SECOND EDITION

# Dialectical Behavior Therapy in Clinical Practice

## Applications across Disorders and Settings

edited by Linda A. Dimeff, Shireen L. Rizvi, and Kelly Koerner

Foreword by Marsha M. Linehan

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# About the Editors

**Linda A. Dimeff, PhD,** is Chief Scientific Officer at Jaspr Health (*www.jasprhealth.com*); Institute Director at Portland DBT Institute (*www.pdbti.org*); and Clinical Faculty in the Department of Psychology at the University of Washington. Since 1994, Dr. Dimeff has collaborated closely with Marsha M. Linehan to develop and evaluate an adaptation of dialectical behavior therapy (DBT) for individuals with substance use disorders and borderline personality disorder; to produce DBT training materials for clinicians; and to train, consult, and supervise clinicians in their practice of DBT. She has worked with public- and private-sector systems throughout the world in their efforts to implement DBT. Dr. Dimeff is a recipient of the Cindy J. Sanderson Outstanding Educator Award from the International Society for the Improvement and Teaching of DBT. She has received over 20 federal grants to facilitate the dissemination of evidence-based therapies and has published over 55 peer-reviewed publications.

**Shireen L. Rizvi, PhD, ABPP,** is Associate Professor of Clinical Psychology in the Graduate School of Applied and Professional Psychology at Rutgers, The State University of New Jersey. At Rutgers, she holds affiliate appointments in the Department of Psychology, the School of Arts and Sciences, and the Department of Psychiatry, Robert Wood Johnson Medical School. Her research interests include improving outcomes, training, and dissemination of DBT for the treatment of complex and severe problems. Board-certified in Behavioral and Cognitive Psychology and in Dialectical Behavior Therapy, she is past president of the International Society for the Improvement and Teaching of DBT and was the Society's Conference Program Chair for 2 years. Dr. Rizvi is a recipient of the Spotlight on a Mentor Award from the Association for Behavioral and Cognitive Therapies and the Presidential Fellowship for Teaching Excellence from Rutgers.

**Kelly Koerner, PhD**, is CEO of Jaspr Health (*www.jasprhealth.com*) and Clinical Faculty in the Department of Psychology at the University of Washington. Weaving together science, design, and social entrepreneurship, she develops highly collaborative, technology-based solutions to get evidence-based practices (EBPs) to the right point of care. Dr. Koerner has extensive practical experience in supporting individuals and systems as they learn, implement, and sustain EBPs in diverse settings (e.g., from paraprofessionals in juvenile justice facilities, to master's-level counselors in community mental health and substance abuse treatment centers, to research therapists in academic clinical trials). Most recently, she and her human-centered design team have worked closely with scientists, people with lived experience, and emergency medicine providers to develop a tablet-based application for suicidal people. She maintains an active research program and is a recipient of the Career Achievement Award from the Dissemination and Implementation Science Special Interest Group of the Association for Behavioral and Cognitive Therapies.

# Contributors

**Sarah Adler, PsyD,** Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, California

**Elissa M. Ball, MD,** School of Medicine, University of Colorado Health Sciences Center, Denver, Colorado

**Brad Beach, BA,** Brad Beach DBT, Los Angeles, California

**Elisabeth Bellows, MD,** private practice, Redwood City, California

**Debra M. Bond, PhD,** Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut

**Chad S. Brice, PhD,** Cognitive and Behavioral Consultants, LLP, White Plains, New York

**W. Maxwell Burns, MD,** private practice, Pacifica, California

**Adam Carmel, PhD,** Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington

**Dawn Catucci, MSEd,** LMHC, Mental Health Counseling for Emotional Well-Being, PLLC, Pleasantville, New York

**Carla D. Chugani, PhD, LPC,** Department of Pediatrics, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

**Katherine Anne Comtois, PhD, MPH,** Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington

**Elizabeth Courtney-Seidler, PhD,** Cognitive and Behavioral Therapies of Ridgefield, PLLC, Ridgefield, Connecticut

**Elizabeth T. Dexter-Mazza, PsyD,** Mazza Consulting and Psychological Services, PLLC, Seattle, Washington

**Linda A. Dimeff, PhD,** Jaspr Health, Seattle, Washington; and Portland DBT Institute, Portland, Oregon

**Lynn Elwood, LMHC,** Greenlake Therapy Group, Seattle, Washington

**Alan E. Fruzzetti, PhD,** McLean Hospital and Department of Psychiatry, Harvard Medical School, Boston, Massachusetts

**Kelly Graling, PhD,** Cognitive and Behavioral Consultants, LLP, White Plains, New York

**Melanie S. Harned, PhD, ABPP,** Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington

**Perry D. Hoffman, PhD (deceased),** National Education Alliance for Borderline Personality Disorder, Mamaroneck, New York

**Jesse Homan, PhD, LPC,** private practice, Cincinnati, Ohio

**Soonie A. Kim, PhD,** private practice, Portland, Oregon

**Kelly Koerner, PhD,** Jaspr Health, Seattle, Washington

**Cedar R. Koons, MSW, LCSW,** private practice, Dixon, New Mexico

**Marsha M. Linehan, PhD, ABPP,** Department of Psychology, University of Washington, Seattle, Washington

**Shari Y. Manning, PhD,** Treatment Implementation Collaborative, Hilton Head, South Carolina

**James J. Mazza, PhD,** School Psychology Program, University of Washington, Seattle, Washington

**Robin McCann, PhD,** private practice, Colorado Springs, Colorado

**Shelley McMain, PhD,** Borderline Personality Disorder Clinic, Centre for Addiction and Mental Health Treatment (CAMH), Toronto, Ontario, Canada

**Jenna Melman, MSW, LICSW,** Greenlake Therapy Group, Seattle, Washington

**Alec L. Miller, PsyD,** Cognitive and Behavioral Consultants, LLP, White Plains, New York

**Maria Monroe-DeVita, PhD,** Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington

**Donald Nathanson, MSW, LCSW-R,** private practice, White Plains, New York

**Juliet Nelson, PhD,** DBT Center of Lawrence, Lawrence, Kansas

**Travis L. Osborne, PhD, ABPP,** Evidence Based Treatment Centers of Seattle, Seattle, Washington

**Luciana G. Payne, PhD,** McLean Hospital and Department of Psychiatry, Harvard Medical School, Boston, Massachusetts

**Francheska Perepletchikova, PhD,** Department of Psychiatry, NewYork–Presbyterian Westchester Behavioral Health Center, White Plains, New York

**Jacqueline Pistorello, PhD,** Counseling Services, University of Nevada, Reno, Reno, Nevada

**Jill H. Rathus, PhD,** Department of Psychology, Long Island University Post, Brookville, New York

**Shireen L. Rizvi, PhD, ABPP,** Department of Clinical Psychology, Graduate School of Applied and Professional Psychology, Rutgers, The State University of New Jersey, Piscataway, New Jersey

**Debra L. Safer, MD,** Department of Psychiatry and Behavioral Sciences, Stanford University Medical Center, Stanford, California

**Jennifer H. R. Sayrs, PhD, ABPP,** Evidence Based Treatment Centers of Seattle, Seattle, Washington

**Sara C. Schmidt, PhD,** Behavioral Tech, LLC, Seattle, Washington

**Kim Skerven, PhD,** Center for Behavioral Medicine, Milwaukee, Wisconsin

**Charles R. Swenson, MD,** Department of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts

**Andrew White, PhD,** Portland DBT Institute, Portland, Oregon

**Chelsey R. Wilks, PhD,** Department of Psychology, Harvard University, Cambridge, Massachusetts

**Lucene Wisniewski, PhD,** private practice, Shaker Heights, Ohio

**Suzanne Witterholt, MD,** Allina Health, Minneapolis, Minnesota

# Foreword

## FROM THE FIRST EDITION

The 20th century saw an explosion of new, innovative, and highly effective psychosocial therapies, each carrying a promise of reducing the pain and suffering of millions of people afflicted with debilitating mental health problems. Effective therapies were developed to successfully treat major depression (in fewer than 20 sessions), panic disorder (in fewer than 15), posttraumatic stress disorder, obsessive–compulsive disorder, substance use disorders, and eating disorders, to name just a few. Dialectical behavior therapy (DBT), a treatment I have spent my career developing and investigating, offered the promise of a life worth living for highly suicidal people with borderline personality disorder (BPD), a group previously considered "untreatable"—and for good reason. These individuals were viewed by most as notoriously difficult to treat and they typically had very poor clinical outcomes.

We arrived at the 21st century facing a serious problem: We now had a number of effective therapies, but few tools and strategies to disseminate and implement them. Clinicians were leaving graduate school without training in many (if not most) of these evidence-based therapies, and there were scant opportunities to fully learn them once working as a social worker, psychologist, or psychiatrist. Those who did read the treatment manuals for an evidence-based therapy often struggled to figure out how to actually *implement* the treatment in their unique setting. We have learned over the years that implementing an evidence-based therapy in a unique, non-research-supported clinical practice is not as simple as "plug and play."

When I disseminated the original version of my (yet unpublished) DBT treatment manuals in 1984, I thought I had said enough about how DBT works *and* how to apply it. I discovered the error of my thinking when I first began teaching DBT workshops to clinicians in various communities. When I published the DBT treatment manuals (Linehan, 1993a, 1993b), I thought I had added enough information to allow easy

access to the treatment. As I continued to train individuals across various clinical settings, many would say to me that they simply could not do DBT in their clinical settings. In 1999 I published a paper in which I outlined the functions of any comprehensive clinical intervention (Linehan, 1999). I had figured out these functions in my many interactions with the community therapists I was teaching (Linehan, Cochran, & Kehrer, 2001). My intent at the time was to help DBT teams implement comprehensive DBT in their own settings. When DBT cannot be fully adopted because the setting in no way resembles the outpatient clinic where it was developed, how is this done in a fashion that preserves fidelity to the treatment method? Even when all the modes are offered, how can you be sure it actually *is* DBT? Distinguishing the functions from the modes of treatment created an important tool in evaluating whether a program was really *doing* DBT. For example, meeting 1 hour a week as a team and reviewing cases is not a DBT team meeting unless there is explicit discussion of what the therapists need in order to be more skillful and/or more motivated to provide DBT to their clients.

This book is personally very exciting to me for a number of reasons. First, this is a book on how to transfer DBT to your own setting if there ever was one: It is filled with very specific tools, strategies, and recommendations for building and sustaining your DBT programs. It reflects two decades of learning about how best to disseminate and implement DBT across a wide array of settings and client populations and how to adapt it in a fashion that best preserves its fidelity. The principles applied throughout this book arise directly from the treatment itself. This book will, without doubt, have an impact on the field—it will certainly influence clinicians wishing to build or sustain a DBT program, but I hope it will also provide a set of tools that may be helpful to the field as a whole as we focus our efforts and energies on improving our capability to transfer what we have developed in the lab to the front lines of treatment.

Second, this book was inspired, conceived of, organized, and edited by two of my students at the University of Washington, Drs. Linda A. Dimeff and Kelly Koerner. Both Linda and Kelly were with me at the Behavioral Research and Therapy Clinics (BRTC), my clinic at the University of Washington, long before DBT was a popular, "in-demand" treatment. Kelly was part of the very first DBT treatment team at the BRTC. She, along with the other students on the team, provided critical feedback that ultimately influenced the development of DBT. Linda joined my lab just as I was pioneering my first adaptation of DBT to a population of polysubstance-dependent individuals with BPD. Linda and other members of my drug-treatment team made significant contributions to the development of DBT for individuals with substance use disorders (described in this edition in Chapter 11) and she has been my chief coauthor of the articles and papers that describe that treatment. Both Linda and Kelly helped form what is now Behavioral Tech, LLC—Kelly as an initial founder with me and the organization's very first President and CEO. Linda was the very first Director of Research and Development at what is now Behavioral Tech Research, Inc. Both Linda and Kelly are experts in DBT and have extensive expertise in training and consulting to teams who are building their DBT programs. Indeed, many of the contributors to this book are also my students and chief research collaborators. As their teacher, mentor, friend, and colleague, nothing gives me greater delight than to see them each actively extend my work in this fashion.

I wish to offer two words of wisdom as I conclude. The first is about how to

approach this book and the second is about how to approach your work in applying DBT. About the first, I recommend that you read widely, and not limit yourself to only those chapters that have the greatest relevance to you and your program. It may be by carefully reading a chapter that appears to have no direct relevance to your work that you have the greatest "ah-ha" moment of all: You'll see the DBT principles at play in a new light; you'll have a creative brainstorm around a particular programmatic roadblock; and you'll feel part of a large DBT community that is thinking creatively, compassionately, and scientifically about how to solve complex problems in the service of improving the lives of some of the most challenging of clients.

About the second, I encourage you to know and follow the data on both CBT (cognitive-behavioral therapy) and DBT, and to keep your allegiance not to DBT, but to what is most effective based on the empirical literature. After nine randomized controlled published trials, we know DBT is effective. We are at just the beginning of what promises to be an important and exciting area of research where we can identify the active ingredients of DBT. What is abundantly clear is that for severely disordered individuals with BPD and other complex behavioral problems, comprehensive DBT (i.e., all DBT functions and modes) is effective. As more is empirically known about what is and is not effective in DBT, I expect that the treatment itself will change—to be in sync with the empirical literature.

Best wishes to you in your further development and mastery of DBT.

MARSHA M. LINEHAN, PhD
*Seattle, Washington 2007*

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## SECOND EDITION NOTE FROM THE EDITOR

Many things have changed since 2007, when this book was first published. On June 22, 2011, Marsha returned to the Institute of Living, the hospital in Hartford, Connecticut, where she was once institutionalized, to tell of her own significant mental health problems that included months of essentially solitary confinement on an inpatient unit. She told her improbable story—first to clients in the institute's outpatient DBT program that is housed in the very unit she was once a patient. She led a small group of us gathered there on that day in a mindfulness dance just opposite the courtyard where, years earlier, she paced and wrung her hands in mental anguish and

despair. After a private lunch with her family and a few friends, she entered a packed auditorium to tell her story to the world. The next day, *The New York Times* ran a front-page article, "Expert on Mental Illness Reveals Her Own Fight" (Carey, 2011), that immediately served as a beacon of hope for all those who, like Marsha, struggled profoundly and were suicidal. She said she told her story not because she wanted to, but because she didn't want to die—at least as she saw it—a coward. She knew her story was a message of hope, that climbing out of hell one step at a time is possible, and a life worth living was *indeed* attainable. Last year, Marsha's memoir, *Building a Life Worth Living* (2020), chronicled her life from her early years up through her meteoric rise (through brilliance and so much hard work) as one of the greatest scientific "geniuses and visionaries who transformed our world," according to *TIME Magazine* (April 27, 2018).

Since the writing of this second edition, Marsha has retired from her long and prolific academic career. We three remain committed to disseminating her life's work and vision, following core DBT principles of clarity, precision, and compassion. Were things different, were she not retired, Marsha would want to convey her absolute delight and pride that Shireen has joined Kelly and me to edit this important book. She would tell you that Shireen is "too fabulous for words!" and then list Shireen's wonderful accomplishments—as a grant-getting, scholarly-papers-writing academic researcher who runs a large DBT lab and clinic where she trains graduate students, and as an active leader in her professional home, the Association for Behavioral and Cognitive Therapies. Shireen, more than most of us, has followed closely in Marsha's incredible footsteps. Marsha is thrilled that her three students—Shireen, Kelly, and I—are still at it, together: carrying the torch with our dear colleagues who join us here in these pages.

To you, dear Marsha.

Linda A. Dimeff, PhD
*Seattle, Washington*

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# Preface

*Dialectical Behavior Therapy in Clinical Practice* has its roots in the early days of dialectical behavior therapy, before "DBT" had become widespread. Back in those early days, the mecca of DBT training was the company formed by Marsha Linehan, called the Linehan Training Group (later renamed Behavioral Technology Transfer Group, and now named Behavioral Tech, LLC). Our dear colleague Cindy J. Sanderson, PhD, one of the smartest, wittiest, and most passionate DBT clinicians and disseminators, was the first Director of Training of the Linehan Training Group. Cindy, along with her best friend and colleague Charlie Swenson, MD, were among the first to learn DBT outside of Marsha's University of Washington setting and the first to adapt it to an inpatient environment at Cornell Medical School. Back in that day, Kelly Koerner, PhD, had barely completed her doctoral studies when she agreed to serve as the group's initial president/CEO as interest and excitement in DBT pushed its growth and dissemination far beyond the literal closet walls of Marsha's lab and into what it is today. Linda Dimeff, PhD, had joined Kelly and Cindy shortly after its launch. Together, along with Marsha and many of the authors in this book, we developed models and materials for standard trainings, intensives, implementations, as well as dozens of hours of digital tools to learn and effectively deliver DBT. As a group and individually, we trained throughout the world—building enduring teams and communities to deliver DBT to fidelity.

Throughout her conversations with early adopters, Marsha intuited the complexities of moving DBT from an academic, tightly controlled, outpatient treatment to an inpatient environment, a juvenile justice rehabilitation environment, a sex-offender treatment facility, and other patient populations beyond those she had initially studied at the university: chronically suicidal, multidiagnostic, complex women with borderline personality disorder (BPD). She developed a model for training and advanced the concept of DBT functions and modes. She passionately guided the world against

reflexively dismantling or "watering down" the delivery of DBT, and instead counseled to keep its many modes intact, in a comprehensive full-fidelity package.

As we trained and supported others in their efforts to disseminate DBT, we found ourselves describing again and again *how to* adapt DBT for use in specific settings and for different patient populations in a fashion that preserved its fidelity. Marsha's treatment manuals (as brilliant as they were and are) told us how to do the treatment, but provided little guidance for how to adapt it for use outside the University of Washington's outpatient research clinic. Because of our own unique proximity to the source (Marsha), we and our other Linehan Training Group colleagues served as conduits as best as we could: passing along the brilliant innovations from others who had adapted DBT to others seeking to do the same. If only we could bring them together—for those seeking a novel adaptation to stand on the shoulders of others who had done it before—and in a way that might endure over time.

That was the initial inspiration for this book—an early idea developed by Linda, Kelly, and Cindy to help others adopt DBT in, and adapt it to, their unique populations and setting, supported by the work done by others before them so as not to have to repeatedly reinvent the proverbial wheel. Sadly, Cindy died after a long battle with breast cancer several years before we began the first edition in earnest. Her memory, along with her work in helping articulate how best to build a full-fidelity DBT program, coursed through the first edition just as they do this second edition.

Since the time of its initial publication in 2007, a worn copy of *Dialectical Behavior Therapy in Clinical Practice* sat on Marsha's round conference table in her office at the Behavioral Research and Therapy Clinics (BRTC) at the University of Washington. Whether it was there because she took pride in a book edited by two of her students or because she, too, used it as a reference (or a bit of both), we'll never know for sure.

Kitty Moore, our fantastic editor at The Guilford Press, encouraged us to consider a second edition 10 years after the date of the book's original publication. By then, the world of DBT had significantly expanded to nearly every corner of the globe, for use with every complex context and patient population. Dozens of tightly controlled randomized controlled trials had been conducted, continuing to support its efficacy and effectiveness. Important and exciting adaptations of DBT were well on their way, including adaptations for young children and DBT delivered as a universal and secondary prevention program in public schools. DBT was integrated with Edna Foa's prolonged exposure to more effectively treat trauma in chronically suicidal patients with BPD. Further research helped refine and expand DBT to assist people on psychiatric disability tangibly build a life worth living by returning to work or obtaining a degree.

We (L. A. D. and K. K.) knew that a second edition was needed and important—to update additional lessons learned and provide a forum to further disseminate some of the most exciting DBT advances in the past decade. And yet, given the vast expansion of the DBT universe, we knew we could not do it alone. We were fortunate enough that Shireen Rizvi, our dear friend, fellow BRTC colleague, and a former student of Marsha's, was the perfect person to help lead this effort with her exceptional project management skills, commitment to DBT, and deep understanding to detect what is and isn't DBT.

This second edition is greatly expanded from the first, with every original chapter significantly updated and 10 new chapters. We hope that it continues to serve as

a resource to many as you strive to deliver DBT with fidelity to improve the lives of individuals with complex mental health problems and a high degree of suffering. The dialectical worldview teaches us that we are all connected and change in transaction with each other over time. This book is one tangible piece of evidence of that, and we are grateful for the opportunity to provide it.

Linda A. Dimeff
Shireen L. Rizvi
Kelly Koerner

# Contents

PART I

# OVERVIEW AND GETTING STARTED WITH DBT

CHAPTER 1

# Overview of DBT

KELLY KOERNER, LINDA A. DIMEFF,
and SHIREEN L. RIZVI

In this chapter, we provide an overview of standard outpatient dialectical behavior therapy (DBT) and its evidence base. Our purpose is to describe DBT in enough detail to help you determine whether adopting DBT will meet the needs of your setting or population. This chapter also serves as an anchor and reference point on the standard outpatient model of DBT so that you can easily compare and contrast it with variations of DBT described in subsequent chapters. This chapter is also meant to be one you could share with colleagues as an introduction to DBT.

## DBT in a Nutshell

DBT is a cognitive-behavioral treatment originally developed by Marsha M. Linehan, PhD, as a treatment for chronically suicidal individuals, and first validated with suicidal women who met criteria for borderline personality disorder (BPD). BPD is a psychological disorder characterized by dysregulation in several key areas of regulation: emotion, identity, interpersonal, behavioral, and cognition. Estimates of prevalence of BPD in the general population are approximately 2–3% (Tomko, Trull, Wood, & Sher, 2014). Yet, prevalence rates of BPD are significantly higher among high treatment utilizers and inpatient samples (e.g., Comtois & Carmel, 2016; Widiger & France, 1989; Widiger & Weissman, 1991). Adequately addressing the needs of individuals with BPD poses several challenges. Individuals with BPD typically require therapy for multiple, complex, and severe psychological problems, often in the context of unrelenting crises and management of high-risk suicidal behavior. With many of these clients, the sheer number of serious (at times life-threatening) problems that therapy must address makes it difficult to establish and maintain a treatment focus. Following the concern most pressing to the client can result in a different crisis

management focus each week. Therapy can feel like a car veering out of control, barely averting disaster, with a sense of forward motion but no meaningful progress.

Treatment decisions are made yet more complicated because clients with chronic suicidal behavior and extreme emotional sensitivity often act in ways that distress their therapists. Suicide attempts, threats of suicide attempts, and anger directed at the therapist can be very stressful. Regardless of their training and experience, therapists can struggle with their own emotional reactions when a client is recurrently suicidal and both rejects the help that the therapist offers and demands help that the therapist cannot give. Even when the therapist is on the right track, progress can be slow and sporadic. All these factors increase the chance of therapeutic errors, including making premature changes to the treatment plan, and may contribute to the fact that those with BPD have high rates of treatment failure (Perry & Cooper, 1985; Rizvi, 2011; Tucker, Bauer, Wagner, Harlam, & Sher, 1987). Intense distress, treatment failure, and repeated suicidal behavior, in turn, contribute to the high use of psychiatric services by this population. Individuals who meet criteria for BPD typically have sought help repeatedly and from multiple sources. Research has consistently demonstrated that individuals with BPD have higher treatment utilization rates than individuals with other personality disorders or mood or anxiety disorders (e.g., Ansell, Sanislow, McGlashan, & Grilo, 2007; Bender et al., 2001; Zanarini, Frankenburg, Hennen, & Silk, 2004). Legal and ethical concerns about suicide make it difficult to limit hospital use, even when "revolving door" use of involuntary inpatient facilities may itself inadvertently cause harm (i.e., be iatrogenic). The experience for individuals who meet criteria for BPD and their treatment providers has historically been a discouraging path of recurrent treatment failures despite their best efforts.

It was within this context that DBT evolved. As Linehan began to use standard clinical behavior therapy (Goldfried & Davison, 1976), she was led by the nature of her clients' problems to balance and complement behavior therapy's change orientation with other therapeutic strategies. Linehan's (1993a, 1993b) careful observation of successes and failures resulted in treatment manuals that organize strategies into protocols and that structure therapy and clinical decision making so that therapists can respond flexibly to an ever-changing clinical picture. Although DBT shares elements with the psychodynamic, client-centered, gestalt, paradoxical, and strategic approaches to therapy (see Heard & Linehan, 1994), it is the application of behavioral science, mindfulness, and dialectical philosophy that are its defining features.

DBT has evolved into a sophisticated treatment, yet most of its concepts are quite straightforward. For example, DBT emphasizes an organized, systematic approach in which members of the treatment team share fundamental assumptions about therapy and clients. DBT considers suicidal behavior to be a form of maladaptive problem solving and uses well-researched cognitive-behavioral therapy (CBT) techniques to help clients solve life problems in more adaptive ways. DBT therapists take every opportunity to strengthen clients' valid responses, which alone and in combination with CBT interventions facilitate change (e.g., Linehan et al., 2002). Because difficult clinical problems naturally provoke strong differing opinions among treatment providers, and because DBT clients' problems themselves include dichotomous, rigid thinking and behavioral and emotional extremes, dialectical philosophy and strategies offer a means of reconciling differences so that conflicts in therapy are met with movement rather than with impasse. Below we discuss each of these in turn as a way to lay out DBT in a nutshell.

## DBT as Framework

A number of elements of DBT provide a structure or conceptual frame for the therapist and client. DBT case conceptualization is based on biosocial theory and level of disorder. These in turn translate into a basic collaborative therapeutic stance and into treatment goals and targets that are hierarchically organized according to importance. These targets are clearly assigned to modes of services delivery (weekly individual psychotherapy and skills training, and as-needed phone consultation for clients; weekly peer consultation for therapists) so that specific duties and roles are assigned and each mode has specific targets it is responsible for treating. We next sketch each of these.

### *Biosocial Theory*

According to Linehan (1993a), the primary problem of BPD is pervasive disorder of the emotion-regulation system. This idea guides all treatment interventions and is used as a psychoeducational frame so that clients and therapists share a common understanding of problems and interventions. From this perspective, BPD criterion behaviors function to regulate emotions (e.g., suicidal behavior) or are a consequence of failed emotion regulation (e.g., dissociative symptoms or transient psychotic symptoms).

This pervasive emotion dysregulation is hypothesized to be developed and maintained by both biological and environmental factors. On the biological side, individuals are thought to be more vulnerable to difficulties regulating their emotions due to differences in the central nervous system (e.g., due to genetics, events during fetal development, or early life trauma). When Linehan first developed the biosocial theory, it was based on her own clinical observations. Since that time, biological measurement has been made possible via psychophysiological measurements, blood tests of hormones and neurotransmitter levels, and brain scans. Thus, a body of empirical research has emerged to support this central notion that those with BPD do experience more frequent, more intense, and longer-lasting aversive states and that biological vulnerability may contribute to their difficulties in regulating their emotions (e.g., Ebner-Priemer et al., 2005; Schulze, Schmahl, & Niedtfeld, 2016). Further, an updated biosocial model by Crowell, Beauchaine, and Linehan (2009) suggests impulsivity is an important additional biological factor in BPD. Because, normatively, many capabilities depend on adequate emotion regulation and distress tolerance, difficulties here result in instabilities in an abiding sense of self, resolution of interpersonal conflict, goal-oriented action, and the like.

Problems arise when a biologically vulnerable individual is in a pervasively invalidating environment. Invalidating environments communicate that the individual's characteristic responses to events (particularly their emotional responses) are incorrect, inappropriate, pathological, or not to be taken seriously. Not understanding how debilitating it is to struggle with emotion regulation, those in the environment oversimplify the ease of solving problems and fail to teach the individual to tolerate distress or to form realistic goals and expectations. By punishing communication of negative experiences and only responding to negative emotional displays when they are escalated, the environment teaches the individual to oscillate between emotional inhibition and extreme emotional communication.

Childhood sexual abuse is a prototypical invalidating environment related to BPD, given the correlation observed among BPD, suicidal behavior, and reports of childhood sexual abuse (Wagner & Linehan, 1997). However, because not all individuals who meet BPD criteria report histories of sexual abuse and because not all victims of childhood sexual abuse develop BPD, it remains unclear how to account for individual differences. Interesting findings suggest that negative affect intensity/reactivity is a stronger predictor of BPD symptoms than childhood sexual abuse and that higher thought suppression may mediate the relationship between BPD symptoms and childhood sexual abuse (Rosenthal, Cheavens, Lejuez, & Lynch, 2005).

The resulting pervasive emotion dysregulation interferes with problem solving and creates problems in its own right. For example, a client may come into her therapy session after having been fired because she lost her temper with a coworker. When the therapist asks what happened, the client is overwhelmed with shame, becomes mute, and curls up in the chair, banging her head against the armrest. This response derails any help the therapist might have offered about managing anger at work and creates a new situation about which the client feels shame (i.e., how she acted in therapy). Such maladaptive behaviors, including extreme behaviors such as suicidal behavior, function to solve problems and, in particular, dysfunctional behaviors solve the problem of painful emotional states by providing relief. For a client, it is difficult to know whether to blame oneself or others: either one is able to control one's own behavior (as others believe and expect) but won't, and therefore one is "manipulative," or one is unable to control one's emotions, as a lifetime of experiences shows, which means that life will always be a never-ending nightmare of dyscontrol. When the person tries to fulfill expectations that are out of line with true capabilities, they may fail, feel ashamed, and decide that being punished or even being dead is what they deserve. When the person adjusts their own standards to accommodate vulnerability but others do not, the client can become angry that no one offers needed help.

This is a key dilemma in therapy. When the therapist focuses on accepting vulnerability and limitations, this sets off despair that problems will never change; focusing on change, however, may trigger panic because clients who have struggled with pervasive emotion dysregulation know that there is no way to consistently meet expectations. The DBT therapist must understand and reckon with the intense pain involved in living without "emotional skin" and directly target reduction in painful emotions and solutions to problems that give rise to painful emotions. For example, in response to intense emotional reactions during therapeutic tasks (e.g., talking about an event from the previous week), the therapist validates the uncontrollable, helpless experience of emotional arousal, and teaches the individual to modulate emotion in session, balancing, moment to moment, the use of supportive acceptance and confrontive change strategies.

### *Levels of Disorder and Stages, Goals, and Targets of Treatment*

In DBT, the current extent of disordered behavior determines what treatment tasks are relevant and feasible. For example, what is relevant and feasible for a homeless client with out-of-control heroin use, who has angrily "blown out" of multiple methadone treatment programs, and who has recently attempted suicide, is different than what is relevant and feasible for a nurse, also addicted to opiates, who avoided a suspended license for stealing drugs from work and has a supportive family and

an employer who is willing to take him back once he's drug-free. While many of the interventions for addiction will be the same, the first person needs more comprehensive help. Treating some of her behaviors (e.g., suicide attempts) will take precedence over treating others. Multiple problems (e.g., drug abuse, homelessness, out-of-control anger) may need to be solved simultaneously. In a commonsense way, DBT's stage model of treatment (Linehan, 1993a, 1996) prioritizes the problems that must be addressed at a particular point in therapy according to the threat they pose to the client's reasonable quality of life.

The first stage of treatment with all DBT clients is pretreatment, followed by one to four subsequent stages. The number of subsequent stages depends on the extent of behavioral disorder when the client begins treatment. In the pretreatment stage, as with other CBT approaches, the client and the therapist explicitly and collaboratively agree to the essential goals and methods of treatment. While it is not important to have a written contract, it is important to have a mutual verbal commitment to treatment agreements. Specific agreements may vary by setting and clients' problems, but for the client might include agreeing to work on the Stage 1 treatment targets for a specified length of treatment and attend all scheduled sessions, pay fees, and the like. For the therapist, they might include agreeing to provide the best treatment possible (including increasing their own skills as needed), to abide by ethical principles, and to participate in consultation. Such agreements should be in place before beginning formal treatment. Because DBT requires voluntary rather than coerced consent, both the client and the therapist must have the choice of committing to DBT over some other non-DBT option. So, for example, in a forensic unit or when a client is legally mandated to treatment, they are not considered to have entered DBT until a considered verbal commitment is obtained. In pretreatment, once the therapist commits to the client, the priority is to obtain engagement in therapy.

Stage 1 of DBT is for the most severe level of disorder. Stage 1 of therapy targets behaviors needed to achieve reasonable (immediate) life expectancy, control of action, and sufficient connection to treatment and behavioral capabilities to achieve these goals. To reach these goals, treatment time is allocated to give priority to targets in the following order of importance: (1) suicidal/homicidal or other imminently life-threatening behavior; (2) therapy-interfering behavior by the therapist or the client; (3) behavior that severely compromises the client's quality of life (e.g., psychological disorders as well as serious problems with relationships, the legal system, employment/school, illness, and housing); and (4) deficits in behavioral capabilities needed to make life changes. DBT assumes that certain deficits are particularly relevant to BPD and provides training to help clients (1) regulate emotions; (2) tolerate distress; (3) respond skillfully to interpersonal situations; (4) observe, describe, and participate without judging, with awareness and focusing on effectiveness; and (5) manage their own behavior with strategies other than self-punishment. These skills are linked to the particular BPD criterion behaviors with mindfulness intended to decrease identity confusion, emptiness, and cognitive dysregulation; interpersonal effectiveness addressing interpersonal chaos and fears of abandonment; emotion-regulation skills reducing labile affect and excessive anger; and distress tolerance helping to reduce impulsive behaviors, suicide threats, and intentional self-injury. It's important to note that DBT actively targets therapy-interfering behaviors of both the client and the therapist, viewing it as second only to life-threatening behavior. In other words, client behaviors that interfere with receiving therapy, such as not attending,

noncollaboration, and noncompliance, or that push therapist limits or reduce their motivation to treat the client are viewed on an equal footing with behaviors of the therapist that unbalance therapy, such as being extremely accepting or extremely change-focused, too flexible or too rigid, too nurturing or too withholding, and so on. Specific targets are mutually identified and then are monitored and provide the main agenda for individual therapy sessions along with helping the client reach individual goals. In DBT, it is important to communicate that the goals of therapy are not simply to suppress severe dysfunctional behavior, but rather to build a life that any reasonable person would consider worth living.

Many clients who are not out of control still experience tremendous emotional pain due to either posttraumatic stress responses or other painful emotional experiences that leave them alienated or isolated from meaningful connections to other people or to a vocation. They suffer lives of quiet desperation, where emotional experience is either too intense (although behavioral control is maintained) or the person is numbed. Therefore, with these clients, the Stage 2 goals of therapy are to have nontraumatizing emotional experience and connection to the environment. In Stage 3, the client synthesizes what has been learned, increases their self-respect and an abiding sense of connection, and works toward resolving problems in living. Targets here are self-respect, mastery, self-efficacy, a sense of morality, and an acceptable quality of life. Stage 4 (Linehan, 1996) focuses on the sense of incompleteness that many individuals experience, even after problems in living are essentially resolved. For many, Stage 4 goals fall outside the realm of traditional therapy and within a spiritual practice that gives rise to the capacity for freedom, joy, or spiritual fulfillment.

Although the stages of therapy are presented linearly, progress is often not linear and the stages overlap. It is not uncommon to return to discussions like those of pretreatment to regain commitment to the treatment goals or methods. The transition from Stage 1 to Stage 2 can also present with uncertainties. The infrequency of Stage 1 behaviors as well as the speed of reregulation (rather than the presence of any one instance of behavior) defines the differences between stages. Readiness for Stage 2 work is idiosyncratic. In general, the client is ready for transition when they are no longer engaging in severe dysfunctional behavior, can maintain a strong therapy relationship, and have demonstrated to their own and the therapist's satisfaction the ability to cope with cues that previously triggered problem behavior. Stage 3 is often a review of the same issues from a different vantage point.

Level of disorder and stages of treatment have implications for service delivery. Many clinics have different levels of care contingent on the severity of behavioral dyscontrol. For example, if it is the case that someone can only get individual therapy by being completely out of control or that clients lose access to individual therapists as soon as they are out of crisis, then the contingencies favor lack of progress and continued crises. What's required is to have reinforcers (e.g., more and more in-depth services) available contingent on progress rather than on continuation of maladaptive behavior.

As mentioned earlier, responsibility for treating specific targets is assigned to modes. For example, the individual psychotherapist is assigned the role of treatment planning, ensuring that progress is made on all DBT targets, helping to integrate other modes of therapy, consulting to the client on effective behaviors with other providers, and management of crises and life-threatening behaviors. This allows the

primary therapist—who is often the person who best knows the client's capabilities—to teach, to strengthen, and to generalize the client's new responses to crises without reinforcing client dysfunctional behavior. This also prevents multiple alternative treatment plans from being run at once.

The skills trainer's role is to ensure that the client acquires new skills. To maximize learning and keep roles from conflicting, they only minimally target behaviors that interfere with skills training (e.g., dissociating in group, coming late), referring the client back to the primary individual therapist to work on the bulk of those problems. Similarly, in suicidal and other crises, the skills trainer refers the client back to the individual therapist, after conducting requisite suicide risk assessment and providing the intervention needed to get the client in contact with the primary therapist.

## DBT as Problem Solving

As mentioned earlier, DBT uses empirically supported behavior therapy protocols to treat psychological problems. As do other CBT approaches, it emphasizes use of behavioral principles and behavioral assessment to determine the controlling variables for problem behaviors. It uses standard CBT interventions (e.g., self-monitoring, behavioral analysis and solution analysis, didactic and orienting strategies, contingency management, cognitive restructuring, skills training, and exposure procedures). Rather than describe such CBT interventions in depth, we assume that the reader is already familiar with them. Here, we highlight those that are unique to or emphasized in DBT. For example, all CBT approaches include psychoeducation and place a strong emphasis on orienting the client to the treatment rationale and treatment methods. However, because the emotional arousal of clients with BPD often interferes with their information processing and collaboration, their DBT therapist frequently must do what could be called "micro-orienting," instructing the client specifically about what to do in the particular treatment task at hand.

As the primary therapist and client identify and commit to goals for therapy in the first several sessions, the therapist gathers the history needed to accurately assess suicide risk and begins to identify situations that evoke suicide ideation and intentional self-injury to manage suicidal crises. In particular, the therapist identifies the conditions associated with near-lethal suicide attempts, suicidal behavior with high intent to die, and other medically serious intentional self-injury.

After the client and the therapist develop their goals and agreements, the client begins to monitor those behaviors they've agreed to target. Whenever one of the targeted problem behaviors occurs, the therapist and the client conduct an in-depth analysis of events and situational factors before, during, and after that particular instance (or set of instances) of the targeted behavior. The goal of this *chain analysis* is to provide an accurate and reasonably complete account of the behavioral and environmental events associated with the problem behavior (Rizvi, 2019; Rizvi & Ritschel, 2014). As the therapist and the client discuss a chain of events, the therapist highlights dysfunctional behavior, focusing on emotions, and helps the client gain insight by recognizing the patterns between this and other instances of problem behavior. Together, they identify where an alternative client response might have produced positive change and why that more skillful alternative did not happen. This process of identifying the problem and analyzing the chain of events moment

to moment over time to determine which variables control/influence the behavior occurs for each targeted problem behavior as it occurs.

As in other CBT approaches, the absence of adaptive behavior is considered to be the result of one of four factors linked to behavior therapy change procedures: skills training, exposure procedures, contingency management, and cognitive restructuring. If chain analysis reveals a capability deficit (i.e., the client does not have the necessary skills in their repertoire), then skills training is emphasized. When the client does have the skill, but emotions, contingencies, or cognitions interfere with their ability to act skillfully, the therapist uses basic principles and strategies from exposure procedures, contingency management, and cognitive restructuring to help the client overcome barriers to using their capabilities.

Similarly, when cognitive-behavioral therapists generate solutions, they typically also preemptively figure out what would prevent the use of the solution or troubleshoot. In DBT, this troubleshooting takes on added emphasis because the client often has severe mood-dependent behaviors and one cannot assume generalization in the same way one would with a less mood-dependent person.

Treating clients with multiple severe and chronic disorders requires the therapist to know treatment protocols for specific disorders but also requires the therapist to have some cohesive way of integrating them to treat an ever-changing clinical picture. The complexity of the task is further complicated because of the work one must do to establish and keep a collaborative and productive therapeutic relationship. One could treat the presenting or major problem first, see what resolves, and then proceed to treat the multiple other psychological disorders sequentially. However, even if one had enough time (and enough insurance coverage) to do so, between one session and the next a typically dysregulated client has had a major life crisis. For example, last week a client took home readings to orient her to treatment for panic disorder. The therapist came to the session ready to discuss the treatment rationale. However, as she looked over the diary card and asked how the week went, the session agenda radically shifted. In the intervening week, the client had had a fight with her boyfriend, who kicked her out of his apartment. She was on the street and had been staying in a homeless shelter for the past 2 days. While at the shelter, she was sexually harassed, setting off nightmares and some dissociative symptoms. Because of all the chaos in her life, she skipped skills training group and she now doubts that she can make it to group this week either. Living on the street, she ran into some of her former drug buddies and she used heroin. She describes the week in a matter-of-fact tone of voice, yet her diary card shows high ratings on misery and suicidal ideation. When the therapist assesses suicidality, she discovers that the client has her preferred means in her car. As the session continues, the client dissociates to the point where she is not talking.

As mentioned earlier, DBT was developed for people with multiple disorders who are often in crisis. DBT interventions will hierarchically target behaviors so that the immediate focus will be to assess and treat suicide risk. However, in addition to getting rid of the immediate means and addressing the problems associated with suicidal behavior, the therapist may also need to address the problems of housing, going to skills group, not using heroin again, managing dissociative behaviors, and processing the end of the romantic relationship (and perhaps shame and despair at not starting treatment for panic). This requires the therapist to apply mini-interventions drawn from effective behavioral protocols to problems as they arise. The required improvisation is akin to jazz—it is built on sound mastery of one's instrument and

understanding of music but tightly linked to the exact moment and players. This flexible application of strategies results from overlearning of behavior therapy protocols and also from dialectical philosophy and strategies that help overcome therapeutic impasses.

## Skills Training

Comprehensive DBT includes skills training as a treatment mode dedicated to enhancing skills capabilities in areas where many individuals with BPD have behavioral deficits. With its focus on teaching and strengthening DBT skills (Linehan, 2015), DBT skills training is provided on a weekly basis for approximately 2 hours. Linehan's (2015) *DBT Skills Training Manual* provides extensive instructions for therapists on how to teach the DBT skills, explicit instructions for practicing the skills in group, and numerous reproducible client handouts and homework sheets. Four skills training modules are taught over the course of approximately 6 months, allowing for completion of all skills twice within a standard DBT outpatient group. DBT skills training modules include skills to regulate emotions (emotion-regulation skills), to tolerate emotional distress when change is slow or unlikely (distress tolerance skills), to be more effective in interpersonal conflicts (interpersonal effectiveness skills), and to control attention to skillfully participate in the moment (mindfulness skills). *Emotion-regulation* training teaches a range of behavioral and cognitive strategies for reducing unwanted emotional responses as well as impulsive dysfunctional behaviors that occur in the context of intense emotions by teaching clients how to identify and describe emotions, how to stop avoiding negative emotions, how to increase positive emotions, and how to change unwanted negative emotions. *Distress tolerance* training teaches a number of impulse control and self-soothing techniques aimed at surviving crises without using drugs, attempting suicide, or engaging in other dysfunctional behavior. *Interpersonal effectiveness* teaches a variety of assertiveness skills to achieve one's objective while maintaining relationships and one's self-respect. *Mindfulness skills* include focusing attention on observing oneself or one's immediate context, describing observations, participating (spontaneously), assuming a nonjudgmental stance, focusing awareness, and developing effectiveness (focusing on what works).

Although all CBT pays attention to generalization, this goal is particularly emphasized in DBT. To generalize newly acquired skills across situations in daily life, therapists employ phone consultation and *in vivo* therapy (i.e., therapy outside the office as needed). While skills acquisition and strengthening is the domain of the skills trainers in the context of the skills training group, it is the task of the individual therapist to help generalize these skills in all relevant contexts.

## Validation

DBT shares elements with other supportive treatment approaches (Heard & Linehan, 1994). Exquisite emotional sensitivity, proneness to emotional dysregulation, and a long history of failed attempts to change either this intense emotionality or the problem behaviors associated with it make supportive treatment elements important. All

clients benefit from validation, but validation is essential for the success of change-oriented strategies with those who are particularly emotionally sensitive and prone to emotional dysregulation (Linehan, 1993a). DBT validation strategies are meant not only to communicate empathic understanding but also to communicate the validity of the client's emotions, thoughts, and actions. In DBT, these strategies are important in and of themselves, as well as in combination with change strategies. Validation is also used to balance the pathologizing to which both clients and therapists are prone. Clients often have learned to treat their own valid responses as invalid (as "stupid," "weak," "defective," "bad"). Similarly, therapists also have learned to view normal responses as pathological. Validation strategies balance this viewpoint by requiring the therapist to search for the strengths, normality, or effectiveness inherent in the client's responses whenever possible and by teaching the client to self-validate. Even patently invalid behavior may be valid in terms of being effective. When a client says she hates herself, hatred might be valid because it is a justifiable response if the person acted in a manner that violates important values (e.g., she had deliberately harmed another person out of anger). Cutting one's arms in response to overwhelming emotional distress is valid (i.e., makes sense), given that it often produces relief from unbearable emotions: It is an effective emotion-regulation strategy. Cutting is simultaneously invalid: It is not normative, it prevents developing other means of emotion regulation, it causes scars, and it alienates others. The same behavior can be both valid and invalid at the same time. From this perspective, all behavior is valid in some way. The DBT therapist strives to identify and communicate what is valid with the client.

In nearly all situations, the DBT therapist may validate that the client's problems are important, that a task is difficult, that emotional pain or a sense of being out of control is understandable, and that there is wisdom in the client's ultimate goals, even if not the particular means they might use to achieve them. Similarly, it is often useful for the therapist to validate the client's views about life problems and beliefs about how changes can or should be made. Unless the client believes that the therapist truly understands their dilemma (e.g., exactly how painful, difficult to change, or important a problem is), they will not trust that the therapist's solutions are appropriate or adequate, and therefore collaboration and consequently the therapist's ability to help the client change will be limited. In this way, validation is essential to change: The therapist must simultaneously deeply understand the client's perspective as well as maintain hope and clarity about how to effect change.

## DBT as Dialectics

Dialectical philosophy has been influential across the sciences (Basseches, 1984; Levins & Lewontin, 1985). In DBT, it provides the practical means for the therapist and the client to retain flexibility and balance. Dialectics is both a method of persuasion and a worldview or set of assumptions about the nature of reality. In both, an essential idea is that each thesis or statement of a position contains within it its antithesis or opposite position. For example, suicidal clients often simultaneously want to live and want to die. Saying aloud to the therapist, "I want to die," rather than killing oneself in secrecy, contains within it the opposite position of wanting to

live. However, it is not the case that wanting to live is "more true" than wanting to die. The person genuinely does not want to live their life as it currently is—few of us would trade stations with our clients with BPD. Nor does the low lethality of a suicide attempt mean that the person really did not want to die. It's not even that the person alternates between the two—the client simultaneously holds both opposing positions. Dialectical change or progress comes from the resolution of these opposing positions into a synthesis. The whole dialogue of therapy constructs new positions where the quality of one's life doesn't give rise to wanting to die. Suicide is one way out of an unbearable life. However, building a life that is genuinely worth living is an equally valid position. The constant refrain in DBT is that a better solution can be found. The best alternative to suicide is to build a life that is worth living.

Cognitive modification strategies in DBT are based on dialectical persuasion. Although the DBT therapist may sometimes challenge problematic beliefs with reason or through hypothesis-testing experiments, as do other cognitive-behavioral therapies, there is a special emphasis on cognitive modification through conversations that create the experience of the contradictions inherent in one's own position. For example, a client who experiences immediate relief from intense emotional pain when she burns her arms with cigarettes is reluctant to give it up. As the therapist assesses the factors that led up to a recent incident, the client nonchalantly says, "The burn really wasn't that bad this time."

THERAPIST: So what you're saying is that if you saw a person in a lot of emotional pain, say, your little niece, and she was feeling as badly as you were the night you burned your arm, she was feeling as devastated by disappointment as you were that night, you'd burn her arm with a cigarette to help her feel better.

CLIENT: No, I wouldn't.

THERAPIST: Why not?

CLIENT: I just wouldn't.

THERAPIST: I believe you wouldn't, but why not?

CLIENT: I'd comfort her or do something else to help her feel better.

THERAPIST: But what if she was inconsolable, and nothing you did made her feel better? Besides, you wouldn't burn her that badly.

CLIENT: I just wouldn't do it. It's not right. I'd do something, but not that.

THERAPIST: That's interesting, don't you think?

The client simultaneously believes that one should not burn someone else under any circumstances and that burning herself to get relief is no big deal. In dialectical persuasion, the therapist highlights the inconsistencies among the client's own actions, beliefs, and values. The dialogue focuses on helping the client reach a viewpoint that is more whole and internally consistent with her values.

A dialectical worldview permeates DBT. A dialectical perspective holds that one can't make sense of the parts without considering the whole, that the nature of reality is holistic even if it appears that one can talk meaningfully about an element or part

independently. This has a number of implications. Clinicians never have a "whole" perspective on a client. Rather, therapists are like the blind wise men, each touching a part of an elephant and each being certain that the whole is exactly like the part they are touching. "An elephant is big and floppy"; "No, no, an elephant is long and round and thin"; "No, no, an elephant is solid like a wall." The therapist who interacts with the client in a one-to-one supportive relationship sees incremental progress. The nurse whose sole contact consists of arguments declining requests for benzodiazepines, the crisis worker who sees the person over and over only at their worst, and the group leader who has to repair the damage of the person's sarcastic comments to another group member have alternative perspectives. Each perspective is true, but each is also partial.

Applying a dialectical perspective further implies that it is natural and to be expected for these differing and partial perspectives to be radically in opposition. The existence of "yes" gives rise to "no," "all" to "nothing." Whether it is the nature of reality or simply the nature of human perception or language, this process of oppositional elements in tension with each other regularly occurs. As soon as someone on the inpatient unit thinks the client can be reasonably discharged, someone else on the team will bring forward the reasons why that is not a good idea. One person voices the position of holding a hard line on program rules, which elicits someone else's description of why in this case an exception to the rule should be made. Both opposing positions may be true or contain elements of the truth (e.g., there are valid reasons to discharge *and* to delay discharge). From this point of view, polarized divergent opinions should be expected when a client has complex problems that generate strong emotional reactions in their helpers.

A related idea is that one cannot make sense of elements without reference to the whole, that is, that identity is relational. The only reason he looks old is because she looks younger; the only reason I look rigid is because you are so flexible. Furthermore, the way we might identify or define a part changes and is changed by changes in other parts of the whole. The client we have all come to think of as "the Critic" in a skills-training group, who is constantly pointing out how unhelpful the skills and skills trainer are, suddenly becomes a joy when a new member joins the group. They share the same blend of humor and skepticism, but where one is caustic, the other is wry—their chemistry together takes the sting out of the criticism and creates a lighter but still pointed feedback loop for the lead skills trainer. The group leader, released from their siege mentality and now genuinely seeing the Critic's humor, becomes more creative and likable themself. Taking a dialectical perspective means that words like "good" or "bad" or "dysfunctional" are merely snapshots of the person in context, not defining qualities inherent in the person. It also draws one into considering a web of causation rather than linear causation. Sometimes the connection is obvious: A change in *A* leads to a change in *B,* as in a man-to-man defense where the defender tracks the opponent closely, guarding against a shot. Sometimes the connection is less obvious, however, more like a zone defense, where a person's shifting leads to some change but not as much as in a man-to-man defense. And sometimes the connection is not obvious at all, such as the "butterfly effect," in which a butterfly flapping its wings in Peru results in a snowstorm in Seattle. Or, the previously submissive Aunt Mary finally reaching the end of her rope and for the first time in a 20-year marriage insisting that Uncle Maurice get his own dinner and later that week young cousin

Maylin deciding to apply for college. This idea translates into a clinical understanding that everything is caused and could not be otherwise, even if you cannot come up with the causes at the moment. From a dialectical perspective, the attention is not on the client alone but rather on the relationships among the client, the client's community, the therapist, and the therapist's community.

Taken together, these views lead to the stance that truth evolves. On a treatment team, this means that no one person has a lock on the truth and any understanding is likely partial and likely to leave out something important. Therefore, DBT puts a strong emphasis on dialogues that lead to synthesis rather than on an individual reasoning by themself from immutable facts.

This philosophy is most easily seen in action during a team conflict. For example, an individual therapist may have a client who enters therapy in a suicide crisis because he is being asked to leave his supported housing arrangement and has damaged the relationship with the residential counselor with whom he had been closest. He is so ashamed of how he's acted that even getting the details about what's going on rather than suicide threats and hopelessness is nearly impossible in the sessions. The client will become homeless if new housing is not arranged soon and the residential counselor who would have handled this problem in the past is not in the mood to help. In the consultation team, the group skills trainers mention that the client has missed 2 groups already and they want the therapist to work on getting him to group. The individual therapist agrees, but says there is no time in session to do it. It is all she can do simply to manage the "crisis of the week" and keep the person alive, let alone deal with therapy-interfering behaviors such as not going to group. The skills trainers, however, know that unless the person learns some new skills and gets hooked up with the group, they are likely to lose the client to dropout. Both sides have valid points: The individual therapist is the one who is "supposed to" work on the therapy-interfering behavior of not going to group, and has bigger fish to fry (suicide crisis behavior); but the client must learn new skills and will lose access to the entire treatment program if he does not get to group. Any solution must take into account the valid points of the dialogue to be effective. The solution may be for the individual therapist to move her session time to just before group time to make the transition easier. The individual therapist may need more support to regulate her fear that the client is going to kill himself (perhaps she is overestimating the client's suicide risk because she is afraid). The skills trainers, similarly, may work to make group more appealing to the client or offer a reminder call early in the day of skills group. It would not be a dialectical solution for either position to capitulate—for example, for the skills trainers to back down on attendance or for the individual therapist to target therapy-interfering behavior at the expense of treating suicide crises. Adoption of a dialectical philosophy leads other team members to notice and comment on the polarization as an expected phenomenon, and then to direct the dialogue to what is left out and what is valid in each position.

### *Dialectical Strategies*

A number of strategies are included in DBT that serve the function of keeping polarized positions from remaining polarized. The first of these is that core strategies are used to balance acceptance and change. For example, DBT requires the therapist to

have a balanced communication style. On the acceptance side, the therapist employs a responsive style in which the client's agenda is taken seriously and responded directly to rather than interpreted for its latent meaning. For example, if a client asks something personal about the therapist, the therapist is more likely to use self-disclosure, warm engagement, and genuineness either to answer the question or to matter-of-factly decline to answer based on their own limits.

However, this style alone or an imbalance toward this style can lead to an impasse. When the glum client who has told the same story of grievance many times has a therapist who simply paraphrases in the same monotone as the client, the probability is that the client's mood will stay the same or worsen. Consequently, reciprocal communication is balanced by irreverence that jolts the person off track to allow the client to resume the therapeutic task at hand. For example, the therapist might use an unorthodox, offbeat manner. The therapist, who had just been as engaged as the client in a power struggle, suddenly shifts tone and laughs, "You know, this moment is just not as black and white as I had hoped." Similarly, the therapist may plunge in where angels fear to tread. For example, they might say matter-of-factly to the woman whose major precipitant to suicidal crises is the threat of losing her husband, "Look, cutting yourself and leaving blood all over the bathroom is destroying any hope of having a real relationship with your husband." Or, the therapist might say to a new client, "Given that you've assaulted two of your three last therapists, let's start off with what led up to that and how it's not going to happen with me. I'm going to be of no use to you if I'm afraid of you." An irreverent style of communication includes using a confrontational tone, using humor or unconventional phrasing, oscillating intensity, or at times expressing omnipotence or impotence in the face of the client's problems.

Another way that DBT balances acceptance and change is in case management strategies. Individuals who meet criteria for BPD often have multiple treatment providers and consequently a number of strategies have been developed to help the client–therapist dyad manage the relationships with other clinicians and family members. DBT is weighted toward a consultation-to-the-client strategy that emphasizes change. The DBT therapist consults with the client about how to handle relationships with other treatment providers and family members, rather than consulting with other treatment providers and family members about how to deal with the client. So, for example, this means that the therapist does not meet with other professionals about the client, but rather that the client is present at treatment planning meetings (and preferably has set the meetings up themself). Rather than meet with another provider without the client present, a conference call might be scheduled during an individual session. If the therapist has to meet without the client present for some practical reason, the conversation is shared with the client or discussed in advance. This same principle holds for conversations with the client's family. Even in a crisis, the spirit of consulting to the client is maintained whenever possible. If the client shows up in the emergency room, and the triage nurse or resident on call contacts the therapist to ask the therapist what they would like done, the DBT therapist is likely to first ask to speak with the client to discuss how going in the hospital does and does not coincide with the client's long-term goals and their agreed-upon treatment plan. The therapist might then coach the client on how to interact skillfully with the emergency room (ER) staff or have the client communicate the plan

to the ER staff and then simply confirm that with the staff, if such is required for credibility. If the hospital staff were concerned about suicide risk and were reluctant to release the person, the DBT therapist would not "tell" the hospital staff to release the client, but instead might coach the client on what was needed to decrease the legitimate worries of the ER staff.

The DBT therapist will intervene in the environment on the client's behalf when the short-term gain is worth the long-term loss in learning—for example, when the client is unable to act on their own and the outcome is very important; when the environment is intransigent and high in power; to save the life of the client or to avoid substantial risk to others; when it is the humane thing to do and will cause no harm; or when the client is a minor. In these cases, the therapist may provide information, advocate, or enter the environment to give assistance. However, the usual role is as consultant to help the client become more skillful in personal and professional relationships.

Other dialectical strategies include use of metaphor or assuming the position of devil's advocate to prevent polarization. The therapist may call a client's bluff or use extending—for example, when a client on an inpatient unit threatens suicide in an angry or blasé manner, the therapist might say, "Listen, this is really serious. We should go right now and put you on line-of-sight observation and get you into a suicide gown." Informed by dialectical philosophy, the therapist and the treatment team assume that their case formulations are partial and therefore move to assess what is left out when there is an impasse (dialectical assessment). The therapist may view a discouraging event as an opportunity to practice distress tolerance (making lemonade out of lemons) or allowing rather than preventing natural change (such as a group leader leaving and being replaced), knowing that this, too, is an opportunity to practice acceptance of reality as it is.

## Research on DBT

Since the publication of the first edition of this book, there have been increased interest and funding for psychosocial treatments of suicidal behavior as well as treatments for clients meeting criteria for BPD. There has now also been considerable research on the efficacy of DBT for BPD and a number of other psychological disorders. Hundreds of peer-reviewed publications currently exist in the research literature, including dozens of randomized controlled trials (e.g., Linehan et al., 2006), multiple review papers (e.g., Miga, Neacsiu, Lungu, Heard, & Dimeff, 2018) and meta-analyses (e.g., DeCou, Comtois, & Landes, 2019). The vast majority of the research indicates that comprehensive DBT is effective for reducing suicidal behavior and nonsuicidal self-injury. Whether DBT is better than other treatments is more equivocal. A few high-quality randomized controlled trials (RCTs) failed to find significant differences between DBT and active control conditions on these suicidal behavior outcomes (e.g., McMain et al., 2009). One explanation put forward for these findings is that in such tightly controlled research, the control treatment conditions also include expert therapists with vast experience in treating suicidal behavior (Linehan et al., 2006), suggesting that the critical ingredient in reducing suicidal behavior is expert-driven suicide-focused treatment.

Despite this increase in attention and the development and study of more evidence-based protocols, it is necessary and humbling to note that rates of suicide are not decreasing (Hedegaard, Curtin, & Warner, 2019). Furthermore, even though many studies suggest that DBT is effective at reducing suicidal behavior, data also suggest that there is little change in disability status or employment status (McMain, Guimond, Streiner, Cardish, & Links, 2012; Bateman, 2012). Together, these suggest that DBT, in its current form and practice, is not doing enough to improve global functioning. This weakness is an important avenue for future work (see Comtois, Ellwood, Melman, & Carmel, Chapter 10, this volume).

Much of the newer research on DBT has been devoted to determining best practices for making the treatment more efficient (and thus faster to "work" and easier to disseminate) as well as best practices in implementing DBT within existing systems (thus reaching more people more quickly). For example, a growing body of literature suggests that skills training "alone," that is, without accompanying weekly individual therapy or phone coaching, can be effective for certain problems and disorders like treatment-resistant depression and binge eating disorder (see Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015). In addition, more and more studies have examined the efficacy and/or effectiveness of DBT across a vast number of settings and disorders. The subsequent chapters of this book review the research literature relevant to the settings and populations of interest.

## Conclusion

In this chapter, we have described the comprehensive outpatient model of DBT to help you begin to evaluate whether adopting it makes sense for your setting or population. For chronically suicidal individuals who meet criteria for BPD, the accumulated scientific evidence regarding the efficacy of standard DBT makes it the treatment of choice. Particularly in those settings that are mandated to provide evidence-based care and that also need a cost-effective approach for consumers who disproportionately use expensive psychiatric emergency services, adopting standard DBT is an obvious decision. Yet for many readers, questions arise as they consider differences between the needs and constraints of their particular setting or patient population versus those of standard outpatient DBT as it has been researched. Subsequent chapters address these common questions and illustrate the successful adaptations of DBT to new patient populations and settings.

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CHAPTER 2

# Adopt or Adapt?

## *Fidelity Matters*

KELLY KOERNER, LINDA A. DIMEFF,
CHARLES R. SWENSON, and SHIREEN L. RIZVI

As described by Koerner, Dimeff, and Rizvi (Chapter 1, this volume), a lot has changed in the world of dialectical behavior therapy (DBT) research and practice since the first publication of this book. As the rest of the book will attest, DBT has been studied and practiced in a multitude of settings and for many different populations than originally intended. Therefore, as *you* consider using DBT and certainly when you begin to implement it, you will likely have questions about whether to adopt the standard, comprehensive model of DBT defined in Linehan (1993a, 2015) or instead to adapt or modify DBT to fit the needs and constraints of your setting or population. For example, it is natural to ask, "Should I consider using DBT if my setting or patients differ from those in the research?" Or, "What if it doesn't seem possible to include every DBT mode in our setting?" Maybe you lack enough therapists to offer weekly individual psychotherapy, or productivity demands make an unreimbursed therapists' consultation team meeting too costly, or perhaps your individual therapists do not want to provide after-hours phone coaching. When the comprehensive model of DBT isn't a perfect match to the needs and constraints of a local setting, it is almost inevitable to think, "We can't use the standard model of DBT."

Differences between a defined model and your particular situation can push and pull for innovation or *adaptation* of the defined model. In fact, some have argued that "local adaptation, which often involves simplification, is a nearly universal property of *successful* dissemination" (Berwick, 2003, p. 1971). Hypothetically, such adaptation could result in a creatively streamlined version of DBT that better fits a service setting or better serves consumers' needs. Yet, there are four implications that should be considered before adapting rather than adopting the standard model of DBT.

1. *A particular modification may or may not work as well as the standard model.* The first implication of modifying the standard model of DBT is that modifications

may or may not retain the active ingredients required to get good clinical outcomes. Although there is a growing body of research on this topic, at this point, relatively little is yet known about the specific active ingredients of DBT (or, for that matter, about any psychosocial interventions). Consequently, one cannot *assume* that the clinical outcomes of an adapted version of DBT will be equivalent to or better than the standard model. For example, even a straightforward line of reasoning—such as, a *little* DBT is better than *no* DBT—is not unequivocally true. Although it is reasonable to think that incorporating some DBT skills into non-DBT individual therapy or doing DBT without phone coaching should still offer some benefit, this has yet to be demonstrated in carefully designed research. Without data, one can't *assume* that a partial implementation or adaptation will be effective (or ineffective): Assessing clinical outcomes is necessary. Modifying without assessing outcomes is a risky strategy.

To the extent that an intervention's benefits are caused by its active ingredients, omitting the active ingredients (or enough of the active ingredients) would result in a treatment that fails to produce the intended benefits. The first consideration, therefore, before undertaking adaptation of DBT is that good clinical outcomes may require adopting and implementing the standard model, the form and the functions of DBT, so that "enough" of the effective elements are active in your setting.

2. *Offering an untested modification of DBT complicates the process of informed consent.* A second implication of adaptation is that modification requires appropriate informed consent to treatment. There is an ethical obligation to be certain that what is offered does no harm and is beneficial. One cannot be certain about the benefits of an untested modification of DBT. Given the current uncertainty regarding which features are the essential features of DBT, one cannot with confidence tell consumers and funders that a particular adaptation being described as "DBT" has the essential ingredients or principles that account for DBT's effectiveness. What exactly are they consenting to receive and pay for? Without data about the efficacy of a modification, it is difficult to accurately inform clients about risks and benefits. Such concerns led Linehan and colleagues to develop a process for therapist and program certification in DBT (*dbt-lbc.org*) that serves as something of a quality control measure so that stakeholders can accurately tell what services are offered.

3. *Implementing an untested modification may present problems with reimbursement.* A third implication of adapting rather than adopting the standard model is that there may be practical problems with getting reimbursed for versions of DBT that deviate from the empirically validated model. As reimbursement for services becomes increasingly tied to documented adherence and program fidelity or certification, partial or blended models that are untested or unaccredited may become ineligible for reimbursement. The fact that many funding sources have been willing to reimburse for DBT has created pressure for programs to say that they are providing DBT, regardless of how close to the defined model those services actually are. If modification or partial implementation is called "DBT" and that modification fails to produce benefit or actually causes harm, it can poison the local waters, turning off consumers and funders to a treatment that could have been of great benefit if provided with high fidelity.

4. *Adapting (rather than adopting) DBT can heighten risk and legal liability.* The fact that DBT is used with high-risk suicidal populations exposes those who use

it to legal risk. Experts in the treatment of suicidal behavior and management of liability following a patient suicide emphasize that the best protection for the clinician or agency is to have provided good clinical care that followed acceptable standards of practice (Silverman et al., 1997). Documenting that one attempted to apply comprehensive DBT and thereby met acceptable standards of practice is likely to be more credible than trying to justify an untested modification of DBT.

Considerations of clinical effectiveness, informed consent, reimbursement, and legal liability all weigh heavily on the side of adopting the proven standard comprehensive DBT model rather than adapting it. Ethical and practical issues also argue for sticking with a validated model. However, on the other hand, real needs and constraints in your setting may be incompatible with the model exactly as defined. In fact, implementation science efforts now focus on systematically studying how evidence-based interventions are adapted and modified (Wiltsey-Stirman, Baumann, & Miller, 2019). Adopting the standard model of DBT may be exactly the *wrong* decision. For example, in an acute psychiatric hospital with a 2-week average length of stay, it is not feasible to teach all the DBT skills; paraprofessional staff at a residential "halfway" house do not have the requisite clinical skills and credentials to provide the individual therapy mode of DBT. Similarly, if you want to see if DBT can help a patient population yet to be researched (e.g., fetal alcohol–affected individuals), the only choice is to adapt.

This tension—"we must adopt" versus "we must adapt"—is the inherent dilemma many teams face as they begin to implement DBT. It prompted the first edition of this book as well. We believe that, in fact, both statements are simultaneously true; these seeming opposing truths stand side by side. If one fails to adhere to DBT as manualized, then there is the risk that the treatment will be less effective, and perhaps even have ill effects—you won't know until you test it. *And* simultaneously, it can be true that needs or setting constraints are such that one can't do DBT exactly as it has been defined in research. Several tips may help in working with this dilemma, or "dialectic."

## Tip 1: Radically Accept the Dialectical Tension and Search for a Synthesis

Our first piece of general advice, regardless of your setting or population, is to expect this basic dialectical tension between adopting versus adapting to arise repeatedly as you explore and begin to implement DBT. Problem solving during implementation should be rooted in the fact that both positions are true: It's true that the best chance of obtaining good clinical outcomes is to adopt and implement the defined model and it's simultaneously true that the model has to meet the needs and fit the constraints of your setting and the population you serve. Rather than abandoning fidelity to standard DBT to meet the local conditions and rather than shoehorning the needs and constraints of your setting or population to fit the defined model of DBT, insist that any solution actually incorporate both of these valid positions. In other words, apply dialectical thinking to the implementation process itself. The ongoing dialogue between the two poles of adoption and adaptation, between adherence to the standard model and creativity, will yield the synthesis of a workable, high-fidelity implementation.

Of course, the devil is in the details! In the rest of this chapter and those that follow, we provide guidance on how to stay true to the defined model of DBT while simultaneously adapting the model to meet local needs. In this chapter, we provide principles that can guide problem solving across settings and populations. In subsequent chapters, authors who have adopted and adapted DBT for a variety of settings (Chapters 4 through 9) and with new populations (Chapters 10 through 17) describe in detail how they have creatively negotiated conflicts between adherence and local needs and constraints. What is common to the adaptations in this book is that each team simultaneously emphasized adherence to the defined model yet in meaningful ways reinvented the model to solve local problems. They have done so in structured but creative ways, with openness to peer and expert review along the way, as well as through the collection of program evaluation data, the final arbiter of whether the particular adaptations were effective.

## Tip 2: Clearly Identify If You Plan to Adopt or Adapt

Another point of general advice is to be as clear as you can, with yourself and with your stakeholders, about whether you intend to adopt the standard comprehensive model of DBT or to adapt DBT. The "right" answer for your DBT program may not be simple or straightforward. A useful starting point is to recognize your predisposition toward adopting versus adapting and to consciously decide which course you will take. Figure 2.1 shows various possibilities of how one might offer DBT or variations of DBT as well as what to call these services to accurately represent them to consumers and other stakeholders.

What you offer can be described both categorically (i.e., the treatment offered is DBT or it is not DBT, indicated by a strong black bar in Figure 2.1) and along a continuum of comprehensiveness (more or less comprehensive and adherent DBT). If you decide not to do DBT at all or you decide to offer comprehensive DBT according to the defined model, then it's clear how to describe your services. On one end, there is no DBT: There either is no intention to use elements of DBT or techniques are eclectically adopted independent of adoption of principles, assumptions, or theory and the treatment is not called DBT. On the other end of the spectrum, DBT is comprehensive and all modes fully adhere to DBT principles, assumptions, and theory. The latter system includes teams offering standard DBT as well as teams who are systematically modifying and advancing the treatment model. Grounded in adherence, they are creatively improving DBT's fit to new populations and settings. However, it is less clear what to call services in the grey zone between these two anchor points. When should (or should not) a program be called "DBT"? What is the minimum number of DBT elements required to expect good clinical outcomes?

