwhelming. I couldn't keep up
on my job, and now I'm on medical leave.
Plus everyone's sick of me being in the hospi-
tal so much. And I think my psychiatrist
wants to send me away because of all my
self-harming.
THERAPIST: How often do you self-harm?
CLIENT: Maybe once or twice a month. I use
my lighter or cigarettes, sometimes a razor
blade.
THERAPIST: Do you have scars all over?
CLIENT: (Nods yes.)
THERAPIST: Your psychiatrist tells me you've
also drunk Clorox. Why didn't you mention
that?
CLIENT: I guess it didn't enter my mind.
THERAPIST: Do things just not enter your mind
very often?
CLIENT: I don't really know. Maybe.
THERAPIST: So maybe with you I'm going to
have to be a very good guesser.
CLIENT: Hmm.
THERAPIST: Unfortunately, though, I'm not the
greatest guesser. So we'll have to teach you
how to have things come to mind. So what is
it exactly that you want out of therapy with
me? To quit harming yourself, quit trying to
kill yourself, or both?
CLIENT: Both. I'm sick of it.
THERAPIST: And is there anything else you want
help with?
CLIENT: Um, well, I don't know how to handle
money, and I don't know how to handle rela-
tionships. I don't have friends; they don't
connect with me very often. I'm a former al-
coholic and a recovering anorexic/bulimic, I
still have a tendency toward that.
THERAPIST: Do you think maybe some of what
is going on with you is that you've replaced
your alcoholic and anorexic behaviors with
self-harm behaviors?
CLIENT: I don't know. I haven't thought about
it that way. I just feel that I don't know how to handle myself, and—you know, and I guess work through stuff, and that is obviously getting to me, because if it wasn't, I wouldn't be trying to kill myself.

THERAPIST: So from your perspective, one problem is that you don't know how to do things. A lot of things.

CLIENT: Yeah, and a lot of it is, I do know how, but for some reason I don't do it anyway.

THERAPIST: Um hmm.

CLIENT: You know, I mean I know I need to save money, and I know that I need to budget myself, and I do every single month, but every single month I get in debt. But, um, you know, it's really hard for me. You know, it's like sometimes I know it, or I know I shouldn't eat something and I do it anyway.

THERAPIST: So it sounds like part of the problem is you actually know how to do things; you just don't know how to get yourself to do the things you know how to do.

CLIENT: Exactly.

THERAPIST: Does it seem like maybe your emotions are in control—that you are a person who does things when you're in the mood?

CLIENT: Yes. Everything's done by the mood.

THERAPIST: So you're a moody person.

CLIENT: Yes. I won't clean the house for 2 months, and then I'll get in the mood to clean. Then I'll clean it immaculately and keep it that way for 3 weeks—I mean, just immaculate—and then when I'm in the mood I go back to being a mess again.

THERAPIST: So one of the tasks for you and me would be to figure out a way to get your behavior and what you do less hooked up with how you feel?

CLIENT: Right.

The therapist used insight to highlight for the client the observed interrelationship between the client's emotions and her behavior. She then began the process of shaping a commitment through the dialectical strategy of devil's advocate.

THERAPIST: That, of course, is going to be hell to do, don't you think? Why would you want to do that? It sounds so painful.

CLIENT: Well, I want to do it, because it's so in-

consistent. It's worse, you know, because when I'm... I know that, like with budgeting money or whatever, I know I need to do it, and then when I don't do it, it makes me even more upset.

THERAPIST: Why would you ever want to do something you're not in the mood for?

CLIENT: Because I've got to. Because I can't sur-
vive that way if I don't.

THERAPIST: Sounds like a pretty easy life to me.

CLIENT: Yeah, but I can't afford to live if I just spend my money on fun and stupid, frivolous things that I... 

THERAPIST: Well, I guess maybe you should have some limits and not be too off the wall, but in general, I mean, why clean the house if you're not in the mood?

CLIENT: Because it pisses me off when it's a mess. And I can't find things, like I've lost bills before and then I end up not paying them. And now I've got collection agencies on my back. I can't deal with all this, and I end up self-harming and going into the hospital. And then I just want to end it all. But it still doesn't seem to matter, because if I'm not in the mood to clean it, I won't.

THERAPIST: So the fact that it makes horrible things happen in your life so far hasn't been enough of a motivation to get you to do things against your mood, right?

CLIENT: Well, obviously not (laughs), because it's not happening.