### *Defining DBT in the Gray Zone of Partial Implementation*

In this gray zone of partial implementation are both those whose ultimate goal is the adoption of comprehensive DBT and those whose ultimate goal is an adaptation. In the case of the former, they may be in the gray zone simply due to lack of resources at the moment. Such a program might implement some of the modes of DBT, as true to the standard model as possible, but omit other modes for the time being (e.g., a

| **Not DBT** | | **DBT-informed treatment** *(less comprehensive/adherent)* | | **DBT** |
|---|---|---|---|---|
| Either no elements of DBT or technical eclecticism | **Adopt** | Elements of DBT | Some modes of DBT but not entire model | Comprehensive DBT |
| | **Adapt** | Elements of DBT | Systematic innovation and evaluation of new treatment | Model-advancing team/ research DBT: systematic innovation and evaluation of comprehensive DBT for new populations or settings |

**FIGURE 2.1.** Using fidelity to name what we offer.

program might start up with a skills-training group and a consultation team, but not with individual therapy or phone consultations). It is not unusual for teams to take a step-by-step route to a comprehensive version of DBT. Alternatively, also in the gray zone of partial implementation are individuals and teams where partial implementation is the stopping point. Here, we would differentiate "DBT-informed treatment" from technical eclecticism (not DBT). We reserve the term "DBT-informed" to designate the intent to significantly anchor adoption or adaptation in DBT's treatment principles, strategies, and modes. In "technical eclecticism" (not DBT), one selectively adds elements of DBT to their therapeutic toolkit as one might take an engine or wheels from one vehicle to customize another vehicle.

Also in the gray zone is the more reactive or haphazard stance toward adopting or adapting where one may be pushed into partial implementation to accommodate pressures of the treatment environment or personal preferences (e.g., "Given productivity pressures, we don't have time for a DBT consultation team, so let's drop that" or "I like the skills group idea, but I'd rather continue with the psychoanalytic frame I use in individual therapy"). This stance can be contrasted with a DBT-informed partial implementation in which setting constraints or needs lead to offering only one or two fully adherent modes. For example, practical considerations might lead a clinic to offer only a DBT skills group, but not other modes including phone coaching or therapist consultation team. (Clients nonetheless might receive comprehensive DBT even in this case if they simultaneously have an individual DBT therapist elsewhere in the community who offers skills coaching and participates in a consult team.) Although there is a growing body of research suggesting that DBT "skills only" is effective for some problems/disorders, it is important to read this research literature carefully. Many of the "skills only" treatment protocols have included phone coaching and/or consultation team as part of the study or have been for less severe populations (see Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015, for a review). Regardless of intent to adopt or adapt and regardless of being en route to comprehensive DBT or not, it is still not fully known whether any of such partial implementations retain enough of DBT's active ingredients to result in good clinical outcomes compared to the full model.

To accurately describe your program to stakeholders, we suggest that you describe it as a DBT program *only* when it is comprehensive. If a partial implementation of DBT is offered, particular care should be given to accurately describing services and to collecting and providing clinical outcome evaluation data to stakeholders to enable appropriate informed consent. We suggest that if your adoption or adaptation is well anchored in the principles and theory that guide DBT, you refer to your program as "DBT-informed treatment." Here, too, what is needed is to be clear about how the treatment differs from comprehensive DBT and to provide program evaluation data. As mentioned before, when partial implementations have been mislabeled as DBT and fail to produce benefits or actually cause harm, such results can effectively turn off consumers and funders for years to a treatment that could have been of great benefit if it had been provided with high fidelity. If elements or strategies are adopted or adapted relatively independently of DBT principles, the resulting program should not be called DBT. See also Stirman, Baumann, and Miller (2019) for guidance on describing adaptations.

## Tip 3: Start with a Small, Tightly Focused Pilot Program

We also strongly suggest, because most of us are not in a position to carefully develop and evaluate the infinite variety of possible partial implementations, that the most ethical and practical course is to first learn and deliver the defined, standard model of DBT within a small, tightly focused pilot program and to evaluate clinical outcomes in your setting and with your population. Guidance about program evaluation is provided by Rizvi, Monroe-DeVita, and Dimeff (Chapter 3, this volume). Such continuous monitoring of program fidelity and valued outcomes has been recommended as essential by the Implementing Evidence-Based Practices Project (Torrey et al., 2001). To follow this advice, for example, you might begin by forming a consultation team of three or more colleagues to meet as a study group to learn DBT using the treatment manuals. To facilitate learning the treatment and establish a structure for the process of program development, you might consider attending a DBT intensive training session). In the next section, we will help you think through typical questions and problems encountered in the implementation of DBT.

## Tip 4: Think Through Typical Questions and Problems Using Functions, Principles, and Adherence

In the process of implementing DBT, common questions and problems unfold. These typical issues are listed in Figure 2.2. During early exploration and implementation, two questions typically come up: "To whom will we offer DBT?" and "Will we adopt and offer comprehensive DBT?"

### *Who Is Your Target Population—BPD and Suicidal Behavior?*

Several principles can guide decisions with regard to whom you will offer DBT. The first is to stay close to the evidence base. As discussed in Koerner, Dimeff, and Rizvi

| Who is your target population? | |
|---|---|
| Will match a population validated in research. | Will offer to broader patient group or use different selection criteria than has been researched. |
| | Specify targets and theory of psychopathology. |
| Will you offer comprehensive DBT? | |
| Yes. We'll offer all modes and functions of DBT. | No. We'll offer non-DBT or non-DBT-informed treatment. |
| Is your setting currently amenable to standard modes of DBT? | Systematically determine modifications and evaluate outcomes. Accurately represent how services differ from comprehensive DBT. |

| Yes | No | See Rizvi et al. (Chapter 3, this volume). |
|---|---|---|
| Adopt standard modes. | Determine which modes to provide. Use functions, principles, and adherence to guide decision making. | |
| Do you/your team have the requisite professional skill set for DBT? | | |
| Yes. | No. Develop and begin to implement a plan to acquire needed skills. | |
| Proceed to develop a small pilot project implementing comprehensive DBT. Evaluate outcomes. | | |
| Adopting the defined model fits setting needs and constraints? | | |
| Yes, adopting model works. | No, adaptation seems needed. | |
| Continue to monitor outcomes. | Systematically make modifications and evaluate outcomes. | |

**FIGURE 2.2.** Typical questions and problems.

(Chapter 1, this volume), the evidence of DBT's efficacy is strongest for those who are chronically suicidal and meet criteria for BPD. If you want or need to serve a broader or wholly different population, then you must carefully consider the theories of disorder and change that guide DBT. For example, research and theory make it logical to consider DBT for populations whose problems arise from pervasive emotional dysregulation. Adaptations for individuals with substance abuse disorders, eating disorders, antisocial personality disorder, and comorbid depression and personality disorder in the elderly all stem from the key role emotion dysregulation is considered to play in those disorders. Some settings offer DBT to individuals who disproportionately use psychiatric services and have repeatedly failed treatment as usual regardless of diagnosis. However, DBT is not a panacea and should not be used as a first-line treatment if there is already another evidence-based practice for the problem or population. For example, it would be a mistake to offer DBT to patients with anxiety disorders or with bipolar disorder who had apparently failed at conventional treatment

before being certain that, *in fact,* the evidence-based treatments for these disorders had been provided with good fidelity to those protocols.

If you plan to offer DBT to a group for whom little evidence yet exists, there are two essential steps to follow. First, use available research and theory on the disorder or population of interest to delineate the disorder-specific targets to be treated and clearly assign these targets to whichever mode(s) of DBT will be responsible for treating them. A common mistake is to assume that all sorts of adaptations will be necessary for a new population before trying and evaluating the standard version of DBT. Another mistake is to reorder the target hierarchy to place disorder-specific targets above life-threatening behavior and therapy-interfering behavior. Instead, retain the commonsense priority of life-threatening behavior and therapy-interfering behavior and make disorder-specific targets the highest priority among the quality-of-life targets. Second, again, it is essential to carefully evaluate your outcomes when using DBT with a new population.

### *Comprehensive DBT and Standard DBT Modes?*

Another early and common dilemma arises about whether to offer comprehensive DBT in your setting and how to respond to obstacles one encounters implementing DBT's standard modes. DBT as it has been manualized and researched for Stage 1 clients is a comprehensive outpatient treatment—that is, it is meant to provide all the treatment clients need to address all the targets and goals that lead to behavioral control and an acceptable quality of life. As discussed in Chapter 1, a key idea here is that the level of disorder determines the comprehensiveness of treatment needed to accomplish treatment goals. To be comprehensive, a treatment should (1) enhance clients' capabilities, (2) motivate clients to use these capabilities, and (3) ensure that clients can generalize these capabilities to all relevant situations. A comprehensive treatment should also (4) enhance therapists' skills and motivation and (5) structure the environment of both clients and therapists in a manner that facilitates clinical progress. In DBT, these primary tasks, called the *functions* of comprehensive treatment (see Table 2.1), are allocated across the standard modes of DBT service delivery (i.e., weekly individual psychotherapy, weekly skills training, as-needed skills-coaching phone calls, and a consultation team for treatment of the therapist). Linehan (Linehan, 1995, 1997; Linehan, Kanter, & Comtois, 1999) articulated this distinction between functions and modes to help treatment developers consider the special needs of clients in Stage 1 and to help early adopters implement DBT in new settings and with new populations when the needs or constraints in the local setting interfered with adopting DBT's standard modes. For example, both a solo private practitioner and a prison setting might find it difficult to run a standard DBT skills group (e.g., because of no suitable room, difficulty getting six to eight clients in the room at once for a 2-hour session). Yet because each DBT mode has specific targets and functions for which it is responsible, simply dropping a mode because it was difficult to implement meant that its functions and targets were not accomplished, potentially undermining treatment effectiveness.

Although the particulars of the mode of skills training might be difficult in the example of a private practice or a prison setting, the function to be accomplished—enhancing client capabilities—can still be accomplished. Enhancing clients' capabilities means that treatment helps clients to acquire cognitive, emotional, physiological,

**TABLE 2.1. Functions and Modes of Comprehensive Treatment**

| Functions | Modes |
|---|---|
| *Enhancing client capabilities:* Help clients acquire repertoires needed for effective performance. | Skills training (individual or group), pharmacotherapy, psychoeducation |
| *Improving motivation:* Strengthen clinical progress and help reduce factors that inhibit and/or interfere with progress (e.g., emotions, cognitions, overt behavior, environment). | Individual psychotherapy, milieu treatment |
| *Ensuring generalization:* Transfer skillful response repertoire from therapy to client's natural environment and help integrate skillful responses within the changing natural environment. | Skills coaching, milieu treatment, therapeutic communities, *in vivo* interventions, review of session tapes, involvement of family/friends |
| *Enhancing therapist skill and motivation:* Acquire, integrate, and generalize the cognitive, emotional, and overt behavioral and verbal repertoires necessary for effective application of treatment. As well, this function includes the strengthening of therapeutic responses and the reduction of responses that inhibit and/or interfere with effective application of treatment. | Supervision, therapist consultation meeting, continuing education, treatment manuals, adherence and competency monitoring, and staff incentives |
| *Structuring the environment* through contingency management within the treatment program as a whole as well as through contingency management within the client's community. | Clinic director or via administrative interactions, case management, and family and marital interventions |

and overt behavioral response repertoires, and to integrate these response repertoires for effective performance. In standard outpatient DBT, a once-a-week 2-hour skills-training group is the primary service mode that accomplishes this function. But by thinking creatively about other ways to accomplish the treatment functions of the blocked mode, one need not abandon what is essential. Other modes of service delivery such as psychoeducation, bibliotherapy readings and handouts, and pharmacotherapy can also accomplish this function of enhancing capability. Skills training can be conducted individually or via peer-to-peer groups. Skills-training videos might be made available to clients, or a collection of videos from the Internet might be organized. In some settings, if group length is a barrier, perhaps splitting skills training time into a 1-hour lecture on new material and then individual homework review might be a more feasible way to accomplish this function.

Similarly, in standard outpatient DBT, individual psychotherapy is the mode of service delivery that has primary responsibility for improving motivation, the second function of comprehensive treatment. This means that the individual therapist is the primary person who strengthens clinical progress and who helps the client to reduce factors that inhibit and/or interfere with their progress (e.g., by reducing factors that interfere such as emotions/physiological responses, cognitions/cognitive style, overt behavior patterns, and environmental events). But say, for example, that you are in a setting that lacks individual psychotherapy. Again, thinking of functions as independent of modes helps clinicians to discover other ways a function can be accomplished. For example, in Swenson, Witterholt, and Nelson (Chapter 5, this volume) and McCann and Ball (Chapter 9, this volume), the authors suggest creative ways for

this function to be accomplished by the milieu in settings where lengths of stay or staffing patterns make individual psychotherapy infeasible.

The third function of ensuring generalization to all relevant environments demands ensuring transfer of a skillful response repertoire from therapy to the client's natural environment and helping the integration of skillful responses within the changing natural environment to result in effective performance. In standard DBT with highly suicidal and emotionally dysregulated clients, crisis calls and skills coaching are considered essential. In addition to employing after-hours and crisis phone coaching, generalization can also be accomplished through milieu skills coaching and treatment(s), therapeutic communities, *in vivo* interventions (including case management), review of session tapes, and systems interventions. This function of generalization takes on particular importance with adolescents; consequently, a major modification in the form of additional involvement of family members has been created to help ensure generalization (Fruzzetti, Payne, & Hoffman, Chapter 17, and Miller, Rathus, Dexter-Mazza, Brice, & Graling, Chapter 16, this volume).

As DBT was transported into routine outpatient settings, some early adopters encountered setting constraints that blocked the individual therapists from taking after-hours calls to provide coaching for their clients. This is a significant and controversial departure from standard DBT. If crisis calls are handled by whomever happens to be on call, that person may or may not know how to coach DBT skills and may or may not be trained to offer needed help while avoiding reinforcing suicidal crisis behavior. In other words, the therapist's DBT training and intimate knowledge of the client are thought to be needed to walk the tightrope of prompting new behavior in a crisis, particularly with individuals who are chronically suicidal and highly lethal. In DBT, it is considered optimal for the person who knows the client best to manage suicidal crises. But, say, system constraints preclude individual therapists from managing crises after hours. Then what? Some teams who have run into absolute barriers to the individual therapist taking a call have used the relevant functions and principles to guide them. They prioritize that, first, the client has assistance generalizing skills to crisis situations, and, second, that reinforcers are aligned to support preferred skillful behaviors over old suicidal crisis behaviors. Then they consider all the ways that the client can get needed assistance in a suicidal crisis without inadvertently being reinforced. For example, maybe the client themself learns to share an up-to-date analysis of the controlling variables for their suicide crises and to convey skills that are most useful or relevant to them. Crisis staff can be trained to coach DBT skills and to use DBT's suicide crisis protocol. Teams can continue to communicate and document for administrators their belief that failing to provide clients with this skilled assistance in suicide crises violates the DBT protocol, could be a source of liability, and so on. Again, a problem that arises here is that there is no evidence one way or another about the empirical effects of providing or failing to provide this standard of care. However, at this point it is considered the standard of care in DBT for individual therapists to be available and willing to provide skills coaching.

This idea of using the functions of comprehensive treatment to help negotiate obstacles to implementing DBT is helpful not just during start-up or initial adoption of a mode, but also useful throughout the implementation process. So, for example, the fourth function is enhancing therapist capabilities and motivation. The idea is that comprehensive treatment requires that therapists acquire, integrate, and generalize their own cognitive, emotional, and overt behavioral and verbal repertoires

needed for effective application of treatment. In addition, this function includes the strengthening of therapeutic responses and reduction of responses that inhibit and/or interfere with effective application of treatment. This is usually accomplished through supervision, therapist consultation meetings, continuing education, treatment manuals, adherence and competency monitoring, and staff incentives. A well-functioning team creates conditions that facilitate looking at one's own reactions and problematic behavior in therapy. The function of the consultation team as being "therapy for the therapist" can be challenged as teams grow to add new members. Too large a group, an imbalance between inexperienced and experienced members, significant differences in commitment to the treatment philosophy, or irregular attendance can all interfere with this function. By keeping the function to be served in mind, however, the clinician will be able to recognize drift and find a direction for problem solving.

The fifth function is structuring the environment through contingency management within the treatment program as a whole as well as by contingency management within the client's community. This function is typically accomplished by the clinic director or via administrative interactions, case management, and family and marital interventions (see Fruzzetti et al., Chapter 17, this volume). So, for example, in the inpatient and forensic chapters, you'll find a detailed description of what structuring the environment means in that setting that can also serve as a more general template for other settings. The authors illustrate how DBT principles inform everything from unit rules, program schedules, and use of physical space to how basic assumptions and agreements are adapted to the setting. With adolescents, structuring the environment is a particularly important function. Thoughtfulness is needed to facilitate confidentiality while the youth, the therapist, and the family jointly manage high-risk behaviors.

These five functions of comprehensive treatment are a first set of principles for thinking through obstacles that arise when implementing a particular DBT mode. As tensions arise, you can ask yourself, "What is the function we are trying to accomplish? Given that we want to offer genuinely comprehensive treatment, is there a way to work around the setting constraint without compromising this function? Is there another way to accomplish this function if we can't do it 'by the book'?"

### *Does Adopting the Standard Model Fit Setting Needs?*

A next set of questions emerges as one gets into the nitty-gritty of implementing DBT. Do the details of the defined model (strategies, protocols, assumptions, agreements, treatment philosophy, change procedures, etc.) fit your setting needs and constraints? DBT is defined not only in terms of its comprehensive functions. It is also defined by its particular form, those broad classes of elements as well as the specific strategies and protocols that differentiate DBT from other approaches to treatment. It's not DBT unless both the form *and* the functions are present.

But what is the consequence of partial adherence within a mode? For example, what if only some of the team understand dialectics or mindfulness? What if program directors or mental health authorities are not willing to stick to the arbitrary rules (e.g., 4 missed sessions rule, 24-hour rule)? What if individual therapists fail to use diary cards or ignore the target hierarchy to organize sessions? What if the spirit of voluntary commitment and consultation to the patient are absent? What if the

skills group fails to cover all the skills? No data as yet identify the elements of DBT that are responsible for outcomes. Therefore, it can be complicated to think through what elements to be especially careful to adhere to. One way to help organize your thinking is to consider the broad categories that might be responsible for DBT's effectiveness. For example, if DBT were a tree, then its unchangeable roots would be dialectics, mindfulness, and behaviorism, and its trunk would be a biosocial theory appropriate to the particular disorder being treated. Also constant would be the large branches of levels of disorder/stages of treatment, functions of comprehensive treatment, and core strategies of validation, problem solving, and dialectics. Smaller branches such as modes, agreements, or particular protocols that combined DBT's core strategies might differ according to local conditions to suit a program or population while remaining conceptually well integrated with DBT's core principles and strategies.

Using broad categories to describe what might be responsible for DBT's effectiveness, for example, gives rise to different hypotheses that can help you stay clear about fidelity.

1. *Clearly structure treatment.* One hypothesis is that DBT is effective because it clearly structures treatment. Teams can actively self-monitor how well they know and use behavioral theory and science, dialectics, mindfulness, and biosocial theory to organize case formulation; and they can also monitor whether the level of disorder, stages of treatment, and the target hierarchy are used to organize their interactions with clients. They can self-assess the clarity of agreements, assumptions, and therapist roles. Teams can scan to ensure that consultation-to-patient strategies and contingencies in the treatment program support skillful behavior on the part of therapists and clients (e.g., the 4 missed sessions rule that activates therapists; the culture feels like a community of therapists helping a community of clients, who are all in it together; more good things flow to those who improve).

2. *Apply behavior therapy.* Another hypothesis is that DBT has its effects because it applies behavior therapy to suicidal behavior and other intentional self-injury. Research evidence would suggest that this active problem-solving stance is effective (Linehan, 2000). Therefore, you can self-assess and do your utmost to develop competence with cognitive-behavioral protocols and strategies.

3. *Add validation.* A third hypothesis is that DBT has its effects because it adds validation, which in and of itself offers a powerful mechanism of change (Linehan et al., 2002). Again, you can self-assess and strengthen the use of validation across modes.

4. *Add dialectics.* Similarly, a fourth hypothesis is that the dialectical stance and strategies are essential—that the constant balance of change and acceptance and ways out of therapeutic impasse contribute to DBT's effects.

5. *Integrate mindfulness practice across modes.* A fifth hypothesis is that DBT's emphasis on the therapist's use of mindfulness as a practice that is integrated throughout all modes contributes to DBT's efficacy.

Each of these is a defining aspect of DBT. Without its presence, one could not call the therapy DBT. Thinking in this way provides directions for you to evaluate

and strengthen these elements of your program and in each mode to optimize the potential mechanisms of change.

Again, we encourage the adoption of strategies and protocols as close to the defined model as possible. In terms of objectively measuring your adherence in each mode, there is not yet an adherence scale that has been validated by research available for this purpose. Although there is not yet research on its psychometric properties, Fruzzetti (2012) developed a DBT therapist rating form that can be freely used to monitor fidelity to DBT strategies. It is based on checklists in Linehan's (1993a) *Cognitive-Behavioral Treatment for Borderline Personality Disorder.* You can consider whether your program is progressing over time by comparing yourself to yourself (e.g., "Compared to where we were 6 months ago, are we getting closer to the defined model?") and/or you can compare yourself to a specific ideal (e.g., "Our goal is to have 90% of all elements listed in the manual in place in each mode").

While adopting most of the DBT strategies and protocols is noncontroversial, there are particular areas that pull for adaptation or drift from the defined model that we cover in detail now. We look first at the program level and then at common concerns with particular modes.

### *Suicidal Behavior and Hospitalization Protocols*

DBT's suicidal behavior and hospitalization protocols can differ from the practices of the wider network. For example, chronically suicidal clients whose use of the hospital interferes with their quality of life often have inadvertently been reinforced for crisis behavior and fragility—they learn that help is more forthcoming as their extreme behavior escalates. In DBT, treatment goals and agreements minimize the link between crisis behavior and additional contact by providing regular noncontingent help and after-hours coaching with strong encouragement to get help before a crisis. In this context, DBT has a 24-hour rule: For 24 hours after a client's intentional self-injury, the primary therapist keeps already scheduled contacts but does not increase client contact. This system can be at odds with the expectations of family members and other professionals in the client's network. Consequently, DBT therapists consult to their clients about how to best orient the client's network to the treatment rationale and instruct the network about what is most likely to be helpful. This may be accomplished by having the client draft a letter to all treatment providers that orients them, by holding conjoint meetings where the client and the therapist orient family members, and so on. This stance of insisting that the client assume an active competent stance in their own treatment plan may also be at odds with past experiences and need to be explained to those in the client's network.

Similarly, crisis and suicidal behavior protocols can conflict with usual practices because DBT allocates the central role of managing these to the primary therapist. In some systems, the person assigned the role of individual therapist may lack the training or authority needed to make decisions regarding management of suicidal behavior and hospitalization. In some cases, this responsibility is always held by the psychiatrist even if they are not the primary therapist or even on the DBT team. Sometimes authority is distributed in such a way that administrators who manage risk also exert influence and may inadvertently reinforce the client when crises escalate. Again, in these situations, orienting the network and consultation to the patient are the primary strategies to use.

### *Arbitrary Rules Regarding Attendance*

Another source of conflict can arise regarding the arbitrary rules about attendance in DBT. Standard DBT has the rule that if a client misses 4 consecutive sessions of individual or group skills training, then the client is discharged from the program for the remainder of the contracted treatment period (after which time the client could negotiate reentry into the program). However, some systems are set up such that they are either legally mandated or in some other way obligated to continue to provide service to the client regardless of their participation or improvement.

### *Challenges Specific to Modes: Skills Training*

Several common obstacles can arise when adopting the format of DBT skills training originally defined in Linehan (1993b) and updated in Linehan (2015). First, the original standard format was a year-long, 2½-hour, once-a-week group. In many settings, this may not work. What is important is acquiring, strengthening, and generalizing new skills—that is why standardly the skills are taught twice, that homework is reviewed and new skills are taught, and that the target hierarchy in skills training is used as a guide to keep focused on teaching skills. Consequently, if your client's length of stay is briefer, you have to consider best practices for retaining the emphasis on acquiring and strengthening skills by teaching each skill with many practice and review opportunities rather than covering more materials in less depth. Second, the standard format typically has two skills trainers. The purpose here, too, is to aid clients in acquiring and strengthening their skills: One trainer functions as lead and ensures that material is covered; the other tracks process and provides support to assist clients and the lead skills trainer in emotion regulation so that skills can be learned. Having two leaders means skills training continues even in the toughest circumstances. If there were to be a clinical emergency such as a life-threatening suicide crisis with one of the group members, one skills trainer can handle it, while the other continues to teach. If, for some reason, you can have only one therapist, attention should be paid to how to otherwise accomplish these tasks. A third frequently faced issue has to do with offering skills training to individuals who do not have a DBT therapist or even any therapist. Here, we return to the principle of Stage 1 clients requiring comprehensive treatment. Early research suggests that a skills-only component may not offer benefits. Yet for less-disordered individuals, it may be that a skills group format is sufficient (e.g., see Wisniewski & Safer, Chapter 13, this volume).

### *Consultation Team*

Many challenges arise in the context of the consultation team. First, at some point, teams typically need to add new members. New members may not have as much formal DBT training, they have not shared the formative experiences of the founding members of the team, and they may not share basic assumptions about clients or therapy (e.g., not viewing it as important to learn cognitive-behavioral interventions). What to do? Many teams successfully recruit team members in ways similar to enrolling new clients. The enrollment process includes a clear commitment from the new member, with clarity around expectations and agreements and how these do and do not fit with their professional goals. Second, part of the team's function is to help team

members observe their personal and professional limits. This also can be expanded usefully as needed to include attending to program limits. For example, team members may have competing roles (i.e., DBT is part-time work) or program leaders may get spread too thin so that they falter in important duties or the aversives outweigh the reinforcement. Growing the program too quickly in response to need and pressure, resulting in more referrals than the team can handle, can also be a struggle. Just as therapy-interfering behavior is prioritized, so, too, should team-interfering behavior be prioritized. In addition to adopting a dialectical problem-solving approach and applying DBT strategies to ourselves, we also advise an attentive and active effort to maximize the reinforcing aspects of the team. In other words, thoughtful and regular attention should be given to how the team serves its function to enhance therapists' skills and motivation and solve any problems that interfere with these goals. This will vary by team and individual member, but may include ensuring that adequate time is spent on cases and not diverted by discussion of ever-present administrative issues or tangential topics; that the size of the team doesn't grow so large that members have too little time to get help on tough cases; that new members are integrated in a way that balances their needs to learn basics without compromising more senior members' needs for more sophisticated discussion; and so on.

## Summary and Conclusions

Our advice is to take a dialectical stance toward the inevitable tension between adopting versus adapting DBT in your setting. The best chance of obtaining good clinical outcomes is to adopt and implement the defined model and to simultaneously look for ways to fit the model to meet the needs and constraints of your setting and population. Insist that any solution provide a synthesis of these two positions so that you have a workable, high-fidelity implementation. Again, the evidence to date supports adopting the standard model (unless one is adopting an adaptation that has itself become evidence-based). We suggest that the goal should be implementing the standard model of DBT (until [if] we learn more clearly which elements cause positive outcomes so that research can guide modification). We suggest that you first develop a small, tightly focused pilot program that is "by the book." As you encounter conflicts implementing standard DBT, use functions of treatment to creatively think through potential solutions. If you encounter conflicts about particular strategies or protocols, focus on adherence and apply the treatment principles themselves to solving these problems. Monitor your outcomes against benchmarks of published outcomes and treatment as usual in your own setting. During implementation, remember to focus attention on garnering support from stakeholders so that the environment becomes increasingly structured to sustain your efforts.

## Using This Book

After reading the first two chapters, the best way to use this book is to next read Chapter 3, on how to evaluate your DBT program, followed by any particular chapters that address specific populations or settings of interest to you. Dimeff et al. (Chapter 4, this volume) highlight pragmatic strategies for implementing outpatient

DBT both in private practice and in public-sector communities. This chapter weaves in solutions to barriers and misunderstandings common across settings and populations. Similarly, Swenson et al. (Chapter 5, this volume) detail the oldest adaptation of DBT and the first application of DBT in a milieu setting, and provide a terrific example of how to preserve DBT principles at every turn despite obstacles to the standard model of DBT. Our suggestion is that program evaluation be undertaken in tandem with program development, rather than treated as an add-on once the program is already underway. These five chapters will provide you with the basics you will need to think through most difficulties with implementation you will encounter. We hope that we can save you the energy of reinventing the wheel, and that some of the materials we present here will be useful to you.

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CHAPTER 3

# Evaluating Your DBT Program

SHIREEN L. RIZVI, MARIA MONROE-DeVITA,
and LINDA A. DIMEFF

The primary purpose of this chapter is to aid in your effort to collect data in your own unique setting so that you can determine for yourself the extent to which your dialectical behavior therapy (DBT) program is working and to answer a variety of evaluation questions that will help you continue to implement your program as intended. A further aim is to make what can be a daunting process one that is accessible, enjoyable, and straightforward, so even clinicians with little to no research experience will feel more confident in moving forward to collect, analyze, and present data on your DBT program.

There are many reasons to collect data from your DBT program, or to conduct a *program evaluation*. First and foremost, it is important to know whether DBT is actually achieving good outcomes in your program. Many researchers and clinicians alike have fallen prey to positive illusions and hold the absolute belief that a client is improving or a treatment is working in the absence of any empirical evidence that such a claim is accurate. The opposite scenario is often true when working with your most challenging clients, including individuals with BPD: The therapist and team become convinced that there has been no change, and as a result they get discouraged and demoralized, when in fact quite a bit of change has taken place, only to be lost in the hurricane of out-of-control behaviors.

Of course, there are many other equally important and compelling reasons to collect data on your DBT program. Here are just a few:

- *Gain additional resources and support from administrators.* Often the best way to convince the "powers that be" (from program directors to high-level administrators) of the need for greater resources, training, and/or support is to use objective evidence to make the case. Many programs, for example, have received considerable funding for extensive DBT training by demonstrating the cost savings if DBT were to work with one client who is currently costing the system hundreds of thousands of

dollars annually in repeat, lengthy hospital stays. Other DBT programs use program evaluation data to demonstrate their success in the service of gaining additional support. For example, few, if any administrators, would consider cutting or rolling back a successful treatment program that is saving the system considerable dollars, dramatically improving client outcomes, and improving staff morale (which may translate behaviorally to decreased use of sick leave and staff turnover rates).

- *Convince potential clients and colleagues to make a commitment to DBT.* One of the most effective ways to increase client referrals to your DBT program is to maintain a track record of client success. In response to a potential client wondering why in the world they should give up severely dysfunctional behaviors (e.g., intentional self-harm, suicide attempts, substance abuse), you are able to communicate with conviction, "If what you want is a life worth living, I am your person and we are your team." You've got the data to back it up. Similarly, all things being equal, there is no better way to attract the most motivated, talented, and devoted colleagues than to demonstrate that you are a team that means business and you've got the data to prove it.

- *Use as leverage for reimbursement.* It is not uncommon for behavioral health organizations to initially limit reimbursement of different DBT outpatient services. Presenting process, outcome, and cost data from your DBT program to the behavioral health organization at the time that you negotiate a new payment rate can provide a powerful leveraging tool, as data from a well-implemented DBT program are likely to show significant cost savings tied directly to client improvements.

- *Treat yourself.* There is nothing like objective data to provide reassurance that you are, in fact, an effective DBT therapist—particularly during rocky periods with a particular client who has convinced you that just the opposite is true.

Three comments before getting started with the nitty-gritty details: First, our intent is to provide the rudimentary tools that will allow programs to begin to collect data right now. It is not our intent to make you an *expert* in program evaluation (nor is it important that you are an expert to collect, interpret, and present important data about your DBT program). Second, with the advent of the 1996 Health Insurance Portability and Accountability Act (HIPAA), as well as a concern for the rights of your clients and their confidentiality, states and institutions have developed different policies regarding informed consent and the extent to which use of data for evaluation is included within the consent form. Thus, it is essential that you review these policies and talk them over with your administration before you commence your project. Doing so will ensure that you are mindful of both the ethical and legal issues involved with conducting research and will minimize potential risk to your clients. Third, *get started*! There is no better time. You will learn what you need to learn in the context of *doing*. By rigorously collecting data, you will ultimately strengthen and solidify your DBT program.

## How This Chapter Is Organized

In this chapter, we will provide tips and a structure for starting your own program evaluation. Specifically, we will describe some defining features of program

evaluation, touch upon how to tailor your evaluation to your own specific needs, and offer the principles to follow as you begin to collect data. Furthermore, some suggestions for standard measures to use will be given as well as a brief tutorial on alternative data collection options, such as case studies and single-subject designs. Finally, tips for how to present your data are included to ensure that all your hard work pays off through a meaningful presentation or report.

## What Is Program Evaluation?

Program evaluation is a systematic procedure for examining the activities, characteristics, and impact of a program on the target population for purposes of improving the program, examining its overall effectiveness, and/or making decisions about future programming (Patton, 2008). Program evaluation can aid in answering many questions relevant to you and your DBT program: Do our clients improve in the outcome areas we would expect (e.g., decrease in suicide attempts and self-injurious behavior, reduction in inpatient hospital days, emergency room visits, and other crisis services)? Are our DBT therapists and skills trainers delivering the treatment as intended? Are total service costs decreasing for clients receiving DBT?

## Common Evaluation Questions and Methods for Answering Them

Although there are many types of evaluation questions to consider, the most common questions include the following:

1. Is the program operating as planned (addressed by process evaluation)?
2. What is the impact of the program on the target population (addressed by outcome evaluation)?
3. Is desired impact of the program attained at a reasonable cost (addressed by efficiency evaluation; Rossi, Lipsey, & Freeman, 2004)?

*Process evaluation* addresses questions related to the activities, services, and overall functioning of the program (i.e., the "process" within the program). Process evaluation is also typically called "program monitoring" when used for quality improvement purposes. Process evaluation may include, for example, assessment of whether the services are in alignment with the goals of the program, whether the services are delivered as intended, the extent to which the program is meeting its intended client population, and/or whether program staffing or training are sufficient. Many programs already collect much of these data because they are necessary for day-to-day administrative processes (e.g., billing, administrative reporting). Example process evaluation questions are included in Table 3.1.

Providers are typically most familiar with *outcome evaluation* since it focuses primarily on the extent to which a program produces the intended impact on the clients who receive services from that program. Outcome-related questions typically assume a set of operationally defined criteria or measures of success (Rossi et al., 2004). These may include instances of self-injurious behavior or urges to use alcohol or drugs, or they may be based on client or therapist reports on an assessment scale

**TABLE 3.1. Sample Process Evaluation Questions**

- Is the DBT program being implemented as intended (e.g., if the intent was to implement comprehensive DBT, does it include all of the functions of comprehensive DBT?)?
- Are DBT services delivered to a level of adherence and/or competence?
- Is DBT being delivered to the intended population (e.g., adults with BPD only? Clients with suicidal behavior? Adolescents with behavioral problems)?
- What is the rate of staff turnover on the DBT team compared to rates agencywide or in other service areas (countywide, national trends)?
- Are clients in the DBT program satisfied with their treatment?

such as the borderline symptom list (BSL). Examples of outcome evaluation questions are included in Table 3.2.

*Efficiency evaluation* is focused on program cost, cost–benefit, and cost-effectiveness of the program. This type of evaluation is often the most convincing and essential to funding agencies and policymakers who will want to know if the program is essentially worth the cost of implementation. Table 3.3 includes sample questions related to efficiency evaluation.

Again, for any given program, you may use a combination of these types of evaluation, and they may differ depending on whether you're conducting a formative or summative evaluation. For example, for your annual report to your agency's board, you may decide to report on the extent to which all DBT modes and functions are being delivered and therapist adherence to DBT (i.e., process evaluation) as well as the degree to which clients showed improvement in self-injurious behaviors, suicide attempts, and use of inpatient and crisis services (i.e., outcome evaluation). However, in your quality improvement program, you may focus on data that relate to identified areas of weakness in your particular program (e.g., new therapist training in DBT during times of high staff turnover).

## Before You Get Started: Deciding Where to Begin

The beauty of program evaluation is that it can and should be designed in a fashion that allows you and other program stakeholders to answer the most relevant

**TABLE 3.2. Sample Outcome Evaluation Questions**

- To what extent do inpatient hospital days, emergency room visits, and crisis beds decrease for clients in the DBT program compared to the year prior to their inclusion in the program?
- To what extent do client outcomes maintain or improve 1 year after completion of the DBT program?
- What is the dropout rate for clients in the DBT program in comparison to dropout rates in other programs agencywide?
- What percentage of clients are no longer on psychiatric disability? Of that group, what percentage have jobs or are enrolled in school upon completion of DBT? What percent are volunteering/contributing in the community?
- Do client outcomes improve when a DBT advanced group is added to our program in the second year? To what extent do client outcomes hold steady or continue to improve when an advanced group is offered during the second year?

**TABLE 3.3. Sample Efficiency Evaluation Questions**

- If there was a reduction in utilization of inpatient hospital and crisis services for clients in the DBT program, how much money was saved in total treatment costs?
- Do the benefits of the DBT program outweigh the costs? What is the net benefit per client?
- What is the return on investment of the DBT program (e.g., clients in DBT returning to the workforce)?
- Would alternative treatment approaches yield equivalent benefits at a lower cost?
- Would the DBT program be equally effective and less costly if staffed by intensively trained bachelor's-level clinicians rather than master's- and doctoral-level therapists?

questions linked to your most important goals. For example, if the goal is to determine whether the costs of conducting DBT are justified by the savings to your system, your program evaluation will naturally involve collecting client data on the utilization of resources (e.g., emergency rooms, psychiatric hospitalization, destruction of waiting room property, professional staff sick leave). If your initial goal is to develop a DBT program that has a very positive valence to staff and clients alike (i.e., clients and clinicians view the program quite favorably and, as a result, clinicians refer their BPD clients and clients opt voluntarily to receive services), then your evaluation may focus instead on staff and client attitudes about DBT.

An individually tailored approach to evaluation design ensures that the evaluation is produced in a manner that is realistic and practical given the allotted resources, while providing credible findings that are useful to DBT program stakeholders. To individually tailor your evaluation, you need to know a variety of details about your program and understand the purposes of your evaluation. The following subsections offer a list of questions that will help you focus your evaluation to fit your program's goals and needs.

### *At What Stage of Implementation Is Your DBT Program?*

The stage of implementation of your DBT program may have a huge impact on how you design your evaluation. Take a look at the following implementation stages (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005) and determine which stage best fits with the current status of your DBT program:

- *Exploration and adoption:* At this stage, program stakeholders begin exploring the possibility of implementing the program. Planning groups typically come together to examine which programs fit their needs, and they make decisions about whether to adopt a particular program.

- *Initial implementation:* This stage includes both the early planning for implementing the program (e.g., securing space, personnel) and initial operation of the program when staff are in place and clients are now receiving services. This stage typically occurs within the first year of implementing a program, but can take longer depending on how much time is required for the program to obtain all of its necessary implementation resources and staff.

- *Full implementation:* Program staff are trained and the program is fully functional. Training, supervision, evaluation, daily operations, and administration are routinized.

- *Innovation:* Once fully implemented, it is sometimes decided that the program requires further refinement or adaptation. During this stage, one must carefully assess whether such changes are to the benefit of the program or cause program drift that threatens fidelity to the intended model and are a detriment to program outcomes.
- *Sustainability:* By this stage, the program has survived some turnover in staff and administration and has successfully recruited, trained, and retained new personnel. During the sustainability stage, the program is focused on long-term survival and continued effectiveness in the context of many internal (e.g., staffing, administration, referral base) and external changes (e.g., public policy, funding priorities).

Once you have identified the implementation stage of your DBT program, you're ready to answer the remaining questions below. Please note that if you're in the exploration and adoption stage, you may first want to consider conducting a formal or informal assessment of *need* for a DBT program (i.e., "needs assessment"). In many cases, the need for DBT has already been established informally and the reason for the program is obvious (e.g., high utilization rates of expensive services, high staff turnover rates due to difficulty with effectively working with clients with BPD). However, even if the need for DBT has been identified, it is not uncommon for programs to have to go the extra mile to convince their administration that a *comprehensive* DBT program versus, say, a program that implements only DBT skills training is needed, or that intensive training and ongoing consultation are required to effectively implement this treatment. While walking you through how to conduct a needs assessment is not within the scope of this chapter, it is important to keep this tool in mind. A useful resource for conducting a needs assessment is the needs assessment protocol and documentation manual published by the National Research and Training Center on Psychiatric Disability (NRTC; Cook, Jonikas, & Bamburger, 2002).

### *Who Are the Primary Stakeholders?*

Stakeholders, sometimes called "constituents," are people and/or organizations who have a vested interest in the program, such as clients, families, clinicians, and program directors. You need to ask yourself who are the people who are both interested in and will make use of the evaluation findings? This answer will provide guidance with regard to which key players should be included in the evaluation design and potentially the ongoing oversight of the evaluation (e.g., an evaluation advisory board), as stakeholder involvement is one of the best ways to ensure that evaluation findings are both informative and useful (Patton, 2008). Knowing your program stakeholders will also help you to determine which evaluation questions to include (see "What Questions Do You Want Your Evaluation to Answer?" below). Evaluation data may be useful to any combination of the following DBT stakeholders:

- *Clients:* "Is my life better in identifiable ways [e.g., decreased self-injurious behavior, hopelessness, depression]?"
- *Families:* "Is the life of my family member [who is being treated] better? Is there a positive change in my own life (e.g., reduced family burden, fewer crisis calls) because my family member's life is better?"
- *Therapists and skills trainers:* "Is our DBT program helping our clients? Am I

delivering this therapy in the way in which it was intended to be delivered? Am I feeling effective and enthusiastic about our program?"
- *Program supervisors and directors:* "Are our DBT therapists adherent to DBT? Are clients and therapists in our program satisfied with their services?"
- *Program funders:* "Is the DBT program actually delivering DBT so that we can justify reimbursement/payment? Is the DBT program resulting in positive outcomes?"
- *High-level administrators:* "Is the program resulting in reduced costs and/or reduced risk of liability, compared to alternatives?"

### What Is the Overarching Purpose of the Evaluation?

Is the purpose to provide feedback on how the program is doing and what changes need to be made to continue enhancing and improving upon the program? Is the purpose to ultimately render judgment on whether the program is effective? Or, is it both? Most evaluations within community programs focus on quality and program improvement at the very least. In fact, available resources to conduct the evaluation (see "What Resources Are Available for the Evaluation?" below) often determine the extent to which program effectiveness can be assessed with much methodological rigor.

Another consideration in deciding the purpose of your evaluation is how it relates to your program's implementation stage. If your program is in the early stages of implementation, you may want to consider focusing on program improvement. This is because some of your evaluation findings may be disappointing at this early stage and you wouldn't want to inadvertently communicate to decision-making stakeholders (e.g., state mental health directors, funding agencies) that the program is ineffective before you have given the program time to show an effect. Disappointing findings may result from any number of factors that are simply part of being a young program: poor initial implementation, a small sample size due to the fact that you only have so many slots available as your program starts out, and assessment of outcomes that typically take some time to exhibit any sort of effect (e.g., clients returning to work). Instead, a program improvement assessment can help you identify relative strengths and weaknesses in your program and target efforts to improve the latter.

### What Resources Are Available for the Evaluation?

Unfortunately, there usually are little to no resources devoted to program evaluation. Even when start-up costs are provided, it is important to consider what resources are available for the day-to-day management of collecting the data, cleaning them up, analyzing them, and providing the results in a timely manner. If fewer resources are available, make sure that the evaluation isn't too large and doesn't require more person-power than is realistic.

### What Questions Do You Want the Evaluation to Answer?

To actually use your evaluation findings, it is imperative to make sure that they is measure the kind of data important to your DBT program. This question overlaps considerably with "Who Are the Primary Program Stakeholders?" since these

questions may differ based on the stakeholders identified and the extent of their involvement in the evaluation process. For example, clients and families may tend to focus on the degree to which the program helps them, whereas program funders and high-level administrators might be interested in whether the program is cost-effective in addition to whether it has a positive impact on clients and families. Furthermore, the stage of implementation may also play a significant role regarding the types of evaluation questions you ask. Programs in later stages of implementation (*full implementation* and *sustainability*) and that have been collecting data for a longer period of time may have more to say about whether the program is cost-effective or whether clients achieve longer-term gains, such as employment or a sustained decrease in self-injurious behaviors.

## Conducting Your Evaluation: Principles for Data Collection

The most typical method for evaluating a program is to measure a number of variables (e.g., incidents of self-injurious behavior, psychiatric symptoms, employment status) on a regular basis and examine how these variables change over time, which is a type of *outcome evaluation*. With these data, you can chart changes on a micro or individual client level, on a day-to-day basis (as with daily diary cards) or at a global level, such as assessing how clients in an entire program are doing before, during, and after participating in the program (also known as a "pre–post" assessment). That is, with the latter, you can measure a number of variables of interest when a client first enters treatment and then measure these same variables when they end treatment, or on a routine basis, for instance, every 3 months or every 6 months. For novice researchers, this task can seem overwhelming even after all the questions about tailoring your evaluation have been answered. Therefore, we have developed seven principles to help you get started with data collection on your DBT program. These principles are also illustrated in Table 3.4, which we will describe more fully below.

### *Keep It Simple*

It is easy to get bogged down with too much data too quickly. It is preferable by far to collect reliable information on just a few variables of interest rather than a lot of data that are of little interest or use to the program, or be so ambitious that you become overwhelmed by the task before you're out of the gate. As a general guideline, think about collecting data on eight or fewer variables of interest. For example, in Table 3.4, the primary variables of relevance for standard DBT and the adaptations described throughout this book are listed.

### *Keep It Consistent*

Measure the same items for all clients in your program. Although it might be tempting to collect different data for different subtypes of clients (e.g., only measuring urges to self-harm for clients with a self-harm history or only measuring urges to drink for those individuals who have an alcohol problem), measuring different variables for each unique subset of your population will undoubtedly complicate your evaluation

**TABLE 3.4. Relevant Outcome Variables for DBT Adaptations**

| DBT adaptation | Population of interest | Setting | Top five to eight outcomes | How each outcome can be measured |
|---|---|---|---|---|
| **DBT in outpatient settings** | Chronically suicidal individuals with BPD | Outpatient weekly individual and group therapy | 1. Number of suicide attempts, number of nonsuicidal self-injurious behaviors<br>2. Psychiatric admissions and length of psychiatric inpatient hospitalization<br>3. Months receiving psychiatric disability payment<br>4. Engagement in work, school, volunteer work | 1. Diary card; Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006)<br>2. Number of days over specified period of time (e.g., monthly)<br>3. Client self-report of income; diary card; verification through SSDI<br>4. Diary card (record average hours per month at work, in school, volunteering)<br>*All data are collected for each client at baseline and every 6 months.* |
| **DBT in inpatient units** | Hospitalized individuals with BPD | Inpatient | 1. Self-harm behaviors<br>2. Violent acts toward others<br>3. Use of medications for behavioral or emotional control<br>4. Attendance at unit groups and modalities<br>5. Length of stay skills practice | 1. Hospital staff reports of "incidents"<br>2. Hospital staff reports of "incidents"<br>3. MAR (Medication Administration Record) or hospital pharmacy data<br>4. Chart notes; attendance sheets<br>5. Chart notes; medical records<br>6. Diary card<br>*All data are collected on each client at hospital admission and discharge. Best if some type of follow-up data can be collected postdischarge.* |
| **DBT for substance use and BPD** | Individuals with substance use disorders (SUDs) and BPD | Outpatient individual and group therapy | 1. Substance use<br>2. Self-injurious behaviors<br>3. Treatment retention<br>4. Anger<br>5. Symptom distress<br>6. BPD symptomatology | 1. Urine screens—conducted randomly monthly; Addiction Severity Index (ASI; McLellan, Laborsky, O'Brien, & Woody, 1980, 1992)<br>2. Suicide Attempt Self-Injury Interview (SASII)<br>3. Treatment History Interview (THI; Linehan & Heard, 1987)<br>4. State–Trait Anxiety Inventory for Adults (STAXI; Spielberger, 1996)<br>5. Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1977)<br>6. Borderline Symptom List (BSL; Bohus et al., 2007)<br>*Other than urine screens, measures are administered to each client at baseline and every 4 months.* |
| **DBT for eating disorders** | Individuals with bulimia nervosa or binge eating disorder | Outpatient weekly group therapy | 1. Frequency of binge episodes<br>2. Frequency of purge episodes<br>3. Weight change<br>4. Emotional eating<br>5. Depression | 1. Eating Disorders Examination (EDE; Fairburn & Cooper, 1993)<br>2. EDE<br>3. Balance beam scale, no shoes<br>4. Emotional Eating Scale (EES; Arnow, Kenardy, & Agras, 1995)<br>5. Depression Anxiety Stress Scales (DASS; Loviband & Loviband, 1995)<br>*Data are collected at baseline, post-treatment, and follow-up.* |

(*continued*)

**TABLE 3.4.** (*continued*)

| DBT adaptation | Population of interest | Setting | Top five to eight outcomes | How each outcome can be measured |
|---|---|---|---|---|
| | Individuals with anorexia nervosa | Outpatient weekly individual or group therapy; intensive outpatient program; partial hospital program | 1. Frequency of binge episodes<br>2. Frequency of purge episodes<br>3. Weight change<br>4. Emotional eating<br>5. Depression | 1. EDE<br>2. EDE<br>3. Balance beam scale, no shoes, after voiding<br>4. EES<br>5. DASS<br>*Note:* All measures are referenced in Telch, Agras, and Linehan (2001). |
| **DBT for adolescents** | Suicidal adolescents with borderline personality features | Outpatient | 1. Suicide attempts<br>2. Inpatient admissions<br>3. Outpatient treatment compliance<br>4. Suicidal ideation<br>5. Depression<br>6. Global psychiatric symptomatology | 1. Self-report/diary card; SASII<br>2. Medical chart<br>3. Medical chart reports of completion of 12-week (2X/week) treatment<br>4. Harkavy-Asnis Suicide Survey (HASS; Harkavy-Friedman & Asnis, 1989a, 1989b); Suicidal Ideation Questionnaire (SIQ; Reynolds, 1988)<br>5. DASS<br>6. SCL-90-R<br>*All data are collected for each client at baseline, after each skills group module, and at posttreatment. Best if some type of follow-up assessment could also be completed.* |
| **DBT with couples and families** | Couples | Outpatient | 1. Validating and invalidating responses<br>2. Aggression and domestic violence<br>3. Relationship quality<br>4. Individual distress | 1. Observational ratings using the Validating and Invalidating Behaviors Coding Scale (VIBCS; Fruzzetti et al., 1995, 2005)<br>2. Conflict Tactics Scale 2 (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996)<br>3. Dyadic Adjustment Scale (Spanier, 1979or Quality of Marriage Index (Norton, 1983)<br>4. SCL-90-R<br>*Measures are administered to each client at baseline, posttreatment, and follow-up. The VIBCS can be used more frequently (often with each session).* |
| | Victims of domestic violence | Outpatient | 1. Distress<br>2. Depression<br>3. Social adjustment<br>4. Safety/re-victimization | 1. SCL-90-R<br>2. DASS<br>3. Social Adjustment Scale—Self-Report (Weismann & Bothwell, 1976)<br>4. Conflict Tactics Scale 2 (CTS2; Straus et al., 1996)<br>*Measures are administered to each client at baseline, posttreatment, and follow-up. The VIBCS can be used more frequently (often with each session).* |

(*continued*)

**TABLE 3.4.** (*continued*)

| DBT adaptation | Population of interest | Setting | Top five to eight outcomes | How each outcome can be measured |
|---|---|---|---|---|
| | Parents of adolescent children | Any | 1. Validating and invalidating responses<br>2. Safety/re-victimization<br>3. Adolescent's family satisfaction | 1. Observational ratings using the Validating and Invalidating Behaviors Coding Scale (Fruzzetti et al., 2005)<br>2. Conflict Tactics Scale 2 (parent–child version; Straus et al., 1996)<br>3. Adolescent Family Life Satisfaction Index—Parent–Child Subscale (Henry, Ostrander, & Lovelace, 1992)<br>*Measures are administered to each client at baseline, posttreatment, and follow-up. The VIBCS can be used more frequently (often with each session).* |
| **DBT in highly restricted and long-term settings** | Adults adjudicated not guilty by reason of insanity (NGRI) | Forensic inpatient | 1. Physical self-harm<br>2. Physical other-harm<br>3. Staff burnout<br>4. Psychiatric symptoms<br>5. Depression<br>6. Coping skills | 1. Hospital incident reports<br>2. Hospital incident reports; seclusion and restraint reports<br>3. Maslach Burnout Scale (MBI; Maslach & Jackson, 1981)<br>4. Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983)<br>5. Beck Depression Inventory (Beck, Ward, Mendelson, Moch, & Erbaugh, 1961)<br>6. Vitaliano's Revised Ways of Coping Scale (WCCL-R; Vitaliano, Maiuro, Russo, & Becker, 1987; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985) |
| **DBT for assertive community treatment (ACT)** | Individuals with severe and persistent mental illness (SPMI) who have BPD-consistent behaviors | Community/ outpatient—ACT team | 1. Days in psychiatric hospital, jail, or crisis residential<br>2. Number of ER visits for suicidal/self-injurious behaviors<br>3. Work, school, volunteer work, or other structured or scheduled activity<br>4. Program retention rate<br>5. Disposition of client after discharge<br>6. Client living situation<br>7. Individual distress | 1. Chart notes or program incident reports<br>2. Chart notes or program incident reports<br>3. Chart notes (percentage of DBT clients who are working and average hours involved in a structured activity, including work each week)<br>4. Chart notes/attendance records<br>5. Disposition plan/chart notes<br>6. Chart notes<br>7. Brief Symptom Inventory (BSI) score (Derogatis & Melisaratos, 1983)<br>*For items 1 and 2, data are collected on each client 2 years prior to program entry, during treatment at regular intervals (e.g., every 4 to 6 months) and at 1-year follow-up if possible.*<br>*For items 3–7, data are collected for each client at baseline and posttreatment.* |

and give you headaches in the long run. Keeping the variables of interest consistent will allow you to combine your data across clients and will yield clearer results later on. One fairly easy way to do this is to use a standard diary card (see Linehan, 2014) for all clients in your program, which includes a set number of variables of interest while allowing for a couple of variables to vary across clients. For example, you might decide to measure instances of self-harm and drug use, urges to self-harm and use drugs, and suicide ideation for all of your clients, but might measure hours of sleep only for those individuals whom you are directly targeting for better sleep hygiene. Furthermore, be sure that you are comparing "apples to apples" with each period of data collection. That is, when examining "baseline" data (also known as "pretreatment" or "pre-DBT" data), be sure that you are comparing data from the same time frame for each client on each measure. For cost and service utilization data (e.g., inpatient hospitalizations, use of crisis services), a common convention among outpatient programs is to collect data on each client 6 months to 1 year prior to entering treatment. Baseline measurement for outcome data (e.g., number of self-injurious behaviors, symptoms of depression) typically takes into account symptoms and behaviors that occurred 30 days prior to each client's admission to the program. See Table 3.4 for typical time frames for data collection across various DBT adaptations and treatment settings.

### *Keep It Useful*

Think about what variables matter to the key program stakeholders—you, your clients and their families, your administration, and potentially any policymakers who may have ultimate control over continued program funding. Measure behaviors for which changes are meaningfully and directly linked to goals (both your program's and your clients'). Be clear beforehand about what information would be most revealing to you and your team 6 months from now. What data will help "sell" your program to those you need to convince?

### *Keep It DBT*

Consider your primary targets for the population of clients that you treat. Include variables that are on your primary target list, as these may be anticipated to change after applying DBT. Table 3.4 describes the primary outcomes for several adaptations of DBT. The outcomes tie specifically into the primary targets of each adapted intervention.

### *Keep It Behaviorally Specific*

Measure discrete, recurring behavior that you can count and observe. For example, when measuring suicidal behavior, collecting data on the number of emergency room visits due to suicide attempts and number of self-harm episodes is more behaviorally specific than asking clients to report whether they were suicidal. Similarly, if you're interested in measuring depression, using a psychometrically sound rating scale such as the Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995) will glean more behaviorally specific data than simply asking clients if they feel depressed.

### Keep It Scientific

Be guided by existing research and don't measure items that you have no reason to believe would change. For example, if your program consists of an intensive 2-week inpatient program for recent suicide attempters, a number of variables may exist that you would expect to change as a result of the targets of the intervention, such as degree of hopelessness, level of suicide ideation, or medication compliance. However, given the length of the program, there is no reason to expect that issues that may take longer to address, such as chronic posttraumatic stress disorder (PTSD) symptoms or quality of life, would change as a result of the 2-week stay.

### Keep It Manageable

Don't do more than you have to. While there may be data that you do not currently collect on a routine basis but would like to, try to also use data that you are already collecting for other purposes. The best and most accessible data may come from the diary card, chart notes, or even billing paperwork regarding services delivered. If your chart note does not include information on variables of interest (e.g., days of hospitalization, emergency room visits, days in jail), and either it would be inappropriate to modify the note or it's simply not possible, generate an additional note that is to be completed once monthly. Some therapists have generated a calendar for the year for each client and recorded significant events associated with variables of interest (e.g., marking the period of time the client was hospitalized, missed sessions or groups, period where half-time work began). Similarly, much process evaluation data can be pulled directly out of billing reports that show the number of hours of treatment provided, attendance numbers, and even type of treatment provided.

## Choosing the Right Measures and Comparison Groups

Now that we have made a clear recommendation to keep things simple and straightforward, you may be saying to yourself, "But what about using well-established, validated research measures and research designs like those used by Linehan and others in large research trials? How important is it to include these sorts of measures in our evaluation and an appropriate comparison or control group?" The decision about whether to use these sorts of measures and add a control condition all depends on your goal as well as your resources. While collecting data in a similar fashion as the large research trials is impressive and offers many other positive rewards and directions (e.g., it is another means to compare your outcomes to those found in other randomized clinical trials [RCTs], or it may increase the odds that your data could be written up and published within a scientific professional journal), there are also many potential negatives to starting such a huge research effort. For starters, such an effort can be resource heavy in many ways. Larger-scale research projects typically require more time from clients (to complete the more lengthy measures) and staff (to organize and systematically administer the assessments, and enter and analyze the data). Similarly, a number of measures cost money for each administration (e.g., Beck Depression Inventory [BDI], Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Symptom Checklist-90R [SCL-90R], Derogatis, 1977). Furthermore, such large-scale

research efforts, particularly if random assignment is involved, would require human subjects or some type of institutional review board (IRB) approval. Comparing your treatment to some other treatment (or treatment as usual) also generally requires twice as many clients and usually twice as many therapists, thus requiring even more financial resources. One way to cut down on this particular resource drain might be to, rather than include another treatment condition, instead compare data from your new program to data from your program prior to implementation. In other words, using chart review or other records, you can measure how outcomes *change* as a result of the addition of your new treatment program. Another alternative is to "benchmark" your outcomes against a gold-standard RCT by using similar measures and comparing effect sizes (see Rizvi, Hughes, Hittman, & Vieira Oliviera, 2017, for an example).

Our suggestion in terms of how to start: If your answer to the question "Will collecting data like those in the published RCTs interfere with our efforts to begin collecting *any* data on our program?" is "yes," then we suggest an alternate route. Start simple first. Get a straightforward program evaluation effort off the ground before considering whether to enter the "big leagues." If you do, make sure it's in addition to your ongoing, existing efforts to gather simple data well.

## Alternative Methods of Gathering Data: Case Studies and Single-Case Designs

There are many instances in which it may not make sense or isn't feasible to conduct a program evaluation as described in this chapter. Perhaps the "program" you wish to evaluate consists of only one or two clients. Or, your program is still in the early phases of DBT implementation, where modes are gradually added, over time, to create a comprehensive DBT program. Or, your system administration decides it wants to take a few well-trained DBT therapists and provide comprehensive DBT "by the book" for only the highest of high-treatment utilizers. In all these scenarios, given the size of the program and the small number of clients with whom you want to apply DBT, it may make more sense to consider other methods intended to evaluate single cases at a time. This section will describe some alternative methods for evaluating the success of your treatment—namely, case studies and single-case designs.

In addition to being more appropriate for a smaller group of individuals, case studies and single-case designs offer many advantages over other types of research designs. First, this type of research is more practical, especially for a novel research idea or hypothesis. In some research design methodologies, only one person is needed for a study. Even with other methodologies, such as multiple baselines across subjects (described below), a study can be completed with three to ten participants. Therefore, it easier to recruit participants, takes fewer resources to conduct the research, and can be completed in a relatively short period of time (depending on the length of the intervention to be studied). Second, as compared to large-scale outcome studies, there is no need for a wait-list/no-treatment control group. Third, as opposed to larger treatment outcome studies in which you might have several "rule-out" criteria to make your group more homogenous (e.g., to study if DBT is effective for comorbid PTSD and BPD, you might have to rule out all individuals who also meet criteria for depression), in single-subject designs, you can treat a more heterogenous set of individuals.

Finally, because of the fine-tuned attention to incremental changes within the person, single-subject designs and case studies allow for the ability to look at within-person variability, usually of great interest to clinicians, and explore clinical course as well as mechanisms of change more readily. For example, if you are conducting skills training with an individual client and notice a significant decrease from one week to the next in terms of depression scores, you can then look at what happened in the session prior to the decrease and attempt to understand what caused the depression to remit that week, even if it is only temporary. Table 3.5 lists some of the pros and cons for these alternative evaluation methods.

### *Case Studies*

Although its relative use has decreased in recent years as greater emphasis has instead been placed on large treatment outcome studies, it is important to remember that the case study method was the standard for clinical investigation up until the mid-20th century (Barlow & Hersen, 1984). A case study is the documentation of procedures used to treat a person with emotional and/or behavioral problems and, regardless of whether it is written for publication in a journal or book, the case study is the necessary first step in evaluating any new intervention. That is, every new treatment begins with the treatment of one person (sometimes referred to as a "pilot case") in which new techniques are applied and the effects of this technique are observed. In fact, the development of DBT occurred within the process of Linehan noting that standard cognitive-behavioral treatment (CBT) was not working for chronically suicidal and self-harming individuals (described in Linehan, 1993). A team observed her sessions with a series of pilot cases as she added new techniques to the standard CBT treatment and through this iterative process, she identified the strategies that appeared effective. These early observations were then translated into a treatment manual and were eventually evaluated in large clinical outcome research trials. The beauty of a case study is that every client presents as an opportunity for assessing the impact of your treatment.

With the advent of journals devoted solely to publishing case material (e.g., *Clinical Case Studies* and the electronic journal *Pragmatic Case Studies in Psychotherapy*), it is not difficult to find examples of case studies in the literature, including examples of case studies using DBT or DBT principles. Swenson and Linehan (2004), for example, discuss the implementation of DBT with a highly suicidal individual who spent the majority of her adult life in inpatient settings. The authors provide an extensive personal history of the client and a DBT case formulation and treatment plan based on target behaviors. Then a sample behavioral chain analysis is described and information about how this client fared in treatment is given. What is notable about this case study is that it is thorough and provides a compelling rationale for using DBT with clients such as this one; however, it contains no inferential statistical analyses, did not require a sample of more than one person, and was simply a record of what occurred in therapy. Other DBT case studies to which one might refer for examples include Geisser and Rizvi (2014) and Rizvi, Yu, Geisser, and Finnegan (2016).

There is no set standard for how to conduct and write up a case study, but here are some guidelines for information you would want to gather and provide. Like any case conference presentation you might make, demographic details, a full

**TABLE 3.5. Advantages and Disadvantages of Case Studies and Single-Case Designs**

| Case studies | Single-case designs |
|---|---|
| **Advantages** | |
| • Only need one client | • One or more clients, depending on which design you use |
| • Does not require much more resources than writing up an account of what you are doing in treatment | • Can systematically determine the causal effects of your intervention |
| • Options exist for publishing in case study journals | • If done well (i.e., effectively following the principles), can publish in a scientific journal |
| **Disadvantages** | |
| • Does not allow you to make causal inferences about your treatment | • Requires that you be very structured in your approach |
| • May not provide a lot of weight if you're trying to demonstrate that your intervention will work for more than one person | • May take more time on the front end because you'll need to study the various types of designs and decide the design for your study |

diagnostic picture, information about relevant history, and presenting problems (i.e., what initially brought this client to see you) generally help set the stage. A detailed assessment of the client's goals and problem areas is also necessary. The frame of DBT provides an advantage here because you can describe your hierarchy of targets and explain why you organized the targets in a particular way, according to the DBT model. The emphasis in DBT on constant assessment and linking to goals is also consistent with what is required in a case study. Case conceptualization is central in a case study, and time and effort should be placed in spelling out specifically what you believe contributes to the development and maintenance of disorder in this client and how your treatment plan will address these factors in a substantive way. Next, you want to provide a detailed description of the course of treatment and progress over time. If you have data, you might want to present them in graphical form in this section to pictorially represent change over time. Finally, you would indicate how the treatment ended, provide any follow-up information you may have about the client, and offer concluding comments with your opinions about the treatment. Sometimes, authors of case studies also provide suggestions for doing similar work with other clients, thus transferring their knowledge learned from the experience to other clinicians.

An important note: The nature of case studies is such that you include specific and personal information about a particular client whom you treated. If you are writing up the case for publication in a journal or another outlet, you are going to want to ensure that there will be no possible way for others to identify the client based on your writing. Changing particularly unique pieces of information and other details that don't significantly affect the accurate description of your treatment is necessary to protect the client. The client's welfare always outweighs the benefit for you of seeing your own name in print.

### *Single-Case Designs*

As mentioned earlier, one potential downside to case studies is the lack of experimental control to account for other non-treatment-related factors that may be responsible

for the clinical changes. Without the most rigorous experimental controls, it is never possible to fully determine whether the treatment was responsible for changes in the target behavior, or if the change occurred due to other factors, such as natural change resulting from maturation or simply the lapse of time or other random factors (e.g., the client's much sought after divorce had finally transpired). In contrast to the case study approach, single-case designs are intended to provide the same level of experimental rigor as controlled studies to address alternative, competing explanations for why the target behavior has changed. Rather than needing a large number of individuals to test hypotheses, sometimes only one client is needed, thus making this method an easy, efficient way to evaluate the effectiveness of your intervention.

In single-subject design studies, the effects of the intervention are examined by observing the influence of the intervention on previously measured baseline behavior, that is, behavior that occurred prior to the start of the intervention. There is a heavy reliance on repeated observations over time; measurement of variables of interest should begin before the intervention is applied and then continue throughout the course of the intervention so that you can note whether the behavior changed when, and only when, the intervention was applied. There are several types of single-subject experimental designs that have several common elements and varying degrees of complexity, including an AB design, ABAB or reversal designs, and multiple-baseline designs. In general, "A" indicates baseline or no-treatment phases and "B" indicates a treatment phase. Before describing in more detail each of these types of interventions, some elements common to all single-subject designs are outlined here:

1. *Identification of a specific target behavior.* Before the study commences, a specific behavior that can be reliably and validly measured must be identified.

2. *Continuous measurement.* The foundation of single-subject designs rests on its measurement. In these types of designs, the same measurement must be applied on a regular basis so that you can accurately assess both subtle and not-so-subtle changes over time.

3. *A baseline period* ("A"). A baseline period during which data are gathered on the target behavior before any intervention is applied is necessary to truly test the effects of your intervention. Without a baseline phase, there is no way of knowing whether your intervention had any true effect.

4. *Stability of the specific target behavior.* For the effects of your intervention to be clearest, you want to demonstrate that the target behavior changes *only* when your intervention is applied. If your target behavior is unstable and vacillates widely before the intervention is applied, then it becomes increasingly difficult to demonstrate that your intervention has any effect.

5. *Systematic application of intervention.* Once a baseline period has been established and you decide to apply your intervention, you must do it in a systematic and conscientious manner. For example, if you want to show that the application of interpersonal effectiveness skills has an effect on the quality of social interactions (as measured by a self-report instrument on relationship satisfaction administered weekly), then you must figure out a way to have the client practice the skills in a methodical and consistent way. If they only practice DEAR MAN once every 3 weeks, then your single-subject design will not be able to demonstrate the intended effect.

These elements are used in various formats to create the different designs. For example, in the simplest AB design, a baseline period "A" is followed by an intervention period "B," and the effects of the addition of the intervention are assessed. In an ABAB design, also known as "withdrawal design," following a specified period of intervention (the first "B"), treatment is then withdrawn and the effects on the behavior are documented. If a treatment is causing the change in the behavior, then, in many instances, you would expect that behavior will regress to initial levels during the second "A" period. Finally, the treatment is applied again with the hypothesis that the behavior will again decrease as a result of the treatment.

For example, say you wanted to directly test the effects of positive reinforcement on maintaining eye contact with the therapist in a client who has been shut down and withdrawn for all of the previous sessions (with the client's informed consent of course!). During the initial baseline period, you would not positively reinforce the client at all and you, or research assistants, would code the amount of time the client makes eye contact. This continues for several sessions while you establish a baseline. Next, you apply your positive reinforcement intervention for several weeks, again coding each session for the amount of time the client makes or maintains eye contact. If you notice positive changes, that is, the client maintains eye contact for a greater amount of time, then you can move into the second baseline period and withdraw positive reinforcement. Assuming your initial hypothesis is correct and that reinforcement increases eye contact, then withdrawing reinforcement will cause the client to stop making eye contact. Finally, after a few sessions of this withdrawal phase, you can once again become your naturally reinforcing self and document the changes.

Of course, as you might be noting, there are some ethical concerns with using a withdrawal design and this concern is heightened when working with vulnerable or at-risk populations. If an intervention is working and the client is improving, then it would be very difficult to justify withdrawing the intervention to measure its effects. Your ability to use an ABAB design depends in large part on the client, the type of intervention, and the target behavior. Having suicidal behavior be your target behavior, for example, should be a good indication to you that withdrawing treatment to see if a client reverts back to being more suicidal would be highly unethical.

A multiple baseline requires taking repeated measurements on clients for differing lengths of time to create a "baseline" against which the intervention can be compared. This allows you to specifically study how the introduction of your specific intervention changed the baseline behavior. For example, say you want to examine how DBT mindfulness skills affect clients' urges to use drugs. If you were doing a multiple-baseline design, you might randomize three clients to three different baseline periods, say, 2 weeks, 4 weeks, and 6 weeks, and monitor their urges to use drugs on a daily basis on a 0–10 scale, using diary cards. After their individual baseline period, you teach the clients the seven skills of mindfulness and ask them to practice these skills every day for 4 weeks. You continue to monitor their urges to use drugs on a daily basis for this 4-week period, at which point you can compare how the mindfulness skills influenced their urges to use drugs. In multiple-baseline designs, graphs are used to indicate the changes that occur, and Figure 3.1 is an example of some ideal outcome data applying this design.

Single-subject design studies are abundant in the clinical psychology literature, and it doesn't take long to find numerous examples. (An excellent resource for

descriptions and instructions for these types of design is Kazdin [2012] and anyone seeking to begin a single-subject design study is strongly encouraged to read this manual.) Relevant to BPD, Rizvi and Linehan (2005) utilized a multiple baseline across subjects to test the effectiveness of a particular component of DBT, the skill of "opposite action," for the treatment of maladaptive shame in five individuals with BPD. Sauer-Zavala and colleagues (2019) used an alternating treatment design to isolate the effects of opposite action in a lab paradigm.

In summary, in addition to the program evaluation guidelines of the previous section, we have also provided you with some information on alternative evaluation methods, including case studies and single-case designs. Each method has its own unique advantages and disadvantages, and it will be up to you and your team to determine what is right for you at this time. But because there are so many options available to you, it's our hope that nothing will stop you from getting started on an exciting data collection process now, whether it be with 1 client or 100. Now that you know how to collect your data, we'll teach you some strategies for presenting your data in the most accurate and appealing way.

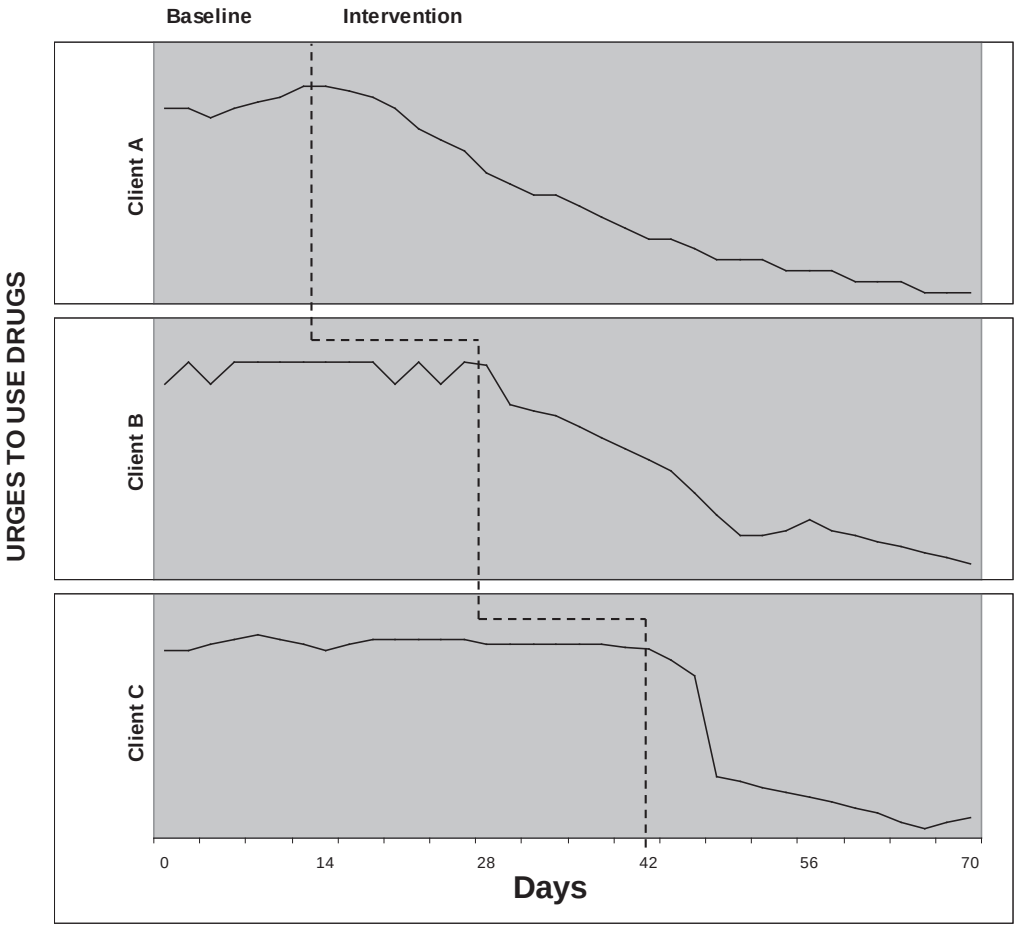


**FIGURE 3.1.** Example of hypothetical results from a multiple-baseline design.

## Presenting Your Findings

It's never too early to begin thinking about how to present your evaluation findings. In fact, contemplating what your findings may look like as you design your evaluation can help to verify that you are collecting the data most important to you and your program. Whether your goal is to present a one-page executive summary to your administration or a conference presentation to dozens of scientists, there are many items to consider when determining how to best present your data.

- *Tailor your presentation to your audience.* How you choose to present your data invariably depends on who comprises your audience. In many cases, particularly as you report program evaluation results, it is likely that your audience will be key program stakeholders who may not have much background in data, evaluation, or statistics. In these cases, it is essential to ensure that you present your findings in the most straightforward and clearest way possible, perhaps avoiding more complicated tables and figures to best present "the bottom line." In the case of presenting your findings to a scientific audience, however, a more formal presentation of key results and statistics is often necessary. If you are less experienced in this domain, it may be important for you to consult with others who have given similar presentations so that you have appropriate models. You may even want to contact a local university to see whether a student with experience in statistics might be willing to consult to your program for course credit or a small fee.

- *Consider leading or ending with a good story.* Once you know your audience, consider whether they would be compelled by a real story about the benefits a particular client in your DBT experienced, or how DBT helped to change that person's life. Often legislators and other policymakers, and philanthropists, for example, like to hear more about the real impact of a program before funding it. A personal story and real program data can prove to be a winning combination for many stakeholders.

- *Stick to the data.* It's not surprising that you would be excited to find results suggesting that DBT had a positive impact on the outcome variables of relevance. This is what we want! However, it's important to be vigilant about not inferring more than what is actually demonstrated by the data. For example, many program evaluations are designed in a manner that does not allow you to ultimately say that DBT was responsible for, or directly caused, the positive outcomes. Most program evaluations do not control for other variables that may have actually had an impact on these findings (e.g., lack of randomization to different conditions). In these instances, what you can report is that positive change occurred after the DBT program was implemented (not that DBT "caused" these changes) and that findings suggest a positive trend in *x, y,* and *z*. Also, be sure to acknowledge limitations to your evaluation to keep you and your program honest.

- *Link the data to your goals.* Remember the questions we reviewed earlier as you design your evaluation: At what stage of implementation is your program? Who are the primary stakeholders? What is the overarching purpose of the evaluation? What resources are available for the evaluation? What questions do you want the evaluation to answer? The answers to these questions will not only help you to design your evaluation, they will also help to solidify what findings are most important to

report and to whom. For example, if the overarching purpose is program evaluation, report your findings in a manner that highlights the extent to which your program has improved in these targeted areas over time.

- *Put your best foot forward*. Where have you found positive findings? Highlight these by picking the top three or four salient findings, perhaps using the DBT targets to prioritize the data or prioritizing based on what is most relevant to your audience (e.g., presenting cost savings to an audience of administrators).

- *Be fair with your presentation*. Results do not always turn out the way we anticipate they will! Be sure to describe important discrepancies in data or places where your hypotheses did not pan out as you had hoped. Offer explanations for why this may be the case, if you know. While negative or neutral findings can be disappointing, they can provide valuable information, particularly if your purpose is program evaluation and identifying areas in need of improvement.

- *Place your findings in context*. Results are difficult to interpret without some basis for comparison. There are several ways in which you can incorporate your findings into a broader context that will make them more meaningful and relevant. First, you could compare your program's evaluation findings with the results from research studies on DBT. When you do this, it may be important to note how your program differs from your point of comparison, which might explain any differences in results. Second, you could compare your program's findings to those of programs that are very similar to yours (e.g., similar training of staff, same target population and setting). Third, you can compare your own program's outcomes now to those of the previous year(s), including outcomes reported before the DBT program was implemented to illustrate changes that have occurred as a result of the implementation of DBT.

Don't forget: A picture is worth a thousand words. The best presentations are those that include simple and easy-to-read graphs and charts that accurately depict the results. This may require that you or someone on your team become a bit of a master of Excel or PowerPoint graphs and charts to illustrate your points. Of course, it's easy to overdo this—sometimes presentations are so flashy that all people can remember at the end were the "tricks" instead of the data. Striking a balance is necessary to effectively communicate your findings in an accurate and stimulating manner.

## Conclusion

In this chapter, we have striven to provide you with enough background information and resources to help you launch your DBT program evaluation. It should be obvious by now that the possibilities are virtually endless in terms of questions you can answer and methodologies you can employ. If you are reading this book and this chapter, it is clear that you are passionate about your work and interested in increasing the quality of life of your clients. So why not demonstrate with hard evidence that you can do this? We encourage you to jump right in, using the advice from this chapter, and obtain some solid information about your program that will help prove that your efforts are paying off or suggest areas for improvements or refinements.

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PART II

# APPLICATIONS ACROSS SETTINGS

CHAPTER 4

# Implementing Standard DBT in an Outpatient Setting

LINDA A. DIMEFF, KIM SKERVEN, ANDREW WHITE, SHELLEY McMAIN, KATHERINE ANNE COMTOIS, CEDAR R. KOONS, SOONIE A. KIM, SHARI Y. MANNING, and ELISABETH BELLOWS

The original treatment manuals for dialectical behavior therapy (DBT; Linehan, 1993a, 1993b) provide clear and methodical detail on the principles that create and support the treatment, as well as guidelines for treatment adherence. Few details are provided, however, about how to develop, implement, and sustain a DBT program, or how to successfully implement DBT in a real-world context. The goal of this chapter is to integrate the principles and guidelines from the original treatment manuals with research in providing DBT and the collective wisdom from our own experiences in outpatient settings to help outpatient DBT programs develop, survive, and thrive. By providing you with all that we know, we hope to help you "fast-track" the effective development of your own DBT program. We will discuss common misconceptions, obstacles, barriers, and errors in implementation, and suggest DBT-adherent solutions to these problems. We will provide step-by-step tips for developing your DBT program—from considerations of inclusion and exclusion criteria to strategies for obtaining insurance reimbursement.

We make the following assumptions: You are knowledgeable about basic DBT principles, assumptions, and strategies, as well as the foundational theories on which the treatment is based (see Koerner, Dimeff, & Rizvi, Chapter 1, this volume), and seek to build a comprehensive outpatient DBT program to fidelity (see Koerner, Dimeff, Swenson, & Rizvi, Chapter 2, this volume); and individuals served by your program are severely disordered, multi-diagnostic clients, including those with borderline personality disorder (BPD) requiring Stage 1 treatment.

## Swimming against the Currents: The Necessary Paradigm Shift

DBT often constitutes a radical departure from "treatment-as-usual" for clients with BPD—it is nothing short of a paradigm shift on many fronts for therapists, administrators, and clients alike (Kuhn, 1962). Recognizing and acknowledging the paradigm shift, as well as the differences between DBT and more traditional approaches, can be extremely helpful in anticipating, assessing, and solving implementation problems as they arise. We highlight several of these differences below:

- *The goal of DBT is a life worth living, not palliative care.* DBT seeks to help clients develop the capability and motivation to build a life that is indistinguishable from our lives or your life—one that includes solid and lasting relationships, employment at a living wage, and other dimensions that provide meaning and relevance to life, as deemed by the individual themselves. Inherent to this goal is the assumption that the client will no longer require mental health services and/or psychiatric disability on a routine basis for BPD. (This is not to say that they would not seek out therapy in the future, just as "ordinary" people do for "ordinary" problems.) Thus, it assumes that the diagnosis of BPD is *not* a life sentence—that people diagnosed with BPD can be fully and successfully treated with DBT, by which they become "diagnosis-free."

It is not uncommon while learning DBT to assume that multi-diagnostic clients with BPD may require mental health services forever and might not be capable of maintaining an ordinary life (e.g., work, family, social connections). This mindset can lead to narrowly defining a life worth living as the absence of self-destructive, impulsive behaviors (e.g., suicide attempts, nonsuicidal self-injurious behaviors, substance abuse), despite the fact that the person is still depending on the mental health system for their social and financial support. This is a mistake, as such an outcome expectancy may ultimately create the reality it envisions. Instead, DBT includes a strong focus on actively building a life worth living—including a pathway (back to) work, intimate relationships, and meaning.

- *Clients get more of what they want based on functional (vs. dysfunctional) behavior.* This basic principle courses throughout DBT and is a radical departure from the standard "disease model" approach of providing clients with *more* when they are dysfunctional. A classic illustration is the 24-hour rule: In DBT, adult clients can contact their therapist for skills coaching whenever they need a means of averting dysfunctional behavior; however, clients are required to wait 24 hours before initiating telephone contact with their primary therapist *after* engaging in self-injurious behaviors. Similarly, *more* treatment in DBT (following the initial treatment agreement) is provided contingent on tangible progress on treatment goals, not on the declining mental status of the client or their lack of change. In DBT, all good things (i.e., reinforcers) come to the client in the presence of *functional* behavior, while reinforcers are withheld from the client in the presence of their dysfunctional behavior.

The anti-DBT error of providing *more* reinforcers in the presence of dysfunctional behavior often occurs with those new to DBT in the following contexts: (1) The therapist stays on the phone longer and is more soothing when the client is more suicidal, dysfunctional, or non-collaborative; (2) the therapist allows the client to control the session and discuss whatever is on their mind despite the fact that the client had engaged in dysfunctional behavior during the past week; (3) the therapist offers the client additional

months or years of treatment despite the fact that they have not demonstrated significant behavioral progress on treatment goals; and (4) the therapist increases session frequency and/or length when the client is engaging in dysfunctional behaviors.

- *DBT is a high-risk treatment.* Compared to most treatments, DBT is high risk. Most non-DBT providers encourage their suicidal patients to go to the emergency department when suicidal for assessment and referral to a psychiatric inpatient service. DBT providers instead encourage active skills use and offer additional, as-needed support to help the patient get through the suicide crisis using behavioral skills and without hospitalization.

In DBT, hospitalization is used minimally and generally as a last resort; considerable effort is exerted to keep the client out of the hospital. The rationale for this position in DBT is described thoroughly by Linehan (1993a). The bottom line is that for most clients with BPD, hospitalization does not reduce the risk of suicide and can instead have an iatrogenic effect (Cole, Shaver, & Linehan, 2018; Paris, 2005; Krawitz et al., 2004; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). From a DBT perspective, it is imperative that the client use DBT skills to effectively manage whatever situation is precipitating the urge to kill themselves. There is no way to ultimately achieve a life worth living except by going through difficult situations, using skills, and getting to the other side of the situation without engaging in dysfunctional behaviors.

Swimming against the current can be both challenging and wearing for the DBT therapist and program managers. This is particularly true early in the implementation process, before there is clinic-specific evidence that DBT works at the local level. It can be still harder in public-sector systems serving clients with a psychiatric disability who may be accustomed to receiving services "from cradle to grave." Given that DBT represents a paradigm shift for many, it can help to orient people (e.g., staff, administrators, clients, partners, and parents) ahead of time to the message that *doing* DBT may mean doing things in ways that are radically different from what they are accustomed to. Before embarking on building a DBT program (and certainly as new staff and clients join your program), we suggest getting an individual commitment from all these individuals to *doing* DBT. As part of this commitment process, we suggest doing *pros* and *cons*.

## Getting Started: Designing Your DBT Program and Taking the First Steps

Like building anything from the ground up, there are several foundational decisions that must be made before construction can begin. This section will help you generate an initial "blueprint" for DBT. We encourage you to seek to apply DBT principles in all efforts to build and sustain your DBT program—including how you manage personnel matters and seek buy-in from administrators.

### *Who Will Receive DBT?: Defining Inclusion and Exclusion Criteria for Your DBT Program*

Deciding on the types of clients to be served by your DBT program is an important first step as it often influences other decisions, including the staff you recruit, where

you house the program, how you advertise for and recruit clients to the program, and how you assess a potential client's "fit" during the intake/assessment phase. The entrance criteria can range from relatively narrow (e.g., the person must meet criteria for BPD, have a history of multiple suicide attempts, *and* be among the system's highest utilizers of inpatient and emergency department services) to relatively broad (e.g., the person must have behavioral dyscontrol due to emotion dysregulation, whether or not they meet criteria for BPD). Recognizing the cost-savings success of DBT for difficult-to-treat clients with BPD, some agencies have applied DBT to all difficult-to-treat, high-utilizing clients. Others have considered offering DBT to clients who have repeatedly "failed" with other approaches.

We recommend initially adhering as much as possible to the population DBT has been most validated on: Level 1 clients with BPD, including those who are chronically suicidal and drug-addicted. If it is necessary to *widen* the criteria (e.g., there are too few Level 1 clients with BPD available to your clinic to justify a DBT program), consider inclusion of those non-BPD Level 1 clients for whom behavioral dyscontrol stems from emotion dysregulation. If it is necessary to *narrow* the criteria (e.g., there are *many* clients with BPD seeking referral), you may consider focusing on those clients with BPD who utilize the greatest number of services or are generating the most challenges for your system. Demonstrating clinical success and resource savings with the most costly of clients is a very reliable way of receiving continued support for your DBT program, from colleagues and administrators, and from behavioral health organizations. Alternatively, practicalities may demand that the limiting factor is the client's ability to pay for services—either out of pocket or because their insurance covers it.

We encourage two simple guidelines as you proceed. First, start with an evidence-based therapy for the problem the client has. For example, the application of DBT for treatment of panic disorder would be ill-advised if the client does not have BPD and has not yet received panic control treatment (Barlow & Craske, 2006), which is a highly effective treatment for panic. Similarly, we would not recommend DBT for bulimia nervosa unless several attempts at evidence-based therapies for this disorder (with different treatment providers) had failed *and* emotion dysregulation was a prominent clinical feature. However, we would recommend DBT as the frontline treatment for clients with panic disorder or bulimia nervosa *and* BPD, as DBT is structured to treat multiple problems, in addition to BPD. Or, you might choose DBT because the client has many behaviors that interfere with the treatment process regardless of diagnosis—this may be known from previous treatment failures or become apparent when the diagnostic treatment is tried. The second recommendation is to be parsimonious. All things being equal (i.e., two treatments have comparable outcomes), apply the simpler treatment first.

### *Choosing the Right Location for Building Your DBT Program*

Whether you are in private practice or in a public-sector system, chances are that you will have multiple options for where to position your DBT program. These decisions will inform the extent to which a clinician's caseload involves providing DBT—ranging from some DBT to exclusively DBT—as well as strategies for training clinicians to adherence in DBT. While some smaller agencies may require that all their clinicians know and be prepared to apply DBT when receiving a referral for

a client with BPD, other agencies (often medium to large in size) will design a DBT specialty program. In this latter approach, clinicians elect to be on the DBT team where they can dedicate themselves to treating the agency's clients with BPD using DBT. Similarly, in private practice, some clinicians dedicate themselves and their practice exclusively to providing DBT to clients with BPD. Other private practitioners limit their DBT practice to a handful of clients with BPD and may join other clinicians (either within or outside of their own practice) to create a DBT program (e.g., three or more solo practitioners provide individual DBT for their own clients and join together to offer a DBT skills-training group and meet together as a consultation team). Table 4.1 summarizes these different public- and private-sector models and highlights the pros and cons for each.

Here are a few factors to consider with regard to sharing staff with other agency teams. First, for some DBT therapists, having another job with different rewards and challenges and/or having fewer difficult-to-treat clients with BPD can reduce burnout. At the same time, there is a risk that non-DBT clinic demands (e.g., meetings, new training initiatives) can interfere with building a strong, cohesive DBT program. Additionally, a further challenge exists for the clinician who is expected to apply radically different treatment philosophies (paradigms) with similar clients depending on the team or clinic. When this is the case, it is important to consider changes, additions, or clarifications in policy to strengthen your DBT team's identity and freedom to adhere to the evidence-based model. The weekly consultation team meeting of 60–120 minutes can play a central role here. If, on the other hand, it is the client who receives treatment from different teams or clinics, clarifying the following is crucial:

1. Which team/clinician is ultimately responsible for the primary treatment plan?
2. Which team/clinician has clinical authority during a clinical crisis?

To be adherent to DBT, the ultimate responsibility for the client with BPD in both cases resides with the DBT individual therapist.

### *Selecting a Team Leader*

In our experience, those programs that survive and thrive are ones with strong administrative support *and* a strong team leader. Ideally, the team leader has *natural authority* on the DBT team (e.g., has the most experience with DBT, is a supervisor, is a unit lead, is an experienced clinician), has *time* to assume the additional responsibilities required, has *talent* (e.g., is organized, is a clear communicator, follows through, is personable), and is *willing*. The DBT team leader should also be a clinician on the DBT team, serving either as a DBT primary therapist, a skills trainer, or both. (This generally means the DBT team leader cannot be the agency manager if that person does not treat clients using DBT.) The team leader need not be the individual who runs the DBT team meetings (this responsibility can rotate) but is ultimately in charge of the DBT team and program.

The team leader's role is analogous to that of the chairperson of a non-profit board, overseeing the team's functioning and ensuring the well-being of team members and the program. The way that this happens will be tied to the setting in which you are practicing. In a private-practice setting, particularly when the clinic is small,

**TABLE 4.1. DBT Program Structures**

| Type | Description | Pros | Cons |
|---|---|---|---|
| *Private practice:* Single group practice model | Group practice with one legal entity, business name, tax ID. Typically, one facility with standardized clinical and business policies and procedures. | • Easy to share clinical coverage.<br>• Greater control over treatment fidelity.<br>• Can negotiate a single contract with third-party payers. | • Shared liability for clinical mistakes and debt.<br>• Requires greater organization, commitment, and financial resources.<br>• Requires creation of unified policies and procedures. |
| *Private practice:* Multiple solo practitioners | Multiple solo practitioners from own independent practice join for purpose of offering DBT. Each clinician is responsible for their own finances and administrative tasks. | • Relatively easy to form and dissolve.<br>• Fewer conflicts about day-to-day operations, policies, and procedures.<br>• Greater individual autonomy. | • Relatively easy to form and dissolve.<br>• May be clinically liable/responsible for cases seen by consultation team members whom other team members have not met.<br>• Solo practitioners can drift out of adherence.<br>• Team leaders may spend unpaid time dealing with administrative issues.<br>• Case consultation and back-up coaching call systems can be complicated by HIPAA.<br>• Multiple individual insurance contracts make it difficult to negotiate as a group. |
| *Agency:* Specialty service | Agency referrals of some or all clients with BPD go to dedicated treatment team specializing in DBT. Clinicians comprising this team work exclusively with DBT clients (for the portion of their time dedicated to DBT team). | • Shares the advantages of single group practice model described above.<br>• Agency can direct training resources to fewer staff, thus creating potential for more thorough, comprehensive training in DBT.<br>• Sustained focus applying DBT may increase DBT program effectiveness. | • Potential for increased risk of burnout as clinicians are treating the agency's most severe.<br>• Other agency units do not benefit from universal clinical strategies used in DBT to manage difficult-to-treat clients.<br>• Agency policies may be inconsistent with DBT principles (e.g., 24-hour coaching).<br>• Team members could be transferred or given new duties. |
| *Agency:* Integrated service | Each agency unit has clinicians dedicated to providing DBT, but do not exclusively treat BPD or provide DBT. Many or all units within the agency provide each DBT mode. | • Clinical skill learned in DBT to treat clients with BPD can be applied, as needed, to other difficult-to-treat clients.<br>• Caseload can include diversity of clients, balancing easier-to-treat with more complex cases to prevent burnout. | • Agency initiatives to learn other evidence-based therapies make it difficult for clinicians to fully develop DBT clinical skills and to devote sustained effort to DBT.<br>• Difficult to maintain DBT program cohesion; risk of moving out of adherence because DBT is not "front and center."<br>• Agency policies may be inconsistent with DBT principles. |

it is the team leader who sets the tone for the overall operations of the clinic. For programs that are located within larger agencies, the team leader is the person who will advocate to make sure your DBT program's needs are met within the organization. If your team is made up of therapists from different practice locations, the team leader will be the person who attends to the team's functioning and acts when needed to ensure consistency in treatment delivery across locations.

Regardless of your setting, it is within the team leader's purview to hire and fire team members, which may involve a collaborative process with the team. Because a main task of the team leader is safeguarding effective functioning over time, be sure that the person you select for this role possesses the skills you anticipate will be relevant in your setting; this may include skills like negotiation, advocacy, dedication to treatment fidelity, willingness to call out elephants in the room, appreciation for the importance of ongoing learning/development, and being forward-thinking in the sense of maintaining the team's well-being over time. Ultimately, the function of the team leader is to ensure that your program achieves and maintains structural fidelity to DBT, that clinicians adhere to the DBT treatment manuals in their respective mode(s), and that clinicians continue to increase their core competencies and to solve problems and overcome barriers that interfere with program fidelity and clinical adherence. A final function of the team leader is to ensure that the DBT team as a whole remains energized and motivated to continue providing DBT services to the highest standards possible.

### *Staffing Your Program*

One of DBT's basic tenets is that participation should be voluntary. *This is just as true for clinicians as it is for clients*. When participation is mandated, clinicians may resist the initiative, slow the team's development, and ultimately significantly compromise the program's viability. We have seen this effect over and over, even when DBT teams have included other members who were highly motivated to do DBT, despite the mandate. The negative effect of even a single unwilling clinician on a DBT team of otherwise willing staff cannot be overstated. So where does this leave administrators and program managers who wish to move forward with a DBT initiative with reluctant and/or uninterested staff? First, consider if you really must include them. It is often easier, faster, and more effective to transfer motivated clinicians from other clinics or to hire DBT clinicians rather than to attempt to convert those who are committed to another form of treatment. Second, the key to motivating those exhibiting reluctance is to remember that "the carrot" (i.e., reinforcer) is more powerful than "the stick" (i.e., punishment, coercion) and to know what "the carrots" and what "the sticks" are for each clinician. Then the task is to apply the strategies of DBT to turn around the attitudes and willingness of even the most reluctant of staff. These strategies will include linking DBT to staff goals, using DBT commitment strategies, creating such a positive valence around the DBT initiative through effective marketing that a groundswell of interest follows, and structuring employment conditions that facilitate motivation (e.g., DBT clinicians have smaller caseloads; learning DBT and making a commitment to serve on the consultation team for 2 years result in a salary increase or upgrade in employment status resulting in a pay raise; coveted agency positions require knowledge and 2 years of experience applying DBT). Such structural incentives can be particularly helpful with highly reluctant and resistant

staff during the early implementation phase before the natural reinforcers of doing the treatment take hold. Table 4.2 lists a variety of additional strategies to facilitate willingness and commitment to applying DBT.

In most cases, however, recruiting staff from within and outside your agency to do DBT may not be as difficult as one might think. Indeed, in many instances, it is the frontline staff themselves (looking for effective strategies for their most challenging

**TABLE 4.2. Commitment Techniques for Getting Others to Buy Into DBT**

| Strategy | Examples |
|---|---|
| 1. If clinicians already have difficult-to-treat clients in their caseload, show them how DBT will help them become more clinically effective and less distressed/burned out. | • Help them understand what DBT is and the research demonstrating its effectiveness.<br>• Adopt their difficult clients and succeed.<br>• Run "office hours" or a monthly "case consultation" to identify effective strategies, skills, and approaches for use with their difficult-to-treat clients.<br>• Teach the clinicians the DBT skills—as helpful treatment strategy or as employee assistance/stress management.<br>• Use videos to show "live" DBT strategies and sessions to model behaviors. |
| 2. Link acceptance and mastery of DBT to the colleague's own professional or personal goals. | • Link pay increases to completion of DBT tasks.<br>• Offer other reinforcers for learning and applying DBT (e.g., once 80% of a unit can pass DBT skills knowledge test, supervisor throws a pizza party for the team).<br>• Have clinicians do the part of DBT that is most tied to their favorite part of the job (e.g., group, individual). |
| 3. Elicit clinician's pros and cons for promoting versus declining DBT. | • Do a group exercise where everyone addresses the pros and cons of doing and not doing DBT.<br>• Do contingency clarification on the short- and long-term consequences of doing or not doing DBT in this job.<br>• Assess for whether DBT is truly voluntary or involuntary for that clinician. |
| 4. Validate and then validate again. | • Don't oversell—that is functionally invalidating.<br>• Validate that learning evidence-based practice does imply that current treatment is inadequate, but that the clinician is not inadequate.<br>• Invalidate the invalid—perceptions that DBT is not a "depth" therapy, does not account for idiographic client details, or is not consistent with anti-oppressive practice.<br>• Validate the grief or frustration of doing something new or unwanted. Repeat as needed (e.g., don't assume validating once is enough). |
| 5. Positively reinforce and shape all use of DBT techniques in the clinicians' daily work and in their team participation. | • Evaluate the clinicians' reinforcers—do they want attention or to be ignored? Are concrete things important, or more emotional items (e.g., recognition)?<br>• Figure out all DBT strategies the clinician already uses and reinforce those when they occur.<br>• Be systematic—develop a shaping curve of desired clinician behaviors and stick with it.<br>• Watch for satiation—easily reached for those feeling pushed into something. |
| 6. Use DBT commitment strategies including "freedom to choose and absence of alternatives." | • See Linehan (1993a) for commitment strategies (p. 284) and for "freedom to choose and absence of alternatives" (p. 289). |

cases) that initiate and push for the development of a DBT program. Often graduate students, social work and psychology interns, and psychiatry residents from educational programs nearby are highly motivated to seek out opportunities to join a DBT team in exchange for learning the treatment. Students are keenly aware of the value of this experience when they are on the job market, whether competing for clinical or academic positions. For recent graduates and other professionals, joining a DBT team, either at an agency or within a private-practice group, can be highly motivating, as they are more likely to get on insurance panels (i.e., become approved clinicians for that company to whom the insurance company directs referrals), thereby inheriting a ready-made referral base and attendant income.

When adding new members to your existing team, it helps to be intentional in your process of growth. That is, take a step back and consider your team's needs, gaps, and what is missing that could facilitate balance on your team. Is your team great with validation, and thus adding someone who is more change-oriented would be beneficial? Or, vice versa? Would adding diverse viewpoints be beneficial (e.g., differences in sex, race, age, sexual orientation, gender identity)? Are you in need of therapists who can fulfill different roles (e.g., individual therapist, skills trainer)? Thinking through these questions ahead of time can help you be more efficient and targeted in your search.

We have found that there is no replacement for deliberate recruitment and hiring of staff to maintain team structure and cohesion. Hiring a staff member who does not fit in well with your team and leaves the program prematurely can create morale problems that can take months (or longer) to solve. As part of the initial interview, you will want to get a feel for the extent to which the applicant is invested in a team approach to treatment, learning the DBT model, and understanding that DBT is a very specialized approach that takes years to learn well. Ask them questions about these points: Have you worked as a team member before? What was helpful/challenging about that? How have you gone about learning new treatments/interventions in the past? How would you see yourself learning DBT; how would you approach the learning process? Why commit to DBT, not a general outpatient practice? Does the applicant understand that DBT is a behavioral treatment, and thus staying consistent within this theoretical framework is necessary with their DBT clients?

Using a structured selection process where your team may get a feel for working with the applicant (and vice versa) can yield valuable information about the candidate's skill set. For example, your program could request an initial application for employment (including CV, cover letter, reference letters, and academic transcripts), and then ask the applicant to do "inbox" tasks to assess actual work performance (e.g., writing a mental health assessment or teaching a skill to the team). You can take this opportunity to provide feedback on the candidate's work, and then ask them to repeat the task with the feedback in mind. This exercise gives you the opportunity to answer some key questions: How does the candidate respond to the feedback (e.g., with defensiveness vs. appreciation)? Do they integrate the feedback and use it to improve their performance? The applicant may not have a specific background in DBT, which at this stage is less important than their interest and willingness to learn and practice the DBT model.

After the hiring process, it is wise to have an organized "onboarding procedure" that outlines the path by which new team members are oriented and become part of your team. Based on our experience, we suggest that your onboarding plan include

what you consider to be essential learning for a new DBT therapist: readings (e.g., Linehan's text and skills-training manual), formal DBT training, DBT supervision, and obtaining commitment to the DBT agreements as well as ongoing learning, training, and practicing DBT. A dedicated "commitment session" should occur between the team leader and the new team member during which consultation team agreements are discussed and verified, analogous to a "commitment session" with a client considering DBT.

Moving forward, a formidable challenge for many DBT programs is *maintaining* their highly trained and skilled DBT clinicians. Clinicians' experience and training in applying DBT make them extremely competitive on the market for lateral DBT positions or promotions to develop or oversee a DBT program. Some may decide instead to build their own private practice. The best way to promote staff retention is to develop and pursue a business plan through which staff can see the prospect of continuing professional and financial advancement. For example, newly recruited staff in a private practice can be asked to accept a certain number of low-fee cases during their initial training period (for 1 year perhaps) and are then allowed to charge higher fees if they stay on longer. The other critical ingredient is to make doing DBT personally rewarding, whether it is having loads of fun on the DBT team, witnessing the turnaround in clients with BPD whom many had previously given up on, or opportunities to do the modes of DBT the clinician most enjoys.

### *Determining Caseload Size*

Several considerations are critical in determining caseload size, including whether the therapist is providing DBT exclusively on a full-time basis or is shared with other teams. For our purposes here, we will assume a full-time caseload where the clinician is exclusively providing DBT. (You can then adjust the numbers accordingly for staff in your setting.) Generally speaking, it is expected that a full-time clinician assigned exclusively to a DBT outpatient team will have between 15 and 20 Stage 1 individual clients with BPD and will conduct or colead one or two 2-hour DBT skills-training groups per week. This caseload size assumes sufficient time for phone consultation and/or *in vivo* skills coaching, weekly participation in a 60- to 120-minute consultation team, and completion of paperwork.

Other factors that may influence standard caseload size include (1) experience in treating clients with BPD; (2) experience in applying DBT; (3) number of unusually complicated or severely suicidal clients already on the caseload; (4) number of new clients with BPD in the first month or two of treatment; (5) additional duties that the therapist is fulfilling (e.g., supervision duties); and (6) team size and referral demands. Less experienced clinicians or those with limited familiarity with DBT may start off with fewer clients with BPD. Clinicians who are seeing primarily adolescents and families (see Miller, Rathus, Dexter-Mazza, Brice, & Graling, Chapter 16, this volume) may have additional time demands related to family work/consultation and interacting with schools and other outside providers, which would require that their caseload be balanced accordingly. Additionally, unusually extreme and severe clients may count as two clients given the amount of effort required to intervene outside of scheduled sessions. Moreover, a DBT clinician's caseload may be reduced during a period when they start off with several new clients, as it is expected that clients in the first few months of treatment require considerably more time.

### Determining Length of Treatment

One of the primary topics discussed and agreed to in the initial DBT "commitment session" with the client is the *length of treatment,* the period both parties (client and therapist) agree to remain engaged together in DBT. The agreement can be "renewed" or extended for another specified period as the treatment length is about to expire, should additional treatment be indicated. It is imperative to determine treatment length prior to the initial meeting between the DBT individual therapist and a prospective client as the therapist will want to get an agreement from the client to participate in treatment for this specified duration.

The majority of DBT programs begin with a commitment of 1 year. To ensure that the client completes two 6-month rotations of a DBT skills-training group, the "year" is yoked to the start date of the DBT skills-training group, not the initial meeting with the DBT therapist. Because the prospective client meets *first* with the DBT individual therapist *before starting the DBT skills-training group,* it may be that the actual treatment length ends up being a bit longer than 1 year for some clients as a consequence of when the start date falls for entering the DBT skills-training group and the fact that the client may continue to see the clinician for a couple of weeks following group graduation. (DBT skills-training groups typically are open for new clients for 2–3 weeks, then close for 4–6 weeks, then open again for another 2–3 weeks, then close for 4–6, and so on, so clients enter during mindfulness training and the beginning of a module, not in the midst of a module.)

The most frequent mistake made by new DBT teams is to not define the length of treatment. Without this in place, stagnation may be reinforced instead of progress, which can contribute to burnout on the part of the therapist and hopelessness on the part of the client. Therefore, adding to the length of treatment should be contingent on clinical progress. Sometimes failing to define length is a simple oversight as the clinicians involved might not be accustomed to determining a specified length of treatment at the start of working with a new client. In other cases, the program considered doing so but opted, in the end, not to set a length. The logic may be as follows: "Our clients are too severe to offer only a year of treatment" or "We work with public-sector clients who are disabled, so we are legally and ethically obligated to continue to provide mental health services to them." *Both arguments represent a misunderstanding and misapplication of DBT.*

Several DBT principles apply to this situation. First, reinforcers (e.g., contact with therapist, progress in treatment) are used to strengthen clinical progress, not the status quo or greater behavioral dyscontrol. This may be particularly relevant for clients with BPD who have systematically been reinforced for dysfunctional behavior over the course of their lives. Second, "contingencies create capability." In other words, clients will work harder and more quickly to develop and use behavioral skills (vs. engage in dysfunctional behavior) if doing so means they can get more of what they want: typically ongoing connection with the DBT therapist, whether this contact is formal or informal. DBT leverages these reinforcers, including attachment to the DBT therapist, in the service of the client's treatment goals. (These principles are discussed thoroughly in Linehan [1993a].) Therefore, *more treatment* beyond the initial treatment contract *should be contingent on significant clinical progress.*

The DBT primary therapist should begin discussing termination and "What next?" around the eighth or ninth month of treatment. It should not be automatically

assumed that an additional 6 months or 1 year will be needed. However, if it is determined by the therapist (in consultation with the team) and the client that additional therapy *may* be required/appropriate upon completion of the initial year, the DBT therapist should clearly communicate what is expected of the client between now and graduation. In cases where the client is working hard and making steady progress, the therapist might simply highlight this pattern and state that so long as they continue like this, the therapist will be more than happy to discuss extending work together, should it be needed. In cases where the client is stuck and shows little progress on Stage 1 primary target behaviors, the therapist might instead describe the behaviors that must change by the year's end to receive additional treatment.

What if a client refuses to change and communicates, "I can't change; you're asking too much"; or wants to change, has worked hard to change, but has still fallen short, and graduation is around the corner? These are important and complicated clinical issues that should be carefully considered by the therapist in collaboration with the consultation team. Teams that are in their early stages of learning DBT may opt for consultation with an outside expert to ensure that the solution generated is optimal and fully adheres to DBT principles. Assuming that the therapist has clinically proceeded in a DBT-adherent fashion, treatment should be terminated at the contract's end and the client transferred to another treatment that may be more effective for them or (if they choose) to working things out on their own. By definition, this means losing their primary DBT therapist as well as the skills-training group that, for many clients, will create the conditions to "shape up" while there is still time to do so rather than risk this outcome. For others, DBT may truly not be effective and the ethical course is to try something else rather than continue to provide a treatment that is not working or producing desired effects. Regardless, clients should be told what would be expected of them in order to re-apply to the DBT program (if they can) should they wish to do so in the future.

### *If Adapting, Adapt Well*

As described by Koerner et al. (Chapter 2, this volume), there are occasions where outpatient programs must adapt the structure of DBT to their unique setting. Sometimes, adaptations may be temporary (as the DBT program gets established); other times, they are longer-term. We recommend that before adapting, every effort is made to look for solutions and syntheses to the problem consistent with DBT fidelity, and that veering from the standard course is only done as a last resort.

Within outpatient programs, the mode that is most challenging to implement is telephone consultation. In some systems, union rules or a clinician's job classification may be the barrier. In other situations, it is the DBT clinicians themselves who are simply unwilling to take after-hours phone calls. Sometimes, clinicians are willing *in principle* to take calls, but become so fearful of their limits being crossed that they become exceedingly unwilling to take the calls, or even refuse to altogether. In our experience, barriers, resistance, and reluctance can often be overcome and fidelity preserved if the *actual* concern or problem is carefully assessed and solutions are thoughtfully generated. *Again, as an overarching guideline, remember that DBT principles can and should be applied at every turn when you are working on program implementation and administration.* For example, some apprehensive clinicians have been willing to provide phone consultation to a few clients with BPD

initially as a "test" to see what it is *really* like (as with phobias, the anxiety and fear are often greater than the reality). Others agree if they can be assured that they will have sufficient supervision to effectively respond to client calls that exceed their limits. Research has indicated that, on average, DBT therapists can expect 2–3 calls per month per client (Oliveira & Rizvi, 2016), which is generally far less than what is feared. Union rules and requirements are designed to protect the worker and not be a barrier to service provision: Clinicians generally *can* provide after-hours services so long as they are *willing* to do so and are not forced or otherwise coerced by the employer.

There may be situations, however, when it is simply not possible for the DBT individual therapist to take any after-hours calls. What are some solutions when this proves to be the case? In some systems, this means rotating call duty between crisis intervention team members who are trained to be DBT skills coaches. Some states have implemented toll-free DBT hotlines that are staffed by skills coaches. Other systems require their mobile crisis team members to be trained in DBT skills coaching.

While addressing some of the function of telephone coaching, these solutions are imperfect. Elements not addressed by these solutions include (1) the relationship between the client and the individual therapist and the ability of each to decrease feelings of alienation and to repair rifts in the relationship outside of work hours; (2) the expertise of the telephone coach on what skills work best for a particular client; and (3) determining the focus of treatment at the time of the phone call. Effective strategies to compensate for some of the inherent shortcomings that arise when primary therapists are not taking all calls include very explicit crisis plans made by the primary therapist and the client; contingency management of crisis staff that reinforces adherence to the crisis plan; if crisis plans are found to be unworkable for crisis staff, crisis staff can request their revision by the therapist and client (but should not revise them on their own); scheduled calls with the therapist during work hours; and "consultation time" in the therapist's workday schedule when clients know to call. It should be noted that while these strategies may be helpful in compensating for some of what is lost therapeutically by not offering DBT phone consultation, they are nonetheless *partial solutions*. It is for this reason that many DBT experts would deem a program without standard DBT phone consultation as not comprehensive, standard DBT.

### *Managing Referral Numbers and Skills-Only Services*

As referrals increase to your program, there may come a time when a significant waitlist develops. In our experience, waiting 6 to 9 months for DBT services is not uncommon. Given that many clients in need of DBT are suicidal, the following question arises: Is there a way to have suicidal clients with BPD "wait well" by receiving DBT skills only (or mostly) while waiting for comprehensive DBT? Informed by empirical findings from Linehan et al. (2015), McMain et al. (2017), and others, a strong case can be made for offering DBT skills-training groups to clients while they wait for comprehensive DBT services. Given recent research findings about the importance of DBT skills, offering skills-training groups for those waiting for comprehensive DBT is a viable, and in our view, ethical approach. Our intention, however, is *not* to recommend a DBT skills-only approach *in place of* comprehensive DBT. The guidelines and recommendations below are intended as a way to help clients "wait well."

To date, there are over 20 studies (including 6 randomized controlled trials) demonstrating the efficacy of skills-only treatment in reducing BPD criterion behaviors (e.g., Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2014; McMain et al., 2017; Linehan et al., 2015; Soler et al., 2009; Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014; Dijk, Jeffrey, & Katz, 2013; Stratton, Alvarez, Labrish, Barnhart, & McMain, 2018). Given the strength of this treatment mode, Linehan (2015b) describes principles for implementing DBT as a "stand-alone treatment" (p. 19). The following principles may serve as a guide in your development of DBT skills-only groups:

1. Provide skills-only treatment within the framework of a comprehensive DBT program. This means that all therapists providing skills-only groups attend consultation meetings on a regular basis and team leaders monitor skills-training sessions for fidelity.

2. Apply all DBT principles, strategies, and assumptions when providing skills-only groups. This includes commitment, validation, and dialectical strategies, balancing change with acceptance, and other problem-solving strategies.

3. Establish a clear suicide crisis management plan for use by skills trainers that specifies what exactly to do, by whom, and when—and clearly delineates the limited role of the skills trainer in responding to crises (see Linehan, 2015b).

4. Highlight your skills program agreements and create a culture of community. Since the primary point of contact for clients will be group members, fostering a sense of belonging is helpful in reducing dropout and building natural supports. Behavioral interventions to accomplish this include highlighting the community aspects of the guidelines for skills training (Linehan, 2015a, p. 12, particularly item 2) and creating a "skills buddy" system whereby clients exchange contact information for the purpose of supporting and coaching each other.

5. Create administrative mechanisms to ensure treatment fidelity and intentional planning. Without an individual therapist, it is possible for treatment-interfering behavior to creep up (e.g., missed groups, lack of insurance authorization, not planfully assessing treatment at the end of a 12-month cycle, billing issues). The creation of wise mind administrative protocols (e.g., automated reminders for authorizations, regular coleader phone calls to clients missing group, checklist systems for intake orientation, extra overview handouts to help with understanding the format and function of group) to help group leaders and clients stay mindful to these issues will greatly reduce barriers to successful treatment.

6. Plan ahead for when *not* to offer skills-only treatment and for onsite crisis intervention. While there is not currently a body of data suggesting which individuals may do worse in skills-only treatment, combining original exclusion criteria (e.g., active psychosis, high levels of cognitive impairment) with agency or clinic limitations (e.g., security issues, age or presenting problem restrictions) is helpful in flagging clients, where the screening therapist may wish to slow the intake process down and seek team consultation before moving forward with skills-only placement. In a similar vein, coping ahead by having a robust treatment plan that clearly outlines onsite crisis intervention protocol (and contact with the outside therapist or entity who is

providing crisis intervention) is essential to effective crisis response during treatment. Note both of these issues (e.g., clients who may not be a fit for skills group, onsite crisis management) are vastly simplified by the existence and use of a consultation team to increase therapist wise mind and help with finding a dialectical synthesis around difficult clinical issues as they arise.

7. Be sure that all clients participating in your DBT skills-only group have a professional in the community who has assumed clinical responsibility for each client in the event of a clinical emergency.

8. Consider offering two 1-hour skills groups for the clients per week (one focusing on skills acquisition; the other on skills strengthening/homework review).

### *Getting Reimbursed for DBT Services*

Strategies for reimbursement vary according to whether your agency is or is not a part of the public sector. Several overarching points are important irrespective of the type of system. First, it is often imperative to orient insurance companies or claims representatives to how DBT is unique from many other treatments: It is a comprehensive treatment involving multiple modalities and providers. Fidelity to DBT involves offering the comprehensive treatment package; fidelity is compromised if DBT is offered in an "à la carte" fashion (based on what the client wants or the insurance provider is willing to pay for). Additionally, while DBT initially begins with making an agreement to 1 year of treatment, it is not assumed that a year will be sufficient for all clients with BPD. Additional time may be required and offered *contingent on progress* in the first year and medical necessity. Finally, it is recommended that you complete reimbursement negotiations *before* accepting the client into your DBT program; you will have the greatest leverage at this point in the process and you have not yet assumed legal and ethical responsibility for a (presumably) high-risk client.

In the private sector, a primary challenge is that DBT requires a commitment of time and money that may exceed the limits set by many insurance plans. Typical benefit plans do not cover all modes of treatment that comprise standard outpatient DBT for an entire year. Those that do pay for DBT individual therapy and DBT skills-training group may not necessarily pay for telephone consultation. Still fewer will be likely to reimburse for consultation team time. A perhaps subtle yet critical dialectic exists between rates of reimbursement by insurance companies and clinicians' ability to make a living/clinics' ability to stay open. "Financial burnout" occurring from unpaid therapy bills can negatively impact providers, agencies, and overall treatment. DBT providers and insurance companies actually share some common goals that are central to evidence-based practice—efficient interventions that work (Rizvi, 2013). If your program opts to work with insurance networks, this fact can help you advocate for appropriate reimbursement rates (see Table 4.3 for details). This involves three steps: connecting with payers, educating them about DBT, and providing evidence of effectiveness (Koons, O'Rourke, Carter, & Erhardt, 2013).

*Connecting with payers* can sometimes necessitate a large investment of time and resources up front, as you are working to familiarize them with the benefits of DBT. It may take some persistence to navigate through an insurance company's network to find the appropriate person for negotiating contracts. At the beginning of the process, you may be interacting with someone who is naive about DBT and perhaps

**TABLE 4.3. Values Shared between DBT, Behavioral Health Organizations, and Payers**

| Value | Description | Reimbursement arguments |
|---|---|---|
| 1. Evidence-based therapy | • DBT is an efficacious treatment, with more rigorous randomized controlled trials (RCTs) supporting its effectiveness for multi-diagnostic Level 1 clients with BPD than any other treatment. (See Chapter 1 for a description of outcomes from DBT RCTs.)<br>• DBT is an empirically derived treatment. It is made up of strategies, components, structures, and behavioral skills, which themselves have empirical support. | The robust evidence base for DBT can be used to strengthen arguments for increased reimbursement, given the treatment's effectiveness. Using outcome data from your own program can bolster this argument even more, as you are able to demonstrate that your program is achieving good outcomes. |
| 2. Significant cost savings compared to treatment-as-usual | • The seminal RCT of DBT found that DBT saved significant amounts per client during the initial treatment year compared to treatment-as-usual (Linehan & Heard, 1999; Linehan, Kanter, & Comtois, 1999).<br>• Pre–post data for clients ($n$ = 14) completing a year of DBT in a community program showed significant decreases in psychiatric service utilization compared to the prior year; decreases of 77% in hospitalization days, 76% in partial hospitalization days, 56% in crisis beds, and 80% in emergency department contacts were reported. Total service costs also fell dramatically.<br>• One outpatient private-practice clinic estimated cost savings over the course of the first year of treatment in DBT by monitoring clients in their program ($n$ = 72). This included emergency department visits, partial hospitalization, and inpatient costs (calculated using the average cost/day by facility). They found a total cost savings of between $902,597 and $1,590,398 (Smith, personal communication, March 21, 2017). | Providing payers with examples of how DBT has saved money in the long run can be helpful. Highlighting the active blocking of emergency department and hospital use in DBT can be meaningful to funders looking to control costs of more restrictive services.<br>Even better, consider collecting this information within your own clinic to build an even more compelling argument for cost savings. |
| 3. High rates of client retention and satisfaction | • DBT studies to date consistently demonstrate its effectiveness in retaining clients in treatment despite the relatively long (typically 12 months) length of treatment.<br>• Client satisfaction, a factor in treatment retention, is high in DBT. | Consistently maintaining clients in treatment is instrumental in the client reaching their goals and decreasing behaviors that are often tied with higher health-care costs (e.g., inpatient hospitalizations, emergency department visits). |
| 4. Strong recovery focus | • The goal of DBT is building a life worth living, not merely symptom relief or a decrease in expensive psychiatric services. By definition, a life worth living in DBT is attainment of ordinary happiness and unhappiness where behavioral dyscontrol, emotion dysregulation, and mental health problems do not define or limit the individual's capacity to live a full, fulfilling, and (extra)ordinary life. | This aligns with the stated goals of many payers, who emphasize that they are invested in the well-being of their clients/members. |

(*continued*)

**TABLE 4.3.** (*continued*)

| Value | Description | Reimbursement arguments |
|---|---|---|
| 5. Clarity and precision emphasized throughout all aspects of the treatment | • Clearly defines behavioral targets.<br>• Clearly specifies functions for each treatment mode.<br>• Clearly specifies how other treatment providers (DBT and non-DBT) interact with each other, as well as the role of the primary treatment provider in planning treatment and coordinating other services.<br>• Specifies criteria for determining when to begin formal exposure for PTSD in a way that guards against iatrogenic effects. | The clarity and precision in DBT help avoid duplication of services. |
| 6. Flexible, principle-based treatment for multidiagnostic clients | • DBT is a principle-driven (vs. protocol-driven) treatment that is flexibly tailored to the specific needs of the client within a standard, structured framework.<br>• Structure of DBT allows for treatment of comorbid disorders, including substance use disorders. | Individually tailored treatment ensures payers that each client's unique goals will be worked on, as opposed to a "one-size-fits-all" approach that may treat problems a client does not have. |
| 7. Tracking clinical progress through continuous monitoring of specific behavioral targets throughout course of treatment | • DBT promotes weekly monitoring of outcomes through the use of diary card (for clients) and session notes for therapists.<br>• Client progress (or lack thereof) is tracked by the DBT consultation team; teams move to assist therapists with conceptualization and treatment planning when DBT clients are showing little improvement or when a relapse has occurred.<br>• DBT encourages programs to collect outcome data on the overall effectiveness at treating DBT target-relevant behaviors and building lives that are worth living (e.g., attaining jobs, getting off disability).<br>• If clients do not show significant improvement after a standard course of DBT, alternatives, including discharge, are found. | Tracking clinical progress allows providers to consistently assess for effectiveness. Thus, adjustments can be made along the course of treatment that can bolster outcomes. Additionally, if it is seen that treatment is not working, alternative options can be sought instead of continuing to pay for an ineffective therapy. |
| 8. Transparency around what is adherent DBT and non-adherent DBT | • DBT has a clear set of modes and functions that are required for the treatment to be considered adherent to the original model and capable of achieving outcomes in the research literature.<br>• Objective evidence of being able to meet these criteria is available by undergoing individual or program certification. | Funders are at times required through client advocacy (or other regional pressures) to identify practices delivering DBT with fidelity, but often lack internal resources to make this determination. Program and individual certification allow clinics to demonstrate adherence and advocate for better reimbursement. |
| 9. Access to care | • Offering skills-only DBT allows programs to be efficient with therapist resources and provide more clients with skills than only offering individual services. | Funders care about access to care and speed of access. Being able to offer services with little to no wait-list is extremely attractive to funders. |

even mental health services generally. Be willing to *provide education about DBT* to anyone you speak with and consider preparing something in writing that breaks down DBT into everyday language that clearly communicates what your program is all about. We crafted a written description to provide education about DBT that briefly includes: the structure and purpose of DBT, symptoms and DBT targets, client populations we treat and typical patterns of service utilization (across all levels) for these populations, and how our program fits in with other services in the community and fills a service gap. We have often conducted this communication via email, but when meeting in person, it can be useful to bring along frontline administrative staff who can quickly address business-related issues and find novel ways of responding to financial challenges.

Once you have their ear and have provided some basic education about DBT, move on to *presenting specific evidence of effectiveness*. While some payers appreciate the research behind DBT, they may be more immediately persuaded by cost–benefit analyses and ways that your program can offer responsive access to services with a limited wait-list. You can approach this from multiple perspectives, including using evidence gleaned from large-scale randomized clinical trials or data from your own program (which is an important argument for collecting data in your own program). For example, a randomized trial demonstrated that DBT clients used significantly fewer emergency services and had significantly fewer hospitalizations compared to those being treated by other experts in the community (Linehan et al., 2006). Overall, cost savings achieved in DBT have been shown to exceed the cost of providing the treatment itself (Wagner et al., 2014).

Whenever possible, include data from your own program. We have found that the most helpful data are those showing impact of DBT on emergency department visits and inpatient psychiatric hospitalizations, as well as reductions in suicidal and nonsuicidal self-injurious behavior and other primary behavioral targets. We have noted that graphs of symptom changes over time tend to be compelling. We have successfully used this method in single cases where an insurance company wanted to discontinue services for a particular client. Producing evidence that your DBT program is working for that individual can support your argument for why their treatment should continue to be covered. You can find more information on collecting evidence and using this process to evaluate your program in this volume (see Rizvi, Monroe-DeVita, & Dimeff, Chapter 3, this volume).

Unfortunately, DBT reimbursement rates do not always reflect the true costs involved in training and ongoing program administration, which is one reason to have a mix of different income sources. Because different payers offer varying rates of reimbursement, you will want to make sure that the combination of those you accept will be adequate to support your program's operations. On the level of the individual provider, if you have a diverse group of payers with varying reimbursement rates (e.g., self-pay, commercial insurance, Medicare), issues of equity can come into play where you want to be sure that all of the therapists working in your program have fair access to all payers. Decisions about types of payment to accept are complex and can call for assessment of how your program balances operational values (e.g., providing health care to individuals who could not afford to pay out of pocket) with being able to stay open and provide incentives to staff for ongoing employment. The payers you work with will also relate to your client base, because insurance networks will be a referral source. It can sometimes be difficult to strike a balance between

generating enough income to stay open *and* working with the range of clients that feels important for you to serve. That is, you may choose to serve some clients with limited means because that is within the scope of your program's values. At the same time, serving only those clients may not generate sufficient income to keep your program going.

Regardless of the mix, having a deliberate approach to working with these payers on reimbursement rates requires ongoing nurturing of the relationship between them and your program. Here are a few questions that may help guide your internal process:

- *For self-pay:* Does your location have clients in the area who would be able to pay for services out of pocket? If you are considering a sliding fee scale, how low can you afford to go? Are you planning to offer any pro bono services? Should the fee be different for trainees versus licensed clinicians? Will you offer a discount for paying in advance?
- *For commercial third-party payers:* Which companies are open to negotiating higher reimbursement rates for DBT services? Which are most prominent in your area? Are any open to negotiating a "package" payment whereby individual therapy, skills group, consultation team, and skills coaching are paid for as a unit? There may be some you choose not to work with simply because the rates they offer for DBT are not adequate to cover your costs.

In the public sector, the issues are often exactly the opposite. While public managed care is also designed to provide services more efficiently, there tends to be less focus on the number of sessions or duration of therapy, as the system expects that most clients who are suicidal or who have BPD will remain in care indefinitely. The primary reimbursement challenge faced in the public sector involves a move by the payer to reduce funding as soon as stabilization is achieved (e.g., once the client is no longer actively suicidal or in crisis) even when ongoing treatment is required to further solidify their gains. It is not uncommon for payers to discontinue services without advance notice. A cutback in services at this time can result in deterioration. An important strategy for maintaining services is to highlight the number and types of supports provided to the individual to achieve stabilization, including the amount of therapy provided, assessment of continued suicide risk, how close the client has come to being admitted to a hospital, the frequency of phone coaching to keep the client at home, and the range of treatment strategies used to manage the client during group and individual sessions. However, when the client is remaining stable with fewer supports, the state or county may not want to pay for the client to continue to improve. If this is the case, it helps to go back to the public mission statement where states and counties often use the language of recovery, including client-driven treatment and employment supports, not just reducing risk or symptoms. You can then use their own words to highlight how DBT is a good fit for public insurance dollars. If all else fails, you may need to help the client find employment that offers a private insurance you can accept.

Some practitioners seek to supplement their income by contracting with referral sources or by offering special services. Especially for new practices, applying for contracts with state agencies, such as social services, vocational rehabilitation, labor and industries, or child and family services, is one means of building a practice while

providing a treatment that would otherwise be unaffordable to clients. One may also want to provide individual therapy or groups for caregivers, partners, or dependents of DBT clients (e.g., "family skills" programs). DBT clients of all ages are often in relationships that experience high stress. Issues of caregiver burden and burnout are particularly salient during Stage 1 DBT treatment of both adolescents and adults. Caregivers are often eager to participate in groups that provide support and teach principles of validation and behavioral change. These groups can be provided on a self-pay basis, usually at a reduced rate (e.g., $15–$20 per session). If such caregivers' groups are fee-for-service, they require no administrative support other than issuing payment receipts. Often caregivers' distress is significant enough to warrant therapy in its own right, regardless of whether the client is in DBT. These caregivers may have acceptable private pay or insurance funding and appreciate a therapist who understands what they are facing and give helpful advice for managing their family member and their own emotional distress. Additional information about serving family members is included in this volume (see Fruzzetti, Payne, & Hoffman, Chapter 17, this volume).

## Maintaining High Standards for Excellence over the Long Haul

Perhaps because of the high-risk nature of the clients served and the profound suffering in the lives of people with BPD, DBT emphasizes clarity, precision, and compassion throughout treatment. Furthermore, it is deeply committed to science and excellence. Whether striving for full fidelity to the treatment, evaluating your program's clinical outcomes, or adhering fully to the manual, in each treatment mode and at all times DBT requires a number of competencies from providers and the team leader alike. This section details strategies that are critical for maintaining the strength of the DBT team—both clinically and programmatically—over the long haul.

### *Measure Your Program's Outcomes*

Rizvi et al. (Chapter 3, this volume) provide simple, pragmatic instructions for collecting outcome data, which will be invaluable for maintaining referrals to your DBT program and arguing for higher rates of reimbursement. For programs situated within larger community mental health agencies, outcome data are also very helpful in persuading administrators to continue their support of the DBT initiative—from allocating resources and further training opportunities to continuing structural support of DBT. Data also demonstrate to the team its strengths and weaknesses, which guides quality improvement. As emphasized throughout Chapter 3, collection of outcome data need not be complex; the most important outcome data will naturally be drawn from the diary card and session notes.

### *Watch for and Address Anti-DBT "Drift"*

Despite significant efforts to maintain fidelity to DBT principles early in the program, drift can occur over time—often in response to clinic changes, a push for other training initiatives, changes in reimbursement rates or policies, or simply the popularity of the DBT program. The most frequent situation is one in which the agency generates

solutions to a perceived problem or concern that are incompatible with DBT. For example, in response to a recent serious event, an administrator institutes a policy in which all clients who contact crisis services be given a next-day appointment. While this solution addresses a real problem, it becomes a DBT problem by providing the client with BPD greater access to their DBT primary therapist following (contingent on) dysfunctional behavior. In cases where contact with the DBT primary therapist serves as a reinforcer, this programmatic policy may function to strengthen dysfunctional behavior.

When this occurs, the first thing to do is to *conduct a skillful assessment* of the problem that the solution seeks to solve. It is only after understanding the problem that the team can both validate the agency director's concerns and offer alternative, DBT-compatible solutions. For example, a thorough assessment of the problem that facilitated a change in clinic policy might reveal that the emergency department or crisis clinic staff have been complaining for a while that clients are overusing their services, and recently a client came to the three times in a week but no outpatient clinician had seen the client during that time. Thus, the administrator generated the solution of next-day appointments. The DBT team is, of course, concerned that crisis behaviors may be reinforced with extra appointments or that, since they are part-time or work on scheduled appointments, fitting in next-day appointments is impractical.

After thoroughly understanding the problem the administrator is seeking to solve, *look for and propose DBT-compatible solutions and/or a synthesis*. In this example, a DBT solution might be that the client would have scheduled phone contact with their therapist instead of a face-to-face appointment following an emergency department visit, and the DBT therapist would explicitly target overuse of crisis services. The therapist might also describe the reasons why it was not useful for the therapist to see the client immediately after use of crisis services both in the chart and at an in-service or staff meeting of that emergency department. It is typically the role of the DBT team leader to then work with the administrator on the team's concerns and possible solutions.

### *Apply DBT Principles and Strategies to Administrators and Other Colleagues*

The example above illustrates another important guideline: Whenever possible, apply the principles and strategies of DBT when working to address problems within the system. This strategy is particularly important in the interpersonal realm—when making requests of administrators, referring agencies, payers, and employees since DBT often requires organizations to make exceptions to standard mental health protocols (as seen in the example above). Effective use of DBT skills can be extremely beneficial. Consider using the mindfulness skill of effectiveness (i.e., doing what's needed in a situation) as well as DBT interpersonal effectiveness skills. For example, use the factors to consider in determining whether it is a good time to make a request/say "no" to a request/present an alternative solution; apply DEAR MAN GIVE FAST skills to how the request is made, and so on. Always remember to keep reciprocity on your side by jumping in to do what is needed quickly and volunteering help when appropriate. It can be useful to think of doing four times as many things as you request, as this is considered a good ratio of positive reinforcement to aversives (e.g., demands, criticism). Use the DBT consultation team to practice, provide feedback,

coach, and reinforce team members in the process of interacting with administration, other clinicians, and so on. For programs nested within larger organizations, Table 4.4 shows common administrator concerns and barriers to implementation that will help you ensure that your DBT program matches with your organization's goals and resources.

### *Networking and Building Goodwill*

DBT programs that succeed over time prioritize building and sustaining strong relationships with stakeholders (e.g., advocates, social service agencies, payers, legal aid, administrators, and other colleagues) and generating goodwill toward and positive attitudes about the DBT program. Possibly the most effective and enduring way to do this is by helping the clinic (administrators and clinicians alike) effectively treat its most challenging, difficult clients. Providing consultation and training to other staff within the agency can also be helpful and often results in interested participants asking questions like "Will you come and talk to my staff?" or "Why isn't this more available?" or "Can I refer this client to you?" Some DBT programs offer "office hours" or monthly lunch meetings to discuss difficult non-DBT cases. Part training and part peer-to-peer consultation, these "brown bags" provide an invaluable opportunity for non-DBT colleagues to get assistance with difficult cases by applying the tools of DBT.

## Keeping It Going: Sustaining Your DBT Program over Time

As the DBT team and program mature over time, old struggles and concerns soon fade and new ones emerge. These include attending to staff motivation, structuring ongoing training, preventing burnout, and dealing with staff leaving. This section is devoted to sharing successful strategies that help to sustain your DBT program.

### *The Changing Team*

One of the stresses for the team is that its membership changes over time. Occasionally, there is someone whose departure is welcome, but this is rare among groups of clinicians who have developed their team together. In addition to the team's experience of grief and loss, there is often pressure to recruit and hire new staff, or to absorb clients into already full caseloads. This focus on filling the position can interfere with processing the loss of a valued team member, which can subsequently interfere with fully welcoming the new member.

Adding new members to a consultation team is an opportunity for dialectical thinking. On the one hand, it is important to socialize the new person to the dynamics of the existing team. On the other hand, trying to keep the "old team" intact with new members is probably impossible. Thus, the dialectical skill of allowing natural change comes to the fore. Watch for the moment when orienting begins to feel more like controlling and realize that the time has arrived to elicit and accord respect to the input of new members. During such transitions, it can help to acknowledge the new dynamics by discussing the team goals for the clinic or to engage in mindfulness exercises focusing on appreciation of all members' strengths.

**TABLE 4.4. Factors to Consider when Implementing DBT within a Larger Organization**

| **Concerns of administrators** (Herschell, Kogan, Celedonia, Gavin, & Stein, 2009) | | **Barriers to implementation** (Carmel, Rose, & Fruzzetti, 2014) | |
|---|---|---|---|
| Type | Examples | Type | Examples |
| *Program fit:* Components of DBT conflict with current practice | Skills coaching when the agency does not allow clients to contact therapists outside of the office | Staff and client recruitment | Budget cuts, lack of sufficiently trained staff, and conflicts between the DBT framework and current practice |
| *Reimbursement:* Concerns about cost | "Nonbillable" time being used for consultation team meetings | Lack of administrative support | Not valuing evidence-based practice, prioritizing other services, stigma about BPD |
| *Staffing:* Deciding which providers will do DBT | How to choose which therapists will be trained in DBT and how to help retain them | Time commitments | Concerns about caseload size, time for participating in consultation team and providing skills coaching |
| *Demand:* Will there be enough? | Will there be sufficient demand for DBT to justify the resources being invested in operating the program? | | |

A different approach may be required when trainees regularly rotate on and off the team. Trainees are generally present to learn DBT. This is fortunate because it obviates the necessity of shaping the team too much toward them. In fact, changing to accommodate trainees can "lower the bar" of adherence and competence of the team, which is not desirable for anyone. Instead, it can be very useful to inoculate trainees against outsider feelings by emphasizing that their primary job is to learn DBT thoroughly by participating in a well-functioning team. Individual supervision of the trainee can be a place for further discussion of the trainee's observations and questions about the treatment. It is important to note that only those trainees who actually treat clients on the DBT team should attend the consultation team (all trainees can attend didactic/training sessions). Trainees should be assigned to a mode that they can be expected to complete during their rotation (e.g., serving as a coleader for 6 months of DBT skills or picking up an individual client should they be able to make a long enough commitment).

### *Enhancing Therapist Capabilities through the Consultation Team*

Remember that the function of the consultation team is to enhance therapists' capability and motivation for doing DBT. Several strategies can be used to accomplish this goal, including utilizing session recordings, didactic teaching, and team members using DBT strategies (e.g., chain analysis and solution analysis) on one another. Table 4.5 describes multiple strategies along with common problems associated with them and suggestions for troubleshooting.

One challenging problem for many successful DBT teams is the large size of the team and the considerable number of clients it serves. For large DBT teams, too many therapists means that some will seldom receive case consultation and few will

**TABLE 4.5. Training Exercises for Enhancing DBT Therapist Capability**

| Strategy | Potential problems | Troubleshooting strategies |
|---|---|---|
| Review recordings (audio or video) of session. | • Buying equipment<br>• Access to equipment<br>• Time to review tapes<br>• Time to give feedback<br>• Clients' reluctance to be recorded<br>• HIPAA concerns<br>• Therapist reluctance | • Cameras are now relatively cheap.<br>• If review and feedback are consistent and reinforcing, therapists will work harder to record.<br>• Assure reinforcement for video review or incorporate a schedule to minimize avoidance.<br>• Do behavioral and solution analysis for not recording or reviewing sessions.<br>• Make feedback written.<br>• Shape frequency of recording and watching.<br>• Start with recordings that the therapist believes are terrible, to reduce defensiveness.<br>• Reinforce that the ratio is 4 positive to 1 negative pieces of feedback.<br>• Orient clients that recording is just like a company "recording a call to assure service quality."<br>• Recordings have been treated by HIPAA officers as "process notes," following those rules. Policies can be easily created to oversee the storage and disposal of the digital files. |
| Rate sessions for DBT adherence. | • Not trained in DBT adherence scale<br>• No ability to record sessions | • See Worrall and Fruzzetti (2009).<br>• Photocopy tables from Linehan (1993a, 1993b) text to create a handout that will be a good proxy for adherence.<br>• If no recording is an option, self-rate immediately after sessions. |
| Use DBT strategies to help clinicians solve their problems in doing therapy. | • Therapists' resistance to therapy strategies used on them<br>• Worry about using too much team time and not having enough time to review clients | • Offer orientation on this approach to the team and demonstrate a commitment to it.<br>• Remember that the team meeting is for enhancing therapists' skills and motivation, not talking about clients. |
| Give a didactic presentation on a journal article or summarize a teaching seminar. | • Time to prepare | • Make funds for outside training contingent on teaching the team what was learned.<br>• Use articles that team members already found and liked, instead of assigning a new task.<br>• Don't have everyone read ahead. |
| Engage in role-plays or behavioral rehearsal instead of "talking through" suggestions and recommendations. | • Avoidance of role-playing | • Each week, schedule someone to prepare a role-play.<br>• Commit to one role-play per team meeting.<br>• Have a frustrated therapist pretend to be a difficult client and someone else role-play the therapist (reinforcing someone else's struggle and generating phenomenological empathy for the client). |
| Case presenters do their homework: describe behavior; identify questions for consultation; have a recent chain analysis and video ready to share. | • Time to prepare<br>• Team becoming mindless and forgetting to stick to its plan | • Everyone takes responsibility not to offer suggestions until the therapist identifies what he or she needs help with.<br>• Make a very simple set of prep questions (e.g., client's overarching goal, target you are working on, help that you want) that become habit.<br>• Spell out the plan on "table tents" as a reminder.<br>• The previous week, schedule someone to bring in a recording (so there is no diffusion of responsibility). |
| Practice irreverent or reciprocal communication styles during a team meeting. | • Forgetting<br>• Lack of awareness of doing something | • Make one meeting a month "irreverence day," asking everyone to try and offer one irreverent comment.<br>• Ring a bell when someone nails the "strategy of the day." |

receive in-depth consultation on cases. There are several ways to manage this situation. One method is to start the meeting with a "team review" of life-threatening behaviors, therapy-interfering behaviors including important issues such as staff burnout and clients at risk of missing 4 sessions in a row before the next meeting, and successes or good news since the last meeting. When done mindfully, this can be accomplished quickly and with the addition of business items can be the basis of the meeting's agenda. Then in-depth time can be spent on a few (e.g., maximum of two or three) therapists. Another strategy is to use internal email or voicemail systems to give updates on group attendance, group homework, therapists' out-of-town dates (to arrange clinical coverage), as well as other announcements that do not require discussion but are important to share among team members.