THERAPIST: Doesn't that tell you, though? This is going to be a big problem, don't you think? This isn't going to be something simple. It's not like you're going to walk in here and I'm going to say, "OK, magic wand," and then all of a sudden you're going to want to do things that you're not in the mood for.

CLIENT: Yeah.

THERAPIST: Yeah, so it seems to me that if you're not in the mood for things, if you're kind of mood-dependent, that's a very tough thing to crack. As a matter of fact, I think it's one of the hardest problems there is to deal with.

CLIENT: Yeah, great.

THERAPIST: I think we could deal with it, but I think it's going to be hell. The real question is whether you're willing to go through hell
a know, because like with budget—now I need to do to it, it makes me
ever want to do the mood for? because I can’t sur-
y easy life to me. re to live if I just and stupid, frivo-
you should too off the wall, clean the house if
off when it’s a like I’ve lost I up not paying collection agencies th all this, and I ing into the hos-
end it all. But it’s, because if I’m, I won’t.
: makes horrible so far hasn’t been get you to do right? (laughs), because
you, though? This dem, don’t you: something sim.; to walk in here: magic wand,” you’re going to u’re not in the
me that if things, if you’re it’s a very tough fact, I think it’s there is to deal
al with it, but I the real question go through hell
to get where you want to get or not. Now I figure that’s the question.

CLIENT: Well, if it’s going to make me happier, yeah.

THERAPIST: Are you sure?

CLIENT: Yeah, I’ve been going through this since I was 11 years old. I’m sick of this shit. I mean, excuse my language, but I really am, and I’m backed up against the wall. Either I need to do this or I need to die. Those are my two choices.

THERAPIST: Well, why not die?

CLIENT: Well, if it comes down to it, I will.

THERAPIST: Um hmm, but why not now?

CLIENT: Because, this is my last hope. Because if I’ve got one last hope left, why not take it?

THERAPIST: So, in other words, all things being equal, you’d rather live than die, if you can pull this off.

CLIENT: If I can pull it off, yeah.

THERAPIST: OK, that’s good; that’s going to be your strength. We’re going to play to that. You’re going to have to remember that when it gets tough. But now I want to tell you about this program and how I feel about you harming yourself, and then we’ll see if you still want to do this.

As illustrated by the foregoing segment, the therapist’s relentless use of the devil’s advocate strategy successfully “got a foot in the door” and achieved an initial client commitment. The therapist then “upped the ante” with a brief explanation of the program and its goals.

THERAPIST: Now the most important thing to understand is that we are not a suicide prevention program; that’s not our job. But we are a life enhancement program. The way we look at it, living a miserable life is no achievement. If we decide to work together, I’m going to help you try to improve your life, so that it’s so good that you don’t want to die or hurt yourself. You should also know that I look at suicidal behavior, including drinking Clorox, as problem-solving behavior. I think of alcoholism the same way. The only difference is that cutting, burning, unfortunately—it works. If it didn’t work, nobody would do it more than once. But it only works in the short term, not the long term. So to quit cutting, trying to hurt your-
THERAPIST: Hum.
CLIENT: I don’t want to . . . I want to be able to get to the point where I could feel like I’m not being forced into living.
THERAPIST: So are you agreeing with me because you’re feeling forced into agreeing?
CLIENT: You keep asking me all these questions.
THERAPIST: What do you think?
CLIENT: I don’t know what I think right now, honestly.

A necessary and important skill for the DBT therapist is the ability to sense when a client has been pushed to his or her limits, as well as the concomitant skill of being willing and able to step back and at least temporarily refrain from further pressuring the client. In these instances, continued pressure from the therapist is likely to boomerang and have the opposite effect of what the therapist intends. Here the therapist noticed the client’s confusion and sensed that further pushing was likely to result in the client’s reducing the strength of her commitment. Consequently, the therapist stepped back and moved in with validation.