While effective in some circumstances, these strategies may not be effective in situations where there are a number of highly lethal, suicidal clients new to the DBT team. When this is the case, it may be necessary to divide the consultation team into multiple teams, either temporarily or permanently. Some teams have developed a model, for example, of a monthly lottery to one of two teams (Team A or Team B) that meet at the same time. Each month, all members have an equal (but random) chance of ending up on Team A as on Team B (members pull their assignments from a hat). This method allows for the members to split into two smaller teams but preserves the cohesiveness of the larger group.

Another way to improve consultation is to review video or audio recordings of therapy sessions. When clinicians play an example that demonstrates the problem they need help with, assessment can begin with a minimum of narration. The target for consultation is shown rather than described and other problems, such as secondary targets, often become clear during the session review. Reviewing session recordings during team meetings is one of the most effective ways to improve DBT adherence in individual therapy. Clients must consent to being recorded and therapists usually have to overcome some anxieties about their perceived competence. As long as the team does not punish showing video, therapist anxiety will diminish over time.

### *Enhancing Therapist Motivation and Preventing Burnout*

The term "burnout" is frequently referenced in literature on working with clients with BPD; modes within DBT (e.g., consultation team) exist to help treat therapist burnout. One way to enhance therapist motivation is to prevent burnout—the main reason (other than more money) that clinicians leave a team or experience a slump in their work. Part of burnout is being emotionally overextended and exhausted by one's work. This is often best addressed by assessing and matching DBT tasks to therapist preferences. For instance, a list of all team tasks (individual therapy, skills training, crisis coaching, teaching, providing supervision, being supervised, providing case management, providing medication management, overseeing data collection) can be ranked on a scale from 1 (e.g., "I hate this and couldn't take it for long") to 5 (e.g., "The opportunity to do this is critical to my job satisfaction"). While it is never possible to completely match therapist preferences to tasks, new information is often uncovered that was not apparent in therapist behaviors. Better matching of tasks means more satisfaction for therapists and less burnout.

Even favored tasks can burn out a DBT therapist when therapists (1) do the same thing day in and day out, (2) do a lot of tasks that are not compensated, (3) don't

see clients progress, (4) work with the highest-risk clients or those who are angry or critical, and (5) work with clients who overuse phone consultation. These burnout factors need to be balanced by positive factors in the DBT team, such as being your own boss, ability to see non-DBT or non-BPD cases if this is reinforcing, support from team members, fun (e.g., parties, evening events), and celebrating successful interventions and not just successful cases.

In our experience, an important place to watch for potential burnout is skills coaching outside of session, which requires that therapists observe their own limits (that may change over time). While out-of-session contact between the client and therapist is effective in enhancing skills generalization, it can also be intimidating, especially for newer DBT therapists. In addition, it can be easy to slip into "therapy on the phone" as opposed to brief, targeted skills coaching. When this occurs, therapists might feel their limits being pushed (leading to burnout), and importantly, the potency of the coaching contact gets diluted. Asking for help from one's consultation team to observe one's own limits is needed in these situations (Koons, 2011). Again, this underscores the importance of building a strong, functional consultation team.

At times, we have noted that therapists themselves may not even realize that they are approaching burnout, while members of the team do. Adhering to the team consultation agreements provides an atmosphere of respect and warmth that is essential to mastering DBT and targeting burnout. A strong team reduces therapist burnout by providing support, encouragement, humor, and community for the therapists. A team becomes most effective when all members are consistently dialectical, radically genuine, ready to address problems, willing to make repairs, and mindful of the overarching goals. If the team drifts off course, spending team time on strategies to improve the team pays off—that is, taking time to fix the "tool" of therapy instead of continuing with a broken tool is often a lot faster way to get to the goal.

Another problem of burnout is that the therapist feels or acts with increasing emotional distance to clients or team members. If this happens, a lot of validation from team members for the difficulty of the task is needed as well as observation of whether the therapist is moving outside their limits. Skills to maintain limits and metaphors or other dialectical strategies to help find balance in the stress are needed. The team needs to assure that the therapist has the skills needed for clients to improve and help the therapist to target hopeless and helpless thoughts. The key is often finding ways for the therapist to evaluate the effectiveness of their interventions apart from positive reinforcement from the client or client improvement; this could be checking DBT adherence, highlighting extinction bursts as indicators of success, and team reinforcement for desired therapist behaviors. Reminders and lots of attention on the occasional stellar success experiences do not hurt either.

Burnout can also be reduced by sharing the treatment tasks for very difficult clients. For instance, family members, social service providers, payers, or apartment managers may be desperate for the client's behavior to change and make demanding phone calls to the therapist. Meanwhile, the client is already very demanding of the therapist's time and energy. It can be helpful in these cases to ensure that the therapist can defer complaints and demands from individuals other than the client to a clinic director, supervisor, or another clinician. This deflection helps prevent the therapist from being punished by the client *and* everyone else for slow treatment progress. It also helps to maintain the treatment alliance between the primary therapist and the client. Occasionally, a therapist needs a break after a run of high-risk suicide calls or

serious instances of crossing beyond the therapist's limits; at the same time, the client may continue to need an active skills coach closely involved. A couple of coaching sessions with another clinician or a week of another clinician taking phone calls often helps to return the primary therapist's interest in and commitment to the client.

Another strategy to prevent burnout is to make burnout an explicit part of the regular consultation team agenda (i.e., have each team member rate burnout at the beginning of each meeting from 0 to 10). This serves two purposes. First, it provides a cue for therapists to consider their own burnout level, and thus identifies burnout much earlier than if the team waited for the therapist to initiate. Second, it normalizes burnout as an expected result of working with challenging clients. This allows the therapist to be less defensive and actively work to reduce burnout while helping relieve the team's anxiety that the therapist is about to quit. However, burnout is a challenging therapist problem to treat as it makes one very sensitive to invalidation. A team trying to intervene quickly without sufficient assessment of the problem, validation, and time to discuss it can make the situation worse rather than better. Substantial team time may be required to assist the individual in addressing the problem and it may take several weeks to resolve, so the team and individual need both patience and persistence.

A final point about therapist burnout is to remember that, while DBT can be demanding for providers and clients alike, there are noteworthy benefits to being part of a DBT team that energize us as therapists and shield us from burnout. Think of it as you would protective factors; participating on a DBT team offers benefits beyond what one would experience as an individual practitioner, such as obtaining needed validation and targeted consultation from colleagues. In fact, the team approach—marked by cohesion, communication, and attentiveness to overall climate—is connected with successful program implementation (Ditty, Landes, Doyle, & Beidas, 2015). DBT therapists commonly reflect on the ways that their work enhances their own lives. Witnessing symptomatic improvement in their clients, watching clients use the treatment to help themselves, and seeing how this connects to their own personal and professional development are all benefits appreciated by DBT therapists (Swales, Taylor, & Hibbs, 2012). As therapists, all of these factors encourage us to do our very best work. Carefully cultivate these elements and seek to infuse them into your team's outlook and be sure to review successes regularly during team meetings.

## Conclusions

Creating a comprehensive outpatient DBT program is a considerable challenge, particularly at the beginning stages of implementation. DBT often requires a radical paradigm shift for the many stakeholders involved, from agency administrators to frontline clinicians, clients, and their family members alike. The requirements are more than philosophical: Implementation of a comprehensive DBT program, done in a way that preserves fidelity to the treatment, frequently requires revising clinic policies and procedure to ensure that they are consistent with DBT for those served by DBT. Furthermore, because of the risk for suicide, the severity of behavioral dyscontrol across many behavioral domains (including interpersonal) and their multitude of other problems, clients with BPD are among the hardest and most stressful to treat. As a direct result of this fact, DBT is a complex and, for many, difficult-to-learn and

difficult-to-apply treatment. Indeed, DBT is a comprehensive, multimodal, and multifaceted treatment; clinical mastery of the treatment requires that the clinician know DBT inside and out, as well as numerous other evidence-based treatment manuals for the client's other problems.

Given the personal stresses and strains in treating clients with BPD, some are tempted to ask, "Why do it?" When translated, this often means, "Why work with clients with BPD when there are so many other clients who are so much easier and simpler?" or "Why *do* DBT all the way?" After having learned DBT and built our DBT programs, it is now easy to say, "We wouldn't have it any other way." The benefits and rewards, despite the struggles we face particularly early on, are plentiful, both professionally and personally (i.e., the skills we teach our clients "cross over" into our own lives and relationships). Many discover that the behavioral skills and strategies in DBT are useful with other clients. For others, answering the "why do it" has all to do with the deep satisfaction and fulfillment they experience in helping someone move from a miserable life to a full and rich life worth living. For still others, DBT has provided their agency a specialty in the community that has served all stakeholders (from clients to top administrators) well.

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CHAPTER 5

# DBT in Milieu-Based Programs

CHARLES R. SWENSON, SUZANNE WITTERHOLT, and JULIET NELSON

This chapter provides a review of the implementation of dialectical behavior therapy (DBT) on inpatient units presented in the first edition of this volume (Swenson, Witterholt, & Bohus, 2007), and expands the focus to include milieu-based programs located in the world of outpatient treatment; namely, day treatment programs (DTPs), partial hospital programs (PHPs), and intensive outpatient programs (IOPs). While the chapter focuses on these programs in particular, in the treatment of adults with severe and chronic emotional dysregulation, other milieu-based programs not specifically covered here—residential programs for adults and adolescents, DTPs and PHPs for adolescents, forensic inpatient and community milieu-based programs, and specialty programs for those with substance use disorders and eating disorders—may also find the particulars of implementation discussed in this chapter useful.

Milieu programs range along a spectrum of DBT implementation. At one end are those programs based almost entirely on DBT, addressing all five DBT functions, with DBT strategies and skills, and using DBT-based goals and targets. At the other end are programs that selectively apply DBT skills training and a few other strategies—perhaps validation, behavioral analysis, diary cards, and contingency procedures—in a more general, mostly non-DBT environment. Midway along this spectrum are programs that provide comprehensive DBT within "tracks" for this subset of patients. In some cases, DBT skills are offered to all program patients, whereas the comprehensive version of DBT is provided only to the dysregulated patients in the specialized "track." These patients are likely to present with suicidal and/or self-harming behaviors, substance use disorders, eating disorders, dissociative disorders, chronic posttraumatic stress disorders, and some antisocial disorders. A characteristic of DBT milieu treatment programs is that frontline clinical staff are expected to learn the DBT skills taught in the program so that they can prompt, and then reinforce, patients to use the skills in their milieu interactions. It is in the service of these functions—enhancing

client's capabilities and generalizing those capabilities to the environment—several hours per day, several days per week, that a milieu setting can offer something more intensive and potentially more effective than standard outpatient care.

## Adaptation of DBT to Inpatient Programs

Since DBT was originally developed as an outpatient approach, the treatment team in standard DBT aims to help clients build community-based lives that feel worthwhile and fulfilling. For several reasons—for example, inpatient admission and treatment can inadvertently reinforce suicidal and other severely dysfunctional behaviors, rates of suicide are unusually high shortly after discharge from a psychiatric hospital (Qin & Nordentoft, 2005), hospitalization frequently leads to negative consequences related to employment or schooling—the DBT team is biased against hospitalization unless absolutely necessary.

Yet one of the first published adaptations of DBT described its feasibility in an inpatient setting (Swenson, Sanderson, Dulit, & Linehan, 2001). A well-timed and well-executed hospital treatment can (1) save a life, (2) interrupt a crisis, (3) remotivate a beleaguered patient, (4) bring a new perspective to diagnosis and treatment, (5) allow for a difficult family intervention, and/or (6) make a medication trial possible. Inpatient DBT allows for psychoeducation regarding disorders and treatment; intensive skills training; behavioral analysis, solution analysis, and treatment planning; safe processing of emerging trauma memories; and the review, repair, and remoralization of a strained outpatient therapy. Finally, the fact that DBT is a practical treatment approach with specific goals and targets is aligned with insurance-based cost-containment strategies and with nursing philosophy with its focus on behavioral objectives. By now, inpatient applications of DBT have developed and spread worldwide. Most are acute inpatient units with lengths of stay from 5 days to 2 weeks; fewer are intermediate units where the length of stay is between 2 weeks and 3 months; and fewest of all are long-term units where patients stay beyond—sometimes well beyond—3 months.

Despite these adaptive reasons for hospitalization, typical features of DBT are frequently a mismatch with typical features of inpatient settings (Swenson, Sanderson, Dulit, & Linehan, 2001). DBT thrives on a collaborative relationship between equals, but the hospital setting structures a one-up, one-down relationship between staff and clients. DBT is based on a nonpejorative understanding of behaviors that comprise the diagnosis of borderline personality disorder (BPD), while inpatient units seem to be fertile soil for judgmental and stigmatizing attitudes. In DBT, therapists consult to patients regarding how to interact with other professionals; in hospital treatment, staff members typically join together in managing the patient. DBT therapists encourage active emotional expression and assertiveness; hospital milieus tend to reinforce compliant and passive problem-solving styles that do not disrupt the milieu.

Our purpose in this chapter is to provide an overview of the adaptations we view as necessary when applying DBT in the context of mental health milieu-based treatment environments. We wish to highlight that milieu-based treatments, particularly those that remove the patient from their natural environment, also include a number of challenges to optimizing therapeutic change: (1) skills acquired during

the milieu stay and problems solved during inpatient treatment may not generalize to the patient's natural home environment; (2) hospitalization can become a preferred means of coping with distress, thereby diminishing the acquisition and use of more functional strategies; (3) hospitalization may interfere with one's life responsibilities (e.g., childcare, work) and as a result cause further problems postdischarge; (4) admission to a hospital can interrupt and weaken outpatient community supports and treatment relationships; (5) hospital stays can bring a patient into contact with an unnatural density of stressors and dysfunctional coping behaviors that can become "contagious"; and (6) if a crisis admission "works" to relieve a pressured situation, including one that includes suicide risk, it can reinforce the very behavioral patterns that prompted the admission. Indeed, for some individuals, engagement in milieu-based programs can produce an unintended iatrogenic effect (see Ward-Ciesielski & Rizvi, 2020), where suicidal behaviors and hospitalization as a way of life are further strengthened, as is one's own self-concept as a terminal "mental patient."

## Adaptation of DBT to Intermediate-Intensity Milieu Programs

Over the past 20 years, the concept of a DBT continuum has taken root. Patients can move on from inpatient settings to outpatient milieu programs to standard outpatient treatment. Patients in outpatient therapy can temporarily attend an outpatient milieu program when more structure and support are needed. As patients move from one DBT setting to another, they benefit from the application of the same principles and vocabulary of care, including treatment stages, goals, targets, skills training, DBT-based protocols and strategies, and the expert application of a uniform suicidal risk assessment and management protocol (Linehan, Comtois, & Ward-Ciesielski, 2012). The presence of a continuum of placements from more to less structure allows a therapist or team to manage patients' risk while maximizing their freedom and maintaining their connections to their natural life setting (see Figure 5.1). At one end of the spectrum is an inpatient setting where patients are confined 24 hours per day, fully staffed. Close to this end of the spectrum are residential programs that are staffed from 16 to 24 hours per day. While lacking the same level of confinement and restrictiveness found in inpatient settings, these round-the-clock treatment environments provide intensive containment, structure, and support with milieu approaches that borrow from inpatient DBT.

Moving along the spectrum, DTPs and PHPs provide a greater degree of structure and support than IOPs to patients whose disorders render them unable to build or sustain enough structure or support in their natural environments. For multicomponent treatment systems, these intermediate milieu-based programs serve two overarching purposes: (1) to divert patients from inpatient admissions and (2) to provide a step-down context following inpatient care. While definitions and parameters of DTPs, PHPs, and IOPs vary from state to state and location to location, due to regional licensing policies and insurance company reimbursement policies, typical parameters—duration of stay, days per week, and hours per day—defining each of these three settings can be found in Figure 5.1. The flexibility of this kind of programming, offering levels of structure and intensity of treatment "dosage" while living in one's natural setting, is what can make it so valuable.

| Setting | Length of stay | Days per week | Hours per day |
|---|---|---|---|
| DTP | Weeks–months | 4–5 days/week | 6–8 hours/day |
| PHP | One–several weeks | 3–5 days/week | 4–7 hours/day |
| IOP | Open-ended | 2–3 days/week | 2–4 hours/day |

**FIGURE 5.1.** Typical parameters in outpatient milieu settings.

## A Brief Review of Research on DBT Milieu Programs

While there is a substantial literature describing the implementation of DBT in inpatient and outpatient milieu settings, research on the process and outcomes of such programs remains relatively undeveloped. Existing studies include those of full DBT programs used to treat specific populations and those targeting a wider transdiagnostic group.

Bloom and colleagues (2012) reviewed all controlled trials and/or outcome studies ($n$ = 11) evaluating the effectiveness of DBT in inpatient treatment between 1993 and 2011. Studies indicated that many variations of standard DBT had been used in inpatient settings—among them approaches that did not include phone consultation, that included group therapy only, and that varied in treatment duration (from 2 weeks to 3 months). Most studies reported reductions in suicidal ideation, self-injurious behaviors, and symptoms of depression and anxiety, whereas results for reducing anger and violent behaviors were mixed. Follow-up data indicated that symptom reduction was often maintained between 1 and 21 months posttreatment. In two reports, Bohus and colleagues (2000, 2004) described promising results of a 12-week inpatient DBT program designed to serve as an intensive prelude to a comprehensive outpatient DBT program. To date, only a single randomized controlled trial (RCT) has evaluated DBT in an inpatient setting. Bohus and colleagues (2013) described a 12-week "modular treatment" combining DBT and interventions targeting PTSD secondary to childhood sexual abuse (CSA) and compared it to a wait-list control. Outcomes demonstrated significant improvement in PTSD symptoms for the DBT condition.

To our knowledge, the first comprehensive DBT partial hospital program was developed by Simpson and colleagues (1998) who adapted the outpatient model for this setting with an average length of stay of 6.4 days. Completers were encouraged to graduate to a standard 6-month outpatient DBT program post-PHP. The DBT PHP included 6.5 hours of structured day programming (mostly groups) with typical DBT interventions and relentless efforts to problem-solve. Individual and/or family sessions and medication management occurred weekly, or as needed. All milieu staff gathered for a weekly DBT consultation team meeting, had DBT training and supervision, and were encouraged to focus on the extinction of maladaptive behaviors through ignoring the behavior and the shaping up of adaptive responses with positive reinforcement. Participants, who had all either recently been discharged from inpatient hospitalization or been diverted from higher level of care with PHP, had access to individual skills coaching on the unit during the day and after-hours skills coaching by phone at night. This program collected outcome measures on 47 individuals at

discharge and at 3-month follow-up. Results showed that depression, hopelessness, anger expression, dissociation, and general psychopathology continued to decrease during the 3 months posttreatment, while most individuals continued in some form of therapy, including the option of continued DBT (Yen, Johnson, Costello, & Simpson, 2009).

This PHP model, including the treatment notebook, protocols, and program description by Simpson et al. (1998), formed the basis for the DBT PHP at a community mental health center in a midwestern college community implemented in 1997. While Simpson's original PHP involved a homogenous population of adult females with BPD, this PHP included an acute, transdiagnostic population. After several years, the PHP transitioned to an IOP and produced significant reductions in depression and anxiety, and increases in hope among participants (Ritschel, Cheavens, & Nelson, 2012). A comprehensive adaptation of the standard outpatient model for a PHP in the southeastern United States achieved similar outcome (Lothes, Mochrie, & St. John, 2014; Lothes, Mochrie, Quickel, & St. John, 2016).

In summary, research demonstrates that DBT can be successfully adapted and implemented in multiple mental health milieu settings. Furthermore, research suggests that the comprehensive DBT model may be enhanced to treat co-occurring and complex disorders when combined with other evidenced-based models and provided concurrently within these milieu settings. However, the lack of RCTs makes it difficult to determine if the positive outcomes are directly related to DBT treatment targets and strategies, or are instead best interpreted as nonspecific treatment effects or "regression to the mean" since most patients only enter into milieu-based services when in acute and/or severe crisis states.

## Principles and Theory for Use in Milieu-Based DBT

Conducting milieu-based treatment for individuals with severe and chronic emotional dysregulation is a bit like riding together down the Colorado River through the Grand Canyon on a large inflatable raft. To succeed, the raft needs to be neither too rigid nor too flexible, balancing the needs of each rafter with the needs of the group as a whole. The milieu is stocked with approaches from all three underlying DBT paradigms—acceptance, change, and dialectics—allowing the team to find the synthesis, or middle path, between a number of dialectics in this kind of treatment: (1) between a flexible treatment structure that is also consistent and firm; (2) between a warm and reciprocal communication style that is also confrontational and irreverent; (3) between an emphasis on patients' autonomy but also offering hands-on support; (4) between ensuring privacy and confidentiality while still emphasizing accountability and safety; (5) and between the frequent use of validation strategies balanced with relentless problem solving.

DBT's biosocial theory for explaining the development and maintenance of BPD behavioral patterns (Linehan, 1993a, 2015) is an active presence in DBT milieu-based treatment. First, the two factors in the model suggest a double-barreled focus in treatment: decreasing the patients' emotional vulnerabilities through skills training and other solutions, while also countering the history of invalidation by providing a compassionate, nonjudgmental, validating environment. Second, when team members themselves become emotionally dysregulated, unbalanced, and judgmental, they

evoke and reflect on the biosocial model as a pathway back to a compassionate way of understanding their patients. Third, when troubling transactions arise between patients and the staff, the biosocial theory can serve as a lens, illuminating ways in which the transaction may be an echo of the patient's earlier experiences with invalidating environments. If the staff can see that they have unwittingly come to play the role of the invalidating environment, they can regain their balance, acquire insight about the transactional maintenance of the problematic behavioral patterns, and intervene with a deeper understanding and validation.

## Goals, Targets, and Phases in Milieu-Based DBT

Defining and sticking to an agenda made up of prioritized treatment targets throughout treatment with this patient population is almost always a challenging task. The rationally defined agenda can be eclipsed in a moment by crisis behaviors and intense emotions. The problem can be even more difficult in milieu-based programs. The sheer number of face-to-face contact hours between milieu staff and patients exposes both groups to a high density of emotionally salient cues. It is thus extremely important to have a clear understanding of the ultimate goal of treatment and to specify behavioral targets on the way to achieving the goal.

Because the ultimate goals of milieu-based programs are necessarily more limited in nature than those in standard outpatient DBT, and because the time frames are typically much shorter, a more limited number of goals and stages/phases are necessary. The ultimate goal of inpatient DBT is to eliminate the need for further inpatient care, which renders it different than the ultimate goals of DTPs, PHPs, and IOPs. The intermediate steps on the way to that ultimate goal can be grouped as three phases of treatment—getting in, getting in control, and getting out—each with its own goal. Notice how much more circumscribed the ultimate inpatient goal for suicidal behaviors is in contrast to the ultimate outpatient treatment goal. In outpatient, the goal is ultimately to eliminate suicidal behaviors. In inpatient, the goal is to make it possible to pursue the elimination of suicidal behaviors as an outpatient. Patients are moved from behaviors requiring hospitalization to the point when they are "just community ready." As such, each patient's inpatient behavioral targets include stabilization of the current crisis, reduction of those patient behaviors that prompt and/or prolong inpatient hospitalization, increase of patient capabilities to tolerate distress and regulate intense emotions, and the creation and execution of a viable plan for discharge and outpatient life. Proposed target categories per phase, to be tailored to each patient's specific circumstances, are summarized in Table 5.1.

Similarly, PHPs and DTPs can usefully be segmented into three phases: (1) entry; (2) execution of the treatment plan; and (3) exit (see details of each phase below). The clearer the treatment team can be about the ultimate goal, the phases, and the targets per phase for each patient, the more likely they will be to create a rational framework, reduce the harmful effects of hospitalization, and stay on track. Otherwise, the treatment agenda can be driven by two other typical forces that complicate and prolong the treatment: (1) the chaos and crises that naturally emerge from a patient population with emotional vulnerability and dysregulation; and (2) the tendency of staff members to expand the range of treatment targets

**TABLE 5.1. Phases and Target Categories for Inpatient DBT**

Phase 1: Getting in

- Orientation
- Assessment
- Agreement on a treatment plan
- Increase commitment to a treatment plan

Phase 2: Getting in control

- Reduce behaviors that prompted and/or that prolong hospitalization/higher-level program
- Imminent life-threatening behaviors
- Inpatient treatment-destroying behaviors
- Egregious behaviors requiring inpatient care
- Increase behavioral skills for regulating emotions, tolerating distress, interacting with others, and self-management

Phase 3: Getting out

- Increase skills for getting out of and staying out of inpatient/higher-level program
- Troubleshoot and reduce obstacles for a successful discharge

to include any dysfunctional behaviors among the patients. For instance, while the designated targets of an acute inpatient DBT program or a PHP might focus on the assessment and reduction of imminent suicidal behaviors and related high-priority problems, the treatment staff, if not disciplining themselves to stick to the agreed upon targets, may also address other problems that manifest, such as trauma history or longstanding difficulties in family, vocational, and interpersonal functioning that would ideally be addressed in outpatient treatment. When the patient is oriented to the finiteness of the goals and targets, they are sometimes sorely disappointed and angry; therefore, this is best handled at the beginning of treatment rather than later, as discharge approaches.

While particular goals in DTPs, PHPs, and IOPs will differ significantly from patient to patient, the ultimate outcome is the same: to resume life and standard outpatient treatment without the additional support and structure provided by these programs. This is true whether stepping down from inpatient programs as a transition back to outpatient life or as the result of a referral from outpatient treatment. Patients' daily lives can become unsustainable in the face of spiraling symptoms of mental health, substance abuse, or physical disorders often in transaction with debilitating changes in employment, finances, family, or other life circumstances. Because patients in these programs will continue to live in their homes, going back and forth between home and the program each treatment day, treatment targets that require problem solving in the natural settings can go on every day, unlike some of the same targets as approached from the inpatient setting. The outpatient DBT milieu-based programs can borrow from some of the features of inpatient DBT: a three-phase framework with prioritized behavioral treatment targets; typical DBT assumptions about therapy and patients; DBT treatment functions such as enhancing capabilities and improving motivation; DBT treatment strategies and skills-training groups; widespread uses of behavioral chain analysis and contingency procedures in the milieus; mindfulness practices; and self-monitoring of treatment targets on diary cards. The nature of the three phases is elaborated below.

### Phase 1: Entry (Inpatient Version: "Getting In")

The entry phase is the milieu program counterpart to the "pretreatment" stage in standard outpatient DBT. The entry phase consists of four processes/targets.

#### Orientation

The patients' entry to the program, on the first day (or sometimes beforehand), provides a unique opportunity to orient them to the program. Many patients arrive with anxiety, shame, hopelessness, anger, and may be experiencing a life crisis. A clear and understandable introduction to the program, including a brief explanation of the central role of DBT skills, can alleviate some degree of confusion, anxiety, and hopelessness. A warm and welcoming style might alleviate some measure of shame. If on the day of arrival, the flow of events in the program makes it difficult for a staff member to devote the time needed for a high-quality orientation, a program can create a short video orientation (i.e., under 20 minutes) for the new patient to watch, followed by a face-to-face follow-up to answer questions and to elaborate.

An often overlooked resource in the orientation phase consists of the other patients in the program. Some programs encourage peers to volunteer as the "peer of the week," or "peer of the day," to be available to help welcome a new admission, view the orientation video and/or review orientation material with the new person, and sit down with the new admit and staff to go over what the newly admitted person has learned. This has value on many levels, both for the person being admitted and the peer greeting the new arrival, and for reinforcing the power of the milieu itself to be a factor in promoting skillful means. Peer support specialists, if they are hired by the inpatient unit, can be a source of wisdom and suggestions for the new patient, helping ease them into what can be a challenging environment. The patient can be further motivated by working with a peer specialist who "has been there" themselves and yet is now a competent contributor to the program.

#### Assessment

Standard assessment will include the patient's psychiatric background and diagnoses, psychosocial history, and mental status exam; the administration of whatever standard instruments and interviews are used in that setting; a review of previous records; and communication with the person referring the patient. In addition, the patient collaborates in their own behavioral assessment through engagement in a behavioral chain analysis of the most recent incident(s) and circumstances requiring admission. Through this process, the team works with the patient to identify the most important causes and conditions leading to the need for this level of treatment. These become the focus of a treatment plan.

#### Agreement on the Treatment Plan

The treatment plan can be structured around the three phases of treatment and the individualization of prioritized target lists emerging from the assessment. It is a manifestation of the patient's goals, the reasons for the admission to that level of care, and the problems or obstacles that are in the way of the patient's goals. These can

be life-threatening behaviors, behaviors that destroy or interfere with the treatment program itself, and a wide range of behaviors interfering with quality of life that are eroding the patient's life and requiring this enhanced level of treatment intensity. Anticipating discharge from the very beginning, the agreed upon plan should include a preliminary version of a discharge plan so that it is kept in mind and shaped from the start.

A preliminary diary card can be created at this point. The first version of the diary card for a suicidal patient in the inpatient setting may include the monitoring of suicidal behaviors and urges, the use of distress-tolerance skills and mindfulness practices, the use of emotion-regulation skills and interpersonal skills in the program, and later include the monitoring of steps taken in the service of discharge planning. Correspondingly, the plan for a patient in day treatment who needs to focus on activities of daily living may track those rehabilitation steps on the diary card. Diary card reviews with the patient are opportunities for staff members to reinforce effort, create a positive moment in treatment, and reinforce perseverance.

### *Commitment to the Treatment Plan*

Throughout the entry phase, and especially upon creation of the treatment plan, the team tries to strengthen the patient's commitment to the treatment. Some "nonspecific" factors are important: an effective orientation, a welcoming and compassionate approach with considerable validation of the patient's feelings, a staff with good morale, and a program that runs well. Beyond that, team members utilize DBT's commitment strategies, as is done in all DBT settings. Programs can be creative in adapting those strategies to level of care. A task could include the completion and discussion of a worksheet where the patient is asked to list the pros and cons of committing to the treatment. The team might push first for a commitment to completing the program (door in the face) and then ratchet downward to a smaller commitment (foot in the door) that the patient can make with more certainty. In applying freedom to choose in the absence of alternatives, it is important to emphasize that while the patient may have been given a strong recommendation, even a mandate, to enter the program, they are not a captive and have the freedom to choose something else (even if there is not a great alternative). It can be an effective strategy to consider the entry phase as a time during which the patient is sampling and assessing the program, while defining the end of the entry phase as the moment of committing to the treatment. Some programs have developed specialized groups as the centerpiece of the entry phase. For example, one DBT inpatient program placed each entering patient into an orientation, commitment, and control group. Graduation from the group is then considered the moment of jumping into the treatment with both feet.

## ***Phase 2: Execution (Inpatient Version: "Getting In Control")***

When a patient completes the entry phase, having made agreements and commitments, the program team collaborates with the patient to accomplish the targets for the execution phase. A given patient in an inpatient treatment might begin by addressing the causes and conditions of suicidal behaviors that escalated prior to admission. Once imminent suicidal crisis behaviors and urges have diminished, the focus shifts to any behaviors that threaten to destroy the inpatient milieu: repetitive physical and

verbal attacks and threats toward other patients in the program, destruction of program property, and so on. During this work on high-priority targets, the patient is targeting skills deficits in the skills-training curriculum. In the absence of imminent life-threatening behaviors and milieu-treatment-destroying behaviors, the focus of treatment may turn to those patterns that continue to interfere with a viable discharge plan: persistent and refractory psychological disorders, social isolation and loneliness, poor compliance with medical management and treatment, and dysfunction in spheres of housing, family, employment, and interpersonal relationships. Because these are the same factors targeted in standard outpatient DBT as "quality-of-life interfering behaviors," they are targeted in a milieu program only insofar as the patient is not yet able to resume life without this level of care. For example, this may include the patient who has become unable to shop for food, to take transportation to therapy, to care for a pet, or to get out of bed in the morning.

Typical goals of a multiweek PHP treatment could begin with assessment, orientation, treatment planning, and commitment, and then move on to clarification of diagnoses; revision of the pharmacological regimen; resolution of a current interpersonal crisis; acquisition and strengthening of a set of emotion-regulation skills; restructuring of daily life; and consultation to the current outpatient treatment plan. IOPs, which can be thought of as enhanced standard outpatient DBT, might be most closely aligned to the goals and targets of standard DBT, where the ultimate goal is the building of a life worth living for each patient. The IOP might help with strengthening of commitment to treatment; reduction of severe behavioral dyscontrol; amelioration of agony and suffering; solution of life problems on the way to greater happiness; and the increase of freedom and meaning in life.

During the execution phase, the presence of a clear prioritized list of goals and targets, used across different modes of treatment, serves to create consistency across the staff with each patient. For instance, when conducting a morning meeting focused on the patients' treatment goals for the day, the staff member in that meeting should have the prioritized target list for each patient for reference and use throughout the meeting.

### *Phase 3: Exit (Inpatient Version: "Getting Out")*

This phase is focused on a successful discharge from the program to the community. While continuing to strengthen the skills to address targets in the execution phase, "troubleshooting discharge" becomes the preeminent target. Due to policies of insurers and payors, whereby overnight passes home from the hospital to practice skills in the natural setting will result in unreimbursed hospital days, a gradual discharge process from inpatient is hindered. Stepping down to an outpatient milieu-based program can help to fill this gap. Fortunately, the transition involved in discharge from the outpatient milieu program allows for more flexibility as the patient graduates from full-time to part-time program participation and on to discharge.

The goal is to exit the program, successfully reestablish life without it, and avoid a costly readmission in the first 30 days or more. With help, and often beginning at the start of the patient's stay, they outline and pursue a discharge plan that includes living circumstances, a plan for standard outpatient treatment, and a crisis response plan to guide assessment and intervention in the case of crisis behaviors in the natural environment. These steps can themselves set off emotional dysregulation, which

can again set off behavioral dyscontrol. This back-and-forth work between steps toward discharge, emotional and behavioral dysregulation, strengthening a commitment, getting in better control, and so on, is typical. Having outlined and having worked toward a discharge plan, the patient is helped to anticipate the factors that will foil the plan, which are then targeted. The skills curriculum in the program offers distress-tolerance skills to help patients tolerate anxieties about leaving, interpersonal skills to help in negotiating with others in the process of getting out, and emotion-regulation skills to enhance more resilient emotional responses. Some DBT programs create specialized groups, usually known as "transition groups" or "discharge groups," in which patients approaching discharge can work on their concrete plans, anticipate interpersonal and emotional challenges, and strengthen DBT skills that will help them navigate those challenges. In the attempt to leave the program and reenter community life with less programmatic support, which can be frightening for many patients, some programs will allow them to attend the transition group leading up to discharge and then for a few weeks afterward. Peer support specialists can be used as experts, models, and effective coaches for the patients as they practice "leaving." Using role-plays to practice "coping ahead," as well as bringing in family members and supportive people from the community, enhances this work. As the patient gets ready to leave the program, a graduation ceremony can help, as it allows all other patients to hear from someone who has successfully completed the three phases.

## Functions, Modes, and Strategies in Milieu-Based DBT

The prior section explicated the sequential steps of treatment in milieu programs, defining phases, goals, and specific targets. This section will address how to help the patient with those steps. Comprehensive treatment in DBT consists of the implementation of five functions. Each function is delivered via one or more modes; the original modes of standard outpatient DBT included skills-training groups, individual psychotherapy, telephone calls, and consultation team meetings. The milieu-based programs address all or some of the five functions but develop modes for delivery of those functions that are a good fit for those treatment contexts.

### *Function 1: Structuring the Environment*

Most simply put, the DBT program structures the environment(s) around the patient in such a manner as to reinforce adaptive behaviors and reduce dysfunctional behaviors, using principles of learning in the service of getting each patient to their goals. This includes structuring the program environment as a whole, in ways that affect all patients, and structuring the environment of each patient in ways appropriate to their particular goals, their particular strengths and sensitivities, and their particular circumstances.

#### *Structuring the Relationship between the Program and Its Surrounding Context*

With milieu programs, structuring the environment requires attending to surrounding contexts: the bigger institution if it sits within a larger organization, payors and insurance organizations that fund the program and the treatments, the community if

it is a freestanding entity within a neighborhood of some sort, and the mental health and medical treatment communities with which the program interacts. Insufficient attention to these contextual entities will eventually starve the program of needed resources, connections, and support. The designated program director represents the program in communicating about the nature and needs of the program, advocating for support and resources, including support for ongoing training, and publicizing the program's successes to relevant parties. The principles, strategies, and skills used in DBT can serve the program director well in working with these agencies and individuals in asking for support (aka the application of DBT to administration). For instance, if the program needs another half-time or full-time employee, the program director can appeal to the higher administration as if it were the DBT "patient," using strategies of targeting, assessment of controlling variables affecting administrators' behavior, using skills of validation and interpersonal effectiveness, and using contingency procedures to reinforce desired administration behaviors. Some administrators are more reinforced by cost savings or outcomes data, others by success stories, and others by strengthening of relationships with the community.

In one case, a partial hospital program, in which attention to context yielded significant benefits, was situated in a residential neighborhood where some individuals protested the program's placement there. Recognizing that in the long run, neighborhood attitudes would significantly influence its ongoing development and success, the program held educational sessions for the community, invited neighbors to some other program events, including an annual barbecue for the neighborhood that became a popular event. Not surprisingly, this outreach netted helpful connections and supports as the program came to be considered a constructive pillar in the area.

One important contextual entity for DTPs, PHPs, or IOPs is a crisis screening team, which usually exists within a local hospital emergency department. Such crisis teams will occasionally assess program patients presenting with high-risk behaviors, determining whether they need to move up to higher levels of care, usually inpatient care. The most effective outcomes of these assessments happen based on collaboration between the crisis team and the DBT program, including the sharing of clinical information and consistency with program philosophy. For example, because DBT emphasizes coaching patients to manage their own environmental challenges themselves, DBT clinicians are biased toward that approach rather than intervening in the social-professional environment on the patient's behalf. Members of a screening team with little understanding of this strategy may attempt to bypass it, thinking that the current crisis supersedes standard practices or that the DBT clinician is being irresponsible. If oriented effectively, the crisis team is likely to collaboratively endorse a stance that asks patients to take more responsibility. Having a crisis screening team that understands and supports a DBT philosophy is a boon to a local milieu-based DBT program.

Preferences vary among milieu-based DBT programs regarding the relationship between the patient's preexisting outpatient therapist and the milieu program therapist or treatment team. There are advantages in having communication with the "outside" therapist during the entry phase and the assessment process, and in planning for discharge during the exit phase. During the execution phase, decisions as to whether the patient continues in the prior outpatient psychotherapy can be made on a case-by-case basis, with an eye toward what will help the patient the most, what will make for a smooth transition back and forth, and what will prevent a confusing

process of "dueling therapies" to take place. Regardless of the decisions, they will ideally involve the patient in shared decision making, which is in keeping with the spirit of DBT and with a patient-centered, trauma-informed recovery model of treatment. It provides one of many opportunities in milieu-based care to help patients elicit their own "wise minds" in making decisions. Encouraging a patient to call and check into their options is a perfect way to reinforce skills of problem solving and mastery.

### *Structuring the Internal Program Environment*

Program leadership also structures the internal program environment, which includes the establishment of functional leadership and a clear and rational organization of staff roles and hierarchies. This begins at the top with the director of the program. The director is well served by clarifying prioritized directorship targets to serve as an agenda for the work, similar to the clarification of clinical targets in treatment. The ultimate goal for these targets is the establishment and maintenance of an effective program with fidelity to a DBT model and in which clinicians are practicing DBT with adherence. Being guided by a set of prioritized directorship targets helps the director to stay on track, to consistently attend to internal and contextual matters that will build and maintain the program, and to differentiate that role from the clinical roles of others whose target priorities will be mostly in the service of direct patient care. Some directors, of course, will play both a leadership role and clinical role, in which case their interventions are guided by directorship targets in the first role and clinical targets in the second. In a nutshell: The director supports the program and the staff; the staff supports the patients. And everyone draws from DBT principles, strategies, and skills in performing their duties. The following is a suggested and prioritized list of directorship targets:

**Target Priorities for Program Leaders**

- Decrease threats to the viability of the program from entities in the context (e.g., problems with payers, higher levels of administration, pervasive attitudinal problems)
- Decrease threats to the program from within
- Remedy aspects of poor program design, problematic protocols, or inefficient management of resources
- Address dysfunctional staff behaviors
- Increase staff's adherence to program expectations and skills in applying DBT protocols and strategies

When assessing factors interfering with program fidelity, adherence, and quality, a leader can follow a DBT sequence of assessing controlling variables, arriving at possible solutions, and then selecting and employing them. In one case, an inpatient program encountered a serious lack of enthusiasm and willingness among the nursing staff to learn and support the practice of DBT skills. Baffled by the problem, the director sought outside consultation, through which she discovered that nursing opinions were heavily influenced by the views of one particular staff nurse. She was an excellent nurse, had won the respect of all staff members, and while having no formal leadership status, she was an "informal opinion leader." Subsequent attention

to that nurse, which included validation of her reluctance, and helping her to weigh the pros and cons of proposed changes, won her over and resulted in mobilization of support across the entire nursing staff.

Clarifying prioritized target hierarchies for members of the clinical team, from the lead physician to the frontline nursing assistants, can be helpful as well. These targets, focused mainly on the treatment of patients, help staff members to stay on track in utilizing DBT principles and strategies in the milieu context to move patients toward their goals. Such a framework provides a rational architecture to milieu treatment with clear jobs for each person that coordinate well with other staff members and that work together to orchestrate a task-focused treatment. These targets should be as behaviorally precise as possible, a good fit for the job and for each staff member's level of training, and clear enough so that they can be assessed and taught. While each program needs to define its own target priorities to fit with its own circumstances, the following could serve as a general framework:

**Target Priorities for Program Staff**

- Decrease invalidation in the environment: of patients, fellow staff, and oneself
- Increase validation of patients, fellow staff, and oneself
- Increase application of behavioral principles to help patients pursue their targets effectively within the program

### *DBT Agreements and Assumptions*

In addition to using DBT principles, skills, strategies, and targets for structuring the program environment, programs specify DBT-compatible agreements to be made and maintained by staff, patients, and teams, and typical DBT assumptions about patients and therapy adapted from the outpatient comprehensive model. It can be helpful if the agreements and assumptions, along with program rules, schedules, and staff roles, are publicly posted and reviewed with each patient. The public and transparent nature of these can strengthen the sense of integrity, openness, and cooperativeness that strengthen a program.

### *Structuring the Physical Space*

Structuring the physical space of a program is another part of structuring the environment, where one aims to create a clear, pleasing, calming atmosphere where the work of treatment is visible. Posters on the walls can highlight the various DBT skills and protocols taught in the program, posted alongside songs, poems, artwork, and inspiring quotations capturing the program's spirit. One such program, which created and taught its own invented skill of "turtling," an effective way of withdrawing from interpersonal stimulation when distance is needed, was home to a multitude of turtle replicas in various forms. Some programs designate a room or corner of the milieu to be a "mindful space" or "self-soothe space" where patients can go to settle, to get grounded, and to use mindfulness and self-soothing skills to regulate intense emotions.

In inpatient settings, with the usual locked doors and sense of confinement, it requires effort and vision to counter the institutional effect. It is important, when

possible, to create a sense of spaciousness and diversity of "mini-environments" in a situation that can be crowded with patients and staff and dense with emotional dysregulation and behavioral incidents.

### *Rules, Policies, and Program Limits*

Rules, policies, and program limits also serve to structure the internal program environment, establishing, maintaining, and reinforcing functional patterns of behavior among patients and staff. To be effective, they should be relatively few, as clear and transparent as possible, and posted for all to see. In addition, they should be consistently reinforced in action in the milieu. For example, if there are aversive consequences prescribed for patients who break certain program rules, these consequences need to be consistently applied by all staff members across all patients, or they lose their effectiveness. The package of rules and policies should be constructed in such a way as to find a synthesis, or middle path, of two opposing poles: at the same time consistent and precise enough to frame problematic behaviors, chaos, and to establish safety and stability, while flexible enough to allow for autonomy, movement, and creativity in problem solving.

Programs need to define behavioral limits that are needed so that everyone feels a sense of safety, security, and respect. In addition, some limits are required because of the rules and limits of the larger organization, of which the program is a part. Finally, in a sense, program limits can be thought of as the limits articulated for the program by the director. In any case, for a functional program, each staff member should adhere reliably to all such program limits. If a staff member disagrees with one of the limits, they should proceed through appropriate channels to address the disagreement. However, inside the domain of those behaviors defined by program limits is still significant room in which each staff member defines their personal limits, those limits within which the staff member can remain fresh, curious, and constructively engaged in the work. One way in which a DBT-based program may be different than programs based on other models is this emphasis on individualized personal limits; there is no requirement for uniformity across different staff members in their limits, except to adhere to program limits.

### *Structuring the Schedule and Relationships among Staff*

A DBT inpatient unit typically begins the day with a group meeting, including some patients and at least one staff member, often called a "goals group" or a "focus group," in which patients identify their concrete goals for the day, aligned with their overarching target-based treatment plans. It can get the workday off to a positive start, providing an opportunity to motivate patients and to reinforce their functional capabilities. Some programs have a current patient "colead" this structured meeting organized around patients' targets and daily activities with a staff member. This is in keeping with harnessing the milieu itself as a motivational modality and works nicely on units that also have a peer who helps orient/greet new patients. As is the case with many group meetings in a DBT program, it might begin with a group mindfulness practice. Staff members make announcements about the day's scheduled activities and help patients to define their daily goals.

In DTPs, PHPs, and IOPs, variations of this may occur, for example, having

goals group once a week or every other day rather than every morning. Staff members have an opportunity in these meetings to set the tone: keeping patients informed of upcoming events and opportunities, validating patients for painful emotions and challenges, publicly recognizing good work and effort, and cheerleading patients as they move into the day facing challenging tasks. Jump-starting each treatment day with substantial reinforcement of adaptive behaviors sets a positive and hopeful tone for the whole day. For an entry phase patient, goals might include the completion of the initial behavioral chain analysis, watching and discussing a video that orients them to the program and to the skills curriculum, working on the first draft of a discharge plan, and/or attending a group where crisis survival skills are taught as replacement behaviors for the kind of dysfunctional behaviors (e.g., self-cutting) that required admission to the program. For an execution phase patient, goals for the day might be to practice observing and describing emotions throughout the day, to "act opposite" to the urge to isolate all day, to sit in on a transition (to discharge) group for the first time, to use mindfulness skills and crisis survival strategies to ward off an impending dissociative episode that day, to set up a meeting with someone from an outpatient program to which the patient hopes to return, and to work on a behavioral analysis of an urge to assault a fellow patient. For an exit phase patient, goals will typically be focused on the contacts, plans, and skills necessary for getting out, and staying out, of the program, while making the best use of regular outpatient services.

After initial meetings, typical inpatient and milieu program schedules move next to a series of meetings, which may include group skills-training classes; other meetings such as "commitment group" (for Phase 1 patients) or "transition group" (for Phase 3 patients); other specialized groups focused on, for instance, trauma, eating disorders, substance use problems, anger management; and individual meetings with psychotherapists, pharmacotherapists, or check-in meetings with nursing staff or peer counselors or case managers. Some programs develop specialized applications of DBT skills tailored to the needs of their patient populations: mindful eating skills for the patients with eating disorders, skills for generating compassion and empathy for those with antisocial features, skills for grounding for those with dissociative disorders, and skills for reducing anger for those prone to angry outbursts. Ideally, the structure of meetings will be such as to allow for skills development in group contexts, individual meetings with staff for therapy and other tasks, and free blocks of time to apply skills, pursue individual interests, and recover from stressful meetings.

Given the diversity of programs with respect to resources, length of stay, and institutional requirements, there is no formula with which to determine whether to offer individual therapy, case management, and other specialized roles. These decisions are made with an eye toward practicalities and preferences. There is no research evidence specific enough to argue in favor of one approach or another. Pragmatically, if a program has a length of stay of 3 to 7 days, the work of a trained individual DBT therapist for each patient may not be indicated. Some functions of individual therapy—orientation, assessment, getting commitment, creating treatment plans, monitoring progress, performing behavioral chain analysis, generalizing skills into the milieu and at home, and preparing for discharge—might be assigned to case managers, to groups, or on inpatient units to primary nursing staff members.

### *Structuring the Clinical Environment with Contingency Procedures*

Finally, and critically, the structuring of the treatment environment involves the use of both informal and formal contingency management procedures that will be further discussed below (see the "Strategies for Improving Patient Motivation" section below). One particular protocol for addressing the most disruptive or egregious behaviors has been helpful on inpatient units and has by now been applied in a variety of other milieu programs. Developed within the first DBT-based inpatient program, the "Egregious Behavior Protocol" (Swenson et al., 2001) is triggered by self-injurious behaviors, suicide attempts, violent outbursts, threats, and some other particularly problematic behaviors, such as bringing substances into the program. The protocol includes three steps, which have been adapted differently depending on the program. Patients are oriented to the protocol upon admission and informed that the protocol is activated in response to the most egregious life- or treatment-destroying behaviors and exists to provide an opportunity to reflect on the behaviors and change them in the future. In some settings, work on the protocol takes precedence over all other treatment activities. In the original inpatient version of the protocol, the steps were as follows:

- *Step 1: Behavioral chain analysis*. The patient is oriented to the protocol and given a behavioral chain analysis worksheet to complete. In doing so, they identify steps in the chain to the problem behavior and its consequences. The patient is asked to identify skillful replacement behaviors that might have averted the problem behavior. The patient is asked to work on the chain as independently as possible, recognizing that some circumstances require assistance by a staff member.

- *Step 2: Review and feedback*. The completed worksheet is reviewed with a staff member, who provides feedback and reinforcement for good work or effort. In some programs, with longer lengths of stay and an emphasis on peer groups, the chain analysis might be reviewed with peers, who are asked to provide constructive feedback.

- *Step 3: Repair.* After reviewing the behavioral chain analysis worksheet with a staff member and receiving reinforcement for the good work that was done, the patient discusses a repair plan, something to do that would repair any "damage" done interpersonally, physically, or to the community. It may warrant an apology to a fellow patient or staff member who was frightened by the patient's behavior, or a broader repair to the community as a whole if the behavior disrupted it. When a repair is decided upon, that action is carried out, and when completed, the protocol is terminated and the patient goes back to treatment as usual.

### *Barriers to Successful Completion of the Protocol*

Each program that utilizes the Egregious Behavior Protocol should have a plan for responding to the patient who refuses to do it. This can vary from program to program. In the original inpatient program where the protocol was developed, noncompliance led to the calling of a unitwide community meeting to discuss this serious matter, the remainder of the patient's treatment modalities were put on hold until the protocol was done, and if the noncompliance continued, steps were taken to have the

patient transferred elsewhere. The other significant obstacle to successful application of the protocol has been inconsistency in the use of it, such that some staff members are diligent in applying it to the designated behaviors while other staff members are less so inclined. The solution is to ensure that all of the staff understand the protocol, agree to implement it as written, and raise doubts and questions about it for negotiation in staff meetings.

### *Function 2: Enhancing the Patient's Capabilities*

With all of its disadvantages, inpatient treatment is an excellent setting in which to acquire skills, strengthen them, and generalize them to the inpatient environment, while still not ideal for helping to generalize them to the natural outpatient life setting. A particular advantage of DTPs, PHPs, and IOPs is that well-designed curricular programming can help patients to acquire and strengthen skills, the milieu staff can help them generalize skills practice to the milieu environment, and the daily movement between the program and home is ideal for the generalization of skills to the home environment.

Milieu programs can offer significantly more time per week for skills training than standard outpatient treatment, along with the chance to coach and reinforce skills in the milieu. Programs have experimented with a wide range of scheduling options for DBT skills training. One popular option is to teach new skills every program day in a group, to give a homework assignment to use the skills, both in the milieu and at home for the following 24–72 hours, and then to review the homework practice with the patients on the following program day. Some programs provide a slightly less intensive format, offering new skills every other program day, alternating with days when homework is reviewed. A popular application group for Fridays involves reviewing skills of the week, then helping patients to "cope ahead" by previewing the upcoming weekend and identifying and rehearsing skills that might be particularly useful.

Whatever the skills curriculum of the program includes, all staff members should become conversant with those skills being taught to patients so that they can coach, reinforce, and model those skills day after day. Furthermore, there are advantages to having staff members learn a broader range of the skills so that they can use them for themselves, can model skillful interactions in the program, and on suitable occasions can teach a particular additional skill to another patient. The chance to practice skills, and to receive coaching and reinforcement, is increased when "nonclinical" program staff—kitchen staff, custodial and maintenance staff, administrative staff—are familiar with the skills and support patients in this way.

Which skills should be prioritized in an inpatient or milieu curriculum? No research suggests an answer to this question, but the consensus of DBT experts and milieu-based programs suggests the following guidelines. The concept of "wise mind" and the practice of all six core mindfulness skills, as avenues to wise mind, are powerful in their own right and prerequisites for learning other skills, so these should be taught. Given the patients' high levels of distress and the unit's goal of helping to reduce problematic behaviors in the context of distress, the teaching of distress-tolerance skills, and in particular "crisis survival strategies" should be prioritized. The skill of radically accepting reality, also taught within the distress-tolerance module, is perfect for the person in milieu care who has many difficult

realities to accept. Core mindfulness and distress-tolerance skills should be amply represented in any milieu curriculum.

Skills should be selected from the other two modules, emotion-regulation training and interpersonal effectiveness training, to provide means to change one's emotional responses and relationships. From the former, the skills of observing and describing emotions, reducing vulnerability to negative emotions, coping ahead and building mastery, reducing suffering through mindfulness of one's current emotion, and acting opposite one's emotion are particularly useful. From the interpersonal effectiveness module, a milieu program should prioritize the teaching of the three priorities in interpersonal encounters, the five factors interfering with effectiveness, and the guidelines spelled out in DEAR MAN, GIVE, and FAST. A reasonable approach for a program would be to select a subset of the skills (unless it is an inpatient treatment or DTP with a long enough stay to cover all skills), teach them, and then learn through trial and error which ones to maintain, which ones to drop, and which other ones to introduce.

Finally, some programs have created their own DBT skills manuals, including only those skills they teach, along with appealing drawings, pictures, quotations, poems, and songs, resulting in an engaging manual specific to that program. A given program can then also include their own favorite practice assignments that are suited to their program. Each patient, and each staff member, can then have their own manual, to be used repeatedly during the program, and for patients thereafter.

Many patients, especially while still emotionally dysregulated shortly after admission, may be uncommitted, even opposed, to learning the skills. This is to be expected. For some, this indifference or opposition will be consistent throughout their stay. The staff's spirit should be one of repeatedly offering the skills, but accepting when certain patients are not ready to put their mind to that cause. The goal is to make the skills part of the curriculum and a pervasive part of milieu life, to find ways to make them interesting and compelling, to reinforce the skills everywhere, and to not get discouraged or defensive if certain patients or groups of patients find the skills unhelpful or objectionable. Our experience has been that if the staff become familiar with the skills and find them useful in their own lives, regularly include them in discussion on the milieu and in meetings, they will more likely act in a manner that reinforces patient interest and commitment to skills training.

### *Function 3: Generalizing the Skills to the Milieu and to the Outpatient Environment*

In spite of the disadvantages of inpatient and milieu-based treatment, such programs offer exceptional opportunities to help patients generalize the skills they acquire and strengthen in the group program into the milieu environment and all interactions. Frontline clinical staff members of such programs offer a priceless set of lessons if they are ready to engage the patients in coaching and reinforcing skills on the fly or during brief check-in meetings in the milieu. Obviously, this means that staff members absolutely must learn the skills themselves, to understand intimately what it takes to practice a given skill, what some of the difficulties might be, and how to address them. Furthermore, in some programs each staff member is asked to think about skillful patient behaviors that they can reinforce that day. The best moments happen when one catches a patient in the act of a skillful behavior and immediately

reinforces it. It helps as well if staff members comment, on the milieu informally and in public meetings with patients present, on each other's use of skills.

While staff members cannot be there after discharge to help patients generalize the skills in the community, they can, prior to discharge, help patients to anticipate how and where they can use them at home. Situations where skills will be needed at home can be anticipated, and through imagery and role-plays patients can "cope ahead" using rehearsals. This can be a major focus in treatment prior to the end of the day when the patient will return home, and/or in transition groups prior to discharge from a DTP, PHP, or IOP.

The transfer of skills from one setting to another cannot be taken for granted. Whether it is taking place should be assessed, and adjustments made so that each patient can find ways to use the skills successfully in their own contexts. Program staff can engage their imaginations in finding ways to enhance the practical value of skills and to demonstrate how they can be used across different settings and circumstances. Some programs have developed patient-specific "distress-tolerance plans" to be utilized in any context. One program created a "skills crash cart," a container filled with skills-related items and protocols to help the highly distressed individual survive an "attack" of intense emotions successfully. Patients can carry their manuals, flash cards, or "cheat sheets" listing all the skills that should be tried. When a patient goes on a pass into the community, they can enact a deliberate plan for using the skills. Some programs with formal contingency management protocols to reinforce effective patient behaviors in the program incorporate rewards for the active use of skills during the day.

Some programs have developed "safety protocols," designed for the patient who is dysregulated and needs support to resist the momentum toward dysfunctional behaviors. The use of such a protocol can be prompted by a staff member or by the patient themself. These usually include a step-by-step protocol that may begin with removing oneself from the evocative situation; writing down a mini-chain of events leading to the dysregulation; brainstorming several skills that might help in becoming better regulated; trying those skills and moving on to others if necessary; and finally reviewing the process with someone from the staff to get reinforcement and further suggestions. Too often, individuals resort to self-harm and other dysfunctional behaviors simply because at that moment they can imagine nothing else that could end their free fall into the chasm of suffering. The program equipped with safety protocols, skills training, and associated resources can help to break the fall.

"Coaching on the fly" or offering in-the-moment reminders to use skills, and sometimes even teaching a needed new skill in the moment, along with immediate positive reinforcement for skills practice, is a powerful mode for generalization of skills in milieu environments. It is one of the unique advantages of inpatient or milieu DBT that staff is there to offer a reinforcing comment at the very moment that a patient, struggling with an urge to self-injure or to strike out angrily in response to a cue, acts opposite to that urge, radically accepting the situation in that moment, and using a distress-tolerance skill. It is a powerful moment when a patient's quiet heroic act in their battle to become stable and skillful—the kind of act that is almost never noticed by others in the patient's network—can be noticed and reinforced by another person. In one inpatient DBT program, staff members are asked repeatedly as part of their orientation, training, and ongoing work on the unit to think about skillful patient behaviors to reinforce that day and to constantly look for opportunities to

reinforce them. To provide positive contingencies in acute-care milieu settings, where too often the focus is on maladaptive behaviors, is helpful.

"Check-ins" between staff members and patients are a hallmark of milieu-based care, including check-ins with peer support workers in the program. These are often extremely important to patients as well as to staff members, a rare moment (typically 5–15 minutes) of individualized attention where problems can be broached and discussed, wounds can be soothed, supportive relationships can be fostered, and skills can be coached. A skills-training model provides a far better match for these meetings than depth psychotherapy models. The "check-in" mode can be compared to phone coaching in outpatient treatment. In order of priority, the behavioral targets of such meetings should be:

- To decrease crisis behaviors
  - Life-threatening, treatment-destroying, and milieu-destroying behaviors
  - Egregious behaviors likely to prolong one's stay at that level of care
- To increase generalization of skills to the milieu
- To increase the strength of the relationship between that patient and that staff member

Functionally, the focus is on acquiring and strengthening skills for gaining control, for interacting on the milieu, and, for outpatient milieu programs, for staying out of the hospital and moving toward higher levels of care—a perfect fit with the overall milieu program mission. The staff member is equipped with the skills, and the check-in becomes an effective, time-limited, target-oriented mode. Sometimes a 10-minute check-in done in this manner in the heat of a distressing moment can be the single most important 10 minutes of the program stay. The staff member then feels effective, having identified with the overall unit mission, and very much part of the treatment team. This is one of the best antidotes to low morale and feelings of disenfranchisement in nursing or milieu staff.

Skills taught in the program should be listed on diary cards so that patients can self-monitor their use of the skills. The cards then serve as vehicles of communication between patients and staff, means for staff members to assess progress in using skills, and providing them with opportunities to reinforce usage. The diary cards can be reviewed in regularly scheduled check-in meetings with milieu staff or in meetings with therapists if present.

Skills-application groups in the program provide another mode for generalization of skills. These can supplement the standard skills-training groups; instead of the agenda of the group being driven by covering one skill after another, though, the agenda is driven by the presentation by patients of various problems they are having on or off the unit. One program called its skills-application group the "DBT Patient Consultation Meeting." A staff psychologist established a weekly meeting, to which all patients were invited but attendance was voluntary. Patients could put a problem on the agenda, with the understanding that DBT skills would be brought to bear as solutions. Patients would bring up interpersonal problems they were having with other patients, with a nurse, or with a psychiatrist with whom the patient was frustrated. They raised the problem of coping with unrelenting urges to self-injure, and sometimes just asked a question about how to apply a particular skill they learned in group. The group leader tried to clarify each problem and then arrive, with group

discussion, at suggestions of skills for solving the problem. Sometimes it was possible to have everyone in the meeting practice the skills, and sometimes it was possible to turn the situation into role-playing.

One such meeting on an inpatient unit was attended by almost all the patients after a difficult incident in a community meeting. The unit chief, frustrated after several episodes in which furniture had been damaged by cigarettes (back in the days when smoking was allowed on inpatient units), suddenly made a rule that smoking would no longer be permitted on the unit without any planning for how everyone would then cope with their nicotine addiction. The patients went to the consultation meeting where the psychologist helped them to articulate the problem(s) and to begin to identify skillful solutions. She had each patient in the room do a brief role-play with her in which she was the unit chief and they used their skills to get him to modify his position. After lots of episodes of practice, which became rather lively, the psychologist called a special meeting of the group later in the day to which the unit chief was invited. Serving as the patients' coach, she helped each patient skillfully address the unit chief about the problem. This marked a huge step toward finding a less drastic solution, and more importantly it provided an extraordinary opportunity for a group of emotionally dysregulated individuals to learn and to practice effectively addressing an authority figure about an emotionally charged matter.

### *Function 4: Improving Patient Motivation*

Patients are motivated by different factors in milieu treatment. A patient may find one group meeting or group leader more motivating than another. Some patients may be motivated by being in a milieu environment where they receive meaningful validation, where they feel that they belong, or where they are encouraged by the presence of frequent positive reinforcement. Others are motivated by the experience, possibly for the first time, of being taught concrete practical skills as tools for changing their lives. Leadership of such a program is wise to track the overall morale of the milieu and the factors in the program that seem to be most motivating. In these respects, almost any group, any relationship, or the environment as a whole can improve patient motivation.

Several lessons for improving motivation in standard DBT can also be brought into the program. First, relationship or interpersonal attachment may exert the most motivational force. In milieu settings, even though time may be short, it is often the case that a patient's attachment to a specific staff member is an important source of motivation and hope. While one cannot insist on attachment, if it does develop, it provides a degree of leverage because the statements and behaviors of that staff member will be experienced as meaningful and influential. Second, the nature of contingencies becomes important. In other words, if it is clear to a patient that the relinquishment of problematic behaviors and the practice of skillful ones will result in desirable changes, motivation is likely to increase. While the methods are different from program to program, both formal and informal contingencies can play a role in enhancing motivation and positive outcomes. While there is no one answer to the question as to whether to incorporate token economy systems, emphasizing arbitrary reinforcement, as a way to increase motivation in a DBT program, typically the emphasis will be much greater on natural reinforcements rather than arbitrary ones.

The brevity and interpersonal complexity of milieu settings conspire against

centering the function of improving patient motivation in any one mode or individual. The milieu team takes the stance that, on any given day, or, for that matter, on any given shift, the best clinician to enhance a patient's motivation is the one on the team who is most effective at motivating the patient to behave in ways that bring them closer to their goals. "Staff," in this sense, of course, does not distinguish between disciplines. It refers to the psychiatrist as much as it does to the psychiatric aide. After discharge or stepping down, it is not unusual for patients to report that they were most affected and motivated by one or another peer, staff member, nurse, vocational counselor, perhaps even the unit clerk. It simply is not possible to count on the individual psychotherapist, if there is one, to provide the most salient reinforcement for the patient in such a network of relationships. On the other hand, the individual therapist may be the prime motivator, but that work can be enhanced by the positive interactions of other staff members in the program who work to get to know the patient.

In staff consultation team meetings, when staff members share endearing stories about patients' courage and trials and tribulations, it promotes compassion and respect for the patients, which then lead to more compassionate, respectful, and effective interventions. As is expected in standard DBT, milieu staff practice the phenomenological empathy agreement, based on which the staff seeks the most empathic interpretation of the patient's behavior that is consistent with the data. An empathic approach enhances the patient's willingness and motivation.

Finally, of course, the milieu staff plays an important part in improving motivation. This mode, the daily informal communication network on the unit, has perhaps the greatest potential for improving motivation and yet is the most unwieldy to characterize or define. Optimally, staff members will be familiar with, or have quick access to, each patient's specific targets, will be very familiar with the skills involved, and will be trained in contingency management strategies and learning principles. The relentless focus throughout the program should be on positive reinforcement of skillful behaviors. This is easier said than done in a setting where there can be considerable emotional and behavioral dysregulation on the part of both patient and staff, yet repeated interventions including those that help the staff cope and feel valued are important in maintaining programmatic health.

## Strategies for Improving Patient Motivation

In DBT, in addition to enhancing motivation through positive reinforcement, cheerleading, and utilizing interpersonal leverage resulting from attachment relationships, clinicians also seek out and address factors that interfere with motivation. In fact, this requires the use of the package of all standard DBT strategy groups, including problem-solving strategies, validation strategies, dialectical strategies, stylistic communication strategies, and case management strategies.

When motivation for behavioral change is insufficient, problem-solving strategies commence with the use of behavioral chain analysis to assess factors that maintain the problem behavior and factors that interfere with change. Behavioral chain analysis is present in all milieu-based DBT programs, which are typically well stocked with chain analysis worksheets. All staff members should be thoroughly familiar with them and ready to assign them to patients for preliminary assessments

of problem behaviors. In one PHP, use of the behavioral chain indicated that a certain patient's downward behavioral spiral resulting in admission to the program was set off in response to the outpatient therapist's vacation. In another case, in which a patient was repeatedly consumed by episodes of self-invalidating cognitions, repeat chain analyses uncovered that such episodes came in response to interpersonal conflict between the patient and other people, or even just between any two people in the patient's environment. The staff could then focus interventions on the patient's awareness of and reactions to the presence of conflict, which made a big difference.

Recognition of patterns sets the stage for insight into patterns, insight paves the way to find solutions, which typically involve the application of behavioral change procedures: skills training, cognitive modification, exposure procedures, and contingency procedures. The patient who has withdrawn from usual life activities and relationships in response to recent losses, and who presents as depressed, can be prompted to schedule activities and encounters, which then brings them into contact with more reinforcing consequences. The individual who is avoiding relationships because of prior episodes of trauma can be taught skills for tolerating distress and/or changing emotional responses, and then oriented to the use of exposure for processing the traumatic memories. The patient with intense resentment of their partner at home but who does not know how to skillfully address their partner's behaviors can be taught to use interpersonal skills and can rehearse encounters with their partner with staff members in the program. In other words, the behavioral chain analysis suggests solutions unique to each case, solutions that decrease problem behaviors and replace them with more effective ones.

Contingency management procedures play a fundamental and constant role in milieu treatment programs, as contingencies always heighten or decrease motivation. Simply put, a patient is more likely to use a given skill if it works to reduce suffering or to bring about a desired change. The decision of whether to self-injure is influenced by the outside-of-awareness calculation, "Would the reduction in my emotional distress from self-cutting outweigh my increase in distress due to a groupwide review of my cutting behavior in the program?" If milieu staff "reward" a patient who has lost behavioral control with more individual attention, other patients desiring attention will naturally be motivated to lose control as well. Contingencies motivate behavior all the time, a fact that can become a powerful tool for behavioral change for the program staff who can figure out the contingencies in that context. Milieu programs have the potential of being powerful environments that routinely teach skills to patients: just as routinely reinforcing those functional behaviors, while not reinforcing dysfunctional ones. This requires an observing eye with which staff notices which behaviors are reinforced by which program contingencies. In one program, staff members were occasionally placed on 15-minute shifts during which their only job was to observe what behaviors were being reinforced by what contingencies, with their observations then reported to the larger staff.

Because the natural tendency is to direct attention to the troubling and problematic behaviors on the unit, it is easy to overlook all the adaptive behaviors going on at the same time. Natural reinforcers should be emphasized: enthusiastic praise, a high five, a quiet word of approval, a knowing glance, or even the absence of any response. Any one of these may be the best natural reinforcer for a given person; staff members must notice what works best for each patient.

To weaken problematic behaviors, the staff can sometimes apply extinction,

which is to remove or weaken the reinforcers found to be maintaining the behaviors. For example, a staff member might consistently not respond in a group meeting to mildly dysfunctional communication behaviors, putting them on an "extinction schedule," while selectively and obviously responding to adaptive communications. The patient who pounds on the program office or nursing station door to get someone's attention might get no response, but they do receive a response when they ask politely to talk with someone. Behaviors targeted for extinction should come from one of two behavioral categories: (1) those behaviors targeted for decrease on a given patient's treatment plan (target list), and (2) those behaviors that violate the limits of the program or of individuals within the program.

Some problem behaviors do not remit even if they are targeted for extinction, and even if adaptive alternatives are reinforced. Under these circumstances, the staff might apply aversive consequences, always as the last resort and done with care. The most common aversive response is simple disapproval, expressed in a way that matches its intensity with the particular patient's tolerance. The use of punishment as a problem-solving procedure is best done in a thoughtful, compassionate context. In other words, there is a sharp distinction between punishment used objectively and compassionately to suppress seriously problematic behavior, and "punitiveness" as an attitude or tone. Certainly, all programs must maintain program limits to maintain order and safety, so the staff is wise to become expert at observing limits and delivering consequences in a manner that is objective, consistent, firm, and always with an attitude of compassion.

"Observing limits" is a contingency procedure in DBT important in milieu programs, a primary tool for preventing staff burnout. This is quite different than the "setting limits" used in other programs. The strategy is based on the fact that each staff member has different personal limits than others, different thresholds of tolerance, different sensitivities. It is the responsibility of each staff member to know one's own limits, to know when they are crossed, to communicate when they have been crossed, and to help patients avoid crossing those limits and to help them find an alternative behavior. Staff members will have personal limits regarding their own tolerance for profanity, their own preference for self-disclosure of various types, levels of tolerance for frequent contact, even preferences with regard to how close another individual stands to them. By observing limits, a staff member is emphasizing, "These limits are my limits and I need you to observe them so that I can work well with you," rather than emphasizing, "You need these limits because you need to change." A message delivered in this spirit spares the patient from being blamed or accused, yet includes a firm request for change. Sometimes staff members will temporarily broaden limits when it is in the client's best interest that they do so. The consultation team may be needed to assist the individual staff member to expand their limits when doing so is extraordinarily difficult. It is very important to ensure that program limits are observed, and that program limits override the application of personal limits. Staff members who would like to exercise limits broader than those of the program should discuss their opinions about program limits with staff only.