THERAPIST: So you’re feeling pushed up against the wall a little bit, by me?
CLIENT: No, not really. (Starts to cry.)
THERAPIST: What just happened just now?
CLIENT: (pause) I don’t know. I mean, I don’t think I really want to kill myself. I think I just feel like I have to. I don’t think it’s really even a mood thing. I just think it’s when I feel like there’s no other choice. I just say, “Well, you know there’s no other choice, so do it.” You know. And so right now, I don’t see any ray of hope. I’m going to therapy, which I guess is good. I mean, I know it’s good, but I don’t see anything any better than it was the day I tried to kill myself.
THERAPIST: Well, that’s probably true. Maybe it isn’t any better. I mean, trying to kill yourself doesn’t usually solve problems. Although it actually did do one thing for you.
CLIENT: It got me in therapy.
THERAPIST: Yeah. So my asking you all these questions makes you start to cry. You look like you must be feeling pretty bad.
CLIENT: Just overwhelmed, I guess the word is.
THERAPIST: That’s part of the reason we’re having this conversation, to try to structure our relationship so that it’s very clear for both of us. And that way, at least, we’ll try to cut down on how much you get overwhelmed by not knowing what’s going on with me. OK?
CLIENT: Um hmm.
THERAPIST: And so I just want to be clear on what our number one goal is, and how hard this is, because if you want to back out, now’s the time. Because I’m going to take you seriously if you say, “Yes, I want to do it.”
CLIENT: I don’t want to back out.
THERAPIST: OK. Good. Now I just want to say that this seems like a good idea right now. You’re in kind of an energized mood today, getting started on a new program. But in 5 hours, it might not seem like such a good idea. It’s kind of like it’s easy to commit to a diet after a big meal, but it’s much harder when you’re hungry. But we’re going to work on how to make it keep sounding like a good idea. It’ll be hell, but I have confidence. I think we can be successful working together.

Note how the therapist ended the session by preparing the client for the difficulties she was likely to experience in keeping her commitment and working in therapy. Cheerleading and relationship enhancement laid the foundation for a strong therapeutic alliance. The following session occurred approximately 4 months into therapy. The session target was suicidal behavior. The therapist used validation, problem solving (contingency clarification, didactic information, behavioral analysis, and solution analysis), stylistic (irreverent communication), dialectical (metaphor, making lemonade out of lemons), and skills training (distress tolerance) strategies.

The therapist reviewed the client’s diary card and noted a recent, intentional self-injury, in which the client opened up a previously self-inflicted wound following her physician’s refusal to provide pain medication. The therapist began by proceeding with a behavioral analysis.

THERAPIST: OK. Now you were in here last week telling me you were never going to hurt yourself again because this was so ridicu-
Borderline Personality Disorder

The therapist proceeded by obtaining a description of the events co-occurring with the onset of the problem. Here it became apparent that maladaptive thinking was instrumental in the client's decision to self-harm. In the following segment, the therapist used the dialectical strategy of metaphor to highlight for the client her cognitive error.

CLIENT: I believe firmly, and I even wrote it in my journal, that if I'd gotten pain medication when I really needed it, I wouldn't have even thought of self-harming.

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CLIENT: Now let me ask you something—you've got to imagine this, OK? Let's imagine that you and I are on a raft together out in the middle of the ocean. Our boat has sunk and we're on the raft. And when the boat sank, your leg got cut really badly. And together we've wrapped it up as well as we can. But we don't have any pain medicine. And we're on this raft together and your leg really hurts, and you ask me for pain medicine, and I say no. Do you think you would then have an urge to hurt yourself and make it worse?

CLIENT: No, it would be a different situation.

THERAPIST: OK, but if I did have the pain medication and I said no because we had to save it, what do you think?

CLIENT: If that were logical to me, I'd go along with it and wouldn't want to hurt myself.

THERAPIST: What if I said no because I didn't want you to be a drug addict?

CLIENT: I'd want to hurt myself.

THERAPIST: OK. So we've got this clear. The pain is not what's setting off the desire to self-harm. It's someone not giving you something to help, when you feel they could if they wanted to.

CLIENT: Yes.

The therapist used contingency clarification to point out the effects of others' responses on the client's own behavior. In the following segment, the therapist again employed contingency clarification in a continued effort to highlight for the client the communication function of NSSI.

THERAPIST: So, in other words, hurting yourself is communication behavior, OK? So what we
have to do is figure out a way for the communication behavior to quit working.

CLIENT: Why?

THERAPIST: Because you're not going to stop doing it until it quits working. It's like trying to talk to someone; if there's no one in the room, you eventually quit trying to talk to them. It's like when a phone goes dead, you quit talking.

CLIENT: I tried three nights in a row in a perfectly assertive way and just clearly stated I was in a lot of pain.

THERAPIST: You know, I think I'll switch chairs with you. You're not hearing what I'm saying.

CLIENT: And they kept saying, "No," and then some little light came on in my head.

THERAPIST: I'm considering switching chairs with you.

CLIENT: And it was like, "Here, now can you tell that it hurts a lot?"

THERAPIST: I'm thinking of switching chairs with you.

CLIENT: Why?

THERAPIST: Because if you were sitting over here, I think you would see that no matter how bad the pain is, hurting yourself to get pain medication is not a reasonable response. The hospital staff may not have been reasonable either. It may be that they should have given you pain medicine. But we don't have to say they were wrong in order to say that hurting yourself was not the appropriate response.

CLIENT: No, I don't think it was the appropriate response.

THERAPIST: Good. So what we've got to do is figure out a way to get it so that the response doesn't come in, even if you don't get pain medicine. So far, it has worked very effectively as communication. And the only way to stop it is to get it to not work any more. And of course, it would be good to get other things to work. What you're arguing is "Well, OK, if I'm not going to get it this way, then I should be able to get it another way."

CLIENT: I tried this time!

THERAPIST: Yes, I know you did, I know you did.

CLIENT: A lady down the hallway from me was getting treatment for her diabetes, and it got real bad, and they gave her pain medication.

THERAPIST: Now we're not on the same wavelength in this conversation.

CLIENT: Yes, we are. What wavelength are you on?

THERAPIST: I'm on the wavelength that it may have been reasonable for you to get pain medicine, and I certainly understand your wanting it. But I'm also saying that no matter what's going on, hurting yourself is something we don't want to happen. You're functioning like if I agreed with you that you should get pain medication, I would think this was OK.

CLIENT: Hmm?

THERAPIST: You're talking about whether they should have given you pain medication or not. I'm not talking about that. Even if they should have, we've got to figure out how you could have gotten through without hurting yourself.

As illustrated by the foregoing exchange, a client with BPD often wants to remain focused on the crisis at hand. This poses a formidable challenge for the therapist, who must necessarily engage in a back-and-forth dance between validating the client's pain and pushing for behavioral change. This segment also illustrates how validation does not necessarily imply agreement. Although the therapist validated the client's perception that the nurse's refusal to provide pain medication may have been unreasonable, she remained steadfast in maintaining the inappropriateness of the client's response.

CLIENT: I tried some of those distress tolerance things and they didn't work.

THERAPIST: OK. Don't worry, we'll figure out a way. I want to know everything you tried. But first I want to be sure I have the picture clear. Did the urges start building after Wednesday and get worse over time?

CLIENT: Yeah. They started growing with the pain.

THERAPIST: With the pain. OK. But also they started growing with their continued refusal to give you pain medicine. So you were thinking that if you hurt yourself, they would somehow give you pain medicine?
CLIENT: Yeah. 'Cause if they wouldn’t listen to me, then I could show them.
THERAPIST: OK, so you were thinking, “If they won’t listen to me, I’ll show them.” And when did that idea first hit? Was that on Wednesday?
CLIENT: Yeah.
THERAPIST: OK. Well, we’ve got to figure out a way for you to tolerate had things without harming yourself. So let’s figure out all the things you tried, and then we have to figure out some other things, because those didn’t work. So what was the first thing you tried?

At this juncture the behavioral analysis remained incomplete, and it would normally have been premature to move to the stage of solution analysis. However, in the therapist’s judgment, it was more critical at this point to reinforce the client’s attempts at distress tolerance by responding to the client’s communication that she had attempted behavioral skills.

CLIENT: I thought that if I just continued to be assertive about it that the appropriate measures would be taken.
THERAPIST: OK, but that didn’t work. So why didn’t you harm yourself right then?
CLIENT: I didn’t want to.
THERAPIST: Why didn’t you want to?
CLIENT: I didn’t want to make it worse.
THERAPIST: So you were thinking about pros and cons—that if I make it worse, I’ll feel worse.
CLIENT: Yeah.

One aspect of DBT skills training stresses the usefulness of evaluating the pros and cons of tolerating distress as a crisis survival strategy. Here the therapist employed the dialectical strategy of turning lemons into lemonade by highlighting for the client how she did, in fact, use behavioral skills. Note in the following response how the therapist immediately reinforced the client’s efforts with praise.

THERAPIST: That’s good thinking. That’s when you’re thinking about the advantages and disadvantages of doing it. OK, so at that point the advantages of making it worse were outweighed by the disadvantages. OK.