Validation strategies are crucial in the development of attachments and the improvement in motivation. They help patients to develop the resilience and motivation to engage in problem solving and to counter the tendency toward self-invalidation. They strengthen relationships between patients and staff members. They convey empathy, sympathy, compassion, and acceptance as a baseline, which helps patients

remain resilient when they are pushed to change behaviors. Staff members look for the nugget of gold in a dysfunctional behavioral sequence, even as they search out the problem behaviors in that chain. One can validate painful emotions that led to cutting behaviors or patient desires to skip a meeting, while pushing for change in cutting and in nonattendance. Staff members sometimes need help to understand that the ideal position in DBT is to be compassionate and 100% validating in one moment, and then to be 100% insistent on behavioral change in the next moment. This kind of agility and wholehearted involvement can be difficult, such that staff tend to move toward a compromise position in the middle that neither insists on change nor radically accepts the patient's difficult plight. The lightning-speed pivot, with practiced ease, from one to the other is a distinguishing quality and part of what is referred to in DBT as "movement, speed and flow."

Dialectical strategies are brought into play when staff members face, or are stuck within, polarized and rigid positions, black-and-white thinking, and treatment impasses. When movement cannot be made through problem solving alone, or validation alone, or shifting between the two, the staff member moves toward a dialectical type of resolution, which is to find a synthesis of the two opposing positions. This means to first locate the validity of each position and then to preserve the validity of both sides in a new construction, the synthesis. Dialectics emphasizes "both–and" thinking, rather than "either–or" thinking. It emphasizes speed, movement, and flow rather than stasis. While it would be too much to review all of the dialectical strategies of DBT in this context (Linehan, 1993a), these include the attempt to make "lemonade out of lemons" (i.e., turn a crisis into an opportunity) and to find metaphors for capturing tense and conflictual situations. The staff is dialectical in their styles of communication in DBT, balancing a warm and responsive tone (i.e., a reciprocal communication style), especially when the patient is "going down the right track" working toward their goals, with a more confrontational and challenging style (i.e., irreverent communication), especially when the patient might benefit from "jumping tracks."

It is tempting in milieu-based treatments for staff members to talk with each other about the patients without the patients being present. It can be a way to ask other staff members to change behaviors, or to plan the patients' treatments with each other. That sometimes even extends to speaking with patients' family members and "outside" providers. While this is not unusual in mental health treatments, it is a significant violation of the "case management" protocol within DBT. DBT practitioners, including those involved in milieu treatment, must help patients figure out how to solve problems with others in their social and treatment network, rather than solving them for the patient. This is a cornerstone in DBT treatment and yet is difficult to maintain under the pressures to communicate with one another in milieu treatment. It is often more convenient to intervene on behalf of the patient without the patient being present, but this deprives the patient of the opportunity to strengthen their own capabilities for self-management. For instance, when a patient complains to Staff Member A about Staff Member B's behavior, A might consult with the patient about how to address problems with B. A might not even mention their conversation with the patient to B. In DBT, it is not A's job to defend B. It is this situation that many inpatient staff call "splitting," with the implication usually being that the patient is doing something pathological, setting up one staff member against another. This concept is not present in DBT. The case management protocol is a radical deviation

from usual institution-based mental health care, and therefore requires vigilance and support from the consultation team.

As an extension of this protocol, the emphasis in DBT is also to have the patient, to the degree possible, be the architect of their own treatment. Patients should attend the meetings where their treatment is discussed and planned, and be in the center of other communications about them. They should be in charge of phone calls for discharge planning wherever possible. When staff members must play a part in these communications, patients should be present to honor the spirit of the protocol.

### *Function 5: Enhancing the Capabilities and Improving the Motivation of the Staff*

Working day after day with individuals who are emotionally dysregulated, who threaten and attempt suicide, who engage in self-harming behaviors, and who lose emotional control with anger, fear, shame, and other emotions is stressful. It is part and parcel of DBT for all practitioners to be part of a weekly consultation team meeting, helping to improve and maintain motivation and to strengthen treatment capabilities. In standard outpatient DBT, therapists gather weekly for 1½ to 2 hours, but in a milieu setting, where staff schedules are shifting and it may be difficult for all staff to meet together at the same time each week, one needs to adapt. On an inpatient unit, a 90-minute consultation time at the same time each week may work for the professional/nonshift staff, but other modalities must be employed for line staff. The crucial point here is that all staff, "frontline" and "professional," need to have regular meetings that attend to the staff's needs in the service of their patients.

In one inpatient program, this challenge came about because nursing staff, case managers, peer support workers, psychiatrists/medical staff, psychosocial rehabilitation specialists, and others with shifting schedules and unpredictable schedule impingements of many kinds could not attend the team meeting regularly. One might argue that the frontline clinical staff, who have the most face-to-face hours with patients, need this mode the most, especially given that they have the least clinical training. Each staff member needs a chance to review difficult encounters with patients, learn more about how to apply the treatment, and receive validation and support from fellow staff and leadership. Otherwise—as is typical in crisis and/or milieu care settings—staff end up burned out by the emotional demands of their jobs. As they deplete their personal resources, they become more detached, or mechanistic, or rigid and punitive. One can hardly judge them for merely being human. Staff are to be forgiven when one recognizes the emotional strains of their jobs and the typical lack of meaningful supervision they endure. Here, creativity and a strong commitment to fulfill all functions of comprehensive DBT are needed to stay on track.

For example, one inpatient unit provided two different consultation teams: one for therapists and one for nursing staff and recreational staff. The therapists met weekly in a more typical consultation team. For the nursing staff, the DBT program leader conducted mini-consultation team meetings, which came to be known as "chalk talks." During a lull in activity during a daytime or evening shift, he would bring together those nursing staff members who could be spared for 10–15 minutes, take them to the room behind the nursing station, and ask them to bring up encounters with patients in the prior few hours that they wanted to review. Once a trusting atmosphere was developed, with considerable validation and positive reinforcement, staff members looked forward to the meetings and became more forthcoming. The meetings were brief,

focused on encounters with patients, and filled with practical ideas on what to do. Role-playing became common and staff were given "mini-homework" assignments through which they could practice for the next encounter with a given patient. These chalk talks supplemented a training curriculum for nursing staff that was delivered in in-service meetings during which therapists on the unit helped to cover for nursing staff functions.

Another unit expanded on these chalk talks by assigning not only the program leader but also all senior DBT clinicians to be mentors for two or three less experienced frontline staff members. Supported by the nursing supervisor, staff members and their mentor would meet for "30-minute hits" once a week. The didactic portion of these meetings, usually lasting 10–15 minutes, was based on a curriculum of DBT principles followed by role-plays of patient encounters and assignments as noted above. The mentoring relationship expanded naturally to "shoulder to shoulder," *in vivo* modeling by mentors and students as they saw patients together throughout the week. Finally, in much the same fashion that outpatient DBT therapists are available for phone coaching to their patients between sessions, mentors made themselves available by pager to their "staff" for in-the-moment consultation regarding DBT strategies when staff were managing difficult patient encounters.

In another example, in a PHP/IOP setting, nontherapist frontline clinical staff attend one of two scheduled consultation team times, which are scheduled to allow for all shifts to attend. Those unable to attend either meeting receive an 8-week DBT staff skills-training program followed up by supervision either in an individual or group format. The persistent and explicit expectation of learning and using DBT skills in the program results in some staff opting out, as it becomes clear to them that this is not what they want to do. It parallels the DBT process of orientation and commitment for patients. As staff members recognize the usefulness of skills and strategies, both in terms of their personal application to the life of the staff member and in terms of the professional application of working with high-need and miserable patients, buy-in and use increase. Sometimes staff members who thought they couldn't afford the 90 minutes for a consult, or administrative staff who didn't believe it was needed, become open and available to the process as it is seen to improve the functioning of the unit or program.

It has been our observation that, with the exception of the patients, the nursing staff on inpatient programs, and the case managers, hospital discharge workers, and peer support staff in outpatient milieu programs, have the toughest time of it. And when these staff members are meaningfully appreciated and brought into a DBT-oriented approach, they can find themselves rejuvenated, remembering what brought them into mental health work in the first place. This, of course, translates into better care for the patients.

## Concluding Comments

While the research is scant, inconclusive, and mostly just suggestive regarding milieu-based DBT treatment, the extensive base of implementation experience strongly suggests that these programs—inpatient, DTPs, PHPs, and IOPs—allow for creative and potent applications of DBT principles, strategies, and skills. The development of such programs in the larger mental health treatment community creates the exciting

potential for using the same principles and language across different levels of programming in a continuum of care.

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CHAPTER 6

# Application of DBT in a School-Based Setting

ELIZABETH T. DEXTER-MAZZA, JAMES J. MAZZA, ALEC L. MILLER, KELLY GRALING, ELIZABETH A. COURTNEY-SEIDLER, and DAWN CATUCCI

With powerful clinical results using dialectical behavior therapy (DBT) for chronically suicidal, multi-diagnostic adults (Linehan et al., 2006), it was merely a matter of time until DBT was adapted for use with a younger population. When Linehan first published her treatment manuals in 1993, the adolescent suicide rate among 15- to 19-year-olds was the third leading cause of death in this age group (fourth among 10- to 14-year-olds). Since that time, however, the adolescent suicide rate has become the second leading cause of death for all youth 10- to 19-years-old (Centers for Disease Control and Prevention, 2020). The need to provide and implement empirically based services to help stem the increasing rate of self-harm and suicidal behavior among adolescents is of increasing importance in the field of prevention. Thus, this chapter will focus on the move to bring DBT to adolescents at the place where they spend most of their time, school, through a universal social–emotional learning (SEL) program and school-based mental health.

## Background on DBT for Adolescents

In the 1990s, Miller, Rathus, Leigh, Wetzler, and Linehan (1997) began applying DBT to suicidal multiproblem adolescents and families in an inner-city outpatient clinic. At the time, no evidence-based treatments existed for suicidal adolescents and, surprisingly, many researched treatments for depression and related disorders excluded suicidal youth. These investigators first adopted and then adapted the original Linehan (1993a, 1993b) text and skills-training manual for the teens and families that had sought help at the clinic. They went on to conduct some preliminary research

(Rathus & Miller, 2002) and subsequently published their treatment manuals: *DBT for Suicidal Adolescents* and *DBT Skills Training Manual for Adolescents* (Miller, Rathus, & Linehan, 2007; Rathus & Miller, 2015).

To date, two reviews and one meta-analysis have been conducted examining the outcomes of DBT for adolescents in various treatment settings (Cook & Gorraiz, 2016; Groves, Backer, van den Bosch, & Miller, 2012; MacPherson, Cheavens, & Fristad, 2013). There are 18 open and quasi-experimental published trials of DBT with adolescents conducted in outpatient, partial, and residential treatment settings. Since these articles were published, several randomized controlled trials (RCTs) of DBT with adolescents have now been completed. Recent RCTs reviewed below have provided strong evidence for DBT being an effective treatment for self-harming and suicidal adolescents in clinical settings. In addition, there is growing support for the implementation of DBT in schools and its effectiveness in reducing suicidal and other problematic behaviors.

## Clinical Outpatient Studies with Adolescents

The first RCT of DBT with adolescents was conducted by Mehlum and colleagues (2014, 2016). Participants were 77 youths (ages 12–18) recruited from community child and adolescent outpatient psychiatry clinics in Oslo, Norway, with a history of at least two episodes of self-harm, with one occurring within the past 4 months, and meeting at least two DSM-IV criteria for borderline personality disorder (BPD). Adolescents were randomized to receive comprehensive DBT (C-DBT; weekly individual, weekly multifamily skills group, as-needed family sessions [no more than 4], and as-needed intersession telephone coaching with the primary therapist) or enhanced usual care (EUC; psychodynamic or cognitive-behavioral therapy [CBT]) for 19 weeks. Primary outcomes for the study were incidents of self-harm (including suicidal behaviors and nonsuicidal self-injury), self-reported suicidal ideation, and level of depressive symptomatology (both self-reported and interview-rated). At the conclusion of treatment, patients who participated in DBT experienced statistically significant reductions in all of the above primary outcomes. Adolescents receiving EUC only demonstrated significant reductions in self-reported depressive symptoms. In addition, patients receiving DBT experienced a significantly stronger reduction in feelings of hopelessness and BPD symptoms.

At 1-year follow-up, results indicated that adolescents receiving DBT demonstrated a significantly stronger reduction in self-harm episodes (Mehlum et al., 2016). Although DBT resulted in a faster decline in suicidal ideation, depressive symptoms, and borderline symptomatology compared to the EUC group, these differences were not statistically significant at 1-year follow-up.

A second RCT was recently completed. The Collaborative Adolescent Research on Emotions and Suicide (CARES) study is a multisite RCT conducted at the University of Washington, Seattle Children's Hospital, Harbor–UCLA Medical Center, and the University of California, Los Angeles. A total of 170 adolescents (13 to 17 years of age) were enrolled in the study across sites. Inclusion criteria included current suicidal ideation, at least one instance of nonsuicidal self-injury (NSSI) or a suicide attempt, and difficulties with emotion dysregulation and impulsivity as characteristic of BPD. Adolescents were randomized to receive C-DBT or individual and supportive group

therapy (IGST) over a 6-month period. Preliminary results show an overall significant decline in suicide attempts over the course of treatment across groups and statistically significant lower suicide attempt rates in the DBT condition (10%) compared to approximately 20% in the IGST condition (McCauley et al., 2016). Early results also indicate a greater reduction in NSSI among youth in the DBT condition compared to those in the IGST group, with prevalence rates posttreatment 33.8% in the DBT group compared to 60% in the IGST group. Finally, there was a greater decline in suicidal ideation within the DBT group compared to the IGST group over the course of treatment. Individuals receiving DBT demonstrated a 26.21 point reduction in suicidal ideation as measured by the Suicide Ideation Questionnaire (Reynolds, 1987), compared to a 19.24 point reduction in the IGST condition. These preliminary results provide further support for the efficacy of DBT in reducing suicidal behaviors, NSSI, and suicidal ideation in youth.

## The Need for Upstream Mental Health Services in School-Based Settings

Despite clinical evidence of an empirically supported treatment for multiproblem youth, the need for mental health services among youth continues to be unmet, with community surveys indicating that 80% of youth in need of mental health treatment will not receive it (Kataoka, Zhang, & Wells, 2002). These statistics are alarming and have led some mental health researchers to look to schools as a place to implement evidence-based treatments (Doll & Cummings, 2008). School-based settings offer an ideal environment to provide emotion-regulation skills using a proactive approach. Because most countries offer educational services to adolescents, infusing coping strategies and decision-making skills that focus on emotional distress provides a unique upstream approach that complements the academic curriculum in helping educate the whole child, while also reducing the likelihood of self-harming and/or suicidal behavior.

There are numerous advantages to implementing DBT skills and/or services in schools. First, schools have become a "de facto" setting for providing mental health services (Cook, Burns, Browning-Wright, & Gresham, 2010). A review of three national surveys examining mental health services to students between the ages of 6 to 17 years found that approximately 80% of students identified as in need of mental health services did not receive them in the preceding 12 months (Kataoka et al., 2002); the small portion that did receive them overwhelmingly received such services at their school. Furthermore, Catron and Weiss (1994) found that 98% of students referred for mental health treatment in their schools received services compared to less than 20% of students who were referred to outside agencies and actually received services.

The second advantage is the school-based setting itself. Schools have a captured and consistent audience, meaning adolescents are already coming into this environment to learn academically, and thus adding mental health skills and/or services would be a natural fit. This allows for continuity of services, coaching, and progress monitoring to take place, while also providing a naturalistic environment to practice DBT skills and strategies.

Related to the school-based setting, the third advantage is that some of the significant emotional stressors that adolescents face happen at school. Examples of these

stressors may include, but are not limited to, academic performance, social interactions, peer rejection/bullying, sexual orientation, and intimacy-related issues. Thus, the school environment provides a practical setting for students to use and refine their DBT strategies on any emotional stressors they are currently experiencing. This type of real-life application allows for increased generalizability.

A fourth advantage of the school-based setting is that the delivery of DBT skills and services is not parent-dependent. One of the biggest barriers for adolescents receiving outside mental health services is their reliance on one or both parents' involvement. In addition, research has shown that parents' life stressors can often be obstacles in helping their children get the mental health services they need (Wagner et al., 1997).

The delivery of DBT skills and services in school-based settings is not without its challenges. The biggest barrier for implementing these services in schools is resources in the form of time, money, and trained personnel. Schools have often cited time issues with regard to the scheduling of SEL curricula or mental health services (classes or individual services) that take away time from academic instruction. However, research does not support this notion; in fact, the research results of schools that have dedicated time to implementing SEL programs have shown increases in GPA, fewer disciplinary referrals, and fewer classroom management issues than schools that did not implement SEL programs (Cook et al., 2015).

## Applying C-DBT in School-Based Settings

In 2007, Miller and colleagues began consulting with schools in Westchester County, New York, to develop and implement a school-based comprehensive DBT (SB-DBT) program (Miller et al., 2007). The preliminary results from an open trial at a suburban high school in Westchester County (Mason, Catucci, Lusk, & Johnson, 2009) showed that adolescents participating in SB-DBT had reduced disciplinary referrals to the assistant principal, reduced absenteeism in class, reduced detentions and suspensions, and an anecdotal reduction in depression, anxiety, NSSI. Adolescents in a comprehensive SB-DBT program at a high school in Pleasantville, New York (Dadd, 2016), demonstrated significant reductions in depression and social stress as measured by the Behavior Assessment System for Children—Second Edition (BASC-2); increased adaptive coping skills, in particular, mindfulness skills; and increased abilities to tolerate distressing situations and reduced maladaptive coping.

In applying the comprehensive SB-DBT model beyond New York, a large public high school in Portland, Oregon, provided SB-DBT services to 56 at-risk high school students (i.e., with histories of NSSI, suicide attempts, suicidal ideation [Hanson, 2015]). Results indicated that before implementing SB-DBT, there were one to two suicides per year and in the 9 years since the implementation of SB-DBT, none have occurred. Examining more general outcomes at the high school level, Hanson (2015) reported that there were, on average, two placements to day treatment programs per year before the implementation of DBT, and only one placement in the 9 years following the implementation of the SB-DBT program. Specifically, the adolescent students participating in SB-DBT also showed significant improvement in their GPA from pre- to postintervention and significant reductions in anxiety, depression, social stress, and anger control as measured by the BASC-2 (Hanson, 2015). However, it is

important to recognize that the research with SB-DBT represents a small portion of the students attending school-based settings, and who have been identified through some screening/referral as either at-risk and/or have engaged in self-harming/suicidal behavior. Thus, the need exists to develop prevention strategies designed for all students, offering an upstream approach at the universal level to reduce the number of adolescents becoming at-risk or engaging in self-harm/suicidal behavior.

## Upstream from SB-DBT: From Intervention to Prevention

It is clear that C-DBT is effective in decreasing suicide and nonsuicidal self-injurious behaviors, substance use, depression, hopelessness, eating disorders, and anger, and it results in an improvement in overall functioning (Harned et al., 2008; Koons et al., 2001; Linehan et al., 2006). Furthermore, several studies have shown that a DBT skills-only intervention also provides a significant reduction in problems related to eating disorders, childhood abuse, attention-deficit hyperactivity disorder (ADHD), depression, and anxiety-related behaviors (Safer, Telch, & Agras, 2001; Bradley & Follingstad, 2003; Hirvikoski et al., 2011; Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014). According to Linehan and colleagues (2015), in a component analysis of the different modes of DBT (i.e., individual DBT only vs. DBT skills group only vs. C-DBT-individual + skills group), interventions with DBT skills training are superior to those without it in improving NSSI, depression, and anxiety. Furthermore, the DBT skills explain improvements in problems related to suicide and NSSI, depression, anxiety, anger, emotion regulation, and interpersonal difficulties. It is important to note that in the component analysis study, for each intervention group, DBT providers had a DBT consultation team with which they met weekly. In addition, those in the DBT skills group only condition also received intensive case management and used the DBT suicide risk protocol. This point is important as it highlights the need for DBT therapist consultation team support and use of suicide protocols when working with individuals at high risk for suicide and other life-threatening behaviors. This population is significantly different from the populations listed above (e.g., those diagnosed with ADHD, depression, eating disorders) and the universal student population for which the DBT Skills in Schools: Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A) curriculum was designed.

Given that DBT skills are shown to be effective in so many areas and, in general, are considered everyday living skills, Mazza and colleagues (2016) developed an SEL curriculum for middle and high school students based on the skills of DBT. DBT STEPS-A is a 30-lesson curriculum that was developed to be integrated into a general education school curriculum. It will be described in detail later in this chapter.

The DBT STEPS-A curriculum has been piloted in schools within the United States and internationally. Schools in Cork, Ireland, evaluated the effectiveness of the DBT STEPS-A program at nine school-based sites (Flynn, Joyce, Weihrauch, & Corcoran, 2018). The study evaluated data from 479 students, ages 15 to 16 years old. There were 385 students who received the active intervention class at one of eight school sites, and 94 students in the control group. Participants' scores on the BASC-2 (broadband measure) and the DBT Ways of Coping Checklist (DBT-WCCL; narrowband measure) were examined pre- and postintervention as outcome measures.

In examining the preintervention scores, similar scores were found across the two groups on both the broadband and narrowband measures. Due to the various dosages of the DBT STEPS-A curriculum across the different high schools, the matched control group comparisons consisted of 72 females from two high schools. Results showed that those adolescents who received the DBT STEPS-A curriculum were significantly lower on the BASC-2 Emotion Symptom Index and on the BASC-2 Internalizing Problems, indicating fewer mental health difficulties, compared to peers who did not receive the curriculum. Furthermore, the effect sizes for these two comparisons were large with Cohen's F squared equal to 0.65 and 0.83, respectively. There were no differences reported between the groups on the DBT-WCCL (Flynn et al., 2018). Ongoing data collection continues in schools implementing the DBT STEPS-A curriculum.

## Continuum of Services in Schools

### *The DBT STEPS-A Curriculum*

Given that most adolescents experience emotional distress during their middle and/or high school years, providing skills or strategies to help adolescents cope with their current or future emotional distress would be an upstream approach in reducing the likelihood of students engaging in self-harming and suicidal behavior. The DBT STEPS-A curriculum (Mazza et al., 2016) is an SEL curriculum focused on developing emotion regulation, interpersonal, and decision-making skills in middle and high school adolescents. It is designed to be implemented at a universal level and taught by general education teachers, although specialized school personnel, such as school counselors, school psychologists, and school social workers, could also teach the curriculum.

Given the data supporting the benefits of teaching DBT skills alone to individuals with a variety of mild to moderate difficulties as cited above, Mazza and colleagues (2016) developed an SEL curriculum based on the skills of DBT (Linehan, 1993b; Linehan, 2014; Miller et al., 2007). The curriculum consists of 30 individual lesson plans that cover an orientation to the curriculum, the principles of dialectics, and skills from each of the four DBT skills modules (i.e., core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness). Each lesson is designated for a 50-minute class period and can be adjusted as needed for varying lengths of time. Each lesson is structured similarly, beginning with a mindfulness exercise, followed by homework review, then teaching of new skills that include multiple examples and interactive exercises, which comprises the bulk of the 50 minutes, and ends with a class summary and assigning of new homework.

The recommended instructional level for teaching the skills curriculum at Tier 1 is a general education teacher who has some mental health awareness, such as a health and wellness teacher. This recommendation is based on the concept of having someone within the school structure who is familiar with the students, is part of the general education instruction team, and teaches classes that are part of the core curriculum of the school, thus playing a role similar to that of a science or math teacher. Health and wellness teachers were identified as ideal instructors because they are

often tasked with providing instruction on drugs and alcohol, risky sexual behavior, bullying, and depression/suicide prevention; they therefore have some background with regard to mental health issues. In addition, students are already accustomed to health teachers addressing such personal topics. However, other types of general education teachers or school staff could also provide skills instruction, such as a language arts teacher, science teacher, coach, school counselor, or any teacher/staff member who provides a welcoming, nonjudgmental environment where students will feel comfortable and supported in learning and practicing new skills.

### *Educating the Whole Child*

As stated above, the opportunity for students to learn coping strategies and decision-making skills that focus on emotion regulation and mental wellness is complementary to academic learning and can enhance students' ability to achieve their educational potential. Given the complementary nature of SEL programs with academic attainment, schools become an ideal setting, an integral environment, where education of the whole child can take place. The implementation of SEL programs, specifically DBT skills and/or services, should parallel the implementation of academic curriculum, meaning service implementation structures need to address the varying emotional needs of students. Thus, aligning the implementation of DBT skills and/or services along a continuum of support, such as a multi-tiered system of support (MTSS), provides a theoretical guide to the level of support services necessary to match the students' needs. The three tiers within MTSS will be explained in greater detail below, including how the DBT STEPS-A curriculum is implemented within a MTSS structure.

The first tier in MTSS occurs at the universal level, meaning services at this level are for all students. Unfortunately, when schools use an identification system to determine student needs, this level often receives minimal attention and/or resources because of the lack of formal identified needs. Yet, it is the universal level that offers the farthest upstream approach in providing students with DBT STEPS-A skills before their emotional distress results in severe dysfunctional and/or self-harming behavior. In addition, a DBT STEPS-A program taught at the universal level provides the broadest application within school-based settings, which increases the likelihood of peer-to-peer coaching and support, along with shifting the school environment and culture to be more nonjudgmental and supportive of effective skills use through a common language. The increased opportunity for adolescents to help each other during emotionally stressful times cannot be overstated, as research continues to show that adolescents tend to disclose to each other first before seeking out an adult for help (Mazza & Miller, in press).

The second tier within MTSS occurs at the selected level, meaning services are provided to students who have been identified as "at-risk" for difficulties, whether academic and/or emotional. Students at this level benefit from increased opportunities and time to practice skills and decision-making strategies. The strategies for implementing DBT STEPS-A at this level include, but are not limited to, teaching in classrooms of 10–15 students, rather than the typical 25–30 students in Tier 1. This strategy offers increased opportunities for engaging students in more in-depth skills development and practice beyond the school classroom. The second implementation

strategy at this level is to allocate more time to each skill; this can be done using two class periods for skills development and acquisition or going through the skills twice, the idea being that once the students understand how the skills are interrelated, the practice and generalization of skills and/or services will be more meaningful. Finally, allowing students individual time with the teacher or other school staff for practice, coaching, and mentoring based on situational specific events (i.e., asking someone out on a date, participating in a sporting event, saying "no" to a friend who wants you to use drugs). This individual time would be offered on an as-needed basis, initiated by the student, and during school hours.

The third tier level in schools is the indicated level; this occurs when students are experiencing ongoing emotional and behavioral difficulties and Tier 2–level coaching is not sufficient due to the ongoing nature of the problems. At this level, skills development may take longer to teach while also requiring increased practice opportunities. For these reasons, implementation strategies include the Tier 2 strategies, along with some additional implementation services. First, weekly individual time for each student must be scheduled with the teacher or school counselor; it may be as short as 15 minutes or as long as 45 minutes. The designated time affords students a predictable time to receive one-on-one coaching and mentoring that is specific to the students' particular skills set or situation; this is not considered, and does not replace, individual psychotherapy for those in need of a higher level of care. In addition to weekly one-on-one sessions with the teacher or school counselor in Tier 3, the schools provide a parent skills-training seminar at least once a module during the evening, so parents can learn about the skills their child is acquiring and how best to support them while they are practicing the new skills. Although this component is directly built into the Tier 3 level of intervention, a parent skills seminar can be beneficial at any level of intervention. This strategy is incorporated in most adolescent outpatient DBT groups along with integration of the "middle path" skills.

Finally, because Tier 3 students frequently present with high-risk and/or challenging behaviors, it recommended that the teachers or school support team meet regularly (i.e., once per week or month). This meeting would offer support and suggestions with difficult cases. It acts as a sounding board and provides consultation to teachers who are tasked with teaching students the skills, while also providing support via peer-to-peer coaching, role-playing, and mentoring to the teachers/individuals who are teaching the skills.

As mentioned above, implementing DBT STEPS-A at Tier 3 does not consist of providing psychotherapy services whereby a student would have specific treatment goals or even a treatment plan. Students in need of therapeutic services would be referred to outpatient treatment, such as comprehensive DBT. Because we know only 20% of students referred to outpatient mental health services receive treatment (Kataoka et al., 2002), we recommend that schools develop school-based mental health programs, allowing a greater number of students to receive the treatment needed. Thus, to address the greater needs of some students while maintaining the services within school-based settings, the implementation of SB-DBT follows on the continuum. SB-DBT services and skills address the next level of intervention if Tier 3 services are not sufficient or if the student is engaged in more severe and/or acute behaviors, such as substance use, suicidal behaviors, or nonsuicidal self-injurious behaviors (e.g., cutting, burning). The section below outlines the implementation of comprehensive SB-DBT.

## Comprehensive SB-DBT

### Modes and Functions

Comprehensive SB-DBT in schools is similar to outpatient DBT as it is defined as having four modes of implementation: individual counseling, skills group, coaching, and consultation team. These four modes are designed to fulfill the five functions of DBT: teaching skills, motivating clients, generalizing skills to natural environments, motivating and improving the skills of therapists, and structuring the environment (see Miller, Rathus, Dexter-Mazza, Brice, & Graling, Chapter 16, this volume). All modes and functions of DBT must ultimately be present in a setting to meet the criteria of comprehensive SB-DBT. Below, each of these four modes is discussed, with a specific focus on modifications to fit a school-based setting.

#### *Individual Counseling*

The function of individual DBT counseling in schools is to increase students' motivation to reduce maladaptive coping behaviors while learning to apply more adaptive replacement behaviors (i.e., skills). Individual sessions can occur with varying frequency, depending on the student's level of distress or severity of impairment. Individual counseling is typically delivered by a school counselor, such as a school psychologist, school social worker, or other school-trained mental health staff.

The school counselor is responsible for developing the student's treatment plan, identifying treatment targets and goals, orienting the student to SB-DBT, and securing the student's commitment to SB-DBT. Once the student has committed to participating in SB-DBT, each individual session begins with the school counselor and student reviewing the student's weekly diary card. The diary card tracks functional and dysfunctional behaviors (personalized to each student), intensity of emotion, and skills use on a daily basis. The diary card is a critical tool in individual DBT because it allows the counselor to gain a comprehensive view of the student's week in a short amount of time and indicates which behaviors should be targeted in the session. Target behaviors are then selected based on the target hierarchy (life-threatening behaviors first, therapy-interfering behaviors next, followed by quality-of-life interfering behaviors); while simultaneously increasing behavioral skills (Miller et al., 2007). Similar to comprehensive outpatient DBT, SB-DBT follows all of the same procedures and principles. The main adaptation made for schools is the length of each session. Similar to the SB-DBT skills group, individual sessions last between 30 and 45 minutes. Thus, the counselor must quickly review the diary card and remain focused on targeting effectively.

#### *Skills Group*

The function of a skills group is to acquire, strengthen, and generalize social–emotional skills (Rathus & Miller, 2015). DBT skills are taught proactively, at least one time per week, and the teaching follows the DBT skills-training program outlined in Rathus and Miller (2015). To be feasible in a school-based setting, groups are typically conducted within a 42- to 50-minute school period. Some schools are able to run groups for 60 to 75 minutes; however, this practice is less common. Schools typically utilize some combination of mental health staff, teachers, and guidance counselors to colead DBT

skills groups. Approximately 4–8 students comprise each skills group, to give sufficient time for homework review and teaching new skills content. Ideally, two trained staff members cofacilitate each group, with one acting as the "group leader" (responsible for leading homework review, teaching the skill, and engaging students in relevant discussion), while the other staff member serves in the role of coleader to monitor student participation and address group therapy-interfering behavior, and leaving the room with individual students as necessary. This role supports the group leader so they can continue to focus on the didactic content of the lesson, the main function of the group. The skills group reviews each of the five skills modules throughout the group: core mindfulness, interpersonal effectiveness, distress tolerance, emotion regulation, and walking the middle path (see Rathus & Miller, 2015, for full descriptions of each skills module).

### *Coaching*

Unlike outpatient DBT, comprehensive SB-DBT relies on *in vivo* coaching and/or coaching that takes place in the school milieu/environment. Students can seek out coaching from trained staff whereby they receive direct instruction (in a timely fashion) about how to apply skills to current emotion dysregulation, cope with distress, or get help utilizing a skill to solve an existing problem. The function of coaching is to further generalize skills taught in group. *In vivo* coaching in the school setting offers the unique opportunity to coach students when they are actually in the emotional state where skills use is most important. A staff member is able to prompt and reinforce skills use as well as prevent a problem from escalating further. Importantly, coaching is a brief intervention focused on immediate skills application. It differs from individual counseling by only addressing the problem at hand (e.g., helping a student make a skillful request, resist the urge to self-harm, reduce intense emotion, or reregulate after a conflict without escalating to a physical altercation).

The goal of coaching is to help students regulate their emotions and behaviors and get them back to class as soon as possible. The school counselor working with the student typically provides the skills coaching because this staff member knows the student's target behaviors best. However, given the constraints on a staff member's time and availability, other staff trained in DBT should also be able to offer skills coaching. Skills group or another student's individual counseling time should not be interrupted to provide coaching to another student requesting the same. Similar to outpatient DBT, students ought to be oriented to using skills until coaching becomes available. School counselors are encouraged to provide a space, such as a waiting area, that would be conducive to students using skills independently (e.g., making available pros/cons worksheets, items for self-soothe and distraction, and ice packs).

### *Consultation Team*

The function of a consultation team is to enhance team members' capabilities to use comprehensive DBT with their students and to bolster motivation and commitment to helping multiproblem youth. To participate in a consultation team, members must have received training in comprehensive SB-DBT and must work directly with students in some DBT capacity (i.e., as a skills group leader, individual counselor, school milieu coach). School administrators or staff who do not work directly with students

conducting a mode of SB-DBT should not be part of the team. We have found that when the administrator or uninvolved staff attends team meetings, this hinders the functioning of the team and is a barrier to addressing burnout. Conversely, all team members who do conduct SB-DBT should consistently be present as part of the consultation team.

The consultation team is designed to facilitate the work of counselors by allowing them to continue SB-DBT with high-risk, multiproblem youth in the school setting by seeking case consultation and support. Ultimately, the school-based consultation team helps hold staff accountable for delivering adherent SB-DBT and likely reducing crises and, in turn, referrals to emergency rooms/psychiatric hospitalizations. The consultation team also addresses school staff burnout, encourages vulnerability, and asks all team members to take a nonjudgmental stance about one's own mistakes or skills deficit.

A barrier to the consultation team that must be addressed prior to starting a SB-DBT program is designating a firm weekly consultation meeting time that is not disrupted by other school needs, such as staff meetings, individualized education plan (IEP) meetings, or other administrative tasks. Ensuring that full administrator support and sufficient time are accommodated in schedules for this weekly meeting is of the utmost importance in providing SB-DBT.

### *Structuring the Environment*

*School Environment.* Since the ultimate goal is to have all school staff coaching and reinforcing effective skills use, we believe it is important to provide psychoeducation to the school staff to generalize skills use as well as create a supportive school culture. In addition to training school staff in the usage of skills and providing coaching, schools also will benefit from educating teachers and staff about the biosocial theory, principles of reinforcement and punishment, as well as acceptance and validation. Many schools admittedly operate like an emergency room, with more time focused on attending to students in acute crises and less time focused on students needing behavioral control. Unwittingly, this stance reinforces extreme and dysfunctional behavior (a student will escalate their behavior to verbal insults to get out of class and be seen immediately by a favorite counselor). Training the staff to apply DBT strategies helps the entire school utilize behavioral principles to reinforce skillful, pro-social behavior, while extinguishing unwanted, maladaptive behavior, with less reliance on punishment as a method to change behavior. These topics can be addressed during school staff meetings or professional development training days.

*Home Environment.* The function of caregiver involvement is to further generalize DBT skills to the student's home environment and increase parents' understanding, compassion, and effective skills use with their child (Miller et al., 2007). Involving caregivers is critical to addressing a potentially major component of the invalidating environment. At minimum, caregivers should be given the opportunity to participate in an informational session about SB-DBT that provides an orientation to the treatment model. An additional area of focus in the orientation session should be the role of validating students' emotions as well as psychoeducation about validation versus invalidation. Similar to Tier 3 for DBT STEPS-A, schools using SB-DBT invite parents to a monthly skills review that aligns with the current module of skills

being taught to their child. In addition, caregivers may need to attend occasional individual family sessions to address more acute problem behaviors that may be affecting academic/emotional/social/familial functioning. Though school-based mental health staff time is limited, we encourage as many opportunities for family involvement as possible to allow for skills acquisition and generalization to the environment.

## Applying Skills Coaching in the School Environment: The Case of Carl

To demonstrate the use of effective school-based skills coaching, we will provide below a clinical vignette of a student enrolled in SB-DBT. The coaching provided by the school counselor can be applied to skills coaching for any student who has taken the DBT STEPS-A class or received SB-DBT.

"Carl" was a junior in high school when he first came into the guidance office; he was very overwhelmed, tearful and angry. Carl had been referred to the school psychologist. Through a clinical interview, Carl gave the following history: His parents were divorced, and he lived with his mother and saw his father regularly. They had shared custody. Carl's relationship with his mother was very strained; they argued constantly. Carl was refusing to follow the house rules and was very angry with his family. He believed that his mother was unsupportive and impossible to live with. His grades had previously been A's and B's and now he was at risk of failing classes. Carl was required to do a significant number of chores within his household, which he was now refusing to do. Carl reported that he was also having difficulty getting along with friends and was currently in conflict with his peer group. Carl was coping by binge-drinking and other problematic behaviors, such as risky sexual behavior and driving his car recklessly. He additionally reported that a few months earlier he was so overwhelmed that he called his father and said he couldn't take it anymore and was going to kill himself. He was evaluated at a nearby emergency room, where he denied any intent to harm himself and was released. In consequence, at their first meeting, the school psychologist administered the Columbia Suicide Severity Rating Inventory; Carl denied past and current suicide plans or intent. Comprehensive SB-DBT was offered to Carl but he refused, stating that his schedule was too tight and he had to work after school. His parents were informed and made aware of community resources for outside counseling.

Carl returned to the guidance office several times over the following weeks. Each time he returned, he was emotionally dysregulated and "unable" to remain in class. Things were getting worse at home, with friends, and in terms of his own behavior, which at times was unhealthy and risky (e.g., binge-drinking, unprotected sex, and driving recklessly). The school psychologist once again offered comprehensive SB-DBT and, using various commitment strategies, worked with Carl to overcome his initial reservations. The most effective strategy for Carl was completing DBT pros and cons skill worksheets that examine the strengths and challenges for changing his behavior versus the strengths and challenges of allowing the situation to stay the same. This exercise highlighted that Carl was not working toward the life he wanted. In considering his life-worth-living goals, Carl said that he loved his family and identified a better relationship with his mother as his primary goal. He also had high aspirations of getting his grades back up and attending a prestigious college. He hoped to be an accountant one day. Looking at his four-quadrant pros and cons

diagram on the whiteboard, Carl dropped his head and agreed that his life was not going well and he needed help. Carl agreed to begin SB-DBT with the school psychologist. His mother was contacted and asked to attend a meeting at school. Within minutes of the meeting, both Carl and his mother were screaming at each other. Carl ran out crying and angry and sat in the guidance office waiting area while his mom continued to yell at the staff and refused to sign the DBT contract to allow Carl to participate. The mother proclaimed: "Carl is disrespectful and nothing will help, I am done with him!" When pressed, Carl's mom responded by saying: "Call his father and get consent. I don't care, I don't agree with counseling, it won't make a difference, counseling doesn't work." The father was contacted and agreed for Carl to participate in SB-DBT.

A parent orientation and skills-training session was set up for the following week, but both parents refused to attend. In this school, the parent orientation and skills-training session is designed as a group meeting for parents of students enrolled in SB-DBT. It provides an orientation for new families and an overview of skills. It is offered at the beginning of each mindfulness module when new students can join the SB-DBT group. The new families arrive for the first half of the session to get oriented to the treatment and sign the SB-DBT contract. Parents of current SB-DBT students join the group after the orientation portion. During this parent training section, a mindfulness skill is taught along with a skill from the upcoming module, for example, a distress-tolerance crisis survival skill.

Although Carl's parents did not attend the parent group, Carl was now firmly committed to SB-DBT. He actively participated in both his group and individual SB-DBT sessions that were scheduled for 42 minutes each week. Over the next few months, Carl's behavior started to improve dramatically; he no longer came down to the guidance office in crisis, but instead sought brief skills coaching when needed. Below is the interaction between Carl and the school psychologist early in SB-DBT treatment. On the day in question, Carl had difficulty staying in class due to problems regulating his anger. He entered the school psychologist's office in a very angry, agitated state and began yelling:

CARL: I need to leave school, I am totally overwhelmed, I have too much work, and I just can't do it. I'm going home. I just texted my mother to sign me out!

SCHOOL PSYCHOLOGIST: Wow! I can see that you are really upset. Tell me what's going on?

CARL: I'm exhausted. I worked after school, and when I finally got home, my mother had me doing stupid chores. By the time I ate dinner and showered, it was 8:30 P.M. I tried to study for my English and math tests, but couldn't finish because I had to FaceTime my friend about a social studies presentation that we have to make tomorrow. I never even started my science project because it was 12:00 A.M., and my mother was screaming at me to get to bed! Now I'm here unprepared and I'm gonna fail everything! I have to get out of here!

SCHOOL PSYCHOLOGIST: No wonder you're feeling overwhelmed. You had a challenging night and not enough sleep and now have work that you still need to catch up on. I know this is really a hard day for you. Have you tried any skills?

CARL: I can't do any freaking skills, I'm so pissed off.

SCHOOL PSYCHOLOGIST: I see this is really difficult for you and that you are really angry. At the same time, though, I'm going to ask you to think of a skill that can help you get into wise mind, so you can make a thoughtful choice. Remember the goal is to get through this moment without making things worse, getting back to class, and moving toward your goals. How angry are you on a scale of 1–10?

CARL: 8.5.

SCHOOL PSYCHOLOGIST: OK, what can you do to get to a 4 or lower so that you are thinking more clearly? Think of what has helped you in the past.

CARL: Fine, I can count by sevens and try to calm down.

SCHOOL PSYCHOLOGIST: That's an effective distract skill. Have a seat for a moment in the guidance waiting area; practice the skill and return to class as soon as you can. The secretary will give you a pass back to class when you are ready. You can come back to me when you have a free period to let me know how things are going.

Carl sat in the guidance waiting area for a few more minutes and then asked the secretary for a pass back to class. He dropped by the school psychologist's office later that day during his lunch hour:

CARL: Hey, the counting by sevens really worked, and I got a 92 on my math test. I guess I studied enough last night. I'm really glad I didn't bail out and go home.

SCHOOL PSYCHOLOGIST: That's awesome, Carl; I knew you could do it. You should be really proud of yourself. You acted really skillfully through a very emotional time. What would have happened if you left school?

CARL: I still would have had to make up the tests and my mom would have been totally pissed at me. We would have argued the whole time. I wouldn't have gotten much work done, and I definitely would have been punished and not allowed to hang out with my friends today after school. That would have totally sucked!

Over time, Carl came less frequently for coaching. When he did, he would often go directly to the waiting area as he began experiencing intense emotions, utilize DBT skills, and then ask for a pass back to class.

Carl was a very active member of the SB-DBT skills group. During his individual sessions, Carl would review his diary card, working toward his goal of decreasing risky behaviors and utilizing his skills to regulate his emotions and move forward in reaching his goals. Chain analysis was also utilized to help Carl understand the impact of his emotional vulnerabilities, such as not sleeping or exercising, and how his thoughts affect his emotions and behaviors. Together, Carl and the school psychologist worked on how to break the chain by problem solving: coping ahead and using skills. When Carl's commitment to change began to waiver, the school psychologist would link Carl's behaviors to his life-worth-living goals to maintain or strengthen his commitment. Over time, his emotions became better regulated, his

risky behaviors stopped, and they were replaced with crisis survival skills, primarily, ACCEPTS, self-soothe, and mindfulness to current emotion. He was able to utilize mindfulness skills and had a more accepting view of himself and others. He became more "willing" and less "willful" in relation to doing his chores at home. He was able to get into "wise mind" and do his homework and projects even when it was difficult to do so and he didn't want to. Interpersonal effectiveness skills helped Carl communicate respectfully with his family and friends; he was now better able get his needs met without damaging relationships or sacrificing his self-respect. He also reported that he was getting along with his mother. Carl's risky behaviors decreased dramatically; he was exercising regularly and living a healthier lifestyle. He reported being more emotionally regulated and therefore driving safely. Carl's grades improved to A's and B's, and he was touring the colleges that he would be applying to in the Fall. He was back on track and working toward the life-worth-living goals that he had set at the beginning of the school year.

Toward the end of the school year, a parent training session was held. On this particular day, to the surprise of the DBT team that was presenting, Carl's mother was among the parents who attended. At one point, Carl's mother stood up and raised her hand to be called on. With apprehension, the presenter called on her. Carl's mom spoke boldly to the group: "This program has changed our life. We got our son back when we were giving up all hope. Thank you!" She then walked forward and hugged the presenters, who couldn't have been more pleasantly surprised. Carl completed DBT, and at the final group meeting, he handed the group leaders a handwritten note thanking them and said, "This treatment has changed everything for me."

## Summary

DBT is an effective treatment. One of the difficulties with DBT is its dissemination to a large variety of individuals at all levels of service, especially adolescents. By moving DBT into the school setting, we not only increase the number of adolescents benefiting from DBT who may not have otherwise received it; we also begin removing barriers, hopefully increasing the percentage of teenagers who receive mental health treatment to greater than 20%. By further moving upstream to a prevention approach, the implementation of the DBT STEPS-A curriculum will provide all students with effective emotion-regulation, decision-making, and coping skills. This wellness approach will move us into the realm of educating the whole child.

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CHAPTER 7

# DBT in University Counseling Centers

JACQUELINE PISTORELLO and CARLA D. CHUGANI

## University Students' Mental Health Problems Are on the Rise

Rarely a week goes by without the media highlighting the increase in university students' mental health problems and/or the inability of university counseling centers (UCCs) to absorb this growing need for services (e.g., Brody, 2018; Wolverton, 2019). Unfortunately, the current media attention is supported by data. Suicide is the second leading cause of death among college students (Potter, Silverman, Connorton & Posner, 2004). Approximately 12% of college students report having attempted suicide in their lifetime—1.7% over the last year—and more than a quarter report seriously considering suicide (American College Health Association [ACHA], 2018). A recent meta-analysis estimated that 22.3% of university students worldwide experience suicidal ideation (SI) and 3.2% attempt suicide in their lifetime (Mortier et al., 2018). Nonsuicidal self-injury (NSSI) is estimated at 12–17% (Whitlock, Eells, Cummings, & Purington, 2009).

In addition to suicidal thoughts and behavior, the mental health problems affecting university students span a wide range of issues, including overwhelming anxiety that makes it difficult to function (ACHA, 2018), eating disorders (Eisenberg, Nicklett, Roeder, & Kirz, 2011), and depression (Eagan et al., 2017). Although the increase in mental health problems among students appears to be a worldwide phenomenon (see Mortier et al., 2018), most of the data, studies, and UCC systems discussed in the literature (and therefore in this chapter) are based on findings in the United States and other English-speaking countries like Canada and Australia.

It is unclear why mental health issues have become more salient in university students. Could it be a reflection of trends of higher suicide rates in the general

population (Curtin, Warner, & Hedegaard, 2016), increased stress associated with attaining a higher education degree (Kadison & DiGeronimo, 2004), changes in the student body composition thanks to legislative changes (American with Disabilities Act [ADA], 1990), a combination of these, and/or other factors? This topic is outside the purview of this chapter but one that has become a pressing concern.

## UCCs Struggle to Meet Students' Needs

UCCs are the front line for mental health services for university students struggling with mental health concerns (Grayson & Meilman, 2006). UCCs vary widely depending on the institution and available resources, yet are commonly the place charged with addressing all the mental health needs of a student body. Despite this charge, there are often system limitations related to time and expense. One-quarter of UCCs impose strict limits on the number of individual sessions students can receive, and half of UCCs work on a brief therapy model (without session limits). Just one-quarter of UCCs see students for however long is deemed necessary (Gallagher, 2015).

Half of UCCs report that wait-lists quickly develop and remain in place until the end of each academic term (Gallagher, 2012). Suicidal risk is a key aspect of this crisis: One-third of treatment seekers report suicidal thoughts and 20% of those at high levels in the last year (Center for Collegiate Mental Health [CCMH], 2019). Importantly, although some universities might prefer to refer suicidal students elsewhere for treatment (see Pistorello, Coyle, Locey, & Walloch, 2017), data show that suicidal and self-injurious students are regularly treated at UCCs and use 20–30% more services than students without these concerns (CCMH, 2017). This is not surprising, given that specialists in the treatment of suicidal behavior are scarce in many parts of the United States and their services can be costly, making it challenging for students without insurance, transportation, or financial support to access off-campus treatment.

The stakes are high when suicide occurs on a campus (Lamis & Lester, 2011). UCCs are commonly held accountable in malpractice litigation, and administrators are starting to realize that untreated suicidality puts their institution at risk. Maintaining a cost-effective, evidence-based approach to treating suicidal students is a campus imperative (Lamis & Lester, 2011). These data may justify the expense and effort of developing a comprehensive dialectical behavior therapy (C-DBT) program where multiproblem, high-suicide-risk students can be treated within a specialty program on campus.

In addition to suicidality, UCCs treat a wide range of problems, such as anxiety, mood disturbances, substance abuse, eating/body image concerns, attention-deficit/hyperactivity disorder (ADHD), academic failure, perfectionism/procrastination, and relationship and family of origin issues (CCMH, 2019). Many of these concerns can be subsumed under the umbrella of emotion dysregulation (Aldao, 2016). Thus, adapted dialectical behavior therapy (DBT) models relying primarily on skills groups may also be an efficacious way to treat a broad range of concerns with fewer staff. In sum, the initial investment of time and resources required to begin a DBT program on campus, be it a comprehensive program or a skills-only initiative, is well justified given the myriad challenges UCCs face in meeting the needs of students.

## DBT at UCCs and/or with University Students: State of the Evidence

A review of the published literature to date found seven studies on DBT utilized at a UCC and two with university students recruited more broadly. As detailed in Table 7.1, these studies vary with regard to the targeted student population, presenting concerns, DBT treatment elements applied, DBT training conducted, and the strength of research methodology utilized.

Three studies have adapted C-DBT in a UCC, suggesting that DBT can be implemented in this setting utilizing its four modes (individual, group, phone/text coaching, therapist consultation team). This research has focused on students struggling with borderline personality disorder (BPD) and/or life-threatening behaviors (LTBs) (Engle, Gadischke, Roy, & Nunziato, 2013; Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012) or those lacking coping strategies (Panepinto, Uschold, Oldanese, & Linn, 2015). The Pistorello et al. (2012) study was the only randomized controlled trial (RCT) with students reporting suicidal thoughts and behaviors; it compared 7–12 months of C-DBT with optimized treatment-as-usual (TAU). Results indicated that compared to TAU, those in C-DBT showed significantly greater improvements in SI, depression, NSSI events, and social adjustment, and particularly so for those lower in global functioning at baseline (Pistorello et al., 2012).

The remaining studies used DBT skills-training groups as the primary intervention. DBT groups, utilized as an adjunct to TAU individual therapy/case management provided in the UCC, exhibited positive findings in terms of clinical symptoms (Chugani, Ghali, & Brunner, 2013; Muhomba, Chugani, Uliaszek, & Kannan, 2017; Uliaszek, Rashid, Williams, & Gulamani, 2016). Offering a DBT skills-training group, accessible only to students who had an off-campus provider of individual care, also showed promise (Meaney-Tavares & Hasking, 2013). Finally, adapted brief DBT skills groups as a stand-alone intervention also appear to be feasible and suggest positive outcomes for students recruited outside of UCCs with emotion dysregulation (Rizvi & Steffel, 2014) and ADHD (Fleming, McMahon, Moran, Peterson, & Dreessen, 2015).

In summary, this is a fledging area of research, prompted by the current context of increasing numbers, severity, and complexity of cases treated by UCCs (CCMH, 2019). The extant literature shows that DBT modes can be feasibly adapted to treat the needs of varying, complex student populations with improvements in symptoms. The remaining sections of this chapter will discuss the implementation of C-DBT and other adapted DBT models in UCCs.

## Implementing a C-DBT Program in UCCs

This section will include a discussion of the following: (1) adaptations to the original C-DBT model for UCCs, (2) how various elements of C-DBT treatment can be implemented in this setting, and (3) the challenges of implementing C-DBT at UCCs.

### *Adaptations*

Adaptations to the original C-DBT outpatient model (Linehan, 1993) are structural for the most part, with DBT principles remaining intact. The relatively minimal adaptations to UCCs are listed below.

**TABLE 7.1. DBT Studies at UCCs and/or with College Students**

| Authors (year) | Population | DBT treatment elements | DBT training for providers | Design/outcomes |
|---|---|---|---|---|
| Pistorello, Fruzzetti, MacLane, Gallop, & Iverson (2012) | College students in treatment at a UCC presenting with suicidality, three or more BPD features, and a lifetime history of at least one NSSI or suicide attempt. 81% female. | C-DBT with all four modes (individual, group, telephone coaching, and team consultation). Skills-training groups and team meetings were each 90 minutes/week. | 30 hours of intensive training followed by weekly supervision by experts. Providers were clinical psychology interns. | RCT: DBT vs. optimized TAU. Students who received DBT showed significant decreases in suicidality, depression, number of NSSI events (if participant had self-injured), BPD criteria, and psychotropic medication use and significantly greater improvements in social adjustment as compared with students receiving optimized TAU. |
| Chugani, Ghali, & Brunner (2013) | College students in treatment at a UCC diagnosed with a Cluster B personality disorder or traits and scored 1.5 SDs over mean on emotion dysregulation measure. 95% female. | DBT skills-training groups: 11 weeks of 90-minute groups covering all four modules as an adjunct to individual therapy in general (not limited to DBT). DBT providers met weekly for 1 hour of team consultation. Coaching available via phone or email during business hours. | Staff was trained via the online skills-training program followed by 2-day in-person training with a DBT expert. | Nonrandomized control trial; DBT skills vs. control group of eligible students who declined to participate. Participation in the DBT group resulted in significant increases in the use of adaptive coping skills, significant decreases in maladaptive coping skills, and a nonstatistically significant improvement in emotion dysregulation as compared with the control group. |
| Meaney-Tavares & Hasking (2013) | College students in treatment at an Australian UCC diagnosed with BPD. Participants were required to have an off-campus individual provider. 75% female. | DBT skills-training groups: eight 2-hour groups, covering all four modules. In the emotion regulation module, discussion of neurotransmitters and their relationship to BPD symptoms was added. Additionally, six 20-minute contacts with group therapists occurred. Weekly individual therapy (not DBT-based) was required. | Group facilitators had formal training in DBT (further specificity is not available in the article). | Pre–post only; no control condition. Among those who completed the full program, there was a significant reduction in symptoms of depression and BPD, and an increase in adaptive coping skills, including problem solving, and constructive self-talk. |

(*continued*)

**TABLE 7.1.** (*continued*)

| Authors (year) | Population | DBT treatment elements | DBT training for providers | Design/outcomes |
|---|---|---|---|---|
| Engle, Gadischkie, Roy, & Nunziato (2013) | Treatment-seeking college students diagnosed with BPD. Gender breakdown was not provided. | C-DBT with all four modes of treatment. Skills group was 60–90 minutes long. Fall semester skills were mindfulness + emotion regulation. Spring skills included all four modules. Team consultation was 90 minutes long. | Core clinicians were trained and then consulted with a DBT expert for assistance with program design. For their training, postdocs on the team completing reading, online training, and 1–2 in-person DBT training sessions. | Nonrandomized control trial; DBT vs. control group of eligible students who did not participate. When compared with an 8–10 session psychodynamic treatment, those in DBT experienced fewer hospitalizations (0 vs. 9) and medical leaves (1 vs. 13). |
| Rizvi, & Steffel (2014) | Undergraduate students with emotion dysregulation based on cutoff of emotion-dysregulation measure. 87.5% female. | DBT skills-training groups: 2-hour weekly DBT skills group for 8 weeks. Students received either mindfulness + emotion regulation or only emotion regulation. | Groups were led by DBT-trained clinical psychology doctoral students receiving weekly supervision. | Nonrandomized control trial; DBT mindfulness + ER skills vs. ER skills only. Students in both groups showed significant improvement in emotion regulation, skills use, affect, and functioning. No difference between the groups was found. |
| Fleming, McMahon, Moran, Peterson, & Dreessen (2015) | College students with ADHD recruited from three universities. Those with current substance abuse/ dependence, suicidality, and severe serious mental health conditions were excluded. 43% female. | DBT skills-training groups: 8 weekly 90-minute group skills-training sessions, and 7 weekly 10- to 15-minute individual coaching phone calls. A 90-minute booster group session was held during the first week of the follow-up quarter. | Both therapists were advanced clinical psychology graduate students who had intensive training in DBT. | RCT: DBT skills group vs. ADHD handout. When compared with those who received skills handouts alone, participants who received DBT showed an overall trend toward lower ADHD symptoms and inattentive symptoms. Those who received DBT fared significantly better on measures of executive functioning and quality of life. |
| Panepinto, Uschold, Oldanese, & Linn (2015) | College students in a UCC identified as in need of building coping skills. Inclusion was based on identified behavioral skills deficits and presentation of such problems as suicide ideation, NSSI, substance abuse, eating disorders, risky sexual behaviors, and impulsive behaviors. 77.2% female. | Modified C-DBT. Although all four modes were included, only these were modified: biweekly individual sessions, 90-minute weekly skills-training groups covering all four modules (6–13 weeks in length), telephone coaching, and biweekly team consultation meetings. Modifications were made based on the UCC setting (e.g., limits on individual sessions). | Five clinicians received intensive DBT training. The remaining clinical staff participated in a 20-hour online training program. | Pre–post only; no control condition. Students showed significant improvements in clinical symptoms and life problems. |

(*continued*)

**TABLE 7.1.** (*continued*)

| Authors (year) | Population | DBT treatment elements | DBT training for providers | Design/outcomes |
|---|---|---|---|---|
| Uliaszek, Rashid, Williams, & Gulamani (2016) | Treatment-seeking college students at a Canadian university. Participants experienced a range of symptoms that could be broadly indicative of severe psychological problems and emotion dysregulation. Students with severe cognitive disturbance or psychotic disorder were excluded. 78% female. | DBT skills-training groups: 12 weeks of 2-hour DBT skills-training group including all modules. 81% of DBT participants received individual therapy while in group. | Groups were led by a clinical psychologist who was intensively trained and experienced in practicing DBT, supported by various coleaders (staff with an MA in counseling or graduate students in clinical psychology). | RCT: DBT skills group vs. time-matched positive psychology group. There were no group or interaction effects for any symptom variable, but all symptoms significantly improved across the course of treatment. Effect sizes for the DBT group ranged from medium to large (0.61–1.23) and small to large (0.33–1.29) for the positive psychology group. Overall, effect sizes were generally larger for DBT. Those who received DBT demonstrated significantly higher attendance and therapeutic alliance, and lower attrition. Dropouts were lower for DBT (15%) than positive psychology (40%). |
| Muhomba, Chugani, Uliazsek, & Kannan (2017) | Students presenting for treatment at a UCC who displayed at least three areas of dysregulation. Participants with active psychosis or disruptive behavior were excluded. 86% female. | DBT skills-training groups: 90-minute weekly DBT skills-training groups (7–10 weeks) including mindfulness + distress tolerance skills. Group length depended on the amount of time needed to recruit participants; all groups received the same content regardless of length. The majority of participants received medication and non-DBT individual therapy. | Group leader was intensively trained through the 2-year intensive training process and received ongoing expert consultation. | Pre–post only; no control condition. Students made significant improvements in emotion dysregulation, use of dysfunctional coping skills, and use of adaptive coping skills. No comparison condition was included. |

- **The C-DBT program is different and separate from other forms of treatment at the UCC.** As most UCCs operate on a brief treatment model, the C-DBT program should be viewed by all involved parties as a specialty intervention with higher intensity of services, limited availability, and stringent inclusion/exclusion criteria (see below). Calling it the "C-DBT program" may help. Setting the C-DBT program apart from other services allows the usual policies and procedures (e.g., session limits) to remain applicable within each UCC. Students can be referred to a wait-list or receive other services while waiting to join the C-DBT program.

- **C-DBT treatment in UCCs is shorter than the typical 1-year treatment contract offered by C-DBT programs in other practice settings.** We recommend that the UCC C-DBT program last approximately one semester (i.e., 16 weeks), with the option of expanding to another semester/term if the student is showing sufficient progress. The primary target of the program is stabilization via the five functions of C-DBT (improving motivation, teaching skills, generalizing to the environment, motivating therapists, and structuring the environment; Linehan, 1993), to allow students to remain alive and in school—the latter if they wish to do so. If a student continues to require treatment after the second semester/round of treatment, a community referral should be considered. This shorter duration of C-DBT with students is based on data from an RCT (Pistorello et al., 2012) showing that significant improvement in SI occurred after as little as 3 months of treatment and that a C-DBT package delivered for 7–12 months was helpful, but a less intensive and/or briefer approach might be adequate for many students (Pistorello et al., 2012). Although this treatment length is shorter than typical C-DBT in other settings, it is longer treatment than typically offered in UCCs.

- **C-DBT treatment conducted at UCCs can be discontinuous.** C-DBT can include prolonged breaks, be interspersed with other forms of treatment when the student is home for an extended period (i.e., summer break), and/or include long-distance sessions during shorter breaks (e.g., winter break). The issue of whether to continue treatment during breaks should follow the local UCC policy. In the absence of a clear policy, DBT teams should make this decision on a case-by-case basis, taking into consideration such issues as student preference, therapist limits, how long the student will be away, whether the student is currently suicidal, whether the student has a therapist at home they could see, and if having phone/Skype sessions is viable with this client–therapist dyad. A rule of thumb is that if a student is going to be gone for more than 2 weeks and is actively suicidal, the team should insist on a local therapist and facilitate a referral/consultation. During longer breaks, files are closed and reopened later when the student returns. Many students elect to not seek treatment during longer breaks. If there is a foreseeable interruption during time committed to DBT (e.g., a student presents at the end of a semester), a later start date for C-DBT may be preferable, with risk/crisis management in the meantime.

- **C-DBT at UCCs may involve parents.** University students are typically considered "emerging adults" (Arnett, 2004) and, unlike previous generations, are often in regular contact with their parents. Parents can be a powerful source of influence on college students, either as a risk or as a protective factor (e.g., Whitlock et al., 2013). Although parental involvement is not formally integrated into treatment with college students as is the practice with adolescents, it is sometimes useful to invite parents to attend 1–2 sessions with the student, using principles from family-based DBT as a guide (Fruzzetti, Payne, & Hoffman, Chapter 17, this volume). Regular sessions with parents would not be possible because it would go beyond the scope of UCCs and they often reside in a different city. However, an occasional session can prove very useful: to present the biosocial theory, educate parents about validation/invalidation, discuss plans for safety management when the student goes home during a break, or educate parents about inadvertent reinforcement of escalation or prepare them for likely prompting events for suicidal crises. These sessions may also be an opportunity for students to express themselves in a neutral setting, for

the therapist to advocate for the client, and/or for the therapist to observe the family interact.

The decision of whether or not to offer occasional family meetings is complex (see Engle et al., 2013). Affirmative answers to some of the following questions might indicate that parental involvement is warranted: (1) Does the student want a meeting with their parents? (2) Do poor interactions with the family serve as prompting events for LTBs? (3) Is there a home visit in the horizon that warrants concern for the student's safety and/or where structuring the home environment might be helpful? (4) Is observing a family interaction key for the therapist to understand the nature of the family dynamics? And, importantly, (5) is it likely that the meeting would *not* make matters worse for the student (e.g., triggering a family crisis)?

- **Risk of academic failure is an important treatment target.** One adaptation of DBT to the UCC setting is the inclusion of risk of academic failure into the hierarchy of individual therapy targets (Engle et al., 2013; Panepinto et al., 2015). Although academic functioning generally falls under quality of life, if the academic behavior (e.g., missing classes) is on the chain to suicidality/NSSI or might result in the student needing to leave school or campus housing (when they wish to stay), then these issues are upgraded to the top of the list of therapy-interfering behaviors (TIBs). The prospect of failing school is often associated with increased SI and/or NSSI urges, due to an underlying desire to stay in school, fears of judgment by family/friends, feelings of failure, or because leaving school might mean needing to leave the country (for international students) or having to return to an invalidating or abusive environment.

To prevent academic failure, it is useful to discuss with students which classes can still be dropped, whether or not their current course load serves them well, and if a letter from their therapist (only when clinically indicated) could help the student drop a class or remain in their current campus housing. Consultation to the patient strategies are also applied by reminding students to check with various campus offices with regard to certain issues, such as the last day a student can drop a class and whether or not they would get a refund, accommodations that can be provided by the disabilities office, repercussions of dropping/failing classes on their financial aid (if they have it), and existing regulations of the residence halls.

- **Skills coaching often occurs via text and is not automatically implemented.** Skills coaching with college students often occurs via text messaging, as students report greater comfort with text communications. Texting allows them to receive coaching in a surreptitious manner without necessarily leaving the situation to make a phone call. Coaching via text is not recommended in cases of suicidal crisis, however, when a phone call is preferable to capture nuances (e.g., voice tone) and engage in interactive problem solving. To be part of a C-DBT team, therapists must be willing to provide skills coaching when it is indicated; however, skills coaching at UCCs is not automatically implemented as part of C-DBT because students tend to have more social/emotional resources than typical C-DBT clients in the community. Skills coaching is implemented only when it appears, through repeated chain analysis, that such coaching might be essential—to break a chain of ineffective behavior, to help a client implement new, adaptive behavior, or to give that student access to a modicum of social support. If students are able to cope with LTBs and generalize skills to their environment without coaching, the latter is not introduced into treatment. This is an adaptation that helps increase willingness by UCC staff to become part of a DBT

team while still attending to the function of generalization. Furthermore, as with other settings, most university students do not regularly use phone/text coaching even when strongly encouraged to do so (Engle et al., 2013)—although occasionally a high utilizer may emerge. The standard DBT strategies for observing limits can be followed (Linehan, 1993), and expectations for coaching via text, phone, or email may need to be articulated with students. For example, some therapists prefer that nonurgent coaching requests be delivered via email (if the current UCC policy allows it) and not texts, as text notification alerts can be experienced as intrusive.

- **C-DBT skills-training groups at UCCs are offered via shorter modules (4–5 weeks) to better fit students' academic schedules.** This adaptation means that a subsection of the starred skills are taught from the current skills manual (Linehan, 2015), with the skills chosen reflecting current C-DBT client needs. Based on student and facilitator feedback, groups last 2 hours to allow for more student interaction during homework review. Offering the early evening groups tea/coffee and snacks can increase compliance with group attendance. To increase efficiency and to benefit the UCC, groups can be expanded to serve not only students in the C-DBT program (see the "Implementing Adapted DBT Programs at UCCs" section below). Depending on the size of the UCC, at least two different modules can run concurrently so that students who have already attended one module can benefit from a different one.

Finally, C-DBT in UCCs includes weekly individual therapy and team consultation, without any substantive adaptations from typical standard DBT (Linehan, 1993).

### *Elements of a C-DBT Program at a UCC*

- **Entry into C-DBT at a UCC starts with intake conducted by a DBT Team member.** DBT team members can identify clients from their own caseload. Subject to availability of openings, referrals can also come from other UCC staff, as well as the student health center, other student affairs offices, or community providers who are aware of the program. Team members should allocate C-DBT to only 2–3 students at a time, as students assigned to this highest level of DBT care are often currently suicidal, self-injurious, or otherwise engaging in multiple crisis-generating behaviors. Clients referred to the program are scheduled for an assessment with a DBT clinician based on time availability, student request, and/or presentation. In general, this assessment occurs during the first 2 sessions, which focus on obtaining a commitment to treatment and assessing for inclusion/exclusion criteria and life-worth-living goals. Access to C-DBT is best presented as a unique opportunity (which it is!). After a student commits to the program, a welcome letter from the C-DBT team can be delivered by the individual therapist highlighting what the student has committed to participate in, the basic principles and modes of therapy in DBT, criteria for extending the contract to a second semester/term, and generally communicating, "The DBT team is here to support you." A frank and clear conversation with the student about treatment length and options for continuing to a second term should occur repeatedly, given the likelihood that students entering treatment in crisis may not always retain this information (Hersh, 2013).

- **C-DBT is reserved for students with severe and chronic impairment.** Not all students will require the high level of care offered by a C-DBT program, and to

preserve resources, less intensive approaches should be utilized whenever possible. C-DBT is reserved for students who demonstrate at least one of the following: (1) problems in multiple areas (e.g., substance abuse, eating disorder, academic problems), (2) chronic SI (i.e., SI has been present on/off for at least a year), (3) history of NSSI and/or suicide attempts, and/or (4) meet the criteria for BPD (i.e., meet five or more BPD criteria).

• **C-DBT requires student commitment and the ability to benefit from short-term C-DBT.** Two overarching issues rule out participation in C-DBT at a UCC: (1) low commitment to C-DBT treatment activities and (2) the need for more than weekly individual therapy to remain enrolled. Commitment can be gauged by a student's willingness to attend individual therapy and 2-hour skills-training group on a weekly basis and complete a diary card for the semester/quarter. If a student does not commit to these three aspects of the comprehensive approach, the therapist has the option of providing a less intensive DBT approach (see below) or a different approach, or referring the student to a different UCC provider (if someone is willing/available) or community setting. Although TIBs and fluctuations in commitment often occur, if commitment to C-DBT is not reasonably firm at the outset, it is difficult to successfully deliver the program within one term. Additionally, extremely low commitment can be frustrating to other students in the program. Commitment is discussed with transparency, and a treatment contract focusing on length and expectations for treatment is signed.

If a student requires more than weekly individual therapy to remain alive and/or function on campus, a UCC is not the best treatment setting. The three areas to assess are as follows:

a. Ability to function on a college campus: Is the student attending most of their classes and able to complete class assignments? Is the student in danger of being evicted from their residence hall (and therefore having to return home)? Are there adjustments to classes (dropping/switching classes) or other interventions (e.g., a behavioral contract with their residence hall) that can improve the chances of a student remaining enrolled?
b. Severity of presentation suggesting a higher level of care: Does the student engage in LTBs that require more than weekly individual therapy to stabilize? Is the student's substance abuse or eating disorder severe enough to require higher levels of care (e.g., the need for medical services—detox or refeeding)? Is the student floridly psychotic or experiencing a manic episode?
c. History of chronicity and/or need for long-term therapy based on the following: Has the student previously had multiple long-term episodes of care without appreciable improvements in symptoms? Does the student have a firmly held belief that they require weekly long-term therapy services (e.g., "I need years of therapy")?