So you keep up the good fight here. Now what else did you try?
CLIENT: I tried talking about it with other clients.
THERAPIST: And what did they have to say?
CLIENT: They said I should get pain medication.
THERAPIST: Right. But did they say you should cut yourself or hurt yourself if you didn’t get it?
CLIENT: No. And I tried to get my mind off my pain by playing music and using mindfulness. I tried to read and do crossword puzzles.
THERAPIST: Um hmm. Did you ever try radical acceptance?
CLIENT: What’s that?
THERAPIST: It’s where you sort of let go and accept the fact that you’re not going to get the pain medication. And you just give yourself up to that situation. You just accept that it ain’t going to happen, that you’re going to have to cope in some other way.
CLIENT: Which I did yesterday. I needed a little Ativan to get me there, but I got there.
THERAPIST: Yesterday?
CLIENT: Yeah. I took a nap. When I woke up I basically said, “Hey, they’re not going to change, so you’ve just got to deal with this the best that you can.”
THERAPIST: And did that acceptance help some?
CLIENT: I’m still quite angry about what I believe is discrimination against borderline personalities. I’m still very angry about that.
THERAPIST: OK. That’s fine. Did it help, though, to accept?
CLIENT: Um hmm.
THERAPIST: That’s good. That’s great. That’s a great skill, a great thing to practice. When push comes to shove, when you’re really at the limit, when it’s the worst it can be, radical acceptance is the skill to practice.
CLIENT: That’s AA.

During a solution analysis, it is often necessary that the therapist facilitate the process by helping the client "brainstorm," or by making direct suggestions for handling future crises.
Here the therapist suggested a solution that is also taught in the DBT skills training module on distress tolerance. The notion of radical acceptance stresses the idea that acceptance of one's pain is a necessary prerequisite for ending emotional suffering.

THERAPIST: OK. Now let's go back to how you gave in to the urge. Because you really managed to battle all the way till then, right? OK. Usually, with you, we can assume that something else happened. So let's figure out Sunday and see if there wasn't an interpersonal situation that day that made you feel criticized, unloved, or unacceptable.

CLIENT: Well, on Saturday I was so pissed off and I went to an AA meeting. And it got on my brain how alcohol would steal away my pain. I went looking all around the neighborhood for an open store. I was going to go get drunk. That's how much my pain was influencing me. But I couldn't find a store that was open, so I went back to the hospital.

THERAPIST: So you got the idea of getting alcohol to cure it, and you couldn't find any, so you went back to the hospital. You were in a lot of pain, and then what happened?

CLIENT: I told the nurse, "I've been sober almost 10 years and this is the first urge I've had to drink; that's how bad my pain is." And that wasn't listened to.

THERAPIST: So you figured that should have done it?

CLIENT: Yeah.

THERAPIST: Yeah. "Cause that's a high-level communication, that's like a suicide threat. Very good, though. I want you to know, that's better than a suicide threat, because that means you had reduced the severity of your threats.

The response above was very irreverent, in that most clients would not expect their therapists to view making a threat as a sign of therapeutic progress. The therapeutic utility of irreverence often lies in its "shock" value, which may temporarily loosen a client's maladaptive beliefs and assumptions, and open the client up to the possibility of other response solutions.

CLIENT: And I just told her how I was feeling about it, and I thought that would do it. And the doctor still wouldn't budge.

THERAPIST: So what did she do? Did she say she would call?

CLIENT: She called.

THERAPIST: OK. And then what happened?

CLIENT: She came back. She was really sweet, and she just said, "I'm really sorry, but the doctor said no."

THERAPIST: Then did you feel anger?

CLIENT: I don't know if I was really angry, but I was hurt.

THERAPIST: Oh, really? Oh, that's pretty interesting. OK. So you were hurt . . .

CLIENT: Because I ended up hugging my teddy bear and just crying for a while.

THERAPIST: Before or after you decided to hurt yourself?

CLIENT: Before.

THERAPIST: OK. So you didn't decide right away to hurt yourself. You were thinking about it. But when did you decide to do it?

CLIENT: Later on Saturday.

THERAPIST: When?

CLIENT: After I got sick of crying.

THERAPIST: So you laid in bed and cried, feeling uncared about and hurt, abandoned probably, and unlovable, like you weren't worth helping?

CLIENT: Yes.

THERAPIST: That's a really adaptive response. That's what I'm going to try to teach you. Except that you've already done it without my teaching it to you. So how did you get from crying, feeling unloved and not cared about, and you cry and sob—how did you get from there to deciding to hurt yourself, instead of like going to sleep?

CLIENT: Because then I got angry. And I said, "Fuck this shit, I'll show him."

THERAPIST: Now did you quit crying before you got angry, or did getting angry make you stop crying?

CLIENT: I think getting angry made me stop crying.

THERAPIST: So you kind of got more energized. So you must have been ruminating while you were lying there, thinking. What were you thinking about?

CLIENT: For a long time I was just wanting somebody to come care about me.
THERAPIST: Um, hmm. Perfectly reasonable feelings. Makes complete sense. Now maybe there you could have done something different. What would have happened if you had asked the nurse to come in and talk to you, hold your hand?

An overall goal of behavioral analysis is the construction of a general road map of how the client arrives at dysfunctional responses, with notation of possible alternative pathways. Here the therapist was searching for junctures in the map where possible alternative responses were available to the client.

CLIENT: They don’t have time to do that.
THERAPIST: They don’t? Do you think that would have helped?
CLIENT: I don’t know. She couldn’t help me.
THERAPIST: She could have made you feel cared about. That would have been a caring thing to do.

CLIENT: Yeah, but I don’t think it would have helped.
THERAPIST: What would have helped?
CLIENT: Getting pain medication.

THERAPIST: I thought you'd say that. You have a one-track mind. Now listen, we've got to figure out something else to help you, because it can’t be that nothing else can help. That can’t be the way the world works for you. There's got to be more than one way to get everywhere, because we all run into boulders on the path. Life is like walking on a path, you know, and we all run into boulders. It's got to be that there are other paths to places. And for you, it really isn’t the pain in your ankle that's the problem; it's the feeling of not being cared about. And probably a feeling that has something to do with anger, or a feeling that other people don’t respect you—a feeling of being invalidated.

CLIENT: Yes.

THERAPIST: So I think it's not actually the pain in your ankle that's the problem. Because if you were out on that raft with me, you would have been able to handle the pain if I hadn't had any medicine, right? So it's really not the pain; it's the sense of being invalidated and the sense of not being cared about.

That's my guess. Do you think that's correct?

CLIENT: Yes.

THERAPIST: See, the question is, is there any other way for you to feel validated and cared about, other than them giving it to you?

CLIENT: No.

THERAPIST: Now is this a definite, like “I'm not going to let there be any other way,” or is it more open, like “I can’t think of another way, but I’m open to the possibility?”

CLIENT: I don't think there’s another way.

THERAPIST: Does that mean you’re not even open to learning another way?

CLIENT: Like what?

THERAPIST: I don’t know. We have to figure it out. See, what I think is happening is that when you’re in a lot of pain and you feel either not cared about or not taken seriously, invalidated, that’s what sets you up to hurt yourself, and also to want to die. The problem that we have to solve is how to be in a situation that you feel is unjust without having to hurt yourself to solve it. Are you open to that?

CLIENT: Yeah.

As illustrated here, behavioral analysis is often an excruciating and laborious process for client and therapist alike. The therapist often feels demoralized and is tempted to abandon the effort, which may be likened to trying to find a pair of footprints hidden beneath layers of fallen leaves; the footprints are there, but it may take much raking and gathering of leaves before they are uncovered. With repeated analyses, however, the client learns that the therapist will not “back down.” Such persistence on the part of the therapist eventually extinguishes a client’s refusal to attempt new and adaptive problem-solving behaviors. As clients increasingly acquire new behavioral skills, more adaptive attempts at problem resolution eventually become discernible.

In the following session (approximately 10 months into therapy), the client arrived wearing mirrored sunglasses (again) and was angry because collection agencies were persistent in pressing her for payment on delinquent accounts. In addition, her therapist had been out of town for a week. The session targets were emotion regulation and interpersonal effectiveness. Dialectical (metaphor), validation (cheerleading), problem solving (contingency clarification, contingency management), stylistic (reciprocal communication, irreverent commu-
nication), and integrated (relationship enhancement) strategies were used. In this first segment, the therapist used cheerleading, contingency clarification, and the contingency management strategy of shaping to get the client to remove her sunglasses and work on expressing her anger.

THERAPIST: It’s not a catastrophe that the collector did this to you, and it’s not a catastrophe to be mad at the collector. It’s made your life a lot harder, but you can handle this. You can cope with this. This is not more than you can cope with. You’re a really strong woman; you’ve got it inside you. But you’ve got to do it. You’ve got to use it. I’m willing to help you, but I can’t do it alone. You have to work with me.

CLIENT: How?
THERAPIST: Well, by taking off your sunglasses, for starters.

The therapist began the exchange by attempting to normalize the issue (“It’s not a catastrophe”), validating the client (“It’s made your life a lot harder”), and cheerleading (“You can handle this. You can cope. . . . You’re a really strong woman”). The therapist then moved to contingency clarification by pointing out that provision of the therapist’s assistance was contingent on the client’s willingness to work. She immediately followed this by requesting a response well within the client’s behavioral repertoire.