Assessing students' ability to function on campus is essential because if a student drops out of school, they are dropping out of DBT treatment as well. Residence halls frequently have requirements, such as a minimum GPA, number of credits, or appropriate behavior conduct. Most schools consider cutting or attempting suicide in a residence hall a conduct violation and may require a student to attend an assessment and/or counseling or to medically withdraw from the university until certain conditions

have been met. Severity of presentation can be difficult to assess in only a few sessions, but a community referral might be best for students who demand more than one semester of treatment at the outset. These students have often been in therapy for several years prior to arriving on campus and expect that same level of weekly therapy and continuity. A severe trauma history and/or severe fears of abandonment may also be indicators that a community referral might be best given the brief nature of therapy at UCCs.

- **Treatment can be renewed for one additional term.** The second round of C-DBT at a UCC is best reserved for students who are making progress—something clearly stated in the treatment contract as a way of reinforcing effective behaviors. For example, if after one semester of C-DBT, the student remains highly suicidal and does not exhibit the agreed upon progress in their target behavior, a community referral should be considered. The second semester is intended to focus more on quality-of-life issues, increased skills use, and life-worth-living goals. To reduce the burden to the UCC, individual sessions are spaced out; skills coaching (if present) is phased out; suicidal ideation, if present, should be less intense and manageable by the student. We also recommend that suicidal and NSSI behaviors be absent for at least 1 month.

TIBs are key in making the decision to extend treatment for a second semester/term or not. Given their reduced length, if students miss (without cancelling/rescheduling) 2 individual sessions in a row, they are considered to have dropped out of C-DBT. As is typical in DBT (Linehan, 1993), the C-DBT team should be relentless in attempting to get students to come to treatment when client motivation wanes. There are also caveats in terms of stopping C-DBT: (1) Sometimes the UCC counselor may need to continue seeing a client who is not DBT-compliant because of other systemic factors (e.g., there is no other treatment option); in such instances, the therapist could continue to see the student via a non-DBT approach until a viable community referral can be made. (2) If a student has dropped out of all classes for the current term but will be returning next term, depending on clinic policy, a student who remains in the area could remain in C-DBT treatment to increase their chances of academic success in the future.

### *Challenges*

There are a number of challenges associated with implementing C-DBT in a UCC setting, some of which are shared by different settings, and others are relatively unique to UCCs. Challenges shared with other settings include the time, expense, and clinician dedication necessary to train in and implement C-DBT. Some universities have more financial and staff resources than others, depending on the size of the institution, funding (private vs. public), and administrative support. The challenges that are relatively unique to this setting include the following:

1. UCCs often strive to provide brief therapy interventions, which conflicts with the initial year-long outpatient treatment generally prescribed for C-DBT (e.g., Linehan, 1993).

2. Trainees are common in UCCs (LeViness, Bershad, & Gorman, 2017), and some of these trainees may not stay long enough for the UCC to justify the expensive training in C-DBT.

3. The university setting inherently involves calendar-bound breaks (e.g., 3-month summer break, 1-month winter or quarter breaks) that interfere with the flow of C-DBT treatment, which is typically conducted on a weekly basis (Linehan, 1993).

4. Some UCC staff, as members of the larger academic institution, may view their work within the boundaries of academic terms and business hours, interfering with the provision of telephone coaching.

5. It can be challenging to schedule groups at times that are compatible with varying class, work, and extracurricular activity schedules.

6. University students must be able to at least enroll in school for the term (semester/quarter) to remain eligible for services. They thus tend to be more highly functioning than many C-DBT clients treated in community settings and may not believe they need C-DBT.

In sum, C-DBT at UCCs is a semester-long program that can be launched as a first-stage intervention or as a second-stage, more intensive approach, after initial interventions, such as treatment-as-usual (TAU) or Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2016), have been applied without success (see Pistorello et al., 2018, as an example).

## Implementing Adapted DBT Programs at UCCs

Given the differences in UCCs with regard to size, scope of services, session limits, and resource availability, a recent and growing trend among UCCs is the implementation of adapted DBT programs. In fact, far more of these models have been researched and published than C-DBT programs in UCCs. Adapted programs can be considered as falling into one of three possible categories: (1) adapted C-DBT (henceforth called "DBT Lite"), (2) adjunctive DBT skills group with non-DBT individual therapy, and (3) stand-alone DBT skills group (see Table 7.2). We will begin by reviewing adapted DBT models with documented positive clinical outcomes, as these have already been implemented and evaluated successfully by their developers.

### *DBT Lite*

"DBT Lite" programs are those that attempt to achieve some *but not all of the functions of C-DBT* (Linehan, 1993), delivered in an adapted format that is aligned with the local UCC service structure and associated limitations. DBT Lite can be implemented in a number of different ways, adjusted to the needs of the local UCC, and can be considered a relaxed version of the C-DBT in UCCs described above. This model always includes skills groups but uses other modes of DBT as needed. Treatment adaptations may include not offering phone/text coaching or spacing out individual sessions—such choices are influenced by the primary student population the program wishes to serve (e.g., programs that serve students with SI and NSSI will typically offer weekly therapy, though it may not be DBT individual therapy). Two examples of DBT Lite focused on different student populations are described below.

**TABLE 7.2. Types of Adapted DBT Programs in UCCs**

| Program type | Description | Target population | Exclusion criteria |
|---|---|---|---|
| **Comprehensive DBT (C-DBT)** | This is a semester-long C-DBT program, with all elements, but in shorter duration and with some adaptations to the UCC setting. Treatment can be extended to a second term. | Students with serious or complex clinical presentations (multiple problems in multiple areas), including those with BPD features, suicidal ideation/behavior, and/or NSSI. | • Students not willing to commit to attending individual and group weekly treatment and completing a diary card.<br>• Students requiring more than weekly individual therapy to function on campus. |
| **DBT Lite** | This is an adapted C-DBT program that incorporates some but not all elements of standard C-DBT. Adaptations to modes of DBT are made to fit the available UCC resources and/or to enhance feasibility and sustainability of the program (e.g., offering telephone coaching during UCC business hours only). | Students with serious or complex clinical presentations, including those with BPD features, suicidal ideation/behavior, and/or NSSI. | • Students with concerns/presentations best characterized by overcontrol rather than dysregulation.<br>• Students whose needs for treatment extend beyond the limits of what the UCC and/or DBT team can reasonably offer. |
| **Adjunctive DBT Skills Groups** | This is a DBT program that only offers DBT skills-training groups. Skills-training groups typically teach a few key skills from each of the four DBT skills training modules. Students who participate in these groups receive other (non-DBT) services (e.g., individual therapy, psychiatry) from the UCC or the community. Treatment is coordinated. | Students with serious or complex clinical presentations, including those with BPD features, suicidal ideation/behavior, and/or NSSI. May also include any students with clinically significant deficits in areas targeted by DBT skills training. | • Students who are suicidal or engaging in NSSI and not in concurrent individual therapy/case management. |
| **Stand-Alone DBT Skills Groups** | This skills-training group can deliver skills from multiple modules, or a single module (e.g., emotion-regulation skills only). Groups are often shorter in length, may be staggered to start midsemester, or may be delivered as a workshop series (e.g., no group screening). | Students experiencing significant deficits in areas targeted by DBT skills training. | • Students who are suicidal, engaging in NSSI, or not clinically stable. |

One iteration of DBT Lite is detailed by Panepinto and colleagues (2015), who took a broad approach to the application of their DBT Lite program by focusing on any student who needed to develop coping skills, as opposed to students struggling with suicidal risk or BPD. This program included every-other-week individual therapy (to account for session limits), a variable-length skills-training group, phone coaching, and team consultation. Phone coaching was provided during office hours, and students could use the existing after-hours on-call system. For after-hours coaching, DBT skills handouts were included in the on-call folder provided to the counselor taking the calls. Skills-training groups ran anywhere from 6 to 13 weeks, depending on the length of time needed to recruit a full group of students. Typically, the groups

included skills from all four modules, although in the case of groups of very brief duration, interpersonal effectiveness skills were omitted. These authors found that students who participated in the program showed improvement in impulsivity and emotion dysregulation, among other factors.

A second example of DBT Lite, and how programs could expand over time, is the program developed by Chugani et al. (2013). This program began as an 11-week DBT skills-training group as an adjunct to non-DBT UCC individual therapy (see the next section) but evolved into a DBT Lite program. The group included skills from all four DBT skills-training modules. Although therapists met for a weekly consultation team, the team members had only completed online training followed by 2-day in-person DBT training. Telephone coaching and individual DBT were not provided. The program's initial success in producing positive changes, relative to TAU, for students with significant emotion dysregulation and Cluster B personality disorders/traits, in maladaptive and adaptive coping behaviors, allowed the center to advocate for the funds for 10-day DBT intensive training, which allowed for program expansion.

Following intensive training, the program evolved from an adjunctive program into a C-DBT Lite example, including 12-week skills-training groups each semester, standard or DBT-informed individual therapy sessions, weekly team consultation meetings, and phone coaching during business hours (see Chugani, 2017). Students were able to utilize DBT-informed phone coaching via the center's after-hours hotline, which had a separate protocol for students in the DBT Lite program. This UCC does not have session limits (although in general, a brief treatment model is applied), allowing the team to provide a fairly intensive level of care when it was indicated (e.g., in cases of LTBs). However, students with less acuity could also participate in groups without receiving the full treatment package, thus allowing the center to maximize its investment of resources.

The two DBT Lite programs described above strategically adapted the standard components of DBT to better fit within their UCC practice structures. Further, these programs broadened the inclusion criteria for participation, thereby enabling their programs to serve more students and a more diverse range of student needs. It is particularly important to consider the UCC's stated mission and scope of practice when designing adapted DBT programs, as those programs that align well with both administrative and clinical priorities may be more likely to be readily adopted and accepted by staff charged with delivering and sustaining the program.

### *Adjunctive DBT Skills Groups*

A more abbreviated approach to delivering DBT in a UCC is providing *adjunctive* DBT skills group. For these programs, the primary intervention component at the UCC is a skills-training group in which skills from all four modules are delivered to students of all risk levels, *but the student's suicidal risk is managed outside of the DBT team*. These programs may be offered as an adjunct to individual therapy provided either on or off campus, but typically do not include other elements of the C-DBT model (i.e., no individual DBT treatment, DBT peer consultation team, or telephone coaching). One such program described in the literature (Meaney-Tavares & Hasking, 2013) is an 8-week DBT skills-training program for college students meeting full criteria for BPD. All students are required to participate in

weekly individual counseling with an off-campus provider, and the program works collaboratively with each student to create lists of after-hours contacts. This type of program is an innovative way of diminishing the cost of needed treatment for students with BPD, while adhering to a previously established scope of services. Students are able to access abbreviated DBT skills-training groups via the UCC, but the primary responsibility for weekly assessment and management of suicidality and other primary treatment targets lies with an off-campus provider. Collaborations between UCCs and off-campus providers ideally will involve a written agreement regarding what services each intends to provide. Such an agreement may be facilitated by using a primary provider agreement for clients receiving DBT skills training, like the one included in the DBT skills-training manual (Linehan, 2015, p. 39).

Another adjunctive skills-training group model meant for students with significant psychopathology and emotion dysregulation is the 12-week program developed by Uliaszek and colleagues (2016). This program mirrors the typical delivery of DBT skills training, but in an abbreviated package suitable for delivery on a university campus. The skills-training protocol includes 3 weeks each of distress tolerance, emotion regulation, and interpersonal effectiveness skills, with a session on mindfulness prior to the beginning of each new module. Although individual counseling is not required in this model, the program developers reported that the majority of DBT participants also receive concurrent individual treatment.

Whereas the two models just discussed are fixed-length programs, variable-length skills-training protocols have also been developed for college students with serious psychological concerns, including suicidality and self-injury (see Muhomba et al., 2017). As with the other models presented in this section, this program focuses exclusively on skills training, but without the requirement of a fixed length of time for delivery. The primary advantage of a variable-length model is that groups can start at various points in the semester, allowing group leaders to be more responsive to the needs of students who may not present during the first few weeks of classes. For example, the program may have one standard curriculum of skills, but offer them via 6-, 8-, or 10-week groups depending on how much time is available in the semester after the group fills to capacity. Because this model also targets students with serious and/or life-threatening concerns, it is likely that the majority of the students in the program will be receiving other services (e.g., individual therapy), but no formal procedures need be in place for providing DBT individual therapy, phone coaching, or therapist consultation.

Even in instances where the intention is to provide group as a stand-alone treatment (Uliaszek et al., 2016), if the sample is one of high severity, most students end up receiving individual counseling or case management to manage risk, and the DBT skills groups become an adjunctive form of treatment; treatment coordination is recommended. However, as noted above (see Meaney-Tavares & Hasking, 2013), the UCC need not assume sole responsibility for providing this extra attention. Students with higher needs are also commonly seen by a campus psychiatrist, who is often located in the campus health clinic. The health clinic and follow-up appointments associated with campus-based psychiatry provide an additional on-campus touchpoint to check in with vulnerable students. UCCs can also network with off-campus providers and community mental health centers to provide a list of affordable and accessible options for students.

### Stand-Alone DBT Skills Groups

Skills-training groups as a stand-alone intervention is commonly the only mode of DBT offered in UCCs (Chugani & Landes, 2016). A stand-alone group is appropriate when the students served do not present with suicidal risk and/or BPD. In a stand-alone group, students are generally clinically stable and the DBT skills group facilitators do not coordinate with individual therapists.

Stand-alone DBT skills groups can be designed to fit into the semester or quarter schedule and can cover all DBT skills-training modules or be specific to one module (e.g., emotion regulation only). The delivery of a single-module program allows UCCs to focus on the in-depth delivery of skills from a single DBT skills-training module. Stand-alone DBT skills groups can also be delivered as a workshop series, where students may attend various workshops (often 60 minutes long) on specific skills. These brief workshops can be viewed as drop-in services provided at the clinic for current UCC clients or, alternatively, as a form of outreach provided by the UCC to the campus community at large.

## Guidelines for Adapting DBT to UCCs

A primary dialectic that UCCs must contend with is the balance between adhering to standard DBT as an evidence-based practice versus adopting a more flexible approach in applying DBT practices and principles to accommodate differences in UCC service structures and scope of practice. Given the wide variation in UCCs, a "one-size-fits-all" approach is not likely feasible. UCCs are already adapting DBT, with group skills training being the most popular component offered (Chugani & Landes, 2016). This next section will focus on program development, balancing effectiveness with feasibility/sustainability.

### Developing a Feasible and Sustainable Program

For some UCCs, C-DBT, reduced to one or two semesters (up to 1 year at most), has been shown to be feasible (Engle et al., 2013; Pistorello et al., 2012). The model proposed here is to use DBT flexibly, across a spectrum of intensity, reserving C-DBT as a specialty program for higher-risk students willing and able to engage in this multimodal treatment. This saves resources and increases the scope of the DBT approach within the UCC, and the specialty format allows the UCC to offer more services to some students with especially high needs. UCCs may consider implementing C-DBT, for example, because they are already treating higher-risk students but would like to do so in a systematic way, or because the current approach appears to be ineffective or results in hospitalizations/medical leaves (Engle et al., 2013).

However, C-DBT, even if only one semester long, may not be feasible for some UCCs due to training, treatment delivery costs, low number of staff, productivity requirements, session limits, or a narrow scope of services. Fortunately, there are many options for delivering DBT on campus. Starting with a flexible and manageable program that allows the program and team to grow at a reasonable rate is key. It is better to start small and grow over time than to launch an initiative that strains staff and resources and thus may not be tenable in the long term.

To begin program development, it is important to consider the balance between the targeted student population with the modes of DBT that can realistically fit into the UCC structure and scope of services. Whereas DBT skills-training groups as a stand-alone intervention are not recommended for students with BPD and/or suicidal risk (due to the lack of opportunity to provide risk assessment or attention to individualized treatment targets), it may be possible to offer DBT groups as an adjunctive service to students who receive individual therapy conducted by other non-DBT providers at the same UCC (see Chugani et al., 2013; Chugani, 2017) or in the local community (see Meaney-Tavares & Hasking, 2013). Thus, there are different methods of matching student populations with DBT components. Community partnerships may be particularly useful if treatment for highly acute students is needed but cannot be realistically achieved at the local UCC without additional, off-campus support. Such initiatives could include, for example, a partnership between a psychiatric hospital and one or more local campuses to develop a specialty, DBT-informed intensive outpatient program designed specifically for college students (University of Pittsburgh Medical Center, 2020). Alternatively, the UCC can develop a list of community providers comfortable treating high-risk presentations and actively coordinate treatment, with the UCC providing the adjunctive DBT skills-training group while the practitioners conduct individual therapy—DBT-based or not. To facilitate the dissemination of DBT to private practitioners, the local UCC can sponsor DBT intensive training and open it up to the community and/or conduct DBT presentations regularly to create more interest/understanding.

A second key area to consider is the balance between resources available versus those needed to develop the program. Important resources to consider are availability of funding for training activities and required materials (e.g., books, photocopies, binders), administrative support for DBT program development and implementation (including time set aside for a weekly peer consultation group for C-DBT as well as continuing education opportunities), sufficient numbers of staff and trainees to participate, staff interest and willingness to learn DBT, and sufficient physical space (e.g., a group room). Although in the long term, DBT may reduce UCC staff burnout by helping a broad segment of challenging students learn skills, the short-term impact of developing a DBT program will likely add some burden—for instance, increased time commitment from staff for training and studying DBT materials. If possible, UCCs should provide release time from typical productivity demands to support staff learning DBT or actively seek out training options that will occur during academic breaks when staff may have more availability. It is also important to acknowledge that UCC counselors are often experienced and have well-established theoretical orientations; DBT may challenge or conflict with some of these preexisting worldviews. Prospective DBT team members must be informed of the requirement to make a commitment to adopt DBT practices and principles (as applicable to the specific DBT program) to ensure they are well aware of general expectations before joining the team. For example, if the UCC program implements C-DBT, prospective team members must be informed of the requirements to attend weekly team meetings and provide skills coaching if necessary.

Another resource worth considering is the availability of trainees. Given that 63% of UCCs have master's-level trainees and 39% have doctoral-level interns (LeViness et al., 2017), clinical trainees are a valuable resource that can help to offset the amount of staff time dedicated to delivering DBT groups. There are several

advantages, both for the trainees and the UCCs, to including trainees as DBT group cofacilitators (Rizvi & Steffel, 2014). First, trainees can participate in DBT training as part of learning requirements and therefore as part of their job responsibilities. Second, trainees may gain exposure in the management of more acute clinical situations, thus honing the trainee's clinical skills. Third, relying on trainees to serve as cofacilitators frees senior staff to conduct other forms of treatment or manage acute situations requiring their expertise. Finally, trainees can learn useful skills, which may pique their interest in continuing to learn an evidence-based approach, thus furthering the dissemination of such practices into UCCs and the local community.

### *DBT Training and Program Implementation*

DBT training can vary depending on the type of program being implemented at the UCC (see Table 7.2). Prior to making a larger financial investment, it may be helpful to form a team and meet weekly to discuss chapters from the DBT treatment manuals (Linehan, 1993, 2015). Doing so will allow the team to function at a comfortable pace and gain greater familiarity with DBT practices and principles prior to making decisions about possible adaptations from the standard model. Supplementing these activities with online training programs, online learning communities, or the support of a DBT consultant may enhance understanding of the texts while still allowing the team to perform its work at its own pace. When more formal training is desired or indicated, select the training activities that most closely align with the program's goals. For example, if the plan is to implement DBT skills-training groups with no or very low intention of offering any of the other components of the standard model, a 10-day intensive training is not likely required. However, for those who do wish to expand their programs, evidence exists that teams which begin offering DBT prior to attending intensive training develop programs that survive longer (Harned et al., 2015).

DBT should also be adapted *strategically*. That is, adaptations should be made when necessary for program feasibility and sustainability, rather than based on including extraneous components because of personal interest (e.g., adding yoga). After developing the program in the manner that best meets the needs of the students and UCC, one can maintain a flexible attitude toward the program structure by pilot-testing different versions of the program to see which is most efficient and efficacious. For example, one may try to deliver groups of different durations to determine which length seems to be optimal for both recruitment and clinical outcomes. In terms of group length, it will depend on the academic structure of the campus (e.g., semester vs. quarter), as well as the time needed to recruit enough participants for a group (e.g., interest in participation by the students and willingness to refer to group by UCC staff) and the flow of students into the UCC (e.g., size of clinic and/or campus). Shorter groups allow for students who present midway through the semester to be included (Muhomba et al., 2017). The use of a group skills-training protocol that requires the majority of the semester/quarter to deliver (e.g., 11–12 weeks) may only capture those students who present for treatment during the first few weeks of the term. Using variable-length groups or shorter groups (as in the C-DBT program reported earlier and by Panepinto et al. [2015]) allows for staggered start dates during the first half of the semester to accommodate more students as they present for treatment throughout the semester. Although this trial-and-error approach may require greater time commitment, in the long run, making decisions about the program based

on evidence, student, and staff input is more likely to yield a sustainable program that will well serve the particular students at a UCC well.

### *Program Evaluation*

A final area we recommend for consideration is program evaluation. Whereas the extant literature provides variants of DBT programs in UCCs, this research is primarily made up of small, uncontrolled pilot studies (see Table 7.1). Further, individual UCCs may elect to develop their own DBT program rather than following one of the models previously described. Thus, we encourage careful consideration of which primary clinical outcomes are most desired (e.g., improved emotion regulation, reduced BPD symptoms or depression, reduced hospitalizations, academic retention) and strongly recommend using relevant measures to ensure that the program is yielding the expected outcomes (see Skerven et al., Chapter 4, this volume). Many free-use measures are available, and the reader is referred to studies listed in Table 7.1 for commonly utilized measures for assessing DBT outcomes in UCCs. There are ways to collect data without adding an undue burden for UCC staff members who may not have time for evaluation activities, such as partnering with a doctoral student or faculty member in psychology, counseling, or social work in exchange for permission to publish the data or use it in a thesis or dissertation project. UCCs already using technology (e.g., tablets) can rely on secure online survey platforms (e.g., Qualtrics) to collect data from students to minimize data entry burdens.

## Conclusion

College students are experiencing higher levels and complexity of psychological problems (including suicidal thoughts and behaviors), and individuals with threat-to-self issues tend to be high utilizers of services (CCMH, 2017, 2019) and can strain UCC resources. Due to its multimodal, principle-driven nature, DBT can be deployed in various ways along a continuum of intensity and cost, fitting the needs and resources of the UCC. Additionally, including DBT as part of the UCC training program is an ideal way to reduce costs associated with program delivery, while providing trainees with the opportunity to learn an evidence-based and highly marketable skills set. Finally, DBT principles may also be useful outside of therapy. In addition to outreach efforts to teach the skills to students, training housing staff and other university employees/faculty on how to avoid inadvertently reinforcing escalation and crisis behaviors may be useful to the broader campus community.

A review of DBT in the literature on UCCs demonstrates that DBT is efficacious in reducing suicidal risk, psychological distress, and increasing skills use. However, most of the research was conducted under the umbrella of program evaluation or initial feasibility/acceptability and lacked randomization and/or control groups. Despite this limitation, every study has shown the feasibility of adapting DBT to UCCs. Some studies showed that DBT had higher attendance and treatment completion rates (Uliaszek et al., 2016) and was associated with fewer hospitalizations and medical leaves (Engle et al., 2013), which are very costly to UCCs and the academic institution itself. Outcome variables relevant to academic institutions, such as medical leaves or poor academic functioning, are essential to demonstrate to institutions

the cost-effectiveness of DBT. In closing, DBT programs in UCCs come in a variety of forms based on student and UCC needs. Although a single best-practice approach to DBT on campus does not exist, current research suggests that DBT can and does work to address some of the most pressing problems faced by UCCs.

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CHAPTER 8

# DBT in Juvenile Justice Programs

DEBRA M. BOND, JESSE HOMAN, and BRAD BEACH

The inspiration for writing this chapter comes from our collective experience in a range of roles (frontline staff, milieu counselor, supervisor, clinician, psychologist, clinical manager, and trainer) working in the juvenile justice (JJ) system with a challenging and delightful group of delinquent youths who, when asked about their life-worth-living goals, struggle to see a future for themselves because they do not expect to live past the age of 25 (Barnert et al., 2015). Their focus is on survival, not success. And yet there is often one hopeful young person who, when the work becomes overwhelming, serves as a reminder of the value of this practice. One such inspiration came about unexpectedly when a group leader read aloud comments a youth had written to her in the back of his skills workbook, an item he initially discarded on the day of discharge:

> *I think DBT meant a lot. It is very important to know these things. At first I was like, "This group is dumb" but after I sat down and read it, it made a lot of sense. In group, I took it as a joke because [there were] a lot of us and we all ignored the leader. Once I was having a little bit of problems. . . . I went to my room and started going through my things. I came across the DBT booklet and read it. It helped!*

This chapter will provide the reader with an overview of the issues that surface when working with JJ youth ages 12–20 charged with, or adjudicated of, criminal offenses in congregate care or residential settings (facilities that house juvenile offenders as a result of some contact with the court). The legal system recognizes that these youth are different from adult offenders and have needs that require treatment and rehabilitation. We will describe the ways in which dialectical behavior therapy (DBT) has been applied to this unique and important setting.

## Overview

Each year, over 2 million youths are arrested in the United States. Fortunately, the number of delinquency cases are decreasing—down by 51% from 2005 to 2017 (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2019)—in all offense categories (property, public order, person. and drug laws). Juvenile offenders are four times more likely to endure four or more adverse childhood experiences (ACEs) (Baglivio et al., 2014). Specific adverse experiences related to family dysfunction increase a youth's chances of involvement in the JJ system as well as greater risk of recidivisim (Baglivio et al., 2014).

Notably, youth in the JJ system have a higher rate of prevalence of mental disorders in comparison to the general population of adolescents (Underwood & Washington, 2016). Youth in confinement have at least one mental health disorder and report at least one documented ACE (Bielas et al., 2016). These youths are at increased risk for suicide, which is the leading cause of death for youth in confinement (Bureau of Justice Statistics, 2002–2005; Hayes, 2009; Teplin et al., 2015). Teplin and colleagues (2015) found prevalence rates of 19–32% for suicidal ideation and 12%–15.5% for suicide attempts in the past year. Combined prevalence rates across the JJ system indicate that youth who are more deeply involved in the JJ system have high prevalence rates. In addition, the prevalence rates of suicide are higher during the course of a youth's correctional stay than at the time of intake. The Centers for Disease Control and Prevention (CDC, 2016) reported that adolescent suicide is now the second leading cause of death, up from being the third leading cause of death in 2012, and youth in the JJ system are at a higher risk. Youth diagnosed with affective and mood disorders often present as irritable and incite angry responses from others, which may increase their risk of aggression and lead to involvement with the JJ system. Once in placement, such youth can participate in fighting and exhibit other aggressive behavior as well as engage in self-injurious behavior. As a result, the CDC, in a position statement, has identified key components of a successful suicide prevention program for juvenile correctional facilities. Thus, there are safety concerns for both youth and staff, and administrators seek to identify rigorous effective treatment interventions that meet the specific needs of juveniles being served.

Refuting the notion that "nothing works" for youth in detention and JJ facilities, *What Works* is a collection of best-practice principles that form a treatment framework for addressing the needs of JJ-involved youth (Landenberger & Lipsey, 2005; Lowenkamp, Latessa, & Holsinger, 2006). A key recommendation is that youth at greatest risk for reoffending receive the most intense treatment using evidence-based practices for those problem behaviors most closely associated with delinquent behaviors. *What Works* also recommends that the intervention fits or is responsive to the specific offending JJ youth being served. A report (*Improving the Effectiveness of Juvenile Justice Programs*) from the Center for Juvenile Justice Reform at Georgetown University (Lipsey, Howell, Kelly, Chapman, & Carver, 2010) recommended treatment programs that are "integrated into a comprehensive strategy." Ineffective treatment programs were found to jeopardize the success of the entire system of care. DBT is a comprehensive cognitive-behavioral treatment that meets these principles.

The use of DBT in a JJ setting makes sense for several reasons: It is a comprehensive cognitive-behavioral treatment framework/structure for complex, multidiagnostic patients.

The framework can easily be adapted clinically to address all kinds of problems; the treatment targets allow a clinician to easily adapt to different sorts of youth and problems while maintaining fidelity. DBT provides a team-based approach that can be extended to the milieu.

The core part of DBT is skills training, and skills have direct relevance for JJ youth: emotion regulation to help with *x,* interpersonal effectiveness that helps them with *y,* and so on.

DBT is based on solid theory, strict research, and clinical practice. DBT not only addresses significant behavioral issues and suicidal behavior displayed by juveniles within the facility but also provides them with a set of coping and life skills that can address their risk for recidivism (Berzins & Trestman, 2004). Enhanced treatment, along with facilitywide suicide assessment and prevention practices, can provide data on JJ outcomes and effective interventions. DBT may help address facility issues related to the development and maintenance of a therapeutic milieu, reduce staff burnout (Haynos et al., 2016), and increase staff self-care. Burnout can be associated with poorer patient outcomes, negative attitudes toward patients, and greater institutional costs (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Finally, implementation of DBT may also be viewed as a dialectical synthesis or solution to the demands to address safety and security and youth accountability, while also meeting demands for a restorative evidence-based model that meets the individualized needs of JJ youth.

## Current Research on DBT in the JJ System

The use of DBT for youth in the JJ system was pioneered at the Echo Glen Children's Center, located in the Pacific Northwest, when the center adapted DBT for use with delinquent girls with mental health problems who were residing in a locked, secure facility. Many of the early DBT studies were done with female offenders, in part due to higher rates of suicide attempts among female offenders in comparison to male offenders (Teplin et al., 2015). Results from this initial study were indeed promising, as evidenced by reductions in parasuicide, aggression, and disruptive behavior in the classroom (Trupin, Stewart, Beach, & Boesky, 2002). Since these early efforts, DBT has been systematically implemented in several states in the United States and Canada (Quinn & Shera, 2009) with JJ youth residing in a locked, secure facility and across the continuum of care, including its use in aftercare outpatient settings.

The ability to conduct rigorous research in correctional settings is limited. Current studies reviewed have utilized semi- or quasi-experimental designs of youth pre- and posttest outcomes, or a comparison of DBT skills groups and control or treatment-as-usual groups. Modifications while maintaining DBT treatment adherence have been implemented using only skills groups and/or material adaptations to include examples that are more appropriate for adolescents, the inclusion of frontline or milieu staff as coaches, and training directly with staff in the milieu.

Within-subject studies have shown a reduction in target behaviors of impulsiveness and aggression, suicidality and self-harm risk behaviors, disciplinary tickets as well as improved self-control and regulation of emotions (Trupin et al., 2002; Shelton, Kesten, Zhang, & Trestman, 2011; Quinn & Shera, 2009; Sakdalan, Shaw, & Collier, 2010; Banks & Gibbons, 2016). Studies using pre- and posttest measures have

also included routine clinical assessment self-report tools such as the Beck Depression Inventory (BDI-II), and the Ohio Youth Scales Problems Subscale also found significant reductions in internalizing behaviors and level of depression (Banks, Kuhn, & Blackford, 2015). There has been some suggestion that poor youth outcomes are related to staff factors of rigidity and flexibility, favoritism of some youths over others, and the use of verbal interactions characterized by extreme irreverence (Quinn & Shera, 2009). Trupin and colleagues found some association between the level of staff DBT training and youth outcomes. Staff outcomes to assess reductions in the use of punitive responses or reduced burnout or overall changes in facility culture have not been consistently assessed. There has been no published research comparing JJ training model adaptations. This may be due, in part, to some DBT training models requiring a commitment of time and resources that are too costly or stretch the staffing of JJ facilities.

Research on the continuation of treatment effects from the facility to the community is also limited. A second study at Echo Glen Children's Center (Drake & Barnoski, 2006) examined youth rates of reoffending up to 36 months after their return to the community. Recidivism rates were lower for youth in DBT treatment in comparison to youth who did not receive treatment. However, the results were not statistically significant due to the small sample size; thus, it was not possible to state that DBT reduces recidivism.

Involvement of family members is recognized as important because it has been determined that when youth lack skills addressed by DBT, their families are also likely to be deficient in these skills. Therefore, the inclusion of parents in DBT treatment prior to discharge can serve to decrease parental invalidation and parental use of ineffective responses to a youth (Quinn & Shera, 2009). The Family Integrated Transitions (FIT) model utilized in Washington State Institute for Public Policy (2006) engages youths and their families before discharge and after their return to the community. FIT clinicians help with generalization of DBT skills to the home and community. FIT data have demonstrated a reduction in rates of recidivism (conviction rates for subsequent juvenile or adult criminal offenses) after release for a 6-month period.

Recently, Fox, Miksicek, and Veele (2019) completed an evaluation of DBT implementation in the State of Washington to determine the impact of DBT from 2012 to 2019. Since the Echo Glen pilot in 2002, Washington state has been using DBT statewide, but there has been variation across programs. Quality assurance data were analyzed to measure the DBT adherence and quality of the therapeutic milieu/social environment on the unit, based on observations of interactions between staff and youth as measured by an environmental adherence (EA) coding tool along with staff, youth, and family surveys. Units with high EA scores were rated by youth as also having high-quality treatment. However, due to the inconsistent ways of reporting incidents across units, researchers were unable to determine the impact of DBT on youth behavior in the milieu. The methodology (logistic regression) to examine DBT effectiveness as determined by its impact on youth recidivism for EA, individual sessions, skills group sessions, and consultation team involvement was developed. High environmental adherence was found to correspond to reductions in felony recidivism rates and to be important for younger youth and youth with high mental health needs.

Overall, despite limited quasi-research and the absence of any random controlled trials (RCTs) of youth in the JJ system, the consensus is that using DBT to target

problematic behavior is a promising approach. More research to look at specific components/modes of treatment, and the effectiveness of these modes on recidivism, is needed.

## Adapting DBT to JJ Populations and Settings

The original DBT treatment manual (Linehan, 1993b) serves as the comprehensive treatment manual for JJ programs, and although there are many ways to deliver DBT, its basic principles are strictly adhered to. The dialectical tension between adherence to DBT principles and delivery in an engaging and culturally relevant manner is one of the most critical factors in implementing and sustaining an effective DBT program in a JJ setting. Unless the youth and direct-care staff can see the genuine relevance of DBT to their lives, the buy-in will often be minimal. Buy-in from clinician staff is essential as clinicians help ensure generalization of skills to youths' families and into the real world. It is also critical to have buy-in from managers and directors at the top levels who can develop policy that is in alignment with DBT principles and help allocate the needed resources to implement DBT. Additionally, management must provide incentives for both staff and youth, and demonstrate their commitment to DBT programming. Management commitment is expressed by ensuring coverage for DBT-trained staff to attend skills groups and consultation team meetings, conduct youth individual check-ins or behavioral chain analyses, and attend training refreshers or other DBT-related activities.

Thus, the training and implementation phases of DBT in a JJ setting are the most critical aspects and will be a primary focus of this chapter. In addition, the chapter will focus on the use of validation and coaching in the milieu. All staff who interact with youth must coach skills in the moment to help youths strengthen and generalize skills into their daily life. We will be using the word "staff" to describe anyone working with youth in facilities: line staff, clinicians, teachers, and the like. Finally, some specific DBT juvenile adaptations and protocols will also be described and examples presented to increase understanding of using DBT in a JJ setting. It is assumed that readers will refer to the many standard DBT adult or adolescent resources for specifics on stages and targets (among them, secondary targets) of treatment and DBT functions and modes of treatment, including skills groups, individual therapy, consultation team, and family therapy.

## Training

In contrast to many training organizations, successful JJ models apply an active approach to training (rather than training as usual methods that rely heavily on didactic lecture). Whenever possible, a team-based experiential and deliberate practice-based learning where concepts are first modeled, then practiced and role-played by participants is utilized. Applying principles of DBT to the teaching itself, trainees are coached in the moment on how to improve their practice using modeling and verbal feedback. Table 8.1 is an example of a juvenile training workplan. Special emphasis will be placed on tailoring the training to meet the needs of the program, its staff, and the youths it serves. Training will combine didactic presentation with modeling

and role-play, along with team-building exercises. Consistent with best-practice standards, materials are distributed at the training.

In some instances, systems are unable to free up their staff for 5 days at a time without considerable compromise to the care of their youth. In such cases, the standard 5-day curriculum can be broken into two segments: an initial 3-day training followed by an additional 2 days usually 2 weeks later. Thus, rather than two 5-day trainings (Parts I and II), there are four, with each part composed of 3-day and 2-day training in close proximity. Both the standard approach and modified version have pros and cons. For this reason, consultation with leadership beforehand is critical.

## Implementation

Implementation of DBT in a JJ setting often requires a major paradigm shift in the culture of the facility. Instead of a sole emphasis on safety and security and the use of punitive measures, implementing DBT focuses on creating a culture that is nonjudgmental, observant, and restorative. Synthesizing safety/security and treatment is essential. If a synthesis is not obtained, DBT programs can be destroyed (Ivanoff & Marotta, 2019). In addition, DBT ensures accountability, attempts to help repair the harm caused in relationships, and commits to using skills and incentives to increase motivation in staff and youth. We also consider DBT in the JJ setting as a milieu program, not a clinical program. In this spirit, because the term "delinquent" has negative connotations for many, some programs have begun to refer to the youth they serve as residents or students. The term "youth" will be used in this chapter.

The initial preparation phase of DBT implementation includes the identification of a core team of facility staff representative of all disciplines who have direct contact with youth. Youth representation is also recommended to increase buy-in. We have found it works best when this team is called "DBT champions" or "DBT warriors," or some such term that helps to increase the sense of a therapeutic milieu rather than a correctional environment. Some programs provide youth and staff with special shirts bearing the logo "DBT Champions" to help develop a sense of belonging and ownership as well as identify key youth and staff to whom questions can be directed by other staff and youth. One Connecticut facility held a monthly luncheon/refresher training session with staff and youth DBT champions to reinforce skills. Staff reported that this luncheon was key to increasing their motivation and sense of connection to each other. When the luncheon was discontinued due to a change in administration, the staff's level of participation in, and motivation for conducting, DBT sharply declined.

### *Use of Commitment and Validation to Enhance Implementation*

Obtaining commitment to DBT can be challenging in a JJ setting for many reasons. In the case of the youth, many are placed at these facilities by the court; thus, placement is generally not voluntary. Add to that the distrust many youth have toward adults and authority figures, as well as the belief that they will not live past age 25 (Barnett et al., 2015), and this task becomes even more challenging. In the case of staff, systems often decide what programs will be implemented and then staff are mandated to participate in training sessions to learn and implement the program.

**TABLE 8.1. Juvenile Justice Training Workplan**

| Type | Focus | Staff included |
|---|---|---|
| Initial implementation consultation with leaders (1 day) | Orientation to DBT implementation: a brief overview of DBT and research to date using DBT in the JJ context; key components of a successful implementation. Special emphasis will again be placed on tailoring the training to meet the needs of those the program invited to participate. Training topics will be coordinated with leadership in advance to ensure maximal impact. | Funders and other key stakeholders/decision makers, facility directors, program managers, and clinical directors. |
| Part I (5 days) | A comprehensive overview of DBT, including DBT stages and targets of treatment, DBT functions and modes, dialectics, validation strategies, cognitive modification procedures, contingency management procedures, exposure procedures, skills-training methods, and special procedures developed and evaluated in JJ environments (i.e., egregious behaviors protocol, strategies to optimize the milieu to generalize learning). | Each program will have a DBT team made up of a variety of providers who will be part of the DBT treatment of no fewer than four individuals and no more than eight. |
| Part II (5 days) | Part II focuses on the following topics: (1) more practice with greater behavioral precision in application of behavioral chain analysis; (2) strategies to improve the implementation and practice of the egregious behaviors protocol; (3) strategies and practice in making DBT skills-training groups fun, engaging, and effective for youth; and (4) developing higher-octane, higher-yield DBT individual therapy treatment plans for youth. In systems with high incidents of self-harm and suicide, assessment and intervention of suicidal behaviors are taught during Part II.<br><br>Team presentations: at least one case for feedback by trainers during Part II. Each team will also provide one program presentation. | Combine clinical and program staff. The DBT team is made up of a variety of providers who will be part of the DBT treatment, including DBT skills coaching. Such providers may include clinicians, teachers, frontline staff, nurses, vocational specialists, and volunteers. Teams are typically made up of no fewer than four individuals and no more than eight. |
| Monthly phone consultation during first year | Monthly phone calls will be scheduled, with each team participating in DBT training. The purpose of phone consultation is to address clinical and/or programmatic questions about the implementation of DBT. | Phone consultation will include the whole team attending the DBT training. |
| Training for coaching on the fly and DBT skills (2 days) | In addition to teaching DBT skills across all DBT skills-training modules, participants will learn principles of *in vivo* skills coaching ("coaching on the fly"), how to structure skills-training groups in the group home environment to maximize positive outcomes, how to weave skills use throughout the milieu, and how to effectively respond to difficult therapy-interfering behavior during groups. | All members of DBT teams plus as many frontline staff, teachers, and other providers as are able to attend. |
| Substance use disorder training (2 days) | Interweave DBT with cognitive-behavioral therapy (CBT), harm-reduction strategies (if allowed by program), and motivational interviewing (MI)—with a specific focus on treating alcohol and drug abuse among youth who may have great ambivalence about stopping or reducing their use. | DBT primary clinicians, DBT consultation team members. |

(*continued*)

**TABLE 8.1.** (*continued*)

| Type | Focus | Staff included |
|---|---|---|
| Additional onsite training may be substituted for the substance use disorder training (2–3 hours each) | Onsite training topics might include, for example, a series of brief 2- to 3-hour trainings with small groups of frontline staff on a handful of DBT skills (e.g., distress tolerance, cope ahead, crisis survival + radical acceptance; rationale for using egregious behaviors protocol and steps for implementing; and/or validation strategies to de-escalate a crisis). | Frontline staff. |
| Onsite consultation/training and program fidelity checks (1 full day each visit) | Site visits are recommended no less than three times over the course of the implementation: at the start of the implementation (to gain a direct understanding of the system and to develop a strategic blueprint for development over the course of the implementation), at the midpoint of the implementation (in close proximity to DBT Part II), and at the end of the implementation (to focus on next steps in development, maintenance, and/or sustainability). | Administration managers, DBT consultation team members. |
| Train the trainer/development of in-house implementation expertise | The best way to ensure implementation success over the long run is to start an implementation with a clear plan for succession planning—from the experts to an in-house team. Because of the complexity of DBT, it is unrealistic to expect a recent DBT trainee to be ready to carry the load of all training after only a year. What is critical, however, is that tracks are laid down from the start for a "train the trainer" pathway. | DBT-trained staff at all levels. |

These are difficult enough challenges on their own. Another hurdle is that many people employed in JJ systems have been trained and primarily work in systems that have a corrections approach. It is not uncommon for staff at all levels to view treatment as being ineffective and "soft." Another problem in our experience is that many staff, especially those who have been in the system the longest, have watched a multitude of programs and treatments come and go during their time in the system (Greenwood, 2008). This tends to result in apathy toward learning something new, as many report feeling frustrated because in their experience by the time they learn the new program/system, another program will take its place. For them, DBT is the next new thing that will likely be replaced in a short amount of time. All of these factors create many obstacles to obtaining commitment in JJ settings.

For both the youth and staff, the goal is to get their commitment to learn and incorporate DBT into their lives. For the youth, this means learning and applying the skills in schools, in the milieu, with their family and friends, and in their lives outside of facilities. For the staff, this means applying the skills and strategies with the youth in their programs as well as with themselves and their coworkers. This is critical as it provides an opportunity for the modeling of skills to the youth.

Because the youth and staff tend to believe that DBT is something they are mandated to do, it is common that many are not interested in learning the therapy. For both youth and staff to buy in, it is imperative to link learning and applying DBT to their specific goals. When obtaining a commitment from staff, just as with youth, linking the learning of DBT to the staff's goals is important. For example, increased safety on the unit, better relationships with the youth, and decreased burnout are

often goals that most staff are interested in. The most effective way to get a firm commitment is through individual conversations with the youth and staff working on the units where DBT will be applied.

Although many youth have the goal of returning home and remaining there, this concept can at times be too far off in the future to feel tangible to them. It is thus important to balance and identify both the short- and long-term goals that the youth want. For example, a youth at one facility knew he would be in the facility for at least 2 years. In talking with him, it became clear that he was despondent about the duration of treatment and therefore not motivated to learn or apply DBT to achieve a goal so far away. His response was that he would "just do my time" and go home. All attempts to get a commitment from him in this way did not work. By paying close attention to this youth (validation Level 1), staff realized that he often had the experience of people not listening to him or taking him seriously. This occurred with his peers, teachers, and staff members not on his unit. A staff member whom this youth held in high regard approached and asked if he would like for other people to listen to him. The youth emphatically said "yes." The staff member then linked learning DBT to obtaining this goal.

There are also ways in which commitment to participating in DBT can be incorporated into a program's structure. For example, at Echo Glen, youth make the choice each morning whether or not to participate in mindfulness. Those who opt out sit outside the circle and face the wall. Those who participate in mindfulness go through the breakfast line before those who did not participate. Programmatic structure can be extremely helpful in securing a commitment from youths, but it should not take the place of obtaining commitment from each youth individually.

### *Using Commitment Strategies in the Milieu*

It is imperative to obtain commitment from youth to work with staff, learn DBT, and identify life-worth-living goals and goals for their lives outside of placement. For a number of youth, this is extremely difficult. The reasons are many. Some have not made plans because they do not expect to live long lives. For others, the thought of contemplating what they *really* want in life is excruciating as they don't believe that they can get it. Still others might have goals but are reluctant to speak about them openly with people whom they don't trust. For this reason, it is imperative to use validation on a regular basis when working with youth to build, maintain, and strengthen relationships.

Even though life-worth-living goals may be difficult to identify early on, commitment strategies can be used in a variety of interactions with youth. Because youth are mandated to the facilities and most are mandated to treatment, it is imperative that DBT practitioners create choice for youth at every turn to avoid psychological reactance caused by "making" them do something they do not want to do. To avoid a reactant effect, we have found it helpful to use language associated with willingness. For example, asking a youth if they would be *willing* to talk or *willing* to learn a new skill can make the difference between hard pushback reactance and the proverbial door opening slightly. Notice the difference between "Would you be willing to talk with me for a moment?" versus "Hey, I need to talk to you now!" The first question puts the ball in the youth's court. This will have a positive effect as it communicates that the youth is important and an equal in the relationship: *They* can

choose whether to talk or not. If they say "no," the staff might gently remind them that they can always stop by to talk, should they change their mind. This kind of response avoids unnecessary power struggles and can often be a powerful factor in developing a relationship with the youth. In the anti-DBT example above, no choice is given to the youth. In other settings with adolescents who have different learning histories and less trauma, this may not be as "big of a deal" as it is for youth detained in a JJ facility. In JJ settings, youth hear commands throughout the day from adults. The repeated use of willingness with regard to seemingly day-to-day requests can go a long way in increasing a commitment to DBT, learning skills, and working on building a life worth living.

Commitment strategies are also critical in high-risk situations. Consider the example of obtaining commitment from a youth who engaged in frequent violent behavior and was unwilling to change his behavior despite numerous, varied efforts by staff to help encourage him to do so. The youth had become angry with his aftercare worker and was threatening to attack her, as his date of release had been pushed out. As this youth had a well-established history of violence toward others, the aftercare worker had no doubt that the youth meant what he said and would act on his threats. Staff attempted to reason with him and encourage him to consider his future and other options. The youth was firmly entrenched in his position and unwilling to move from it. The more staff encouraged a change, the more entrenched the youth became. Another complicating factor was that the youth had also recently been assigned to a different clinician, as his previous clinician had retired.

Upon meeting with the youth, the first task of the therapist was to quickly try and build a relationship. This was done by asking the youth about himself and utilizing validation Levels 5 and 6, answering the youth's questions honestly and using self-disclosure. When the therapist brought up the idea of doing chain analysis with him, the youth's demeanor cooled. He looked the therapist directly in the eyes and said, "Look, I will do this [chain analysis] with you, but I am sure you have heard that if the [expletive] doesn't give me my date back I'm gonna get her."

THERAPIST: I have heard that. It seems to me that your mind is pretty made up about it.

YOUTH: Yep.

THERAPIST: Look, that is your call to make. If that's what you're going to do, that's what you're going to do. [signaling acceptance of the youth and his ability to make choices] Tell me this, though: What will happen to you if you go for her? [assessing the consequences of the behavior]

YOUTH: I know what's gonna happen. (*Begins looking around the unit at line staff.*) He's gonna come for me, and he's gonna come for me, and he's gonna come for me. And they'll get me. But you know what? I'm gonna get some of them first. (*Becomes excited: His chest expands, his arms begin to tense and flex, and he smiles widely at the thought of getting some of them.*)

THERAPIST: OK, then. That's your call, you know what's gonna happen. How about this? I am not gonna try and get you to do something you don't want to do. [indicating acceptance] If at some point though—while talking to me—you change your mind and you want me to teach you other things

you could do instead of choking her out, will you let me know? [indicating freedom to choose in the absence of alternatives and willingness over willfulness]

YOUTH: OK.

THERAPIST: Great! So, tell me about what happened 2 weeks ago.

The therapist and the youth conducted the chain analysis. Multiple times during the chain, the youth brought up wanting to attack his aftercare worker. Each time this occurred, the therapist responded with the same use of freedom to choose in the absence of alternatives and willingness over willfulness. Throughout the 30-minute chain analysis, the youth displayed no sign of softening in his stance to attack his aftercare worker. It was therefore a great and pleasant surprise when the youth looked the therapist right in the eye and asked if he would teach him some skills so he wouldn't attack his aftercare worker. The therapist taught him paced breathing and paired muscle relaxation. They practiced these skills on the spot. The therapist elicited a commitment from the youth to continue practicing them on his own. Situations were identified as to when these skills would be helpful on the unit and in school. The youth identified staff that he could enlist in coaching him. After obtaining the commitment from the youth, the therapist looked at him and said, "I am just curious, why on earth would you actually do this. It is going to be way harder." [playing devil's advocate] The youth paused for a moment and said, "Well, I actually wanna go home and get of here." The therapist acknowledged that using the skills would actually help him go home sooner than if he assaulted his aftercare worker, which would result in a new charge and potential placement in a higher-security facility. Troubleshooting was then conducted to identify pitfalls in the youth's plan and to generate solutions. After this meeting, he didn't attack the aftercare worker.

Not only did this exchange result in commitment from an unwilling youth, it also had the effect of increasing commitment from staff members who were skeptical about the use of DBT. Seeing the strategies modeled and the therapist obtain an outcome that was different from previous outcomes without getting into a power struggle and with no escalation of emotion by the youth was critical for staff to increase their willingness to learn. In our experience, when it comes to increasing commitment from skeptical staff, one of the best ways to do so is by having them observe DBT in action. Often, once reluctant staff see the strategies work, their willingness to learn them significantly increases.

Although only a few commitment strategies were highlighted in this section, the same approach can be used with all of the different strategies. The principle for using these strategies with the youth in JJ is to actively highlight that they have a choice: in how they behave and what actions they engage in. The different commitment strategies can then be utilized to help assess the consequences of various choices and to strengthen the youth's commitment to skillful behavior.

### *Validation*

The development of a strong relationship in JJ settings with youth who have experienced significant trauma and who often have multiple and complex mental health

problems is essential and can be very difficult. Building a strong relationship involves significantly more time and use of acceptance and validation strategies than in standard non-DBT outpatient settings (Fasulo, Ball, Jurkovic, & Miller, 2015). Often youth have interacted with many people in their lives who are consistently and highly critical of their behavior and who make frequent attempts to change them, but to no avail (Fasulo et al., 2015). Trying to change them without understanding the context in which their behavior occurs and observing what is simultaneously valid in their invalid behavior only further distances them from their nondeviant peers and strengthens their relationship with other deviant peers.

For example, a youth who had recently been released was returned to a facility after assaulting an adult male. The youth committed this offense after the adult had grabbed and then pushed the youth's younger sister. Initially, the clinician and staff attempted to get the youth to see that his behavior was problematic and that he needed to learn DBT skills in order to change. These attempts were met with anger and defensiveness, with the youth unwilling to talk any further with the team about engaging in DBT. His intention was to just do his time and then go back home and continue doing what he knew best. About a week later, one of the team members approached the youth, saying, "I bet it's hard being back here when all you were trying to do is to be a good brother and stick up for your sister." The youth looked surprised by these comments but admitted it was. The two talked further, and the youth disclosed to the team member what had happened. The team member paid specific attention to validating the youth's fears: that if others saw his sister treated this way and he did not defend her, she would be in greater danger. This resulted in the youth talking more openly about the assault. The youth acknowledged that when he saw the man push his sister, he "lost it" and wasn't able to control himself. The team member reflected back, suggesting to the youth that his anger was like a light switch: It was either on or off. The youth bought into this description, agreeing that once his anger was set off, it was not something he was able to control. The team member validated how difficult a circumstance that was and asked if the youth would like to react differently the next time his anger flared up. The youth replied "yes." This conversation led to the youth committing to learn DBT skills.

In addition to histories of pervasive invalidation and social rejection, race, class, age, socioeconomic status, level of education, and other real and perceived differences between staff and juveniles also interfere with a youth's trust in what is being taught and their belief that the skills (in the case of DBT) will actually work (Fasulo et al., 2015). In our experience, it is not uncommon to hear youths say, "This is rich people's b#$@ s$#t" or "This is white people's b#$@ s$#t" or "This s%^t won't work from where I come from. You have no idea what it is like where I am from." Frequently, these statements by youths are delivered with tremendous anger and hostility as they actively dismiss efforts by the team to help them solve an important problem. These are critical moments in working with a youth. If the clinician or staff becomes defensive, argumentative, or even just tries to convince the youth that what they are saying is inaccurate *and* that these are skills for humans of all walks of life, the youth is likely to become even more entrenched in their position. Specific use of nonjudgmental acceptance and validation is critical in developing strong relationships with the youth, and for turning moments of conflict into opportunities for understanding and alliance.

### Levels of Validation in the JJ Settings

Much has been written about validation strategies and the levels of validation in DBT (Fruzzetti & Ruork, 2019; Linehan, 1997; Linehan, 1993a). The goal of this section is to give examples of how to utilize such strategies effectively in JJ settings. In our experience, validation and acceptance in the milieu are active and ongoing tasks required at every turn and in every interaction. Staff actively accept the youths, respond to them as important and worth paying attention to, and take their issues seriously. Staff also search for the truth or validity in youths' responses and avoid trivializing issues, discounting them, or viewing them through a pejorative lens. For example, instead of saying, "Obviously you don't care, because if you did, you wouldn't be getting into trouble for the same things over and over" to a youth who is frequently on thin ice in the program, staff would say, "Changing behavior is hard!" We acknowledge that changing behavior can be a very difficult task while working the floor due to the demanding nature of the youths and the obvious dysfunction present throughout the shift.

#### *Validation Level 1 (V1): Listening and Observing*

V1 is critical in JJ settings and is often difficult to accomplish given a variety of environmental factors for many youths on the unit—multiple staff, radios, and other distractions. As challenging as V1 is, staying awake and paying attention to each youth are imperative as both communicate to the youth that they are important and being regarded as a human worthy of respect. One way to consider using V1 is to greet each youth on the unit the way you would acknowledge someone you care for at the start and ending of each shift. In our experience, those staff who go around and say hello and check in with each youth, and then do the same when leaving their shift, tend to have the strongest relationships with the youths. This can be challenging when the nonverbal communication of the youth signals "Stay away from me" and/or "I don't give a damn about you." It is important nonetheless that the staff put themselves in the world of the youth and search for phenomenological empathy at these times and proceed warmly independent of the youth's off-putting nonverbal communication (Fruzzetti & Ruork, 2019). If the youth does not respond or remains cool, the staff can simply opt to back away and check in later on with the youth. This will often depend on the relationship between the two.

#### *Validation Level 2 (V2): Accurate Reflection*

V2 is utilized when staff reflect back the youths' own thoughts, feelings, assumptions, and behaviors in a nonjudgmental way. Staff communicates understanding of the facts and helps the youths sort out discrepancies in what they are perceiving and what is really going on. For example, a youth in one skills group became furious when the group leader began telling the youths how using the skills could help their lives and jumped into a discussion of change before a firm foundation of validation had been established. The youth yelled at the group leaders, "This s$^t may work for you in your f@#^$&g mansions, but it won't work for us on the streets." The coleader responded using V2, "It sounds like so far none of these skills have been presented in a way that applies to you." To this statement, all the youths heartily agreed.

The leaders then paused and took a more validating, acceptance-based approach by inquiring about the youths' own direct experiences. The youths and leaders went on to discuss how the skills could be taught in a way that is compatible with the lives of the youths. For the youths, a big part of this was having the leaders understand what their lives were like (acceptance and validation) and to use examples and models that the youths identified with.

### *Validation Level 3 (V3): Articulating the Unverbalized*

V3 occurs when staff is able to read a youth's behavior and communicate what is going on without the youth having to say a word. This serves to validate the youth by verifying responses as justifiable, normal, and understandable. It may be as simple as saying, "That sure is aggravating" after observing a peer-to-peer interaction, or "That's scary, isn't it?" after a frightful incident. V3 involves paying close attention to the youth and can be particularly powerful when the validation is accurate. For example, one youth was pulled out of a skills group for a phone call from his lawyer. Prior to the phone call, the youth had been in a good mood and participating in the group. When he returned, he dropped into his chair with his shoulders slumped forward and eyes on the ground. The coleader who happened to be sitting next to him leaned over and quietly said, "Tough phone call, huh?" The youth looked at the coleader, nodding, and said "yes." The coleader then offered, "I am around if you want to check in about it after group." The youth agreed "yes." He subsequently sat up and paid attention to the group. Although his participation did not return to the level prior to group, the youth was paying attention to the group and exhibited a visible decrease in negative affect.

### *Validation Level 4 (V4): Validating in Terms of Previous Learning or Disorder*

V4 validates a youth's behavior by taking into consideration its causes, including their history, the antecedents of the behavior, or the consequences of the behavior. For example, a youth refusing to come out of their room may be engaging in behavior that does not seem valid in the current context (on a particular day at the facility), but may be in a different context: If that youth was tormented, beat up, or teased constantly in detention, their behavior would be validated by the line staff given what had happened to the youth in the past. The staff's response of "That makes sense, how could you do otherwise? Let's work on this issue" would be a Level 4 validation.

### *Validation Level 5 (V5): Validating as Normal in the Moment*

When engaging in V5, staff searches for the "kernel of truth" in present responses, magnifies the truth, and reinforces it. V5 also includes validating normative and ordered responses as well as acknowledging small steps in the direction of progress and the use of skillful behavior. For example, one youth became extremely enraged after a peer made a crude sexual comment to her. This behavior is valid as anyone may respond in this way. The staff might validate the client, "Of course you were furious after she said that to you," as opposed to saying, "You have an anger management problem."

Often identifying the kernel of truth is challenging. For example, it is common for youth to state that they plan on going back to their gangs, or stealing and dealing, or the like, once they get out. Frequently, this is a disparaging moment for the staff members who care about the youth and have worked hard to try and get them to change their lives. Such a statement can be difficult to accept and see as valid. This is yet another time for acceptance and validation, and to ask for more information from the youth. When the staff accepts this proposal as being a choice available to the youth and encourages them to further talk about such an option, it becomes clear that for the youth gangs and other criminal behaviors offer community, acceptance, power, prestige, money, all of which are important values for humans (Linehan, 2015). Understanding and accepting this often opens the door to conversations about how to work toward these goals/values in other ways.

### *Validation Level 6 (V6): Treating the Person as Valid—Radical Genuineness*

At V6, the highest level of validation, staff look past the "disorder" and treat the youth as a valid person, not just an inmate. V6 requires a genuine, flexible, compassionate stance without a role, so to speak. This is often difficult to put forward on the floor when the line staff is in charge of controlling the group, enforcing rules, and trying to be professional. V6 involves believing the youth and believing in them as a capable individual surely able to become skillful and effective, and to get better. In our experience, this is particularly powerful with youth in JJ as frequently their experiences are that people see them as criminals, unintelligent, failures, and problems. For example, one youth mentioned to a staff member that he was in trouble again because he was "stupid" and not smart enough to stay out of trouble. After validating the youth's frustration and disappointment, the staff member questioned, "What do you mean you aren't smart enough? You are an incredibly smart and resilient person." The staff then described a variety of instances where she had seen the youth engage skillfully and with intelligence. She insisted, "I completely believe in your ability to get a life you actually want to have." The youth's demeanor changed from one that communicated self-loathing and shame, to one that communicated pride.

It is likely that working in JJ will require more validation and acceptance of youths than in outpatient or even other inpatient settings. The use of validation on the floor can have tremendous impact in balancing the emphasis on changing behavior, and especially the tendency to view most of the youths' behavior as pathological. The results validation offers include stronger therapeutic relationships between youth and staff, less hostility and aggressiveness toward staff by youth, greater mutual trust and understanding, and, ultimately, a much more therapeutic environment where as the youth often say, "We can be ourselves."

## Coaching on the Fly/Milieu Therapy

All DBT-trained staff serve as milieu therapists and staff coaches to assure acquisition, strengthening, and generalization of skills. "The overarching goal is to increase and strengthen functional behaviors and decrease dysfunctional behaviors to help youth reach their goals in the community and with their families. Staff need to view

all interactions with youth as opportunities to do treatment and to see themselves as treatment providers" (Juvenile Rehabilitation Administration, 2012).

JRA developed the following core values for DBT treatment with juvenile youth:

- Be youth-centered, with the needs and strengths of the youth dictating the types and mix of services provided.
- Include protocols and techniques that highlight cultural competencies and reflect that cultural values, beliefs, and practices have been acknowledged and respected.
- Be practiced in a culturally competent manner whereby staff can assist in minimizing youth stressors and can incorporate cultural practices that support optimal coping behaviors.
- Be aware of differences, have knowledge of differences, develop skills in working with differences, and have a desire to learn about different cultures and backgrounds.
- Encourage staff to develop a repertoire of cross-cultural skills that can be used to increase competence across differences and as a template for successive encounters with youth and families from diverse backgrounds.
- Recognize that the milieu is not static; it is flexible and features common structures intended to be supportive to youth development, such as daily routines, consistent rules, and enjoyable activities.
- Provide support, involvement, and validation from adult direct-services staff as well as the youth's peers, and other participants in unit activities.
- Support the youth's right to feel safe and respected.
- Reflect the increase in positive treatment outcomes correlated with a treatment environment that is safe, nurturing, consistent, supervised, and highly structured.
- Increase the youth's experience of trust in the milieu staff.
- Support all treatment modes; they must be provided in a context that meets the youth's psychosocial, developmental, educational, cultural, and treatment needs.
- Be practiced in an atmosphere that is the least restrictive necessary, fosters respect for others, and is nonjudgmental.

DBT targets specific to the JJ setting include unit or milieu destructive behaviors that impact the safety and security of the program—such as high-level egregious suicidal, assaultive, aggressive, or other violent behavior; escape planning; inciting others; and grooming others (Linehan, 1993a; JRA, 2012). Staff coaches work to stop behaviors that destroy treatment or shut down unit programming. Staff- or youth-interfering behaviors occurring in the milieu are observed and addressed. Skills and behaviors are generalized in a culturally sensitive manner in all relevant settings. Coaches teach and increase the use of skills, and manage and suppress low-level behaviors.

Staff working the floor coach youths in using skills learned in skills training and reinforce them when they are used. Clinicians use individual sessions as well as skills groups and time on the floor in the milieu to also coach youths. Staff attempt to empower youths to use skills to deal with certain situations, rather than changing the situation for them (which is usually what juveniles want). Staff may suggest skills

to use in problem situations rather than solving the problem for youths, or assuming that they know what to do in a given situation. For coaching to be effective, it is imperative that staff members have already built solid relationships and obtained commitment from youths to learn and practice skills prior to the crisis. If commitment and coaching only occur in the moment of a crisis, they are likely to be much less effective. Coaching includes obtaining a commitment, developing a plan, practicing the skills in day-to-day situations, reinforcing skills practice, as well as coaching during the crisis.

Coaching in the moment refers to the critical role of line staff when working with youths directly. Specific coaching skill needed by staff may include cheerleading and prompting more effective behavior, interrupting dysfunctional behavior, and drawing out more effective and functional behavior at that exact moment (as opposed to dealing with it later on), focusing on generating solutions with youths and getting them to attempt new solutions in the moment, helping youths look ahead to upcoming events and troubleshoot (by increasing the skills of problem solving and creating a positive association with asking adults for advice and guidance), and repairing relationship ruptures.

Youths often need more staff contact than can be provided in an individual session and also cannot receive the individual attention they need "on the floor." Some youths are also triggered by coaching as they experience shame but present as angry and uncooperative during coaching on the unit in the presence of their peers. Thus, check-ins consisting of short periods of time between staff and youth off the floor are beneficial. These moments can occur in the office, at the cafeteria, on a walk, and the like, and afford youths the opportunity to get assistance with any daily challenges between individual weekly sessions. Check-ins can be initiated by the youth or staff and generally focus on averting crisis situations, helping with skills generalization, repairing the therapeutic relationship, or processing time for other issues. There is no set time or number of check-ins. They are usually determined by the urgency of the issue or staff's ability to get off the floor.

When coaching, it is helpful to remind and coach youths in the skills to be used. Coach when a youth is using a skill independently (provide feedback to the youth) or implement role-plays. Highlight the use of skills on the floor when observed and reinforce attempts to use those skills (points, verbal praise, following through on the expectations of a youth [functional validation]).

## Specific JJ Adaptations/Protocols

DBT skills adaptations should consider the interests and reading levels of youths. At times, it can be helpful for the individual therapist or a line staff to preteach skills to youths, so they do not have to understand concepts for the first time in front of their peers.

One Connecticut facility used a favorite emotion-regulation skill adaptation (Roy, Indik, Rushford, Hammer, & Cerat, 2004) for reducing vulnerability to an emotional state of mind that changed Linehan's (1993b) PLEASE acronym to I SEEM MAD (see Figure 8.1).

A modification made at the youth facility in Echo Glen, Washington, to teach emotion-regulation skills shows how to make material relevant to clients:

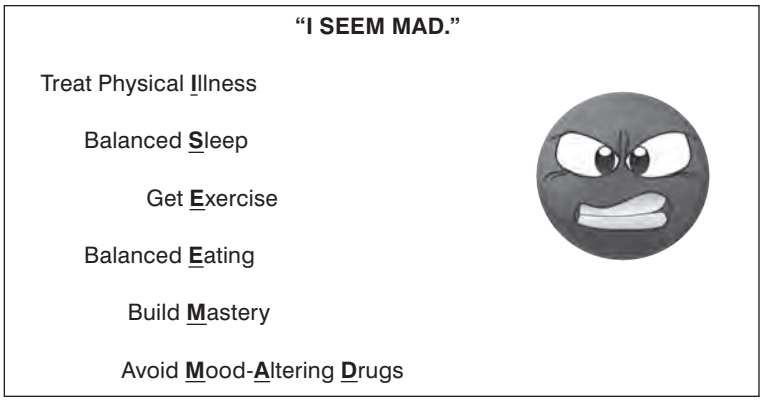


**FIGURE 8.1.** I SEEM MAD adaptation of DBT PLEASE emotion regulation skill.

*In teaching emotion regulation, staff asked youths if they knew what the quarterback for the Seattle Seahawks, Russell Wilson, and the hip-hop artist Future had in common. Most of them knew that both had dated the R&B artist Ciara and that Russell Wilson had married her. Ciara and Future also had a son together. The group was asked what emotions and behavior urges might come up for Future in this situation. Many immediately indicated anger, that he might want to assault Russell Wilson. When asked for examples of other emotions, they were able to identify and learn about the emotions of envy and jealousy and the difference between the two. The group was also able to review the DBT skill of state of mind and what the most effective response might be in the situation they were asked to consider.*

Mindfulness activities can be done throughout the day and help youths to participate willingly and learn to control their minds instead of being controlled. Mindfulness practice done at the beginning of each transition period both in the unit and at school, and during recreational activities when refocusing is required can be quite effective. For example, having a youth balance a peacock feather on their finger for 1 minute requires intense concentration. Playing a quick numbers game where one youth must call out a number, counting from 1 to 20, without looking at others; if two youths call out the same number at the same time, the group must start over at number 1. This is an enjoyable exercise and encourages youth to work together.

Another program started its day with a goal-setting and mindfulness group each morning before breakfast. Youths and staff members shared their goals for the day and the skills they planned to use to help them reach those goals, and named staff or peers who could support them during the day. Then they engaged in a brief mindfulness practice that was also fun. Youths who serve as DBT champions might volunteer to lead the mindfulness practice. This modification often increases the participation of other youths and encourages buy-in from staff.

At one facility in Connecticut, all youths kept a DBT goals and skills chart posted on the door to their room. Staff placed stickers on the youths' doors when they observed them attempting to use a skill.

### Protocols for Use in the JJ Setting

Specific protocols for addressing dysfunctional and egregious behavior in the milieu (see Figure 8.2) and de-escalation are essential for safety and accountability in the JJ setting. These protocols provide staff with specific skills to address problem behavior in a nonjudgmental way and to avoid power struggles while still being validating and behaviorally specific. We have found that if staff approach a youth saying, "Use your skills," that youth is more like than not to become willful. When staff point out specific behaviors and express a desire to coach, youth are more willing and cooperative.

The de-escalation guide encourages staff to use self-management skills to assess their own state of mind before engaging with a youth. JJ staff often believe it is important for them to not back down and show a youth who is in charge. However, when the staff is the trigger, it is more effective and safer for all if the staff is able to walk away and remove themselves from the situation. The guide provided in Figure 8.3 supports staff in completing this process.

1. *Observe* the dysfunctional behavior.
2. *Describe* the behavior as dysfunctional: "This behavior is your worst enemy, it always gets you in trouble."
3. Figure out a response (use a skill) that would be more effective: "What skills can you use?"
   a. Is the skill a good one, the best one can hope for in the real world? Skip to item 5.
   b. Is the skill not useful, no response at all, or are you unsure? Go to item 4.
4. *Instruct* (teach) the youth what to do: "Here is something you could do instead."
5. *Orient* to importance of new behavior: "This new behavior must be done to make it in the facility and in the real world."
6. Get a *commitment* from the youth to try the skill in a given situation: "Are you willing to do this?"
7. *Practice* new behavior on the spot or at another time if that is not an option (at least once): "I am going to tell you 'no' again; I want you to use the skill."
8. *Troubleshoot* (figure out what might interfere with the youth using this skill in the future): "So, what could get in the way of this working the next time?"
9. *Reinforce* the youth and move on.

To get ahead of the problem behaviors, you need to accomplish key tasks:

- Get a commitment.
- Identify targets and put them in order of hierarchy; do chain analysis of problem behaviors.
- Teach skills to use instead; practice them so they are strong enough to work.
- Do solution analysis to prevent problem behaviors from happening again.
- Develop and update the treatment plan.
- Generalize skills to situations where needed in the program.
- Keep everyone motivated to follow the same plan.
- Behavioral Rehearsal Steps
- Teach skills, role-play skills, practice skills.
- Cue exposure/cue management.
- Coach a skill in milieu.
- Reinforce skills use in a real situation.
- Skills use will likely then become automatic.
- Although the other modes of treatment are crucial elements in the youth's treatment program, line staff spend a majority of their time "on the floor." Obtaining commitment to practice and use skills is paramount. If willfulness surfaces, treat it immediately by asking the youth if they are feeling willful. Ask if they would like to reduce their willfulness.

**FIGURE 8.2.** Protocol for milieu dysfunctional behavior.

- Assess your own state of mind: Are you able to effectively work with the youth in this situation, or have your own emotions escalated? Do you need to step back?
- Take a look at the staff involved: Does anyone need to be removed or replaced to lower the tone?
- Assess the immediate location for safety: Is there anything you can do to minimize the risk?

**Strategies**

1. Remove the trigger for the behavior.

   Short-term
   - Identify the trigger and remove the youth from the trigger (could be another youth, staff, or some different factor).
   - If necessary, move to a designated safe zone.

   Longer-term
   - Teach the youth skills to manage the trigger.
2. Use validation strategies.
   - Show that you are paying attention.
   - Identify the emotion underlying the problem behavior and validate it.
   - Find the kernel of truth.
   - Recognize the youth's point of view.
   - Listen, show up, hear what is being said.
3. Us skills coaching.
   - Walk the youth through the way you want them to respond, step by step. Clarify what skill will get them through this situation.
   - Practice the skill with the youth.
4. Use physiological interventions.
   - Demonstrate in your own natural posture, relaxing your hands and loosening your shoulders; be visual and practice with the youth.
   - Relax your face and lower your tone of voice.
   - *Breathe* slowly and deeply out loud and get the youth to breathe with you.
   - Go for a walk with the youth.
5. Use distractions.
   - Find a distraction that briefly directs the youth's attention away from the problem.
   - Shift attention to something else that engages the youth.

**Points to Remember**

- Are you in a location where you can talk to the youth with some privacy?
- Be aware of the time involved; some strategies take longer than others.
- What other activities are going on? Who is supervising the other youth?
- Know your youth. Develop a relationship ahead of time!

**FIGURE 8.3.** Review of de-escalation strategies: A quick reference guide.

The egregious behavior protocol (EBP; see Figure 8.4) is a *treatment intervention* that follows an egregious behavior by a youth in the facility program. The cornerstones of this intervention are safety, engagement, empowerment, and skills building. It must be voluntarily agreed to and received by the youth. That is, *they must be willing to do it*—even if they don't like it or complain when they have to do it. A youth who refuses to complete an intervention would reasonably be required to remain in closer proximity of staff and unable to participate in some more desirable aspects of programming until the process is completed. The purpose is to create time, space, and support for the youth to (1) examine the behavior and what led up to it, (2) identify who was hurt and impacted by the behavior and make amends, and (3) demonstrate an understanding of how to manage the contributing factors differently in the future for the sake of a different outcome.

**Sample Egregious Behaviors**

1. Harm to self (self-injury, suicide gesture or attempt)
2. Harm to others (assault or violence toward staff or other youth)
3. Major program disruption (may include an attempt to go AWOL, major destruction of property, group disturbance or incitement, refusing to physically move such that the program cannot continue, major destruction of a program area [e.g., a classroom] such that the program cannot continue)
   - EBP is treatment, not punishment, for these kinds of behavior. Negative consequences that are the result of serious misbehavior (such as extended placement in the program, loss of privileges, or other sanctions) occur as part of the hearing process or other sanctions; they should *not* be part of EBP.
   - EBP should take place in a location that is quiet and free from distractions. It is important to *support* the youth undergoing the intervention. Assist them as necessary with chain analysis, repair (restorative justice), and correction.

**Chain Analysis**

- Youth examines the factors that contributed to the incident, including thoughts, emotions, body sensations, and behaviors that led up to it, and what followed the incident (outcomes). This assessment of what happened is done in the context of the relationship between the youth and the staff completing the chain analysis.

**Repair (Restorative Justice)**

- Identify those who were harmed or negatively impacted by the problem behavior and to whom amends need to be made.

**Correction**

- Demonstrate for the youth a way (or ways) that the incident (as has just occurred) might go differently in the future—with a different (positive or neutral) outcome. This could include a demonstrated commitment to use DBT skills next time, spending time with the person harmed either physically or emotionally, and correcting the physical and emotional harm so that we are "all OK."
- When egregious behavior happens, immediately stop the programming for the youth involved and prepare to move forward with EBP. *Do not start EBP on a youth when they are upset, emotionally or behaviorally dysregulated, or refusing staff directives.*

**EBP Step by Step**

Step 1: Immediately achieve safety.
Step 2: Attend to any medical needs.
Step 3: Assess the youth who engaged in egregious behavior for readiness for EBP.
Step 4: Ask the youth if they are ready to complete the expected egregious behavior intervention. If "yes," youth moves to the intervention location with staff to begin the chain analysis. If "no," commitment strategies are used.
Step 5: Youth conducts behavior chain analysis.
Step 6: Youth works on chain analysis for the minimum amount of time specified by the program. Programs implementing egregious behavior intervention choose a 1- or 2-hour minimum time period for their intervention. Staff monitor the youth and assist as needed for the minimum time period. Once the youth has completed the egregious behavior intervention, the staff must continue to supervise them in the intervention location until the minimum time period is up. Even though a minimum time period may exist, the focus is not on the time, but the quality of the work being done. This can cut down on the time.
Step 7: Staff reviews the chain analysis with the youth.
Step 8: Staff and youth identify and practice solutions/skills.
Step 9: Staff then discuss any needed repair and correction with the youth.
Step 10: Team reviews behavior chain analysis.
Step 11: Engage in correction and overcorrection.

**Overarching Concepts**

Egregious behavior intervention is a treatment component. We are interested in reinforcing *recovery* from a problem. Everyone is affected by serious behaviors.

**FIGURE 8.4.** Egregious behavior protocol.

## Conclusion

DBT when adapted well is a powerful solution to address the challenges of youth in JJ facilities and congregate care settings. DBT is able to effectively address the individualized needs of juveniles and target specific life-threatening behaviors and quality-of-life interfering behaviors both in the facility and within the community. More importantly, DBT helps juveniles who do not expect to develop life-worth-living goals; they begin to have hope and see a future for themselves.

DBT can positively impact the culture in JJ facilities and builds on JJ staff desires to develop positive relationships with youths and coach them to be more effective and productive. DBT offers staff specific evidence-based skills to target problematic behavior in the milieu, hold youth accountable, and decrease engagement in power struggles. DBT improves staff morale and reduces staff reliance on punitive correctional measures.

Successful DBT implementation begins with administrative commitment from the top down, where administrators lead by example and place DBT near the top of the agenda in all staff and administrative meetings. DBT offers administrators the tools for cultural reform and a format to resolve tensions across staff disciplines and within the treatment team. DBT provides a hierarchy for dealing with issues of safety and security and protocols for managing egregious behavior.

The overarching goal of applying DBT in the JJ system is centered around the concept that coaching on the fly starts with getting a commitment from everyone at the facility, including youth, line staff, clinicians, teachers, and administrators. Everyone must use DBT with each other and with youth (administrators with supervisors, supervisors with line staff, staff with coworkers, staff with youth, and youth with other youth). Everyone must look for opportunities to use skills and actively validate.

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CHAPTER 9

# Comprehensive DBT Forensic and Correctional Programs

## *Orchids, Not Dandelions*

ROBIN McCANN and ELISSA M. BALL

The number of individuals with serious mental illness in the criminal justice system has increased over the last decade (Fuller, Daily, Lamb, Sinclair, & Snook, 2017). In the United States, the notion of rehabilitation remains secondary to the control of detainees. Mental health services are typically limited to the treatment of acute symptoms associated with psychosis or severe depression.

The terms "forensic" and "correctional" will be used in this chapter to describe legally prescribed settings where mental health services are offered, if not mandated. Correctional settings provide custody and confinement for individuals who have committed crimes and are judged "wholly" responsible for their behavior. Forensic hospitals provide treatment for individuals who have committed crimes, but who are judged not guilty by reason of insanity (NGRI). Safety and security are the first priorities of both correctional and forensic settings, although mental health services are more available in forensic settings.

As of 2013, there were 30 studies that had examined dialectical behavior therapy (DBT) within forensic or correctional settings, including 11 randomized controlled trials (RCTs; Ivanoff & Chapman, 2018). Most of these RCTs did not examine comprehensive DBT (C-DBT), meaning all four therapy modes, including individual DBT, DBT skills training, consultation team, and skills coaching. An exception was Van den Bosch et al.'s (2005) work with an outpatient group of female offenders. Six months after treatment ended, the DBT group as compared to treatment-as-usual evidenced decreased self-harm, decreased impulsivity, and decreased alcohol use.

Another review indicated that at least five sites implemented C-DBT (Layden, Turner, & Chapman, 2017). The sites included high-security forensic hospitals, a

prison for individuals serving life sentences, one correctional outpatient site, and one forensic outpatient site. At least two of these sites implemented C-DBT not by modes, but by functions[1] Four of the five sites, including our own, a forensic hospital, referenced promising albeit nonrandomized data. While the DBT research base remains sparse (Ivanoff & Chapman, 2018), nonrandomized data indicate decreases in impulsivity, self-harm, violence severity, and disciplinary infractions.

Although implementing DBT has been compared to planting a tree, our experience is that implementing and maintaining a comprehensive DBT program in a forensic or correctional setting are more akin to planting an orchid in acidic, that is, inhospitable, soil. A C-DBT program does not easily take root in a forensic hospital and, once rooted, remains perennially vulnerable to infiltration by hardy dandelions, prickly thistles, and unsightly crabgrass. While one mode, DBT skills training, thrives like the resilient dandelion, other modes are considerably less resilient. These vulnerable DBT modes, team consult and individual DBT, like orchids, thrive only when tended with care and precision by master gardeners.

## Why DBT?

A number of factors make DBT a natural fit for use in corrections settings. First, while the rate of personality disorders (PDs) in correctional populations is high, treatment of PDs in correctional or forensic facilities is low. Second, DBT is compatible with best-practice principles for effective forensic treatment. These principles include *risk, responsivity,* and *need* (Andrews & Bonta, 1998). The *risk* principle means that you get more bang for your buck when treating the riskiest and most severe cases. DBT targets high-risk, multi-diagnostic, difficult-to-treat individuals who engage in life-threatening behavior. Correctional populations are composed of difficult-to-treat, high-risk to recidivate individuals. Antisocial personality disorder (APD) and substance use disorders are the most frequent diagnoses in adult correctional settings. The *responsivity* principle means matching treatment to the learning styles of offenders. Broadly speaking, this means cognitive-behavioral treatment is titrated to the capacities of the offender. A clinical example of titrating DBT for an impulsive and head-injured offender is illustrated by the case of Joey in this chapter. Finally, the *need* principle means that effective correctional treatment targets risk factors associated with criminal or violent recidivism. Such risk factors overlap with the treatment-interfering or quality-of-life interfering targets in the DBT target behavior hierarchy, including substance use, criminal peers, criminal beliefs, poor problem solving, and insufficient anger management.

[1] A comprehensive DBT program includes all five functions of DBT: improve client motivation, enhance client capabilities, enhance therapist motivation and capability, assure generalization to the environment, and structure the environment. Alternatively, a comprehensive DBT program could be considered to include all four DBT modes: DBT Individual Therapy, DBT Skills Group, Team Consultation, and Phone or Milieu coaching. In contrast, a "partial" DBT program includes some, but not all, of the modes and thus does not serve all five functions of a comprehensive treatment. The term "informed" DBT, while ubiquitous, is not recommended. While one mode, DBT skills training, thrives like the resilient dandelion, other modes are considerably less resilient. These vulnerable DBT modes, team consult and individual DBT, like orchids, thrive only when tended with care and precision by master gardeners.

The third reason to apply DBT in forensic or correctional settings is that its biosocial theory applies to forensic and/or correctional populations. While gender biases in diagnosis may obscure the similarities between borderline personality disorder (BPD) and APD, biosocial theory appears relevant to individuals with both diagnoses. Both disorders are notable for invalidating environments, particularly neglect and abuse. Both disorders are hypothesized to reflect biological vulnerabilities. For example, Crowell et al. (2009) hypothesized that the initial biological vulnerability for individuals who develop BPD is impulsivity followed by emotional sensitivity. Impulsivity plays a central role in both APD and BPD. Males, who are more likely diagnosed with APD than females, may be more likely to externalize aggression and females, who are more likely to be diagnosed with BPD than males, may be more likely to internalize aggression (Paris, 2005).

Our discussion of DBT programming is organized by DBT modes and their concomitant functions. DBT modes include individual DBT, skills training, skills coaching, and team consult. Validation, problem solving, and dialectics—the three foundations of DBT—will be highlighted. Validation will be highlighted in individual DBT and in the case of Jessica. Problem solving will be highlighted in both individual DBT and skills generalization, with a focus on the more difficult to implement problem-solving solutions such as chain analysis, contingency management, and skills generalization. The chapter will end with a discussion of forensic dilemmas and additional tasks for the forensic team consult observer.

## Individual DBT

The purpose of individual DBT is to increase an offender's motivation to change, that is, to increase the offender's ability, readiness, and willingness to use skills to build a life worth living without aggression toward self or others. Individual DBT is the most difficult mode to plant in forensic settings because of inadequate access to trained clinicians.[2] Treatment is instead commonly provided by individuals with low levels of formal clinical training (Ivanoff & Chapman, 2018). Correctional settings may lack rooms in which to conduct individual therapy. If a room is available, offenders may be chained to their seats or even sit in cages. Increasing offender motivation in this context is, needless to say, challenging.

Broadly speaking, an individual DBT session begins with a review of the offender's diary card, generating a session agenda consistent with the target hierarchy. Consistent with standard DBT, the session will likely include chain analyses conducted by the therapist, role-playing, and the offender's commitment to use the skill or complete a homework assignment prior to the next session. Validation is the sugar coating that helps offenders swallow these tasks. This section will discuss the trickiness of validation given egregious offenses, and the trickiness of chain analyses given bureaucratic limits. This will be followed by a case study illustrating the forensic target hierarchy and use of validation.

[2]The components of a DBT individual therapy session include: (1) review of diary card to structure today's individual therapy session, (2) review of last week's homework, (3) chain analysis of salient targets, (4) solution analysis and practice, and (5) commitment.

### Validating Offenders

Validation is one of DBT's two core strategies. Most forensic inpatients adjudicated NGRI have committed violent offenses. How do you validate an offender who perpetrated unimaginable egregious acts that evoke disgust in the clinician? When do you validate? When do you invalidate?

Incarceration is the prototype of invalidation. Society via the criminal justice system has communicated with the incarcerated that they are so "bad" or "evil" that they must be contained. Concomitant with entry into prison or hospital, some offenders may receive a psychiatric diagnosis for the first time. For offenders adjudicated NGRI, the criminal justice system has communicated that they are not only dangerous, but make so little sense they must be incarcerated "one day to life" in a psychiatric facility.

The commonly held belief that NGRI offenders continue to be dangerous to the public is not supported by facts. Specialized programs for offenders with serious mental illnesses indicate reduced rearrest rates at 5-year follow-up at 10% or less (Fuller et al., 2017). For example, at our hospital, Creek (2014) found that 4% of 218 NGRI outpatients aggressed over 5-year follow-up. Ball (2010) found that 15% of NGRI outpatients aggressed over 7-year follow-up.

Validation means communicating to offenders that they make sense. All behavior, even horrific criminal behaviors, is valid on some level. Let's apply the levels of validation to Joseph, an offender who argued that Deuteronomy 20:10–14 instructed him to rape a young child. Level 1 involves the clinician listening, watching, feeling (observing his or her body sensations) in an unbiased nonjudgmental way, and paying attention without judgment or preconception. These acts convey to Joseph that he is worthy of consideration. Level 2 might be "You're saying that Deuteronomy 20:10–14 instructs you to break in young girls," providing Joseph with the opportunity to confirm or disconfirm his clinician's understanding. Level 3 might be "You're saying that you should break in young girls and you look like you're worried about telling me this." If Joseph responds "yes," it is likely that Joseph has experienced validation. Alternatively, if Joseph responds with withdrawal, disbelief, or anger, it is likely that Joseph did not experience validation. Thus, the clinician might consider another Level 3, perhaps acknowledging that, from Joseph's point of view, Deuteronomy 20:10–14 justifies his prior offending. However, the therapist might accurately worry that such acknowledgment could validate what is invalid: justification of offending. Level 4 is the go-to validation when the clinician is flummoxed, when in the moment the clinician cannot determine what to validate: "It makes sense that you interpret Deuteronomy 20:10–14 in your way given that it may help you to understand your own history of sexual victimization," or "It makes sense to me that you're attempting to understand how you could rape a young child." Because Joseph's actions are not normative and likely to elicit disgust, likely to push others away, Level 5 is not clinically appropriate. Radical genuineness (Level 6) can be one of the most difficult levels for forensic and correctional staff to accept. In response to Joseph stating, "Some people might find my argument wrong," the clinician might simply reply, "Yes, that's true."

### The Challenge of Chain Analysis

Over 20 years of DBT implementation, we have observed the following. First, we have pondered: When should the individual therapist maintain the offender's

confidentiality? When should the individual therapist disclose contents of the individual therapy session to the team? Second, adherent DBT chain analyses are like orchids, and chain analysis *protocols* are weeds, vulnerable to misuse, routinization, and institutionalization. Finally, access to additional licensed clinicians does not necessarily result in more chain analyses (let alone more individual DBT).

### *The Challenges of Ensuring Confidentiality*

While disclosure between the DBT individual therapist and the unit team can maintain unit safety, such disclosure may interfere with offender–client confidentiality, thereby eroding unit safety. Ideally, the individual therapist documents and/or discusses risk-relevant details of their sessions with other team members. However, the leakiest (tale-bearing) team member may delimit confidentiality and the therapeutic alliance. A loquacious staff member may share sensitive offender information with staff outside of the unit. Should the offender learn of this, treatment alliance and unit safety can quickly erode. In addition, some team members are, or believe they are, obliged to disclose information to administrators outside of the team, particularly in a hierarchical management system typical of correctional institutions. Such disclosure can result in punishment, even charges, for the offender. Staff, particularly in the context of assault, would not, and perhaps could not, maintain the offender's confidentiality and possibly would divulge incriminating information.[3] The DBT individual therapist can manage the dialectical balance between confidentiality and disclosure by never placing the full, detailed chain analyses of chargeable behavior in offender's records. Instead, the therapist can summarize the vulnerability factors, prompting events, cues, and consequences leading to alleged problem behavior without naming the specific problem behavior that the chain addresses.

### *Individual DBT Case Study: Jessica*

The interplay between validation and change strategies is illustrated in the case of a suicidal NGRI offender who had murdered her infant. "Jessica" was 29 years old when she was admitted to the hospital prior to adjudication to NGRI first-degree murder. Her admission diagnoses included postpartum depression with psychotic features, recurrent depressive disorder, bulimia nervosa, posttraumatic stress disorder (PTSD), and rule out bipolar disorder.

Jessica's development was notable for biologically based emotional dysregulation and an invalidating environment characterized by childhood sexual victimization, early losses, witnessing of domestic violence, and antisocial modeling.

Jessica was a "good girl." She quietly sought to please and engaged in no overt behavioral problems, taking on significant household duties, working part-time outside the home beginning in her teens, and earning good grades in school. By age 6,

[3]If the clinician does have a dual role and is mandated to share confidential information to administrators, Ross, Polaschek, and Ward (2008) recommend that clinicians are explicit with clients at the outset regarding what they must or must not disclose. When disclosing, carry out the disclosure in a caring, interested, and nonauthoritarian manner.

after being chastised by her mother for reporting her stepfather's sexual abuse, Jessica learned to maintain her mother's confidentiality, informing no one of her mother's or her own victimization. Despite bulimia nervosa, one suicide attempt, and two episodes of untreated major depression, Jessica completed college, obtained a master's degree in business, and worked as a certified public accountant for 3 years prior to her daughter's birth.

After the birth of her daughter, Jessica repeatedly shared her thoughts of suicide with her husband, friends, and mother-in-law, but did not share her thoughts of infanticide. On the night she smothered her 6-month-old daughter, she was delusional, thinking her baby was neurologically impaired. She wished to protect her baby from misery and protect her husband from the burden of a special needs child.

Within days of her arrest, her husband served her with divorce papers. Jessica never saw or spoke with her husband or in-laws again. Upon the advice of her attorneys, she avoided talk of her daughter, her grief, and her thinking at the time of the offense. As with most NGRI cases, her adjudication took more than 1 year. Her inability to verbally process her grief further complicated and prolonged her grief.

After NGRI adjudication, a violence risk assessment was completed. Jessica's profile was notable for the absence of most static risk factors associated with violent recidivism. Jessica's Psychopathy Checklist–revised (PCL-R) score was in the very low range. She did not have a history of conduct disorder, substance use, or any violence prior to her NGRI offense. A National Crime Institution Center (NCIC) file and her in-laws confirmed that she had been a law-abiding citizen prior to killing her baby. Furthermore, her in-laws reported that she had been an attentive and kind wife and mother; this report appeared consistent with Jessica's kind and attentive behavior toward her unit peers. In sum, there was no evidence that Jessica had ever had criminal attitudes or engaged in aggressive behavior, except in the context of her postpartum psychosis.

Concomitant with progression to the DBT unit, Jessica committed to "staying alive, finding a way to live with what I did, and finding my voice." Jessica's Stage 1 primary targets included:

1. *Imminently life-threatening behavior.* Jessica hanged herself twice despite hospital suicide precautions on a high-security unit.

2. *Unit-destructive behavior.* After progression to the DBT unit, Jessica repeatedly had sex with a male peer, 10 years her junior. She once falsely accused him of nonconsensual sex. After hospital administration learned of her allegation, all women offenders were administratively removed from residing on the DBT unit, only participating in day programming thereafter. The treatment team made Jessica's goal, privilege progression, and discharge from the hospital contingent on no sex with DBT patients, no false allegation against others, and increased ownership of her own behaviors.

3. *Treatment-interfering behavior.* Despite staff requests that she refrain from doing so, Jessica maintained a romantic and sexual relationship with the same male peer. Additionally, Jessica declared that she wanted to become pregnant, eliciting staff concern. She did not discourage romantic pursuit by additional male offenders. She dismissed staff concern, opining that staff victimized her for demonstrating a

normal woman's search for love and validation. Treatment targets included no sexual intercourse; honesty; and problem solving with staff regarding her desires, urges, fantasies, and behaviors with men on the unit; and skillful management of shame.

4. *Quality-of-life interfering behavior.* Jessica, wishing to please others, exhibited difficulty saying "no." She reported difficulty sleeping, depressed and euphoric moods within the same day, intermittent poor concentration, racing thoughts, increased libido, and thoughts of suicide. Targets to increase included heightened self-validation and observation of her limits, and continued accurate reporting of symptoms to her psychiatric prescriber.

The treatment team also engaged in treatment-interfering behavior. Some staff, appalled by her offense and by her sexual behavior, judged Jessica insufficiently remorseful regarding the death of her daughter. They criticized her dress ("too revealing") and judged her as "manipulative." Staff became polarized, with some regarding Jessica as the victim, others seeing her boyfriend as the victim. Such judgments elicited Jessica's shame. The DBT individual therapist, as is sometimes the case in a criminal justice context (see the "Forensic Dilemmas" section below), at times aligned with Jessica against the rest of the treatment team. Some staff scoffed at the therapist's hypotheses that Jessica's hypersexuality and associated rule violations might not represent a character defect ("slutlike behavior"), but instead were the secondary target of inhibited grieving versus unrelenting crises. Her crises, for example, suicide attempts and sexual relationships, functioned to distract Jessica and staff from her grief.

While Jessica committed to end all self-harm, she continued to experience suicidal ideation. Though ambivalent about refraining from romantic relationships, she agreed that such relationships caused conflict with staff, thus prolonging her hospitalization. Therefore, she committed to end her pursuit of all romantic relationships and to honestly disclose romantic feelings or intent in therapy. While she maintained her commitment to end self-harm, she had more difficulty maintaining her commitment with regard to romance. For example, when staff observed her holding hands with a male peer, Jessica lied, denying her behavior. Such interactions led to crises, which distracted both Jessica and staff from her grief. While skillful when calm, when feeling shame, anxiety, or depression, Jessica initially could not observe, describe, or identify her emotions and urges. Because her skills deficit was so contextual, that is, evident only in the context of intense emotion, some staff experienced her as disingenuous. Staff did not understand how she could be so skillful in one context and so skill-less in another.

Jessica's suicidal ideation and impulsive sex appeared driven by a secondary target: inhibited grieving versus unrelenting crises. The treatment for inhibited grieving was informal exposure. The treatment for unrelenting crises was problem solving. In Jessica's case, impulsivity interfered with her ability to problem-solve. In other words, her problem-solving skills were excellent if she refrained from impulsivity.

The DBT therapist, a licensed clinician, listened non-judgmentally to Jessica report her thoughts and feelings (Level 1 validation). Jessica acknowledged having "fooled" herself regarding her romantic intent with her peer. After the therapist inferred that she likely yearned to feel lovable (Level 3 validation), Jessica expressed her emptiness, having abruptly lost her daughter and husband. She recognized

similarities between the emotions she had felt with her daughter and her male peer. Validation enabled Jessica to begin treatment for "inhibited grieving": Jessica allowed herself to experience grief.

Validation also improved Jessica's relationship with staff. Her DBT therapist stated that she could not imagine how difficult it would be to be one of only two women residing on a forensic unit with 23 men, some of whom had raped and murdered (Level 5). The therapist confirmed that some of Jessica's male peers, particularly given their own histories of victimization, appeared afraid if not disgusted by her (Level 5). Conversely, the therapist was careful to avoid validating the invalid. For example, when Jessica claimed, "I didn't know I was flirting," her therapist retorted in an easy manner: "Give me a break, Jessica."

As Jessica experienced validation in individual therapy, she began to increase self-validation, which in turn decreased her emotional intensity and impulsivity, allowing her to use her generally excellent ability to understand the perspective of others. She found several DBT skills particularly useful. By refraining from acting on her emotion, she experienced or observed her emotion, learning to accurately label it. Telephone coaching also helped to decrease impulsive behaviors; the number of crises or problematic interactions would then decrease, further enabling Jessica to experience her grief and other emotions, including anger and shame. Her self-validation appeared correlated with validating staff. For example, rather than engaging in a tirade, Jessica informed staff that she understood how they distrusted her given her past behavior (Level 4) and understood that nursing staff were held accountable for the misdeeds of patients (Level 5).

As she approached release to the community, Jessica struggled with expectations from some that she obtain a tubal ligation. Her anger again inhibited her grief regarding her loss of the capacity to give birth. Her therapist validated that her anger made sense given that a gynecologist and a psychiatrist had opined that she could be safely monitored through a pregnancy, delivery, and postpartum (Level 4). Validation helped to ameliorate her anger. Jessica considered the pros and cons of giving birth to another baby and decided to obtain a tubal ligation.

Jessica has now lived safely outside the hospital for years. Though anniversaries associated with her daughter remain painful, Jessica reports happiness. She lives alone but has a boyfriend. She is employed. She has a strong support system and nurtures it carefully. She has achieved her goals: remaining alive, finding a way to live with herself, obtaining a release from the hospital, and "finding" her "voice."

### *Chain Analyses without Individual Therapists*

Jessica received individual DBT from a licensed clinician. What of offenders who lack access to licensed clinicians?

Chain analysis protocols can be used in the absence of sufficient access to licensed clinicians. One of the individual therapist functions, conducting chain analyses, can be provided by implementing chain analysis protocols with contingencies. NGRI offenders who complete their chain or solution analyses and use skills can be progressed more quickly than those who do not. In brief, all good things come to offenders who do DBT. We distinguish here between a collaborative chain analysis, that is, a chain analysis conducted between the DBT individual therapist and the offender according to standard DBT versus the protocols for egregious and worrisome behavior, that is,

chain analyses assigned by staff and written by the offender working alone (Swenson, Witterholt, & Bohus, 2007).

Egregious behavior is defined as imminently life-threatening and unit-destroying behavior (McCann, Ivanoff, Schmidt, & Beach, 2007). Line staff usually assign the egregious protocol. Offenders work alone, unassisted, and non-collaboratively on their chain analyses, using a worksheet for a specified period of time. After completing their written chains, offenders present their work to staff for feedback. In the case of other harm or unit-destructive behavior (but not self-harm), offenders can present their work to peers and clinicians in a chain analysis group (McCann et al., 2007) to develop a plan for repair and more skillful behavior. While a single licensed clinician cannot provide weekly individual DBT to 20 offenders, the single clinician could provide weekly group therapy to 20 offenders split into two chain analysis groups. The group enables the clinician, staff, and peers to develop a collaborative picture of events. Privileges are returned after a presentation of repair if the DBT team agrees that privileges can be safely returned. Our impression is that such presentations function to inform all unit members of each offender's vulnerabilities and risk factors, thereby providing all unit members, including offenders, with information to maintain unit safety. The offenders are the first to observe, the first to detect, and, at least in a DBT unit, can be the first to report their peers' problem behavior.

After observing the usefulness of the egregious behavior protocol and noting that treatment-interfering behavior was, thankfully, more frequent than imminently life-threatening or unit-destructive behavior, McCann and colleagues implemented a worrisome behavior protocol. Worrisome behavior is defined as treatment-interfering and/or quality-of-life interfering behavior (McCann et al., 2007). Staff assigned the protocols and offenders worked alone, unassisted, and non-collaboratively on their chain analyses using a worksheet for 1 hour and presented the work to staff for feedback. When staff approved the work, offenders immediately returned to normal programming and privileges, but later presented the work to their peers in chain group and developed a plan for repair and more skillful behavior. In the context of a well-functioning DBT team consult, the benefits of the egregious and worrisome protocols (immediate written data, quick return of privileges in the case of worrisome protocols, time savings for clinicians and staff) outweighed the cons (staff assigning protocols to avoid coaching or to inflict retribution).

However, when the DBT team consult did not function well, the egregious and worrisome protocols, just like crabgrass, multiplied and routinized: becoming just another form for the offender to complete, no extra work for staff. Without a functional DBT team consult, treatment-interfering or quality-of-life interfering behaviors inflate to egregious status with accompanying penalties. Rather than assessing cues or consequences maintaining problem behavior, some offenders and staff confuse behavior with colloquial definitions of consequences, for example, misconstruing the protocols as the "consequences" of the problem behavior! In sum, in the context of a poorly functioning team consult, the egregious and worrisome protocols can retain the aversive function of chain analyses, but lose the benefits of chain analyses.

The following may help ameliorate the problem by providing the functions of individual therapy without sufficient clinician numbers:

1. Given the typically prolonged length of stay in forensic and correctional facilities, consider referring offenders who have completed a year of DBT skills training

to chain analysis group (McCann et al., 2007). Review chain analyses of egregious (excluding self-harm) and worrisome behavior collaboratively in group. Group members are often more aware of their peers' antecedents and consequences than staff and therapists. Skilled group members and a skilled group leader can weave solutions, that is, skills, contingencies, exposure, and cognitive interventions, into the analysis. In this context, the function of chain analyses including exposure, improved autobiographical memory, learning new behaviors, and aversive consequences (Rizvi & Ritschel, 2014) is more likely to be preserved.

2. Similarly, consider providing additional functions of individual therapy, that is, assessment and solution analysis, in small groups as suggested by Swenson, Witterholt, and Bohus (2007).

3. Distinguish between behaviors of commission or omission. When needed or effective behavior is omitted (e.g., the offender did not sign out, take medication, obtain toxicology, clean his room), consider implementing the shorter, less punishing, missing links analysis (Linehan, 2015, pp. 23, 38) in place of chain protocols.

4. Rather than assigning chain protocols, coach skills in the moment.

## DBT Skills Generalization: Contingencies and Coaching

Contingencies are consequences that result, on average, in an increase or decrease in behavior. What DBT clinician working in the Department of Corrections has not despaired after receiving an administrative mandate that all reinforcements must be noncontingent, available to all inmates regardless of their behavior, because reinforcements are defined as "rights not privileges"? If only DBT therapists could control the world, that is, control their clients' contingencies.

While the court, not the treatment team, determines if the NGRI offender can progress to the community, the DBT team, not the court, determines whether and when the offender progresses to the community. Similarly, while administrative issues such as bed space may sometimes determine when offenders progress to a less secure unit, the DBT psychiatrist determines which offender progresses. The forensic DBT clinician can manage the contingencies between themself and the offender within the individual DBT session, which is also the case in standard DBT. The bad news perhaps is that forensic clinicians must, like all other clinicians, observe the limits of their institutions. These limits may include administrative mandates that may not be consistent with DBT.

Consider the following scenario: A minimum-security offender cuts his wrist, requiring stitches. The DBT therapist completes a chain analysis and assesses the following (among other considerations): whether his self-harm was suicidal or nonsuicidal, whether his self-harm was a function of antecedents or consequences, and whether regression to a higher-security unit would reinforce self-harm and/or avoidance.

### *When the Team Manages Contingencies*

In the context of a flat, non-hierarchical organizational structure, should the DBT team determine cutting was not suicidal, that the offender cut himself to avoid a feared

peer—meaning regression to a higher-security unit could reinforce both self-harm and avoidance—the team psychiatrist could determine that it was to the offender's benefit to remain in the minimum-security DBT unit. In this non-hierarchical organizational structure, the DBT team could avoid reinforcing avoidance and self-harm.

### *When the Team Cannot Manage Contingencies*

In the context of the likely hierarchical organizational structure of a correctional setting, if the DBT team determines that it was to the offender's benefit to remain on the minimum-security unit, their decision may be overruled. As Ivanoff and Chapman (2018) have noted, institutional policies will take precedence over understanding the factors maintaining self-injury for a particular individual. If policy mandates regression after self-harm, the offender will be regressed regardless. In this case, avoidance and self-harm will be reinforced. Policies and procedures, particularly policies related to or seemingly related to liability, may take precedence. Clinicians may be unable or unwilling to effectively advocate. What is one to do? Apply Linehan's options for solving any problem (Linehan, 2015):

1. Radical acceptance: Follow and disagree with the policy. The first step of radical acceptance is observing that you are fighting reality: that you believe what is should not be. The causes of the policy may need identification prior to accepting "everything is as it should be." See Distress Tolerance Handout No. 11B for the eight remaining steps of radical acceptance (Linehan, 2015).

2. Change one's emotions about the policy. In other words, make lemonade out of lemons. Model observing limits by honestly describing limits out loud to relevant individuals. So in the case of the offender who repeatedly requests that you violate a new policy, which you opine as unneeded, you might say, "I don't like the new policy, but I have to accept it. You've asked me to violate the policy for the last 5 days. Don't ask me anymore. However, I would be delighted if you asked me how to cope with this new policy." Similarly, in the case of the offender whose self-harm is maintained by avoidance, who nevertheless will be administratively regressed, self-involving self-disclosure may be warranted. This might sound something like the following: "I am worried that you're being administratively regressed, such regression appears to reinforce your self-harm. This is your problem in life here."

3. Solve the problem. Continue to advocate for change, remembering that structuring the environment so that all good things come to those who practice DBT is one of the five functions of C-DBT. Change, in the absence of a relevant lawsuit, is slow in forensic settings. Consider yourself water flowing over an ineffective and harmful policy. You lobby for change like water over rock, over and over, until the policy changes.

4. Stay miserable. Perennially threaten to quit.

### *The Animal Is Never Wrong: Skills Generalization*

NGRI offenders remain hospitalized not because they are mentally ill, but because they have been dangerous, continue to be dangerous, or at least are opined as dangerous. As previously indicated, in the context of specialized treatment programs, the

commonly held belief that NGRI offenders continue to pose a danger to the public is not supported by data. Conversely, prisoners remain incarcerated until they kill their number (complete their sentence) regardless of whether they are dangerous. A prison has been described as a "behavioral deep freeze" (Andrews & Bonta, 1998) in which prisoners lack exposure to everyday cues such as money, relationships, jobs, art, the opposite sex, or family members. NGRI offenders similarly lack exposure to everyday cues. Offenders have little to no control over their lives and little opportunity for decision making. While such restriction may or may not maintain security, such restriction does not promote skills generalization.

Skills generalization reflects the tendency of behavior in one context to generalize to another context. DBT therapists do not assume or hope that skills generalization will occur. Rather, DBT therapists and offenders create situations in which skills generalization can be assessed and practiced. This section will discuss:

- Two methods of skills generalization from the forensic setting to the community: *in vivo* exposure and DBT phone coaching
- Structuring the milieu to elicit skills and skills coaching to promote skills generalization in the context of extreme emotions

### In vivo *Exposure and DBT Phone Coaching*

While prison has been described as "a deep freeze" restricting behavioral practice and generalization, the forensic hospital is more like a tank of water. Mammals have difficulty generalizing their skills from one situation to another; dolphin trainers call this "new tank syndrome" (Pryor, 1984). When trainers move dolphins from one tank to another tank, they expect that dolphins will forget what they previously learned. For example, dolphins that previously learned tail walking become temporarily unable to tail walk in the new tank. In other words, in the context of new cues, it is not only expected but also natural for a mammal, whether a dolphin or human, to forget what has been previously learned. Rather than criticize, berate, interpret, or charge the dolphin, the trainer rehearses previously learned skills in the new tank or context, enabling the dolphin to habituate to the new cues and recall prior learning. As animal trainers say, "The animal is never wrong."

#### In vivo *Exposure*

An offender released to the community after years of hospitalization is released from a sterile tank to a wild and exciting sea. Given that it is expected and natural for a mammal to forget what they have learned, it is essential to expose offenders to cues prior to progression to the community. Some settings, such as a forensic hospital in which offenders are treated from maximum security through conditional release, lend themselves to *in vivo* exposure. However, *in vivo* exposure is possible only if clinicians are not so habituated to their tanks that they are unwilling to venture into the sea. Further, pejorative explanations, rather than "phenomenologically empathetic" explanations, for offender "failure" in the community can interfere with clinicians' motivation to provide cue exposure. A clinician who concludes that the offender had "faked" their skillful behavior while incarcerated or who concludes that the offender is "self sabotaging" will likely not feel motivated to provide *in vivo* exposure.

Thus, given that forensic settings are relatively cue-less: Lacking cues from makeup to crayons to plastic bags to cars to marijuana, how do we help offenders habituate to cues and generalize their skills in a community? Ideally, the DBT therapist and offender identify emotionally evocative cues prior to progression to the community. For example, Greg, a combat veteran diagnosed with PTSD, was adjudicated NGRI after he attempted to drown his girlfriend. Prior to his NGRI adjudication, Greg sometimes became so enraged at "slow" or "tailgating" or "incompetent" drivers that he exited his own car, and grabbed and beat the offending driver. While receiving prolonged exposure for PTSD, Greg had learned to communicate his anxiety using the Subjective Units of Distress Scale (SUDS) ratings. He had also learned to decrease his anxiety with four square breathing. His therapist, who happened to be exactly the type of driver Greg loathed, determined that it would be useful to expose him to the cue of a tailgating driver. Hospital police were notified of this *in vivo* exposure plan on hospital grounds; police were requested to stand by. The therapist and Greg communicated by cell phone. When the therapist began tailgating Greg's car, his SUDS rating of anger predictably increased. Greg used four square breathing to decrease his SUDS with little coaching from his therapist. This exposure appeared successful in that Greg, who has now driven in the community for 5 years, has not been known to reengage in road or any other rage. Greg's skills transferred from one situation (high anxiety) to another situation (high anger); this is an example of stimulus generalization.

### *Phone Coaching*

As is the case in standard DBT, forensic clinicians used not only *in vivo* exposure but phone coaching to help offenders use skills. On minimum-security units, offenders may have cell phones. Therefore, their individual therapist can provide standard phone coaching. Standard DBT phone coaching structure applies.

One DBT individual therapist began phone coaching with an offender well known for making more requests than anyone desired. Most judged him to be "intrusive" or worse. Prior to beginning phone coaching, the therapist oriented him to the parameters of phone coaching, that is, to call for coaching before a crisis (this offender's target behaviors included assaults and threats), that the call would last no more than 10 minutes, and so on. Nevertheless, as expected, given that calling his therapist via phone was a new context or "new tank," the offender called more frequently than the therapist wished, calling to chat or complain, not to request phone coaching. Like the dolphin, he forgot what he learned in his therapist's office. During the next face-to-face session, the therapist and the offender completed a chain analysis in excruciating detail. The therapist's specific and genuine feedback (e.g., "Call me only for phone coaching" and "I'm not your emergency hotline" and "I've got a life" and "Call me no more than three times weekly") quickly shaped the offender's behavior and, to the therapist's relief, generalized to his behavior with her in the milieu (but did not generalize with others).

### *DBT Skills Generalization from the Skills Group to the Unit Milieu*

Skills generalization means that the offender uses skills across situations, across people, and across time. No matter who approaches the offender, even Nurse Ratchet or

Voldemort, the offender is expected to be skillful, although, of course, no one is skillful all the time. There are orchards of lemon trees in forensic facilities; being effective means making lemonade.

While staff turnover is high, offender turnover is low. While the NGRI adjudication is generally indeterminate, as staff say, "one day to life," the average length of stay for NGRI patients has been estimated as between 5 and 7 years (McClelland, 2017). This means there is usually a cadre of offenders, potentially DBT skillionaires, who can orient newcomers to the DBT milieu. In a functioning DBT milieu, offenders are aware of each other's vulnerabilities and frequently intervene to prevent problem behavior and facilitate DBT skills.

This section will discuss structuring the milieu and milieu skills coaching to promote skills generalization. Skills generalization in the context of intense emotions is relevant to risk mitigation. Offenders must access exposure to emotion-inducing cues. While forensic environments are relatively cue-less, emotionally evocative cues nevertheless occur. The source of such cues includes seemingly arbitrary administrative mandates and the intermittent skill-less behavior of peers, staff, and ourselves: behavior that becomes magnified in the tank. No one is skillful all the time; our mistakes are the perfect time to practice. Generalization from skills group to the milieu can be facilitated by:

1. Structuring the milieu to elicit skills by linking skills to common situations
2. The frontline staff coaching skills

### *Structuring the Milieu*

The milieu can be structured to elicit skills by linking a low-frequency behavior to high-frequency behavior (the Premack principle) or situation, for instance, waiting in line. Lines are ubiquitous in forensic facilities: for medication, for chow, for towels, and the like. Boredom while waiting in line is common. However, as one DBT trainer observed, "Boredom is the opposite of mindfulness" (J. Waltz, personal communication, 2016). A poster located at the back of the line cueing one-mindfulness is the perfect skill to practice while waiting in line for medication. Homework can be assigned prescribing mindfulness specifically: On the medication line, for example, sense your feet on the floor, listen to the breathing of the person in front of you, count your own breath.

Another high-frequency situation perhaps as potentially onerous as waiting in line is the offender's obligation to request staff for access to almost anything: the shower, a shampoo vial, the courtyard. Offender requests can be made skillfully using interpersonal effectiveness skills (DEAR MAN, GIVE, FAST) or less skillfully, that is, demanding or refusing to ask at all because "others should know" what one wants. Staff become adept at requesting the "GIVE skill" from the demanding offender, shaping a DEAR MAN for the withdrawn offender, and setting a contingency with an offender who suggests that he should not have to ask for what he wants.

The milieu may be further structured by identifying a skill of the day or week. Identification of the skill depends on what the milieu needs at a particular time. For example, if many are experiencing extreme emotions, perhaps related to an extreme event, a skill for extreme emotion is in order (see the Distress Tolerance Handout No. 6, TIP Skills: Changing Your Body Chemistry; Linehan, 2015). The unit might have

a TIP contest; contest criteria might include frequency or effectiveness of TIP use and/or of coaching TIP. In one setting, for instance, staff, upon learning about the use of ice water to decrease emotional arousal, put their own faces in bowls of ice water as offenders practice putting their faces in their respective bowls of ice water. Contest prizes for offenders and/or staff include stickers, letters from managers/administrators, extra time for desirable staff, and items from the Dollar Store.

### *Coaching Skills*

The advantage of milieu coaching or coaching on the fly is that staff are intervening with the offender when they are emotionally aroused. Staff can observe the problem behavior and quickly intervene with skills coaching. The challenge for all coaches is to quickly, accurately, and behaviorally describe the offender's behavior out loud in that moment. The coach's emotional arousal may interfere with such a description. The offender's emotional arousal may interfere with receiving the description. Humility is key because coaches might have observed the offender yelling profanities but missed seeing what cued their profanities. Like the blind mice, we know only a piece of what happened.

While other coaching formats have been suggested (see Swenson, 2009), the following is the minimum:

1. Describe the offender's problem behaviors, as specifically as possible.
2. Validate.
3. Ask, "What skill can you use?"
4. If the offender is unwilling or unable to generate a specific skill, be sure that you can generate a specific and relevant skill in the moment.
5. If the offender rejects your help, remain graceful and skillful, and keep the door open for future coaching.

## *Skills Generalization Case Study: Joey*

This case illustrates the application of skills training, skills coaching, and contingencies to promote skills generalization with a difficult-to-treat client: an aggressive man with cognitive deficits. The DBT individual therapist linked the team's clinical goal (to end aggression) to Joey's goal (to own a dog). Mindful of Joey's cognitive deficits, the team gradually tested and developed his capabilities in the community.

Upon admission, "Joey" was a single 23-year-old. Because of his history of multiple and severe assaults across contexts (in the hospital, in the community, in jail, in prison and group homes) and diagnoses of paranoid schizophrenia and antisocial personality disorder (APD), the district court had stipulated to a verdict of NGRI to several charges of second-degree assault. The district attorney, agreeing to the "slight possibility" that a hospital could help him, agreed to this adjudication to protect the community from Joey. Joey's admission diagnoses included personality disorder due to traumatic brain injury, cocaine or marijuana dependence in remission, borderline IQ, personality disorder not otherwise specified (PD-NOS) with antisocial and paranoid features, and closed head injury.

Joey's development was significant for biologically based emotion dysregulation and an invalidating environment, with onset at age 10 when he was struck by a car

while walking home from school. He suffered a brain injury with frontal and bilateral temporal lobe involvement, limited motor cortex involvement, and a permanent disfiguring scar on his forehead. After a prolonged period of rehabilitation, Joey returned to school, but his emotional management, impulse control, and intellectual functioning did not return to baseline. His speech was moderately impaired, contributing to interpersonal conflicts and anger outburst. A year after Joey returned to school, his previously healthy, active, and loving father died of a myocardial infarction. His mother, also previously healthy and loving, became so depressed she could not work. Joey and his brothers became involved in street gangs. After his mother developed metastatic cancer, Joey attempted suicide. Following the death of his mother, he and his brothers were placed in foster care. He was transferred from foster home to foster home, and between psychiatric hospitals and residential treatment centers due to his aggression.

Joey's risk assessment for violence identified him as high risk; his PCLR rating was moderately high. Neuropsychological testing indicated significant brain impairment. Joey performed within the brain damage range on 100% of the component test within the Halstead–Reitan Neuropsychological Battery (HRNB). Deficits included attention, problem solving, reasoning, learning, memory, sensory and motor functioning, and information processing.

Prior to DBT treatment, his hospitalization was notable for violent and/or racial threats and physical assaults including biting two male staff members. Joey and some staff predicted that his only way out of the hospital was "in a box."

By the time he arrived in the medium-security DBT unit, he had committed more than 20 assaults in the hospital. Upon entering, DBT Joey's Stage 1 targets included:

1. Life-threatening and physically threatening behaviors: prior suicide attempts; carrying and using weapons; verbal threats of physical harm ("I will kick your ass"); fighting stance; spitting; taunting; name-calling; racial slurs escalating to assaults (biting, hitting, slapping)

2. Unit-destructive behaviors: loud and public profanity directed at staff and peers ("fucking liar . . . fat pimple-faced bitch," "fucking moron"); not disengaging from an argument with peers and staff. even with prompts; focusing anger at one person; reiterating angry allegations; false accusations about staff and peers

3. Treatment-interfering behaviors: yelling profanities; name-calling limited to less public displays; intense repetitive criticisms of therapeutic decisions about other patients, including blaming and exclamations of unfairness ("All the murderers and rapists get treated better than I do. . . . People treat me like a retard. . . . I won't kiss your ass like your pets"); angry responses to praise or compliments; mocking staff and peers in group treatment; missing appointments; sleeping through group sessions; poorly enunciated low-volume speech

4. Quality-of-life interfering-behaviors: Nonreciprocal communication pattern (interrupting, looking at floor around the room, joking in an offensive manner, horseplay, telling lengthy "unlikely" grandiose stories about himself); not following medical recommendations, such as not using a continuous positive airwave pressure (CPAP) machine for his sleep apnea; using no emotion-related words, except "pissed off"; history of extensive substance use

Joey attended, but appeared to sleep, through DBT skills-training groups. He stated he was incapable of doing group homework assignments. Staff reviewed material he did not learn in group and helped him complete his homework. While he repeatedly failed both written and oral exams of DBT skills acquisition, he appeared to absorb some skills content, using distraction, self-soothe, and acting opposite to anger. After 2 years, his behavior control improved adequately to progress to the intermediate DBT unit. Rather than learning DBT skills acronyms or completing written DBT group homework, staff expected him to practice skills to earn on-grounds unsupervised privileges. Staff set a contingency; to leave the unit, Joey role-played specifically targeted skills. He eventually earned on-grounds unsupervised privileges, which enabled him to earn the industrial therapy job of delivering newspapers throughout the hospital. Over time, Joey was able to increasingly observe his anger and act opposite to it by asking to leave the area. His compliance with staff coaching to take a time-out also increased. His off-ground privileges remained contingent on peaceful behavior. When he threatened others, directly or indirectly (i.e., threatened to kill or "fuck up" someone not present), and when he kicked and pushed during horseplay, his privileges were withheld. His behavior became stable enough that he began volunteer work in the community at the zoo and dog shelter. His dream of renting a house and living with a dog coalesced.

After 5 years of inpatient progress, Joey was deemed eligible for progression to community living with follow-up from the hospital's outpatient team. However, administrative decision makers only approved his placement in a structured, highly supervised group setting. This setting was inconsistent with Joey's stated goal: independent living with a dog. He was discharged to a group-assisted living facility. His outpatient treatment providers and assisted-care facility staff were all oriented to an initial contingency management plan to address severely treatment-interfering or physically threatening behaviors. Specified problem behaviors (e.g., Joey saying, "I'm going to mess her up," verbal and social profanity worse than "bitch, fuck you") would result in an overnight stay at the hospital and completion of chain analysis. More serious behaviors would result in a 30-day inpatient stay. Any actual assault or other life-threatening behavior would result in a return to hospitalization for an unspecified period of time.

When Joey engaged in treatment-interfering behavior team members could: ignore (a.k.a. extinguish), observe limits (e.g., when you call me a "bitch" I want to leave), or terminate contact (aversive contingency). As is often the case in forensic institutions, the plan was weak on implementing the positive reinforcement of target-relevant adaptive behaviors. In Joey's case, verbal praise and compliments were not reinforcing. Fortunately, remaining in the community was. There was a single huge delayed reinforcer: 1 year without a return to inpatient stay for problem behavior with resultant reconsideration of independent living with the associated possibility of adopting a dog.

Community circumstances tested Joey's anger management. Though he used profanity and called staff "stupid," his motivation to get a dog won out; he did not require return to inpatient status during his first year of community placement.

Although prior neuropsychological and psychiatric assessors had warned that Joey could never live independently, the treatment team helped Joey structure the environment to promote his goal of living with a dog. Joey's attention, concentration, and problem-solving deficits in the context of independent living could have resulted in any number of negative outcomes, such as a house fire or failure to take his

medication. Concerns were expressed whether his dog would become out of control, even aggressive. On the one hand, Joey needed to change. He underwent home safety training and was fitted with a 24-hour home alert device. He saved money for dog training classes. On the other hand, the environment needed change. Home health-care staff were deployed to oversee his medical safety. Medicaid paid for pill dispensers that alerted Joey to medication times and continued beeping if medications were not taken from the dispenser. The alert notified the home health-care agency every time medications were missed. With support from treatment staff, Joey rented a small house within walking distance of the hospital. He chose a dog from the local shelter. The dog, named Max, received obedience training. Joey reached his long-term goal: to live independently with a dog—for Joey, a life worth living. Max accompanied Joey everywhere. Joey has safely lived in the community for more than one decade.

## Forensic Dilemmas

Prior to joining a DBT consultation team, team members agree to "keep the agreements of the team, especially remaining compassionate, mindful and dialectical." How do you remain dialectical in nondialectical settings? How do you remain compassionate working in the criminal justice system—a system that is, at best, invalidating and, at worst, dehumanizing? The DBT team consult is an orchid: vulnerable, thriving only when tended with care and precision. The DBT team consult is the most important flower in the DBT bouquet. As one DBT trainer opined, "A DBT program is as good as the DBT team consult" (A. Chapman, personal communication, 2017).

This section will discuss forensic dialectical dilemmas and humbly suggest solutions. Prior to sharing our suggestions, we will briefly define dialectics and discuss characteristics of the criminal justice context that drive the dynamics of forensic and/or correctional DBT team consult. Dialectics means:

1. Behaviors are context specific. For example, Jessica was usually skillful, except in the context of extreme emotions.
2. Identity is transactional. You can't be a criminal without a system adjudicating you as such.
3. When polarization occurs, we acknowledge truth in both positions and search for synthesis, not compromise. Dialectics is not a gray wash, but black and white like polka dots.

When stuck, when in conflict with offenders and team members, we complete a dialectical assessment, meaning searching for what is missing and what is being left out. The story of the seven blind mice and a strange something illustrates dialectical assessment (Young, 1992). In sum, each mouse perceived part of the truth, but only the dialectical mouse perceived the whole truth.

Like six of the seven blind mice, clinicians and staff may be overly confident regarding their perception of the strange something. This certainly may be exacerbated in a forensic residential context. Forensic and correctional team members are more likely than standard DBT team members to witness the same offender across time, experiencing days, months, and even years with the same offender. The offender may behave differently with forensic residential staff as compared with a

DBT individual or group therapist. As behaviorists say, "Behavior is situation specific." When the DBT team becomes polarized, with some members perhaps declaring, "He is using skills" versus others insisting, "Wake up, he is a psychopath," the functional DBT team moves to dialectical assessment. A DBT team member, that is, the dialectical mouse, searches for what is missing from the team's understanding. A dialectical answer is the synergy of these perspectives.

The legal and psychiatric context may reinforce forensic team members to drift from dialectics. The criminal justice system is perceived not as dialectical, but as universal: There is one truth. People are adjudicated guilty or not guilty, sane or insane, However, in contrast to perception, our experience with courts in Colorado is that they are dialectical; they seek the truth in multiple positions. Psychiatry is also perceived not as dialectical, but as universal: You are delusional, you are not delusional, you need medication, or you do not. In our experience, psychiatry is more dialectical than some may perceive.

### *Mandatory Treatment with Court-Committed Offenders*

Several models have been proposed for working therapeutically with offenders mandated to treatment. Several decades ago, Monahan recommended that forensic clinicians ask themselves, "Who is the client?" He recommended that the client should be the offender, unless the offender poses a risk to society. This bidimensional model suggests that the answer to "Who is the client?" depends on the offender's dynamic risk. Should the offender's dynamic risk increase, priorities will change; the priority is community safety. Given that the interrater reliability between the individual therapist and other team members' assessment of risk may not be high, a situation can evolve in which the therapist's priority is the offender, whereas the team's priority is community safety or even the institution. Different experiences and training between therapists and unit staff may exacerbate such a disagreement.

A more recent tridimensional model suggests that clinicians may "identify" with one of three narratives: the offender, the victim, or the court. Its authors (Chudzik & Aschieri, 2014) suggest that while clinicians may be more attracted to one narrative than another, all clinicians unwittingly take all positions, sometimes switching positions with the same offender. When clinicians identify with offenders, they may minimize the offender's risk and believe themselves the only ones who can understand and treat the offender. Conversely, when clinicians identify with the victim, they may no longer see the offender as a person, but as an enemy or even an incarnation of pure evil (Baumeister, 1996). Finally, when clinicians identify with the court and/or the criminal justice system, clinicians become extensions of the system. They may perceive themselves as arbiters of social law, as judicious or retributive. They may confuse control with therapy. Imagine a forensic team with 10 members or more. The likelihood of team members taking different positions at different times is high and thus the likelihood of conflict is high. We have applied the tridimensional model to DBT by adding observation of these dilemmas to the team consult observer's task.

### *Treating Team Polarization*

When the offender is the first priority, the team may fail to sufficiently assess and treat the offender's criminogenic risk factors, speciously arguing that because this

offender has not engaged in violent behavior in the institution, there is no reason to be concerned about such risk factors. The individual therapist may focus exclusively on trauma, viewing the offender as also a victim, perhaps the therapist's way of coping with the offender's offense (Ross, Polaschek, & Ward, 2008). The individual therapist may see themself as the only one who can understand and effectively treat this particular offender. The offender may similarly see their therapist as the one and only person who understands them, the only person who matters; the offender may disregard, even denigrate, other team members, notably line staff—for instance, "I don't have to listen to you, I'll wait for my individual therapist." The therapist and offender may unite against other team members, the institution, and the judicial system; they have forgotten their forensic context. Such forgetting is a dialectical failure.

How do you treat polarization between the offender and the institution? The treatment targets for the offender and perhaps the therapist and the team include mindfulness of legal context, radical acceptance, and self-validation. The offender, after making staff repairs, needs to decrease their sense that they are the center of the world and increase their mindfulness of others, particularly staff other than the individual therapist, staff other than the unit staff (administrators), and people other than mental health professionals (criminal justice members and the community at large). The offender and the therapist can increase dialectical thinking; the thought that they are "two against the world" is their mortal enemy.

When the pendulum swings in the opposite direction, that is, the institution is the only priority, what are offenders to do? The offender and therapist can increase radical acceptance of the offender's position, perhaps one of the lowest power positions in the United States.

When control is the only thing that matters, the therapist and/or other team members confuse therapy with control. Risk principles are forgotten. Predetermined risk-reduction goals may function to depersonalize offenders. Responsivity principles are forgotten. Offenders may be mandated to groups, lockstep without regard to their treatment needs or personal desires. Offenders may continue to repeat the same program year after year, compensating for inadequate staffing or responding to administrative or accrediting agency demands for treatment hours. In response, offenders may withdraw or, alternatively, say all the "right things" to placate everyone. This withdrawal elicits suspicion from staff. The team becomes an arm of the criminal justice system.

When control is the only factor that matters, the treatment target for the offender is radical acceptance, getting or remaining under the radar, and mindfully waiting for another day. The Japanese proverb "The nail that sticks up gets hit." is relevant to the forensic context. Be the nail flush with the wood. Don't get hit. When shame is justified, appease and hide. Wait for controlling others to move on to another offender, another unit, another setting.

### *Team Consult Observer Tasks*

There are at least two significant differences between standard DBT team consult and forensic DBT team consult. First, in standard outpatient DBT, the consult team functions to bring the therapist and client back together. In contrast, in forensic DBT team consult, the team may insist that the offender must change and the individual

therapist may insist that the offender is doing the best they can. In forensic DBT team consult, the team functions to bring the therapist and the offender back to the treatment team. Why the difference? In standard outpatient DBT, other consult team members may have little to no contact with the client discussed in team consult. In the forensic residential setting, team members may have more face-to-face contact with the offender than the individual therapist.

The second difference between the standard DBT team consult and the forensic DBT team consult is the criminal justice context. It is not uncommon for the transactions between team members to mimic the roles of prosecutor, defendant, and defense attorney. The solution to this team-consult-interfering pattern is mindfulness. Thus, the observer has an additional task: to ring the bell when the team members take the role of prosecutor, or defendant, or defense attorney. If emotions are high, it may be effective to suggest a breathing practice prior to describing the behavior. As one team member observed, "Sometimes it is like jingle bells in here."

## Conclusion

Some modes of DBT, for example, skills training, can grow like dandelions in forensic settings, while other modes, particularly individual DBT and DBT team consult, need careful tending. The criminal justice context is akin to acidic soil. Validation and mindfulness of forensic dialectical dilemmas are the lime and ash ameliorating the acidity. On the one hand, implementing and maintaining a C-DBT program in a forensic hospital may be beyond the most talented gardener's skills. In this case, as a wise woman advised, "Love the dandelions" (Linehan, 2015). On the other hand, a C-DBT program, like the orchid, is potentially immortal; it divides and multiplies, creating new shoots, bulbs, and flowers.

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PART III

# APPLICATIONS ACROSS POPULATIONS

CHAPTER 10

# DBT–Accepting the Challenges of Employment and Self-Sufficiency

KATHERINE ANNE COMTOIS, LYNN ELWOOD, JENNA MELMAN, and ADAM CARMEL

The goal of this chapter is to provide information on the development of DBT–Accepting the Challenges of Employment and Self-Sufficiency (DBT–ACES), a 1-year program designed to help graduates of standard dialectical behavior therapy (SDBT) move off of psychiatric disability by finding and maintaining employment and becoming self-sufficient. This chapter includes an overview of the history of DBT–ACES, before describing the DBT–ACES program including a brief presentation of the DBT–ACES modes, skills modules, and unique contingency management and exposure-based strategies that function to initiate and maintain employment and self-sufficiency behaviors. A case study is presented to illustrate these concepts.

## The History of DBT–ACES

DBT–ACES (Comtois, Carmel, & Linehan, 2020a) was developed at Harborview Mental Health Services (HMHS) in Seattle, Washington, to help psychiatrically disabled clients with borderline personality disorder (BPD) overcome systemic issues associated with maintaining living-wage employment and self-sufficiency. HMHS was the first site to implement DBT outside of Linehan's research clinic and had been conducting an SDBT program for psychiatrically disabled individuals with severe and chronic BPD since 1988. Program evaluation has demonstrated outcomes comparable to those of research trials (Comtois, Elwood, Holdcraft, Simpson, & Smith, 2007). However, we also found that as successful as we were in reducing suicidal behavior and associated emergency room and inpatient psychiatric admissions, patients who came to us deeply entrenched in public services returned to "treatment-as-usual" care in public mental health centers following their year of SDBT, where progress would

seem to get arrested or even reversed. Long-term public mental health care appeared to be the expectation of case managers and psychiatrists who assumed care for these SDBT clients. And in Washington state, as in many states within the United States, treatment in the public mental health system funded by public insurance plans is contingent on ongoing psychiatric disability. We decided as a team that becoming stable after a year in SDBT wasn't enough to help these clients reach their life-worth-living goals and found it heartbreaking to see a year of incredibly hard work on the part of both the clients and the team insufficient for sustainable change or a life worth living. We tried adding a second year of SDBT and achieved the same results. A different approach was needed.

The challenge the clients experienced in returning to treatment-as-usual (TAU) is that treatment in the public mental health system tends to focus on general stability (via medication management, case management, symptom-related group therapy), rather than pushing for a life worth living. Many treatment and social service providers keep clients connected to mental health clinics or other public assistance by providing opportunities for housing, volunteering, employment, and social events that are tied to being "a patient." In addition, the important goal of many providers is to ensure that client's publicly funded insurance and/or and disability benefits are not at risk—in part, because a loss of benefits means a loss of the very treatment or service they provide. Although this approach can be helpful to assure stability, many clients continue to live a life of poverty and inactivity, leading to depression, anxiety, shame, and suffering in quiet desperation (Killeen & O'Day, 2004; Underlid, 2005).

Many of our clients had never held jobs. They frequently came from families who were themselves reliant on the social safety net due to poverty, addiction, and mental health challenges. Our clients' belief in themselves and their capabilities was limited, and these beliefs had been inadvertently perpetuated and reinforced by the mental health and social service system (Carmel, Torres, Chalker, & Comtois, 2018). For example, many times we encouraged clients to work more hours or get better-paying jobs, but they were reluctant because it would threaten their disability benefits and their job coach/case manager discouraged it. The message such clients explicitly or implicitly received was that they were not capable of succeeding in a competitive-wage job and that attempting to do so would be too risky as it would likely threaten their financial stability and housing. Thus, clients were encouraged to "play it safe." Clients frequently talked about wanting a "normal life": having a romantic partner, being able to travel, owning a car, or having a pet. What these clients identified as a life worth living seemed so realistic and attainable, yet the contingencies of the system punished this level of recovery and self-sufficiency. As a team, we saw the capability of the people we worked with; we thus found this pattern heartbreaking and intolerable. We realized that unless we helped them find a way out of this cycle, misery, shame, and quiet desperation would likely continue and they would remain "mental patients" in their own eyes and in the eyes of their family and friends. They would miss the social as well as financial rewards of employment, the symptom reduction associated with a behaviorally activated and structured life, and the ability to make their own choices rather than have to justify their choices of where to live, how they spent their time, and their bank account with those who held the purse strings. To achieve this freedom, we recognized the need for a new treatment that provided strong contingencies and almost continuous positive reinforcement for employment and self-sufficient behavior as well as effective exposure to fear, frustration, and shame that

arises in the face of job hunting, applying for school, budgeting, time management, and other activities required to achieve work and financial independence.

Research on SDBT had shown improvements in social adjustment that include employment, but not differences in employment specifically (Bateman, 2012; McMain, Guimond, Streiner, Cardish, & Links, 2012). We considered other evidence-based practices for severe and persistent mental disorders, such as Supported Employment (Blum et al., 2008; Cook et al., 2005; Drake et al., 1999; Markowitz, Bleiberg, Pessin, & Skodol, 2007) and Assertive Community Treatment (Drake & Deegan, 2008; Gold, Meisler, Duross, & Bailey, 2004; Gold et al., 2006; Horvitz-Lennon, Reynolds, Wolbert, & Witheridge, 2009) that have demonstrated improvements in employment. However, these interventions have not been evaluated for BPD and clinical experts in the field have not encouraged their use for BPD (Swenson, Torrey, & Koerner, 2002; Weisbrod, 1983). We found no treatment for BPD or severe and persistent psychological disorders that has evaluated successful termination of disability payments or leaving the public mental health system as treatment outcomes.

We carefully considered the many factors that keep clients in the public mental health system, including financial incentives, finding the majority of their social support there, listening to negative messages about the limits of their capabilities and potential, and allowing others who fear the client will fail to influence major decisions for them. Given there are so many systemic disincentives, we found that we had to develop contingencies in the form of deadlines, ambitions, and systematic reinforcement of adaptive behavior to reinforce clients to return to work. These contingencies included a normative-productive activity requirement, development of a career vision and plan, as well as requiring competitive, taxable employment, by a fixed date, on the open job market. As a focal part of the treatment, we required clients to cross the divide between the desire to work and actually being employed. Our rationale is that many of our clients have never worked or had negative experiences in the workplace that make it scary or humiliating to go back. We want them to enter or return to these environments while in treatment with us so that they have support, coaching, validation, and encouragement when they inevitably stumble so their fears of working are not realized. The goal of the DBT–ACES year is for clients to become competent in enough skills, be exposed to the feared cues, and create strong environmental contingencies. In this way, clients achieve sufficient momentum to continue to accomplish their employment, social, and independence goals after treatment ends.

In consultation with Linehan and other DBT experts, we began to develop a highly structured, contingency-based advanced level of DBT focused on a life worth living outside of the public mental health system. Working in a public mental health agency funded primarily by public insurance, we were forced to address the challenges that our clients face in living outside of the social service system tied to psychiatric disability. To reduce our clients' dependency on social services and increase living-wage employment, we focused DBT–ACES skills on increasing self-sufficiency, goal-setting, problem solving, troubleshooting, reinforcement of self and others, and dialectics. While there are a number of skills in DBT–ACES to address the challenges described above, DBT–ACES is largely a principle-driven treatment. One important principle is that clients are not "mental health patients"; they are people focused on progress and problem solving in the face of fear and shame, each with their own ambitions, goals, and challenges. DBT–ACES helps clients to hold the dialectic that

on the one hand, they may have a history of serious mental health issues that can appear in many domains of their life and, on the other hand, the frustrations that clients experience day-to-day as they move toward employment and self-sufficiency are largely understandable, experienced by most people, and are manageable by developing skills and resilience. DBT–ACES seeks a synthesis of both validating and overcoming emotion dysregulation and mental illness barriers, while helping clients see how much they share with other unemployed people who have not struggled with serious mental health and emotional issues. Thus, this synthesis occurs not to ignore emotional issues nor to avoid working; instead, it is to challenge oneself to accept life's difficulties, accept help and support, and keep taking the next step.

We have recently expanded the reach of DBT–ACES to include clients who are not on state and federal psychiatric disability programs but are financially supported by family, friends, or other organizations such as employer disability programs, churches, or nonprofits. We have found that the issues and needs are very similar for these individuals and have not required any substantive changes to DBT–ACES.

## Overview: The Problem of Psychiatric Disability

Psychiatric disability has a range of forms. In the United States, state and federal governments maintain designations of disability that indicate an inability to work enough to support oneself and most include mental and psychiatric disorders as the causes of such disability. Employers often have a similar—although generally short-term—disability designation. Finally, there are unofficial versions of disability where family, partners, friends, religious or other organizations financially support individuals whose psychiatric problems interfere with their ability to work. In all cases, the individual is in a position of dependency, unable to make choices without justification and permission from those subsidizing them—and is more often than not living in poverty or below the socioeconomic standing of their family and friends. In DBT–ACES, all of these situations constitute dependency and are considered a psychiatric disability if they are primarily the result of mental or emotional problems.

Psychiatrically disabled individuals are often engaged in mental health services with the hope of ameliorating their disability. Treatments are variable and range from only pharmacotherapy, to long-term individual psychotherapy, day treatment, clubhouses, or other more intensive services. If not supported by family wealth or generous employer supports, psychiatrically disabled individuals are generally embedded in a range of social services beyond mental health. This includes disability income, publicly funded insurance programs, public housing, food stamps, childcare assistance, and the like. As individuals improve and move toward employment, their participation in these safety net programs is threatened. Families and employers likewise often withdraw financial support when the disabled individual shows improvement. For most individuals, moving forward with employment with the goal of getting off disability often feels like jumping without a net. One DBT–ACES client had been receiving federal benefits for psychiatric disability for over 20 years when she made the plunge to return to work. She found that her cash and food benefits were immediately decreased: before her cash flow from work had stabilized. She made the challenging decision to continue toward her ambition and life-worth-living goals in the face of these adverse contingencies.

The journey toward living-wage employment means moving through a loss of benefits toward the goal whereby earned income is higher than the combination of disability supports. Thus, DBT–ACES is different than many other supported employment programs that encourage clients to make only enough money so as to not put them at risk of losing their benefits. The goal of DBT–ACES is to find a dialectical synthesis by focusing on self-sufficiency and employment as key steps toward recovery and normative functioning, while buffering the loss of resources that comes with making such a change.