CLIENT: I knew you’d say that.
THERAPIST: And I knew you knew I’d say that.
CLIENT: Sunglasses are your biggest bitch, I think.
THERAPIST: Well, how would you like to look at yourself talking to someone else? (long pause) They make it difficult for me. And I figure they make it harder for you. I think you do better when you’re not wearing those sunglasses. It’s like a step; you always do better when you go forward. And when you do, you feel better. I’ve noticed that. (long pause) So that’s what you should do; you should take off your sunglasses, and then we should problem-solve on how to cope when you can’t get angry. There’s nothing freakish about that. Something has happened in your life that has made it so that you’re afraid to be angry, and we just have to deal with that, you and me. It’s just a problem to be solved. It’s not a catastrophe; it’s not the worst thing anyone ever did. It’s just a problem that you have, and that’s what you and I do. We solve problems; we’re a problem-solving team. (pause)

CLIENT: (Removes sunglasses.) All right.
THERAPIST: Thank you. That’s a big step, I know, for you.

The therapist’s use of reciprocal communication informed the client of her feelings regarding the sunglasses. Note the matter-of-fact attitude taken by the therapist and her continued attempt to normalize the issue (i.e., “There’s nothing freakish about that . . . it’s not the worst thing anyone ever did”). Also note the framing of the issue as a problem to be solved, as well as the therapist’s use of the relationship strategy to enhance the therapeutic alliance. The therapist also made a point of validating the client by letting her know that she realized this was difficult.

THERAPIST: Now, c’mon, I want you to find it inside yourself. I know you’ve got it; I know you can do it. You can’t give up. You can’t let your feet slip. Keep going. Just express directly to me how you feel. That you’re angry at yourself, that you’re angry at the collection agency, and that you’re damn angry with me. (long pause)

CLIENT: (barely audible) I’m angry at you, at myself, and the collection agency.

The therapist continued to rely on cheerleading and praise as she continued the shaping process in an attempt to get the client to express her anger directly.

THERAPIST: Good, did that kill you? (long pause) That’s great. Is that hard? (long pause) It was, wasn’t it? Now say it with a little vigor. Can’t you say it with a little energy?

CLIENT: (Shakes her head no.)
THERAPIST: Yes, you can. I know you’ve got it in you. I have a good feel for what your strengths are. I don’t know how I’ve got this good feel, but I do. And I know you can do it and you need to do it, and you need to say it with some energy. Express how angry you
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CLIENT: They're persistent.
THERAPIST: Um hmm. (pause) Who's the safest to be angry at? Yourself, me, or the collection agency?
CLIENT: Collection agency.
THERAPIST: OK, then, tell me how angry you are. You don't have to make it sound like 100. Try to make it sound like 50.
CLIENT: They really pissed me off! (said in a loud, angry voice)
THERAPIST: Well, damn right. They piss me off, too.

As illustrated by the foregoing exchange, a primary difficulty in working with clients who have BPD is their not uncommon tendency to refuse to engage in behavioral work. Thus, it is absolutely necessary that the therapist maintain persistence and not give up in the face of a client's "I can't" statements. In situations like these, the use of irreverent communication often succeeds in producing a breakthrough and gaining client compliance.

POSTVENTION

After completing the writing of Cindy's case history for publication in this Handbook, 14 months into therapy, Cindy died of a prescription drug overdose plus alcohol. We considered dropping the case history and replacing it with a more successful case. However, in Cindy's honor, and because we think much can be learned from both failed and successful therapy, we decided to leave the case in. The immediate precipitant for Cindy's overdose was a call to her estranged husband, during which she discovered that another woman was living with him. As Cindy told her therapist during a phone call the next morning, her unverbalized hope that they might someday get back together, or at least be close friends, had been shattered. She phoned again that evening in tears, stating that she had just drunk half a fifth of liquor. Such drinking incidents had occurred several times before, and the phone call was spent "remoralizing" Cindy, offering hope, problem-solving how she could indeed live without her husband, and using crisis intervention techniques to get her through the evening, until her appointment the following day.
Cindy’s roommate was home and agreed to talk with her, watch a TV movie together, and go to bed (plans on which the roommate did follow through). Cindy stated that although she felt suicidal, she would stop drinking and would not do anything self-destructive before her appointment. She was instructed to call the therapist back later that evening if she wanted to talk again. The next day, when Cindy did not arrive for her appointment, the therapist called her home, just as her roommate discovered Cindy dead, still in bed from the night before. At this point, the therapist was faced with a number of tasks. The therapist called to inform other therapists who had been treating the client, and she spoke with a legal consultant to review the limits of confidentiality when a client has died. Once the family (Cindy’s parents and estranged husband) were alerted, the therapist called each to offer her condolences. The next day, the therapist (who was the senior therapist and supervisor on the treatment team) called a meeting of the treatment team to discuss and process the suicide. It was especially important to notify the individual therapists of the remaining three members of Cindy’s skills training group. Group members were notified of the suicide by their individual psychotherapists. Within minutes of the beginning of the next group session, however, two members became seriously suicidal, and one of them had to be briefly hospitalized. (By the third week following the suicide, however, both had regained their forward momentum.) A third group member took this occasion to quit DBT and switch to another therapy, saying that this proved the treatment did not work. In the days and weeks following the suicide, the therapist attended the funeral and met with Cindy’s roommate and with her parents.

What can we learn from this suicide? First, it is important to note that even when a treatment protocol is followed almost to the letter, it may not save a client. Even an effective treatment can fail in the end. In this case, DBT failed. This does not mean that the progress made was unimportant or not real. Had this “slippery spot over the abyss” been negotiated safely, perhaps the client would have been able to develop, finally, a life of quality. Risk is not eliminated, however, just because an individual makes substantial progress. In this case, the therapist did not believe during the last phone call that the client was at higher than ordinary risk for imminent suicide. In contrast to many previous phone calls and therapy sessions in which the client had cried that she might not be able to hold on, during the last call the client made plans for the evening, agreed to stop drinking and not to do anything suicidal or self-destructive, and seemed to the therapist (and the roommate) to be in better spirits following the phone call. Her roommate was home and available. Thus, the therapist did not take extraordinary measures that evening to prevent suicide. Indeed, the problem behavior focused on during the call was the drinking. The topic of suicide was brought up by the therapist, in the course of conducting a risk assessment.

Could the therapist have known? Only (perhaps) if she had paid more attention to the precipitant and less to the affect expressed at the end of the phone call. In reviewing notes about the client, the therapist saw that each previous near-lethal attempt was a result of the client’s believing that the relationship with her husband had irrecoverably ended. Although the client could tolerate losing her husband, she could not tolerate losing all hope for a reconciliation at some point, even many years hence. Had the therapist linked these two ideas (complete loss of hope and suicide attempt), she might have been able to work out a better plan with the client for a reemergence of the crisis later in the evening. The value of both conducting thorough behavioral assessments and organizing them into a coherent pattern is highlighted in this case. Second, when all is said and done, an individual with BPD must ultimately be able and willing to tolerate the almost unimaginable pain of his or her life until the therapy has a chance to make a permanent difference. Ultimately, the therapist cannot save the client; only the client can do that. Even if mistakes are made, the client must nonetheless persevere. In this case, the DBT protocol of “no lethal drugs for lethal people” was violated, even though the client had a past history of near-lethal overdoses. Why was the protocol not enforced? There were two primary reasons. First, the client came into therapy with a strong belief that the host of medications she was on were essential to her survival. Any attempt on the therapist’s part to manage her medications would have been met by very strong resistance. Although the drugs were dispensed in small doses, the only safe alternative would have been to have the person living with her (her husband at first, then her roommate) manage her medications, which the client also resisted. In addition, the “no lethal drugs” protocol of
DBT is regularly criticized by some mental health professionals, who believe that psychoactive medications are a treatment of choice for suicidal individuals. In the face of professional and client resistance to the policy in this case the therapist relented. The second reason was that the lethal behavior of the client during therapy consisted of cutting and slashing; thus, her using drugs to commit suicide did not seem likely, and the therapist allowed herself a false sense of safety with respect to them. Third, a group member’s suicide is extraordinarily stressful for clients with BPD who are in group therapy. Although it is easy to believe that alliances are not strong in a psychoeducational behavioral skills group, this has universally not been our experience. The suicide of one member is a catastrophic event and can lead to contagious suicide and NSSI behavior, and therapy dropouts. Thus, extreme care is needed in the conduct of group meetings for some time following a suicide. Similar care is needed with the treatment team, where the thread of hope that maintains therapists in the face of a daunting task is also strained. It is important that the personal reactions of therapists, as well as a period of mourning and grieving, be shared and accepted. Fears of legal responsibility, never far from the surface, must be confronted directly; legal counsel must be sought as necessary; and, in time, a careful review of the case and the therapy must be conducted, if only to improve treatment in the future.

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REFERENCES