Normative functioning is defined as acting as if you don't have mental health or emotional problems around others who are acting as if they don't have mental health or emotional problems. This applies to work, school, social contacts, and community living (e.g., dealing with a bank, medical providers, insurance agents, government officials, paying your bills). The key issue is that the setting is "normative" if it is not defined by its members' emotional problems or psychiatric illness (e.g., not a community mental health center, sheltered workshop, clubhouse). We have found that individuals with BPD are very sensitive to the expectations of those around them and that they have more success in environments where the focus is off their emotional and psychiatric problems. Many of our clients have found it easier to not disclose their emotional problems to members of these new settings and communities. When the community only expects normative behavior, it appears to help the DBT–ACES clients' ability to produce it.[1]

### *DBT–ACES Recovery Goals: What Is Recovery from Disability?*

DBT–ACES is offered after the client completes SDBT when employment and recovery from psychiatric disability are the client's goals. Some SDBT programs have a fixed duration (e.g., 6 months or 1 year) and clients can enter DBT–ACES after they have completed that program (see Figure 10.1). For clients in SDBT without a predetermined end point, eligibility to transfer to DBT–ACES is dependent on quality of life being the primary treatment target. What differs when a client graduates from SDBT and starts a DBT–ACES program is that the Recovery Goals are the highest priority of all quality-of-life interfering behaviors. If other significant quality-of-life interfering behaviors are occurring, the client's treatment is postponed unless they are key factors controlling the DBT–ACES Recovery Goals.[2]

DBT–ACES is conceptualized as a Stage 1 treatment for those who have successfully resolved life-threatening and therapy-interfering behaviors that attends to unemployment, social isolation, and psychiatric disability as the primary quality-of-life issues that tend to drive misery, behavioral dyscontrol, and, more distally, suicide

[1] It is important for DBT–ACES clinicians to be aware of the implications of the decision not to disclose disabilities, so they can effectively orient their clients. For instance, according to U.S. federal law, if disability limitations are not stated at the time of employment, the employer is not required to provide Americans with Disabilities Act (ADA) and other disability accommodations if they are requested later. Other employer, local, state, or federal regulations and policies may also apply to your clients' disability-related decisions. DBT–ACES clinicians and clients explore the dialectical tensions in such decisions to help the client make a wise mind choice.

[2] To be enrolled in DBT–ACES, the client's life-threatening and major therapy-interfering behaviors must have stopped, allowing the Recovery Goals to be the primary focus of treatment. This is discussed in the application process below.

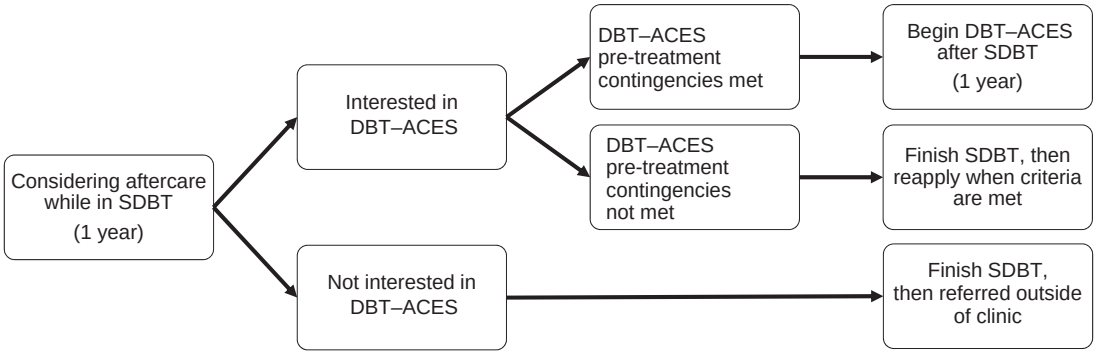


**FIGURE 10.1.** Process of Admission to DBT–ACES Following SDBT. Admission to DBT–ACES is contingent on (1) completion of an application; (2) performance evaluations by the individual and group therapists; (3) creating a resume ready to use; (4) passing a test of DBT skills; (5) engaging in 20+ hours per week of normative and productive activity (i.e., scheduled activities outside their home, where the client acts like they don't have emotional problems around other people acting like they don't have emotional problems); and (6) at least 2 months of no life-threatening or significant therapy-interfering behavior.

risk (Stage 1A). Though DBT–ACES doesn't officially start until after SDBT, we have incorporated a few elements into the end of SDBT to help the client assess whether or not DBT–ACES will be a good fit for them (see more information on the DBT–ACES pre-treatment process below).

DBT–ACES uses the same general hierarchy as SDBT: (1) decreasing life-threatening behaviors, (2) decreasing therapy-interfering behaviors, (3) decreasing quality-of-life interfering behaviors, while simultaneously (4) increasing DBT skills mastery. Secondary targets in DBT–ACES are identical to secondary targets in SDBT. As in SDBT, therapists adhere to the treatment hierarchy, which means that suicidal or therapy-interfering behavior is given priority when it appears; however, the focus of treatment is quality-of-life interfering behaviors and the Recovery Goals (see Table 10.1). Recovery Goals are targeted in the order agreed upon by the client and individual therapist. Quarterly throughout the DBT–ACES year, clients reassess their progress on these targets using the Recovery Goal self-assessment (available upon request), and this is reviewed by the therapist and the consultation team to ensure that the individual therapist is targeting effectively.

For example, clients with social anxiety frequently engage in avoidance behaviors that interfere with both obtaining employment and making friends. Socially anxious behaviors then become a focus of DBT–ACES individual therapy to achieve the employment and social network goals. However, if social anxiety is not related to a DBT–ACES Recovery Goal, addressing it would be postponed until the Recovery Goals were substantially met. A second example would be continuing use of substances. Substance abuse is a common quality-of-life interfering behavior. In SDBT, an assessment is made to determine if the client's substance abuse is a life-threatening or therapy-interfering behavior or a key factor controlling whether a top target occurs. Substance abuse is only addressed if it is a key controlling factor until the life-threatening and therapy-interfering behaviors are in substantial control. At that point, substance abuse may become a quality-of-life treatment target of its own.

**TABLE 10.1. DBT–ACES Recovery Goals**

Living-wage employment and off psychiatric disability

- Choose a career path to living-wage employment, knowing its fit with your wise mind values and talents as well as the practical issues of pay, health insurance, leave and retirement benefits, hours, shift times, required training or certification, and routes to advancement.
- Demonstrate capability to financially support yourself (and your family) in your chosen career without psychiatric disability payments or partner/family's income.
- Demonstrate capability to financially support yourself (and your family) in at least one fall-back job without psychiatric disability payments or partner/family's income (if needed).
- Have sufficient health insurance to maintain health care and medications.
- At work, maintain better than 90% follow-through at on attendance, arriving on time, appropriate dress and manner, following directions, and job tasks.

Interpersonal proficiency

- Be interpersonally easy to work or associate with—even with difficult people and during stressful times.
- Demonstrate the capability to regulate emotional expression and actions, and find wise mind in all interpersonal situations—even with difficult people and during stressful times.
- Know your wise mind personal limits and act on them with yourself, employer, friends, family, colleagues, and members of your community.
- Receive praise, raises, promotions, and offers for more desirable jobs and roles within your community.

Life outside work[a]

- Have at least a couple of local and/or long-distance friends whose values align with yours.
- Have at least one person or group for casual interactions (e.g., in the lunchroom, at church, for coffee, see a movie, in a book club, within a volunteer organization).
- Have at least one close supportive person with whom you can experience intimacy and discuss private issues (someone who is not your therapist).
- Have at least one local person or group that would notice your absence and take action to find or contact you.
- Be an active member of an organized recreational activity that is either fun or meaningful and not related to mental health (e.g., a volunteer organization, church, sports team, gym class, Spanish lessons, ballroom dancing).
- Disengage from relationships with family members that are ineffective or destructive.
- Disengage from or end friendships that are ineffective or destructive.
- Choose relationships based on evidence that the other persons will likely be compatible in their lifestyle, needs, and values.
- Take steps to find an effective and rewarding romantic relationship (if desired).

Emotional proficiency

- Able to experience negative emotions when they build, remain, and fall away mindfully—not avoiding or rushing through them, or mentally moving into a different moment.
- Able to experience positive emotions when they build, remain, and fall away mindfully—not avoiding or rushing through them, or mentally moving into a different moment.
- Able to reduce problematic emotions effectively and fast enough to prevent them from leading to problems.

Self-management

- Have an effective method for managing your monthly budget and one-time expenses (e.g., new tires), so you stay within your income.
- Put aside sufficient emergency funds to cover 3 months of living expenses in case you lose your job.
- Have an effective method for accumulating savings to purchase possessions you would enjoy.
- Have an effective method for getting out of debt/reducing debt to a reasonable level.
- Have an effective method for managing your time so you spend it in line with your wise mind values.
- Have an effective method for managing your time that ensures key things get done on time.
- Have an effective method for managing your time that balances work, leisure, household, and downtime.
- Have an effective method for preventing illness and psychiatric symptoms from impacting your functioning.
- Have an effective method for managing chronic illness or pain to minimize its impact on your quality of life.

[a]These categories are expected to overlap.

Similar principles exist in DBT–ACES, although clients have stopped most crisis and therapy-interfering behaviors (and the use of substances to the extent that it causes these behaviors). The DBT–ACES therapist targets remaining substance use problems if they relate to the Recovery Goals. For instance, drinking too much the night before work causing one to be late or stay home, drinking to reduce social anxiety when it is not acceptable to the friends with whom the client is hanging out, and use or possession of illegal substances that interfere with obtaining a job or with school performance would all be addressed as part of the Recovery Goals. Later, when the client is meeting their Recovery Goals, other substance use may be targeted if the client wants to do so or may not if another quality-of-life interfering behavior is a higher priority to the client.

At times, clients who are in DBT–ACES would like to work on issues related to trauma and posttraumatic stress disorder (PTSD) symptomology. Often the presence of these symptoms may interfere with Recovery Goals, though that is not always the case. When it is not the case, the DBT–ACES therapist is willing to treat the trauma as long as progress on the Recovery Goals remains stabilized and consistent and life-threatening and therapy-interfering behavior doesn't reappear. Discussion with the DBT–ACES consultation team is often key in deciding these targeting dilemmas.

## DBT–ACES Modes of Treatment Delivery

DBT–ACES is fundamentally DBT. DBT–ACES takes the principles, assumptions, agreements, and treatment strategies of SDBT and explicitly uses them to generate and strengthen behaviors in the environments where they are most needed. SDBT can be compared to military basic training in which inductees learn and master basic skills but don't have to put the skills to use. DBT–ACES is more like being deployed: the place where it is essential for new soldiers to implement and integrate their skills to improve and potentially save their lives. While SDBT is considered completed before DBT–ACES begins, the same therapist who provided SDBT can continue to work with the client to provide DBT–ACES. Once in DBT–ACES, clients are not allowed to return to SDBT. The rationale for this is that we want to keep the bar high, maintain our belief in their success, and we don't want to inadvertently reinforce an escalation in suicide or self-harm behaviors. We fear that by allowing clients to remain longer than the agreed upon treatment period or if reemergence of crisis behaviors results in a return to SDBT, it would have the effect of avoiding the DBT–ACES contingencies that assure forward momentum toward self-sufficiency goals. To enter DBT–ACES, clients demonstrated they can successfully manage their life-threatening and therapy-interfering behavior. Even if life produces more challenges or they feel more vulnerable or less capable, we do not want to functionally validate those beliefs by offering SDBT again and removing the opportunity for them to reach their goals and meet the contingencies of DBT–ACES.

Of course, the other side of the dialectic is that sometimes clients don't have the skills they need. In such cases, the DBT–ACES therapist teaches the needed skills, practices them in session and *in vivo,* and verbally validates the difficulties. The DBT case management strategies are key here: finding the right balance of consultation to the patient and environmental intervention to meet the client's reality. The consultation

team plays a key role in whether or how much to intervene for the client or "lower the bar" and when to keep the bar high. In DBT–ACES, therapists encourage and coach clients to manage difficult situations themselves—keeping in line with their long-term goals related to work, relationships, emotion regulation, and self-sufficiency and to do so in DBT–ACES. However, if in their wise mind, a client believes they cannot move forward with DBT–ACES and/or need to return to SDBT, they can drop out of DBT–ACES and reapply at a future date when the perceived barriers have been addressed. In our clinic, they would need to seek SDBT or other services elsewhere.

There are only small changes from SDBT modes of treatment delivery, and those differences are primarily in the format and content of group skills training. The following sections outline each treatment mode, highlight changes, and address pitfalls that arise specific to DBT–ACES.

### *Individual DBT*

Individual therapy in DBT–ACES is fundamentally similar to individual therapy in SDBT. As in SDBT, the weekly DBT–ACES individual therapy sessions are the mode around which all other treatment modes revolve. The individual therapist is responsible for identifying a client's personal goals and DBT–ACES Recovery Goals, implementing core validation and problem-solving strategies, as well as applying contingencies, skills training, exposure and cognitive modification procedures, synthesizing dialectical tensions, and all other DBT strategies.

The differences between the two treatments stems from the higher demands on and enhanced skillfulness required of DBT–ACES clients. There is relatively more emphasis in DBT–ACES on cueing client's effective behavior rather than blocking dysfunctional behavior and teaching new behavior. Though the primary SDBT targets of (1) self-harm behavior and (2) therapy-interfering behavior remain primary targets in DBT–ACES and are monitored each week, they are infrequent, thus rarely taking up individual session time. Instead, the primary focus is Recovery Goals. The Recovery Goals lend themselves to a full range of exposure strategies and manualized behavioral treatments for psychological disorders (e.g., behavioral activation treatment for depression or cognitive-behavioral treatment for social phobia), and it is more likely that a client can see such a treatment protocol through than is typical with beginning SDBT clients given the skills acquisition and increase in emotion regulation as a result of treatment.

Individual DBT–ACES uses all the same SDBT strategies to treat the Recovery Goals plus the skills taught in the DBT–ACES skills curriculum. Exposure and contingency management (particularly dragging out new behavior and the reinforcement of adaptive behavior) predominate in DBT–ACES sessions. In terms of the DBT functions, in DBT–ACES, there is greater emphasis on improving motivation and generalizing skillful behavior than enhancing capabilities, as is appropriate to graduates of SDBT. For instance, when the client brings up an emotionally challenging situation at work, the therapist expects that the client has already been using skills to address it. Clients generate further ideas for problem solving and skills use in the face of the therapist who sets this expectation both verbally and nonverbally. Similarly, the therapist is more likely to prompt the client to generate a dialectical stance in response to a polarized position that drives a negative emotion, rather than being the first to highlight both sides.

Two potential pitfalls in DBT–ACES individual sessions include the escalation of self-harm, crisis-generating, or therapy-interfering behaviors; or the reduction in client or therapist motivation (urgency) prior to reaching a goal. In DBT–ACES individual sessions, the client's escalation of self-harm, crisis-generating, or therapy-interfering behavior requires the standard protocols as well as the same set of acceptance and change strategies as in SDBT. Such a relapse or escalation can occur when fear or shame arise in the face of new challenges, expectations have been set too high, or escalation functions to avoid taking the next employment or career step. Such "bursts" of dysfunctional behavior are expected *and* can be demoralizing to the client and therapist in DBT–ACES and may lead the client or therapist to back away from the challenges of finding work, applying for school, sticking with a job, and so on.

There have been several instances over the years where a DBT–ACES client engaged in self-harm behavior. In each case, they were put on probation and warned that if they were to self-harm again, they would be placed on treatment suspension (aka therapy vacation). In all but one case, the client was able to examine what had happened, problem-solve, and recommit to refraining from such behavior. In the one case where the client was unwilling to do just that, the client was discharged from the clinic and started work with a therapist elsewhere. Clients are welcome to reapply to DBT–ACES when they use skills to prevent self-harm behavior for at least 8 weeks.

The other typical struggle in DBT–ACES occurs when the client or therapist loses motivation, resulting in an inclination to settle for less than the original goals. This sense of complacency or "good enough" is certainly understandable and not unusual in DBT or other psychotherapies. However, given the expectation of achieving the Recovery Goals, this problem is more salient in DBT–ACES. As in SDBT, DBT–ACES requires constant dialectical balance between change and acceptance. However, in contrast to many SDBT clients, the DBT–ACES client is not suffering as intensely and their life is more stable and supported than it has been in some time. This means that life itself does not always provide the urgency the treatment needs. Thus, the individual DBT–ACES therapist is called upon to create urgency to help the client make needed changes. For example, if a client is working full time at a minimum-wage job and is feeling stable, but their ambition is to be able to afford a home and travel, the therapist would need to help the client feel enough urgency to continue pushing forward. This is done by helping the client hold the dialectic and get through the Career Activities contingency (discussed later).

Loss of motivation also frequently shows up in the realm of social relationships. By the time they are in DBT–ACES, most clients have made significant changes in their life and realize they would like more friends or relationships of greater depth. Relationships and deeper connections are essential to life satisfaction and protect against suicide (Chu et al., 2017; Joiner, 2009; Joiner & Van Orden, 2008). If the therapist doesn't persist in making this a target of therapy, the client will continue to run the risk of withdrawing, feeling disconnected and isolated, and will continue to remain vulnerable and at risk of recurring suicidal ideation (SI). Though clients realize relationships are a goal, they often feel paralyzed and do not know how to move forward in making the changes they desire. With DBT–ACES, there are always other Recovery Goals to work on and social relationships can get overlooked or postponed even though they are critical for the client's life-worth-living goals. The

astute DBT–ACES therapist, with the help of the consultation team, will recognize the urgency of this situation and realize that this is a Recovery Goal that needs to be targeted while a client is in DBT–ACES (along with employment and career).

For example, one DBT–ACES client had successfully returned to school and begun working for the first time in her life. While it was important to celebrate these successes, social anxiety continued to interfere with her participation in social groups. Given that being part of a group was core to her life-worth-living ambition, this anxiety could not be ignored. By linking to goals, highlighting the short-term nature of social anxiety treatment, and ways that social avoidance led to persistent depression, the therapist and client created urgency and set weekly targets for the client to spend time with at least one friend outside of work, treatment, or a support group meeting, and to make an intentional and mindful effort to initiate a social contact with someone. Exposure is key to success in DBT–ACES, so to improve social relationships, therapy generally involves *in vivo* exposure to social settings and behaviors, informal exposure such as blocking shame behaviors in individual and group therapy sessions, and exposure-based treatment protocols. DBT–ACES also recognizes the truism that "contingencies create capabilities" (Carmel, Comtois, Harned, Holler, & McFarr, 2016). For social relationships, therapists in our clinic have used contingency management to generate behavior. For example, there was a case where a client was so avoidant of social situations that before he was able to begin DBT–ACES, he was required to sign up and join a soccer team. For another client, most of her social interaction occurred in treatment, 12-step, and support group settings. While one can argue that these may be normative, what wasn't normative for this client was that she didn't engage with anyone outside of these settings and each of these environments required her to be attached to part of her identity as an addict or someone with mental health issues. Systematic reinforcement of adaptive social behaviors is consistently provided in these circumstances to maintain positive reinforcement as the dominant contingency used in DBT–ACES. The hallmark DBT–ACES contingencies of work and career development (described below) and the systematic use of individualized contingencies create motivation to achieve stable employment, a range of fulfilling relationships, enriching lives and self-sufficiency.

### *Group Skills Training*

DBT–ACES skills training is a weekly 2-hour group following a specific format and skills-training curriculum. The group begins with sharing good news for the week, then each member and group leaders share their ambition and check-in steps, followed by a 15-minute break, and then review of homework and learning of new material.

The hierarchy for DBT–ACES group is the same as that for SDBT. That is, the key target is increasing skills acquisition and strengthening, and this target is only trumped by group-destroying behavior. As in SDBT, therapy-interfering behaviors are primarily addressed during individual sessions, though in DBT–ACES group they don't always get ignored. As group is a venue where interpersonal skills are needed and professional behavior is expected, emotional or interpersonal missteps are often highlighted as they occur to cue the client to move toward a more effective response. Most often, this is done through nonverbal communication such as a furrowed brow

or tilted head in response to ineffective behaviors. Often more effective responses can be evoked by a light or irreverent statement such as "I bet your boss would love that response!"

This further ties in with the DBT–ACES Recovery Goal to not only find and keep a job, but also be the employee given raises, praise, promotions, and great references. Achieving this goal requires effective interpersonal skills and exceptional professional behavior, even when feeling vulnerable or annoyed. DBT–ACES sessions are opportunities for clients to practice professional behavior. Skills groups are opportunities for clients to show up and present themselves in a pro-social way and provide an opportunity for them to receive feedback from an environment where there are no great or long-lasting consequences.

The primary difference between DBT–ACES group and its SDBT counterpart is that the behavioral expectations of the group members are higher, the general feeling in the group is more relaxed and open (frequently due to low therapy-interfering behavior compared to SDBT), and reinforcement of other group members' effective behavior and progress is explicitly encouraged. Also, the group leaders function as members of the group who share their ambitions and weekly check-in and model effective shaping, coping, and problem solving. The culture created is open, light, and collaborative—as we want to model and reinforce this style for workplace, classroom, and social settings. Group members are asked to validate and reinforce one another, they are expected to help each other problem-solve challenges and barriers, and validate and coach each other through difficulties they encounter both in reviewing their check-ins and homework. Clients are also encouraged to "read the room" and figure out when to speak and when to stay silent or just smile or nod. Coaching on how to do this is provided by group leaders and individual therapists.

The primary goal of the DBT–ACES group skills curriculum is for clients to learn enough of the basics of behaviorism, problem solving, acceptance, and validation to largely become their own therapist (at least as it relates to general emotional stability). Specific capabilities include being able to mix and match skills, and understand *explicitly* what they experience *implicitly* in individual therapy, including behavioral assessment, reinforcement, goal-setting, problem solving, troubleshooting, cognitive restructuring, self-validation, and dialectics. The goal is for clients to be able to apply these strategies to themselves in a variety of environments, as well as understand the specific steps needed to create their own social support system and effectively interact with people at work, new and established friends, and treatment providers. Comparable to the difference between undergraduate and graduate training, an undergraduate student will learn subject matter in theory but in graduate school they will begin to meaningfully apply what has been learned in structured practice, become a practitioner themself, and be able to teach others (e.g., the Career Activities, Work as Therapy, and Check-In for DBT–ACES are like internships in graduate school). To do this, DBT–ACES leaders model the desired behaviors, label these principles and strategies as they arise, and reinforce clients' adaptive behavior throughout group sessions, over and over and over again.

Much of DBT–ACES group is focused on each client's individual life ambition and weekly targets. When clients begin DBT–ACES, they are asked to create an ambition that is something they passionately want to achieve as a permanent change in their life—a goal that is not the means to an end but an end in itself. Then each week, the clients, with help from the coleaders and each other, identify an "action step"

toward their ambition and an employment step that is behaviorally defined, clear when it is completed, under their control, and at which they have a better than 50% chance of success. For example, one client's DBT–ACES ambition was as follows:

> *I want to be a highly respected worker who is a key contributor on my team, has insightful ideas, produces high-quality work and is valued, and who is perceived as such by my coworkers. I want to do work that is challenging enough to be interesting, and when it is so difficult that I want to quit, I stick it out and push through it. I want to be a sufficient adult in terms of house upkeep and paying bills on time. I want a relationship where we work as a team and I behave in a way that reduces conflict with my wife by not reacting with defensiveness and actively behaving in ways that cultivate kindness, teamwork, and respect. I want to be a more patient person so that I have the skills to be a kind and understanding dad in the future. I want to live an active and healthy lifestyle where I feel confident that I can meet any challenge that I pursue, including being able to do one pull-up, and one double under (on demand).*

The ambition doesn't need to be this specific, just clear enough to embody the underlying values, and experienced by the client with enough passion that the client has a general direction to work toward. Other DBT–ACES ambitions could be "Wake up happy more often than not" or "Be the mom my son needs" when these simpler ambitions are at the heart of the client's life-worth-living goals. Longer or shorter, the ambition needs to capture what is truly important, meaningful, and motivating for that client. Action steps for this client for the week may be to complete financial aid paperwork for school or do 6 hours of studying for the LSAT, or practice a half-smile at one time each day when irritated and take five deep breaths before responding. One action and employment step is all that is needed each week, although more are acceptable if they fit the client's ambitions and available time without resulting in partially versus fully completing the action steps for that week.

During the Check-In section of each DBT–ACES group, every client and the coleaders remind everyone of their ambition and then report on their progress on their action step that week and what they did that was effective and any way they avoided working on it. Avoidance is problem-solved, and a new action step is chosen and committed to for the following week. We ask clients to do this using opposite action to shame, adopting an alert body posture, looking up at others, and with a confident tone of voice. We ask the other participants to practice interpersonal skills by mindfully noticing what is reinforcing to each specific person and actively working to reinforce each other's hard work.

As in SDBT, new skills are taught and homework is assigned to practice the new skill (see below for more on the skills curriculum). The primary difference for DBT–ACES is that the skills and homework each week are specifically focused on the DBT–ACES Recovery Goals.

### *Telephone Consultation*

In SDBT, telephone consultations in which the client contacts the therapist for *in vivo* coaching are utilized as both a crisis management intervention and as a useful

means for cueing and reinforcing early skill acquisition. In DBT–ACES, telephone consultations differ in that they emphasize consultation-to-patient strategies aimed more at skills generalization and self-sufficiency. There is less need for the crisis management function as it is expected that clients are stable and can manage situations that formerly triggered a crisis on their own without the need for immediate assistance.

Some potential pitfalls of telephone consultations for DBT–ACES are these: (1) Telephone consultations may be underutilized due to their association in SDBT with crisis behavior, and (2) telephone consultations could interfere with "self-sufficiency" targets by inadvertently reinforcing reliance on cueing from the therapist. The association with "crisis management" in SDBT treatment makes it a challenge for clients and therapists to adapt to a more developmentally appropriate use of telephone consultations. This is dealt with in DBT–ACES by regular reminders in team meetings to assess the utility of telephone consultations and to assess any possible unwitting reinforcement of avoidance behavior on the part of the client. DBT–ACES clinicians also use phone calls as well as emails and texting as a vehicle for clients to report their skillful and mastery behavior more often. Reinforcement of adaptive behavior is extremely important as clients overcome their anxiety and shame, and approach the workforce and social community.

### *Therapist Consultation Team*

The basic functions and procedures of the weekly DBT–ACES consultation team meetings are again identical to those of SDBT (and, in our case, the SDBT and DBT–ACES programs within the same team meetings). As in SDBT, the weekly consultation team meetings include all individual and group therapists. All therapists make and keep the supervision/consultation agreements, cheerlead other therapists, maintain a balance of acceptance and change strategies, and maintain the integrity of the "team" as an active agent in the therapy. The consultation team is also where the team devises and authorizes the application of specific contingencies, such as individually tailored changes in behavioral expectations, requirements for collateral substance abuse treatment when it is necessary, or therapy suspensions.

The main pitfall of DBT–ACES consultation team meetings is that it is more challenging for the consultation team to track incremental improvements in DBT–ACES Recovery Goals across clients than it is to identify and target specific self-harm and therapy-interfering behaviors in SDBT. This makes it difficult to know if a therapist is targeting effectively or inadvertently reinforcing avoidance. This problem is addressed by, once a quarter, 30–45 minutes of consultation team time devoted to a focus on the current DBT–ACES clients and whether the individual therapists are targeting the most effective Recovery Goals. In our team, we have found it helpful to tie these quarterly team discussions to when the DBT–ACES clients conduct a reassessment of their Recovery Goals, which we do every 3 months either during DBT–ACES skills group or as a group homework assignment. If the therapist has this self-assessment in front of them, they can see how their targeting compares to the client's perspective. The team can discuss any changes that need to be made, or do "therapy for the therapist" if the therapist knows what to do but isn't doing it.

## Major Adaptations of SDBT for DBT–ACES

DBT–ACES has four major adaptations from SDBT: (1) the DBT–ACES pre-treatment process, (2) DBT–ACES Recovery Goals (described above), (3) career and work contingencies, and (4) DBT–ACES skills curriculum. Details for each of these can be found in the DBT–ACES manuals (Comtois, Carmel, & Linehan, 2020b) and materials at *www.dbtaces.com*.

To be considered for DBT–ACES, a client must (1) be engaging in 20 hours per week of normative and productive activity (i.e., scheduled activities outside their home in which the client acts as if they don't have emotional problems around other people acting as if they don't have emotional problems), as documented on the back of their diary card; (2) exhibit at least 2 months of no life-threatening behavior or self-harm; and (3) exhibit at least 2 months of no significant therapy-interfering behavior that is evaluated by performance evaluations of individual and group SDBT. There are no exclusion criteria.

When DBT–ACES directly follows SDBT, the therapist begins working on these requirements as soon as 6 months into SDBT and DBT–ACES pre-treatment (which occurs alongside SDBT) begins two skills modules (i.e., approximately 16 weeks) before the end of SDBT for those wanting to continue directly into DBT–ACES (see Figure 10.1). Returning to DBT–ACES at a later time or attending DBT–ACES after completing SDBT elsewhere requires the same criteria at the time of enrollment. The DBT–ACES intake staff conduct DBT–ACES pre-treatment with the client and SDBT therapist, and coach them on how to prepare for DBT–ACES. DBT–ACES criteria are always required, but they are not a one-time offer. Interested clients are encouraged to keep working to meet these criteria until they achieve them.

While the vast majority of clients who apply for DBT–ACES are accepted, it is the minority of SDBT clients who apply. In the initial evaluation of DBT–ACES in which all clients were on federal or state disability, about 50% of those who started SDBT applied to DBT–ACES. This was also true in a DBT–ACES program in Germany. However, only a quarter of recent SDBT clients applied to DBT–ACES in our Harborview program, which now includes a range of disability sources; similar rates of applying to DBT–ACES were found in a program started in California (Comtois et al., 2010; Comtois et al., 2020). While some clients were on their way to employment and school without needing DBT–ACES, the majority who did not choose DBT–ACES decided they did not want to find employment or get off psychiatric disability. This has been a disappointment to the DBT team when the client is not at retirement age. However, the client's wise mind is always supported, and DBT–ACES is never conducted unless it fits the client's goals.

### *DBT–ACES Pre-Treatment*

Our goal in DBT–ACES is to provide exceptional learning opportunities for those seeking a productive and satisfying life outside the disability/dependency/social service system, while minimizing the possibility of failure. Based on anecdotal clinical experience, clients who have been successful have generally demonstrated competency in three areas: (1) mastery of DBT skills, (2) ability to voice and demonstrate desire for a productive and satisfying life away from the mental health system and social services,

and (3) no or minimal therapy-interfering behaviors. We use an application process to determine these competencies. The DBT–ACES goal is for everyone to successfully complete the application. Multiple tries on any section are encouraged as perseverance and determination must be reinforced. Clients can reapply to the program until they get in.

The pre-treatment process is broken down into five parts, each of which functions to provide the clients with an opportunity to demonstrate their proficiency in specific areas that are typical of successful SDBT graduates. The DBT–ACES pre-treatment is designed in line with job and college applications and involves a client completing an application form, therapists completing performance evaluations of the client's work in SDBT, a test of skills knowledge, a resume, and an interview.

The application includes a description of DBT–ACES and what makes it different from SDBT, a list of the Recovery Goals, a description of the career development and Work as Therapy requirements, and a timeline with key dates to ensure that the client and therapist stay on track and complete the application on time. A checklist of steps is also provided to assist the client with completing the full process. A key issue is that the pre-treatment process needs to be introduced by 6 months before DBT–ACES to assure the client has sufficient time to understand what is involved in DBT–ACES and to consider whether it is in their wise mind to apply. This functions to both create urgency around eliminating behaviors that may prevent them from attending DBT–ACES, while still providing sufficient time for them to meaningfully reduce such behaviors. Also, the client application form often takes clients 2 months to complete correctly. Finally, in our clinic where SDBT is always completed in a year, a definitive decision on whether the client will be proceeding to DBT–ACES immediately after SDBT must be made by the end of the 11th month of a 1-year program, to provide at least a month for the therapist and client to terminate SDBT and plan next steps if they are not staying for DBT–ACES.

For example, in our 1-year SDBT program, most clients start considering DBT–ACES with their therapist at 6 months; they begin DBT–ACES pre-treatment two modules before the end of SDBT, so the pre-treatment process can be mostly complete prior to beginning the final module of their SDBT year. As the DBT–ACES criteria are based on 8 weeks of no high target behavior, having the pre-treatment process completed before the last skills module allows the client 8 weeks, if needed, to resolve any behaviors interfering with DBT–ACES (e.g., suicidal risk, low attendance), so the client remains fully eligible for DBT–ACES immediately after SDBT. If the majority of the pre-treatment process is not completed before the last module of SDBT, we do not have a client come to DBT–ACES immediately after SDBT, but instead have them take off some time (at least 3 months) and apply when they are better prepared to do so. This prevents chaos at the end of therapy, with the client trying to get into DBT–ACES and end SDBT simultaneously. We found that if there is not a clear deadline well before the end of SDBT, clients sometimes view not getting into DBT–ACES as a failure and need therapy time to pivot: to give themselves credit and relish in the success of finishing an incredibly demanding year of SDBT.

The DBT–ACES pre-treatment process gives clients an opportunity to apply their DBT skills as well as the problem-solving and behavioral assessment skills they learn in SDBT to their future choices. The goal is to highlight successes and problem behaviors the clients have overcome, plan for the future, and decide how the DBT–ACES program will help them achieve their goals.

Sometimes clients can become frustrated that the entire pre-treatment process

focuses on them as the problem, not on how the therapists have been difficult to work with or how life has made things hard for them. This viewpoint should be validated as absolutely correct. DBT–ACES pre-treatment is an evaluation of their capability to describe and consider their piece of the puzzle, and figure out how to overcome the limitations of others and the system. The rationale is that most job applications, school entry criteria, and the like, are also based solely on an applicant's capacity to do the work regardless of the workplace environment or challenges. In addition, being able to move forward in the face of what a client deems wrong or unfair is often what is called for in work and school settings. If the client needs the environment to be particularly hospitable to them to achieve success, they may spend an ineffective amount of effort trying to get powerful environments to change and will likely be blocked in their progress to return to work and exit social services.

As part of DBT–ACES pre-treatment, the client also needs to submit performance evaluation forms, completed by their individual therapist and a group leader, evaluating the client's performance in SDBT. To succeed in employment and in the DBT–ACES program, clients will need to be able to effectively manage their behavior and emotions in boring as well as challenging one-on-one and group situations. Our team has utilized a genuine employment evaluation adapted to individual therapy and skills group. This form evaluates them in 11 different categories (e.g., performance quality, reliability, verbal and written communication, problem identification, social integration) and has ratings that range from "outstanding" to "needs improvement/unsatisfactory." The purpose of the evaluation is for the group leader and therapist to provide feedback to the client highlighting their strengths as well as constructive feedback on areas for improvement. It reflects the approach that clients need to follow in DBT–ACES as they would on a job, in a college class, on a date, or with family during the holidays.

To provide maximal learning and minimal worry for the SDBT client, the DBT–ACES pre-treatment materials contain optional "interim performance evaluations" that are identical to the final performance evaluations but offer an additional opportunity for a progress report that the client can get from both the individual therapist and group leaders. Many clients like to give these forms out as soon as they start considering DBT–ACES to learn about and improve behavior that might show up as poor on their final evaluation.

Mastery of SDBT skills is evaluated by having the client complete and pass a written test. The questions on the test cover mindfulness (How do you know when you are being judgmental? What are the "WHAT" skills?); interpersonal effectiveness (Which skills should be used in an interpersonal scenario?); emotion regulation (What does PLEASE stand for? Match the emotion with its opposite action.); and distress-tolerance skills (How do you know if your distress-tolerance skills are working?). A score of 75% or above is considered a passing grade. Study materials as well as skills module quizzes to prepare for the exam are available to clients so they can prepare for the exam or practice to retake it. The exam can be retaken as many times as needed to pass.

Once the pre-treatment materials are completed and approved by the individual therapist, the client schedules a one-on-one meeting with the DBT team leader (or another DBT team member who is not their individual therapist and is preferably least known to the client) to present the materials and be interviewed about their readiness to begin DBT–ACES. This meeting functions as both exposure to a job/school type of interview as well as a commitment session designed to reinforce the

client's progress, orient to the ways in which DBT–ACES differs from SDBT, confirm the client is committed to DBT–ACES and strengthen that commitment, and troubleshoot potential problems.

If the client has participated in SDBT at another DBT program or some time beforehand, it is still recommended they complete as much of the application process as they can—the limiting factor usually being the performance evaluations from group and individual therapists. If it was an outside SDBT program, the key is to ensure that the SDBT therapist understands what is involved in DBT–ACES and the pre-treatment process, so they can support their client throughout.

### *Career Activities and Work as Therapy Contingencies*

DBT–ACES includes two series of graduated contingencies for normative and productive activity to facilitate living-wage employment: "Career Activities" and "Work as Therapy." The first, Career Activities, is tied directly to the client's personal living-wage career ambitions and reflects the most effective activities to achieve them. This can include paid employment and/or college, vocational training, internships, self-employment, and so on. For instance, a client who would like a career in nursing will need both education and related work experience—perhaps as a medical assistant or hospital volunteer. A client who wants to land a job in retail management, by contrast, likely needs to focus on finding employment in the desired retail sector and working their way up. Classes in management might be helpful, but overall, educational training is less important. A client who wants to be an artist or writer will likely need a living-wage job that pays the bills and health insurance, while leaving sufficient time during the week to paint or write as well as the time and skills to market their work.

Career Activities should be directly tied to the client's career ambitions. Specific activities are decided by a synthesis of the client and individual therapist's wise minds but ought to have a direct tie to the desired career (e.g., taking an interesting college class outside of their career area is not a Career Activity). The DBT–ACES team can assist in deciding what to include and exclude from Career Activities when the individual therapist–client dyad needs help. DBT–ACES clients are required to engage in Career Activities for 10 or more hours/week by 4 months into DBT–ACES and for 20 or more hours/week by 8 months into DBT–ACES. If this objective is not achieved, then therapy suspension takes place (see below).

One common pitfall of Career Activities is that at times clients identify time spent "researching" their career as hours toward the 10-hour requirement, rather than activities that directly require diving in and "doing." This "research" frequently ends up functioning as avoidance and does not ultimately help clients reach their DBT–ACES goals. While we understand that research is an important part of major life decisions, we have found that when we do not get commitment for a specific action plan immediately and set limits on the number of hours that research can count toward Career Activities, clients and individual therapists can easily become stuck and frustrated. In DBT–ACES, we want to block avoidance at all costs.

For example, one client wanted to start her own business as a life coach. However, she experienced fear and trepidation about diving in. Thus, she was spending most of her career hours researching how to start her own business and making flyers and other marketing elements for her business. It became clear after a period of time that she was spinning her wheels and increasing her anxiety. When the team and her

individual therapist communicated that it was time to transition into "doing," the client voiced fear and frustration, yet quickly found an office job in a space with other people doing similar work. This job allowed her to network and use office space for free to begin building her practice. Transitioning into doing led her to build mastery, feel increased confidence, and blocked avoidance. Had the team not made the contingency of "doing" clear, it likely would have taken this client significantly longer to reach her DBT–ACES goals.

The second DBT–ACES contingency, Work as Therapy, is based on the goal of the DBT–ACES program assisting clients to become financially independent of psychiatric disability, the social service system, and family or friends' financial support. For any DBT–ACES client, there will likely come a time when they lose a job, get laid off, move to a new city, or otherwise have to start over. When they have to do this without disability payments, it means quickly finding and maintaining employment—hopefully in their career area but not always. To ensure that DBT–ACES clients have the skills to (1) find a job quickly and (2) keep it until they find a better one, the Work as Therapy contingency requires finding a standard job[3] on the open market and working there for a minimum of 10 hours/week for at least 6 months. The client must begin their Work as Therapy job by Month 4 of DBT–ACES. Work as Therapy hours also count toward career activity hours so at Month 4, meeting Work as Therapy hours functions as meeting the Career Activities requirement. By Month 8, however, the Work as Therapy requirement of 10 hours is less than the Career Activities 20-hour requirement, so clients must focus on their career as well as their current job. (Of course, if their career is best served by the Work as Therapy job, they can do that for their full 20 Career Activities hours or more—such as someone who wants to work construction and finds a Work as Therapy job in construction.) Finally, Work as Therapy can be started during SDBT (i.e., without waiting until DBT–ACES has begun). This timeline takes some pressure off clients who would otherwise have to find work within 4 months, particularly in a down economy.

In the initial development of DBT–ACES, we gave our clients a choice: to return to work *or* school as a step toward employment. Clients overwhelmingly decided to return to school, and we soon realized that while they were stepping outside of their comfort zone by returning to school, it frequently functioned as avoidance of employment. Thus, we began requiring competitive employment, in a taxable job, as a requirement of the program. At the end of DBT–ACES, the goal is for the client to have developed the skills, capacity, and belief in their ability to work, which cannot be evaluated or developed without actually working.

Over the past decade of our DBT–ACES program, there have been a few exceptions to the Work as Therapy contingency when compelling evidence exists that the client has the skills needed to find and maintain a competitive job *and* the Work as Therapy contingency is interfering with key Career Activities the client wants to pursue. In such a case, the DBT–ACES team can be lobbied by the client for an exemption with a DEAR MAN letter that includes a letter of reference from a previous employer

[3]In the United States, we classify a standard job as a "W2" job, which refers to the Internal Revenue Service tax form number, W2, for a standard job where a boss is the employer (as opposed to the client being an independent contractor, self-employed individual, or an unpaid intern) and will report this employment to the government (as opposed to an "under the table" job). If conducting DBT–ACES outside of the United States, comparable principles apply.

or another demonstration that the required Work as Therapy skills exist and that the Work as Therapy contingency stands in direct conflict with Career Activities. One example was a client who had worked for a special education center in the past, but had left that job to create a special education private practice. During SDBT, she was finally obtaining private clients and did not want to disrupt the process to return to a job. She requested and received a letter of recommendation from her former employer indicating that they would gladly hire her back, and she petitioned the team to be excused from the Work as Therapy contingency as long as she maximized the Career Activities contingency. In another instance, a client had a history of successful teaching and received several teaching awards before depression triggered her decline into disability. She wanted to focus her Career Activities on a full-time teaching certificate in a graduate program that would not leave time for an outside job. This client had already completed 6 hours/week of Work as Therapy for 3 months. It was clear that she was able to function in a work setting. She successfully petitioned the DBT–ACES team to excuse the remainder of her Work as Therapy requirement. As can be seen in these cases, the criteria for an exception were (1) the skill already exists and (b) not completing Work as Therapy is primarily (if not solely) in the service of Career Activities to maximize sustainable living-wage employment. These exceptions are rare. In almost every case, a reason for Work as Therapy exists and it is worth doing.

If a DBT–ACES client does not meet a Career Activities or Work as Therapy requirement for 4 consecutive weeks, they are asked to leave treatment until they can achieve the contingency for 1 week and then immediately restart DBT–ACES. This is called a "therapy suspension"[4] and uses all the principles of a therapy vacation from SDBT. As with a therapy vacation, the goal is negative reinforcement: The withdrawal of treatment (hopefully an aversive contingency) ends as soon as the person completes 1 week of the contingencies (e.g., works 10 hours in a Work as Therapy job), with the goal of reinforcing adaptive behavior. During suspension, the individual therapist pines for the client's return, but does not provide therapy sessions and the client does not attend DBT–ACES skills training. Coaching is limited to clarifying how a client can meet the contingency and to cheerleading progress.

Several implications of these Career Activities and Work as Therapy contingencies are worth discussing. While most DBT–ACES clients end up working more than the 10-hour minimum for Work as Therapy and it is usually easier to find work for 20 or more hours than for only 10, DBT–ACES selects 10 hours as the minimum for Work as Therapy to leave time for nonwork Career Activities such as school or an unpaid internship. We have learned that 10 hours/week for 6 months is enough of a behavioral sample to assess and resolve problems with employment. Given that many DBT–ACES clients have physical limitations, other responsibilities such as children or elderly parents, or limited transportation, we try to keep our requirements to a maximum of 20 hours/week. This does not always work out in practice, but the goal is not to exhaust or overwhelm clients. It should be noted that unless a client works

[4]Therapy suspension can be indefinite but is ideally very brief. In our clinic, we are unable to keep clients who are not actively engaged in treatment on our caseloads; thus, when a client is on suspension, we will keep them on our caseloads for 4 weeks with the hope that they will return quickly. If they are unable to meet the contingency in that period of time, they are discharged from the clinic and asked to contact us when they have met the contingency. We do our best to get them back in as quickly as possible.

for pay at least 20 hours/week, the reduction in other supports (e.g., housing or food stipends) will likely squash incentives to work (see the "Overview: The Problem of Psychiatric Disability" section above).

Career Activities make inherent sense to DBT–ACES clients and are generally easy to define and pursue. Work as Therapy, on the other hand, requires substantial orientation and justification to clients as it is (1) less obviously beneficial, (2) less fun, (3) more frightening, and (4) the kind of activity at which they have previously failed and that led to disability in the first place. Importantly, Work as Therapy is not designed to be a stressful, minimum-wage, or otherwise negative job experience, which many SDBT clients think of when they first hear about the requirement. Occasionally, such jobs are the starting point, but generally clients can find work in an area of general if not specific career interest (e.g., working in a garden store if they want to be a landscape designer). In fact, it is generally easier to find and maintain employment in a higher-paying job in their area than in a job they would dislike. Clients are also encouraged to use the money earned at Work as Therapy to support their other Career Activities, such as buying a car or art supplies, or paying for classes. Jobs in the client's career area may not be easy to get after a long period of unemployment, but are more feasible after they develop an employment history and have a positive reference from another job. For example, one client who had training as a medical assistant could not get a medical assistant job. To meet the Work as Therapy deadline, she took a fast-food job while continuing to apply for medical assistant positions. Several months later, she secured employment as a medical assistant, which she attributed to not only having a job while applying for work but also the capacity to be on time, stick it out, and be flexible—all abilities that she gained by having the fast-food job.

We recommend that SDBT therapists begin orienting to these contingencies as early as 6 months or more before DBT–ACES starts, so clients have a chance to think about the implications and come to a wise mind decision. The pre-treatment process is an excellent way to facilitate a consideration of the issues. Ideally, SDBT therapists very much want their clients to attend DBT–ACES but do not *need* them to; thus, they can both help clients push forward, while allowing them to make what is quite a big wise mind choice about their future.

### *DBT–ACES Skills Curriculum*

The following modules form the DBT–ACES skills curriculum (Comtois, Carmel, & Linehan, 2020b): perfectionism versus reinforcement, establishing and reevaluating relationships, time management, managing emotions effectively, succeeding after DBT, and applications of mindfulness. Each module is 1 month long and thus the curriculum is completed in 6 months. Those completing DBT–ACES over the course of a year will repeat the curriculum twice.

When DBT–ACES began, the curriculum was largely variations on SDBT skills plus additional skills that were later added as part of the revised SDBT skills manual (e.g., Check the Facts, Problem Solving). Over time, other behavioral strategies and topics were added to address common struggles for DBT–ACES clients, such as poor management of time, perfectionism, inadvertent punishment of their own skillful behavior, and problems interacting effectively with non-DBT clinicians after graduation. Recently, the curriculum was boiled down to 6 months, removing skills taught

in SDBT with the revised skills manual, removing strategies better handled in individual therapy, keeping the most effective skills handouts, and so on, to the current 6-month curriculum (available at *www.dbtaces.com*).

As with SDBT, DBT–ACES therapists must themselves learn all the skills in the DBT–ACES curriculum. While no one is a master at all of these skills, DBT–ACES therapists (like all DBT therapists) strive to be coping models for clients—that is, models who have struggled with the skill and found a way to make it work. The process of learning each of the DBT–ACES skills also means the therapists have a real understanding of how the skills can go wrong and what is needed to overcome obstacles so they can incorporate this into initial teaching and review of practice assignments.

### *Case Study: Gina*

This case demonstrates the application of DBT–ACES in the treatment of a chronically suicidal individual receiving psychiatric disability who had stabilized while in SDBT, and who was motivated to enter DBT–ACES. The background of the case is presented, followed by a description of individual and group treatment, including how the DBT–ACES contingencies were used to promote self-sufficiency.

"Gina,"[5] a 30-year-old white, heterosexual female referred to us for the management of chronic SI and self-harm behavior, had been in and out of mental health treatment since she was 15. Despite years and years of mental health and substance abuse treatment, she continued to experience significant anxiety, depression, and PTSD. She had a history of significant substance abuse starting when she was 13, had been in residential treatment several times, and was referred to us from her outpatient substance abuse program to help her reduce cutting and suicidal behaviors. She had been hospitalized three times in the previous 2 years secondary to SI and self-harm, with one hospitalization following a suicide attempt. When she started SDBT, she was being supported by a cash allowance of around $330 per month from the state for psychiatric disability, on state insurance benefits, and living in low-income clean and sober housing.

Gina's SDBT year initially focused on closing the door to suicide, learning skills to regulate and manage emotions, and stopping self-harm. The client responded well to SDBT. She no longer thought about suicide and, although she would occasionally have urges to self-harm, she ceased self-harm behavior in her fifth month of SDBT.

Throughout her life, Gina had held several jobs; however, due to emotion dysregulation and skills deficits, the longest she had maintained a job was 1 year at a local coffee shop. She has lost jobs for various reasons, including getting fired for being intoxicated at work, getting so angry and frustrated with coworkers that she walked out, and debilitating depression that interfered with attendance. Gina's DBT–ACES ambition was to have a meaningful career, maintain sobriety, get off disability and be self-sufficient, and one day have a partner and a cat. However, she was not certain what she wanted to do as she had never seriously considered an inspiring career path. Five years prior to her participation in DBT–ACES, she had a short stint in college with limited success, but eventually became demoralized and dropped out when

[5]While this is a real case from our clinic, we have changed the details of our client's background and story for privacy reasons.

she failed a math class for the third time. When she began DBT–ACES, she had not worked in 4 years, and each time she considered returning to work, her anxiety level increased and her urges to use escalated, which resulted in her avoiding the situation and deciding to "wait to return to work when ready." This idea of waiting until she was ready was reinforced by much of her substance abuse community, family, and friends. Thus, fear and social contingencies were functioning to reinforce avoidance.

Six months into SDBT, Gina's therapist oriented her to DBT–ACES and discussed the possibility of continuing their work together in DBT–ACES after SDBT, with returning to work and finding a career path as their focus. Though the client was nervous, she knew in her wise mind that this was something she wanted and needed to do. As the SDBT year progressed, the therapist continued to work with the client to increase her participation in social activities and volunteering. The client began taking the lead and chairing AA and NA meetings, and assumed more responsibility at the clean and sober house where she lived. Though this increase in activity was a positive experience for her, the bulk of it was within a community where she felt "safe" and knew most of the other people.

From a behavioral shaping perspective, this was progress, though to work toward the life that she desired would require her stepping outside of her recovery community and interacting with people with whom she was not as familiar. Given her commitment to do DBT–ACES, she and her therapist began to create a résumé (getting assistance from others as needed), and eventually she applied for several jobs. The focus of SDBT at this time was largely on exposure. Thinking about work and casually looking for jobs online led to a spike in shame. When she experienced shame, her typical responses would be increased self-judgment, self-invalidation, hopeless thoughts, self-harm urges, and believing that she would never be able to work. She would then escape the situation and continue to avoid. She and her therapist worked together to gradually expose her to anxiety-provoking situations and interpersonal skills as interviews came and went.

Gina submitted her DBT–ACES application in her 10th month of SDBT and started DBT–ACES after graduating from SDBT. After a couple of months, she started a job in an ice cream shop. (As described above, this means she was meeting both her Work as Therapy and Career Activity requirement, 2 months ahead of the due date.) Soon she was given the responsibility of opening and closing the business; this provoked additional fear and anxiety for her as this was much more responsibility than she was accustomed to, and would grant her access to large amounts of cash, which, historically, would have been a risk factor for drug use. At this time, her therapist was made aware that the client had structured her life to have limited access to cash and had asked a friend from her sober community to manage her money. This led the client and therapist to focus some of their work together on issues around urge surfing, money management, and tackling debt.

Another target of individual therapy was applying skills to increase effectiveness at work and, dialectically, to search for a job that better fit her personality and values. Though the client was now employed, she really didn't like her job at all. She had significant judgments of the people who lived in that neighborhood and negative appraisals of her coworkers and customers, and she believed that she was being judged by everyone she interacted with at work. Individual sessions focused on cueing her to increase mindfulness, using opposite action, and how to tolerate misery until she was able to problem-solve and land a job that would be a better fit. A couple of months

later (i.e., 4 months into DBT–ACES), she was hired for a job that she enjoyed, that she cared about, and where she worked with other people whom she liked.

While she was meeting her Work as Therapy contingency, this was not the sort of work she wanted to continue as a career. Therefore, she needed to begin considering what to do for her Career Activities hours. (As described above, by Month 8, the 10 hours of Work as Therapy will be met by the job, but 10 more hours of Career Activities will be required, and the job would only count if it was the best next step for her career.) Gina's plan was to return to school at the community college and, to do that, she needed to repay her financial aid debt. The first months of her DBT–ACES group check-ins centered around the steps she needed to take to re-enroll in school and pay off her debt, with the DBT–ACES group therapists reinforcing all adaptive behavior and blocking avoidance, whereas her DBT–ACES individual session focused on shame, self-acceptance/compassion, engaging in an exposure therapy protocol for her fears of mathematics, and taking steps to form relationships in environments where she didn't identify as someone with a substance abuse or mental health issue. Her therapist worked with her to identify other people and events to engage with, on how to interact with people that shared values different than hers in such a way that she could continue to be friends with them if she chose, and not to do or say things that might erode how she felt about herself. The vast majority of out-of-session contact with Gina provided coaching to her for interpersonal situations where there was a conflict between her values and wanting the other person to like her. In addition to coaching around interpersonal skills, there was out-of-session contact to cue exposure strategies. As part of exposure protocol to anxiety and shame when she encountered cues related to doing math, her therapist would message her several math problems or equations that she would have to solve that day; Gina was then asked to take photos of her completed work and text them back to the therapist.

At the time of the client's DBT–ACES graduation, she was due to start school the following week, and despite a wise mind offer from her therapist to extend therapy for a month to assist with the transition to math class, she declined. Her own wise mind was insistent that she had the skills and wherewithal to do it on her own, using only her natural social supports, and the support of her sponsor and 12-step community. The client made a visit to the clinic several months later to attend the DBT–ACES graduation of a friend of hers. At that time, she reported that she had completed her math class with a high GPA, had been offered a promotion at work, and had moved out of her low-income clean and sober housing and into a place of her own.

The DBT–ACES Recovery Goals are broad and ambitious—even for those who don't struggle with emotional and mental health issues. Given the histories of SDBT and DBT–ACES clients, it is rare that goals and targets follow a clear, distinct path without barriers. As was illustrated with this client, on the surface, it might appear that progress was simply a matter of getting her employed to earn a paycheck and pay off debt to attend school. While there is some truth in that perception, there was a lot of emotional terrain that Gina had to navigate for her to be able and willing to accomplish those goals without engaging in crisis-generating behaviors or avoidance. These barriers included, among others, beliefs about herself and others, encountering numerous events and scenarios that previously would have prompted her to relapse, guilt about her past, shame about who she was, and the need to problem-solve debt to go to school and secure better housing. The goal of any DBT treatment is about developing a life worth living. DBT–ACES is a way to help stretch across the divide

for someone who successfully completes SDBT and hasn't quite developed their life-worth-living ambitions. Though not for everyone, it has been demonstrated to be a fast track to success. At its core, DBT–ACES is a year of willingness, a year of opposite to emotion action, and a year of throwing oneself in completely.

## Conclusions

DBT–ACES is clearly more than a graduate program for DBT. Similar to SDBT, DBT–ACES was developed over a decade of trial and error—adding new skills, adapting the group format, developing the Recovery Goals and work contingencies—for which we are very grateful to Marsha Linehan and our clients in helping us recognize, struggle with, and find syntheses to key dialectical tensions. We added expectations and requirements gradually over time and were reinforced by discovering the clients could meet and exceed them. The full DBT–ACES program that has resulted requires considerable time and commitment from both clients and the DBT team, but has achieved over 75% employment or school enrollment. In our original pre–post evaluation, clients in DBT–ACES were three times more likely to be working or in school and five times more likely to be working 20 hours a week or more in the year of DBT–ACES than their SDBT year (Comtois et al., 2010). Recent evaluations including the German and California programs have replicated and exceeded these pre–post results (Comtois et al., 2020).

Many DBT–ACES principles and strategies can be integrated into SDBT without conducting the whole program. Certainly, the Recovery Goals can be used to organize the quality-of-life interfering behaviors of many clients who want to become more self-sufficient or go to work or school. Setting contingencies for normative productivity and requiring that clients pursue scheduled activities outside the home can be a useful strategy to increase behavioral activation among SDBT clients. The check-in process is an excellent process for teaching clients to be their own therapist: how to set achievable action steps, block avoidance, and reinforce practice. Finally, the DBT–ACES skills modules can also be integrated into SDBT to target problem behaviors and address particular skills deficits, such as using material from the perfectionism versus reinforcement module to target perfectionism.

DBT–ACES has solved much of the heartbreak we experienced as a team when deeply entrenched and complex clients didn't achieve the lives they wanted after only a year of treatment. DBT–ACES created the structure and contingencies these clients needed to make significant progress and gain momentum toward their life-worth-living goals. On our consultation team, there was no more effective way to reduce burnout than hearing from our clients who have graduated from DBT–ACES years ago, telling us of their "normal" and above-average lives filled with careers they are excited about, friends, family, and love.

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CHAPTER 11

# DBT for Individuals with Borderline Personality Disorder and Substance Use Disorders

LINDA A. DIMEFF, SHELLEY McMAIN, JENNIFER H. R. SAYRS, CHELSEY R. WILKS, and MARSHA M. LINEHAN

## Overview of the Problem

Substance use disorders (SUDs) commonly co-occur with borderline personality disorder (BPD; Trull et al., 2018; Trull, Sher, Minks-Brown, Durbin, & Burr, 2000) and result in serious and complex behavioral problems. The co-occurrence of SUDs and BPD is second only to the co-occurrence of mood disorders and antisocial personality disorder in comorbidity prevalence (Trull & Widiger, 1991). In their extensive review of 70 studies published from 2000 to 2017, Trull and Widiger found that approximately half of those individuals with BPD had at least one concurrent SUD problem—most frequently, alcohol use disorder (AUD). Of individuals presenting with SUD, approximately 25% also met criteria for BPD. Those with current opioid, cocaine, and AUD were most likely to receive a BPD diagnosis. This overlap is not unexpected—after all, impulsiveness in areas that are potentially self-damaging (such as substance abuse) is one of the diagnostic criteria for BPD. Indeed, levels of impulsivity is higher among individuals with both disorders (Links, Heslegrave, Mitton, & Van Reekum, 1995; Tomko, Trull, Wood, & Sher, 2014; Trull et al., 2004). However, the high comorbidity between BPD and SUDs is not entirely explained by this overlap in criteria. For example, Dulit and colleagues (1990) found that 67% of current patients with BPD met criteria for SUDs. When substance abuse was not used as a criterion of BPD, the incidence dropped to 57%, which is still a very significant proportion of the population.

Individuals with BPD and SUDs are difficult patients to treat and have a wider range of problems compared to those with either SUDs or BPD alone (Links et al.,

1995). For example, rates of suicide and suicide attempts, already high among individuals with BPD (Frances, Fyer, & Clarkin, 1986; Stone, Hurt, & Stone, 1987) and substance abusers (Beautrais, Joyce, & Mulder, 1999; Links et al., 1995; Rossow & Lauritzen, 1999), are even higher for individuals with both disorders (Rossow & Lauritzen, 1999). Furthermore, substance abusers with BPD are uniformly more dysfunctional than substance abusers without a personality disorder. Studies comparing substance-abusing patients with and without personality disorders have reported that those with personality disorders have significantly more behavioral, legal, and medical problems, including alcoholism and depression, and are more extensively involved in substance abuse than patients without personality disorders (Cacciola, Alterman, Rutherford, & Snider, 1995; Cacciola, Alterman, McKay, & Rutherford, 2001; McKay, Alterman, Cacciola, Mulvaney, & O'Brien, 2000; Nace, Davis, & Gaspari, 1991; Rutherford, Cacciola, & Alterman, 1994). In one study, remission of BPD was found to be impeded by the presence of a SUD (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004; Zanarini, Frankenburg, Weingeroff, Reich, & Weiss, 2011). A few studies of substance abusers that have compared those with BPD to those with other personality disorders found that patients with BPD had more severe psychiatric problems than patients with other personality disorders (Kosten, Kosten, & Rounsaville, 1989; Skinstad & Swain, 2001).

How do we account for the high rates of overlap between SUDs and BPD? A multitude of interacting factors, including biological, psychological, and sociocultural components, contribute to the development and maintenance of substance abuse in conjunction with BPD. Evidence for a genetic predisposition to abuse psychoactive substances in individuals with BPD is suggested by the high rates of addiction problems in family studies of individuals with BPD (Anokhina, Veretinskaya, Vasil'eva, & Ovchinnikov, 2000). There is also evidence of a relationship between trait impulsivity and substance abuse (Levenson, Oyama, & Meek, 1987). Substance-abusing individuals with BPD have been shown to exhibit higher levels of impulsivity relative to their non-substance-abusing BPD counterparts (e.g., Kruedelbach, McCormick, Schulz, & Greuneich, 1993; Morgenstern, Langenbucher, Labouvie, & Miller, 1997), which may largely account for the high rates of concurrent SUDs (Trull et al., 2000). People with BPD are at an increased risk for addiction problems due to the pervasive emotion dysregulation that underlies their disorder (Linehan, 1993c; Marziali, Munroe-Blum, & McCleary, 1999). The reliance on psychoactive substances, like other problematic behaviors (e.g., cutting, hand banging, excessive spending, binge-eating), functions (albeit dysfunctionally) to regulate out-of-control negative emotions. Indeed, many people with BPD report that their use of drugs is an attempt to manage their overwhelming affective states, including sadness, shame, emptiness, boredom, rage, and emotional misery. At a biological level, the escape from negative emotions through the use of drugs is reinforced by a dopamine spike in an individual with otherwise low levels of dopamine in the mesolimbic area of the midbrain following extensive drug use over time (Leshner, 1997; Leshner & Koob, 1999). Whereas initial substance abuse produces pleasure because of increases in the dopamine system, prolonged use makes it harder to experience sensations of pleasure because the dopamine system is altered (Leshner & Koob, 1999), resulting in what Leshner and Koob (l999) refer to as a "changed brain." Finally, environmental factors also play an important role in the development and maintenance of addictive behaviors for individuals with BPD. Adverse family experiences such as poor

communication, conflict, and abuse are often observed to characterize the histories of individuals with BPD (Herman, Perry, & van der Kolk, 1989; Zanarini & Frankenburg, 1997). Effective treatment must attend to the multitude of factors that interact to maintain addictive behavior.

## Rationale for Applying Dialectical Behavior Therapy for Individuals with BPD and SUDs

The decision to use and evaluate dialectical behavior therapy (DBT) for individuals with BPD and SUDs was influenced by a number of developments. Within the broader mental health and addiction treatment systems, there has been a growing recognition over the past several decades of the limitations of traditional approaches in the treatment of people with concurrent disorders. Historically, many clinicians held that addiction problems must be overcome before mental health problems could be successfully treated. This perspective contributed to a long-standing differential approach to the treatment of people with concurrent mental health problems and SUDs compared to those with mental health problems without SUDs. Many individuals were barred from accessing specialized mental health services until their substance abuse problems were stabilized.

In recent years, a heightened awareness of the limitations of sequential approaches to treatment has promoted a growing movement toward the use of integrated approaches for concurrent disorders—that is, treatments in which both addiction problems and mental health problems are addressed by the same clinicians. To support the development of integrated treatment models, increased funding opportunities have been made available through major organizations, including the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The adaptation of DBT for substance-dependent individuals with BPD was developed in the context of a study funded by the NIDA to evaluate DBT for substance-dependent individuals with BPD (Linehan et al., 1999a; Linehan & Dimeff, 1997).

A number of other compelling reasons existed to justify the extension of DBT to the treatment of comorbid BPD and substance abuse. First, studies emerged that indicated DBT was effective in reducing the impulsive behaviors associated with BPD, most notably suicidal behaviors (Linehan, Armstrong, Suarez, Allman, & Heard, 1991; Koons et al., 2001). The finding that DBT could be successfully used to treat multidisordered individuals who did not respond well to standard treatment protocols raised hope that it could help to reduce other impulsive behaviors, such as substance abuse. Furthermore, the theoretical underpinnings and core treatment strategies of DBT shared many commonalities with prominent addiction treatments. According to one popular theory of addictive behavior, known as the "self-medication hypothesis," individuals use drugs and alcohol to modulate their emotional states (Khantzian & Schneider, 1986). This premise is consistent with DBT's biosocial theory, which maintains that emotion dysregulation is at the core of BPD-criterion behaviors (Crowell, Beauchaine, & Linehan, 2009). The view that substance abusers have difficulties regulating affect, and that negative emotional states precipitate substance use, is supported by a large body of empirical evidence (Kushner, Sher, & Beitman, 1990; Bradley, Gossop, Brewin, & Phillips, 1992; Cummings, Gordon, & Marlatt, 1980).

Moreover, risk for alcohol relapse was predicted by having high emotion dysregulation (Berking et al., 2011). Finally, at the level of clinical practice, the core strategies of DBT, which draw on cognitive-behavioral models and acceptance-based traditions, figure centrally in prominent addiction treatment models. Cognitive-behavioral strategies are the basis of relapse prevention, a widely established, effective treatment for addictive behavior. Core techniques in DBT, including cue exposure, skills training, and contingency management, are also the cornerstone of addiction treatment. The extensive use of validation in DBT is similar to Miller and Rollnick's (1991) motivational interviewing approach. The dialectical balance in DBT between problem solving and a fundamental acceptance of current reality, including things that may not be possible to change, has similarities to a core philosophy of 12-step approaches.

DBT is the first integrated treatment model developed for people with concurrent substance abuse and BPD. Since the development of the original treatment manual, DBT has evolved through research and clinical practice. To date, it has been implemented and evaluated by research groups in a number of countries, and with diverse groups of people with BPD and SUDs.

## Empirical Findings

A number of randomized controlled trials (RCT), uncontrolled and quasi-experimental studies have now been conducted to date supporting the efficacy of DBT and DBT-SUD for substance-dependent individuals, including those with BPD. In his detailed and comprehensive dive into the DBT-SUD literature, Salsman (2020) reviewed 8 RCTs, 12 uncontrolled and quasi-experimental trials, along with a handful of small *N* and case studies. Overall, DBT-SUD's efficacy was supported.

The seminal University of Washington (UW) DBT-SUD study (Linehan & Dimeff, 1997) sought to determine whether DBT-SUD was superior to community-based treatment-as-usual (TAU). Twenty-eight substance-dependent women with BPD were randomized to 1 year of DBT ($n$ = 12) or the TAU control group ($n$ = 16). The majority of participants (74%) were polysubstance users who met substance-dependence criteria for a range of psychoactive substances; the primary substances of choice were alcohol (52%) and cocaine (58%). DBT was superior to TAU in reducing drug abuse throughout the treatment year and at 16-month follow-up, and was more effective in retaining participants over the 1-year treatment period (64% vs. 27%). DBT participants also showed significantly greater social functioning and global adjustment at 16-month follow-up compared to TAU participants. Importantly, analysis of therapist adherence to DBT found that the patients of therapists whose sessions were consistently rated at adherence had significantly better outcomes on urinalyses than patients of therapists who were not consistently rated as adherent.

The second UW study (Linehan et al., 2002) used a more rigorous control condition to account for usual threats to internal validity (e.g., prestige of receiving treatment at the UW, application of standardized, manualized treatment, modes of treatment, and time engaged in treatment). Additionally, all participants ($N$ = 23) were required to have a primary SUD diagnosis of opioid dependence, in addition to BPD. Many participants also met criteria for dependence on cocaine (52%), sedatives (13%), cannabis (8.7%), and alcohol (26%). Subjects were randomly assigned to either 1 year of DBT or comprehensive validation therapy with 12-step intervention

(CVT + 12S). Developed by Linehan and her colleagues (Linehan, Tutek, Dimeff, & Koerner, 1999b), the CVT + 12S condition included individual therapy and encouragement to attend 12-step meetings. CVT + 12S treatment emphasized the application of DBT acceptance strategies within a disease model/12-step frame much like 12-step facilitation treatment used in Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity; Nowinski & Baker, 1992). Study results indicated that both treatments were significantly effective in reducing opiate use during the first 8 months of active treatment. However, there was a divergence between the groups by the 8-month assessment point. Between the 8-month point and the end of the 12-month active treatment, subjects receiving the CVT + 12S intervention significantly increased their opiate use compared to subjects in the DBT group, who maintained their reductions. There were significant differences between groups on treatment retention. All 12 subjects assigned to the CVT + 12S remained in treatment, whereas 4 out of 11 DBT subjects dropped out of treatment.

The first published independent replication study of DBT with drug-addicted individuals with BPD was conducted by researchers in the Netherlands. Verheul and colleagues (2003) conducted a randomized trial to evaluate the effectiveness of standard DBT versus TAU control. Participants consisted of 58 women diagnosed with BPD, including those with and without SUDs. Results showed that DBT was more effective than TAU in reducing treatment dropouts, frequency of self-mutilating behaviors, and self-damaging impulsive behaviors, including alcohol abuse. Interestingly, there were no differences between conditions on other drugs of abuse. In contrast to Linehan's research with substance-dependent individuals with BPD, this study did *not* make use of the modifications to DBT for substance-dependent individuals, but instead made use of standard DBT. Moreover, addiction problems were not targeted.

In another RCT of DBT-SUD (McMain et al., 2004), 27 women with concurrent SUDs and BPD were randomized to DBT or to a TAU control treatment that involved a nonmanualized treatment for patients with concurrent addiction and mental health problems. In terms of alcohol use outcomes, the results favored DBT: Use of alcohol did not change significantly among TAU subjects, while alcohol severity scores were substantially decreased in DBT subjects—roughly one-third lower than at pretreatment. Both groups showed improvements in drug use outcomes: DBT subjects had greater initial reductions in drug use, although by final outcome, TAU subjects revealed an overall greater improvement. The results of this study showed that DBT had the most impact on reducing self-damaging behaviors and alcohol use. Similar to the findings in the Verheul et al. (2003) study, DBT was not more beneficial than standard treatments for addiction problems in reducing drug use. Although more research is needed, these findings suggest that whereas DBT may be equivalent to standard treatments in reducing drug use, it may have an added advantage of improving other behavioral problems related to BPD, such as impulsivity and self-harm behavior.

Encouragingly, standard, non-SUD-focused DBT is effective at reducing SUD and AUD diagnostic status. In a secondary data analysis from an RCT on suicidal women with BPD (Linehan et al., 2006), Harned and colleagues (2008) found that 87.5% of individuals with an SUD fully remitted from their SUD diagnosis, and were greater than 2.5 times more likely to achieve full remission than individuals randomized to the "treatment by experts" group. Furthermore, remission rates for those

in DBT were comparable to egregious behavior protocols (EBPs) designed for SUD (Crits-Christoph et al., 1999).

Building off the previous studies, Linehan and colleagues (2009) conducted a multisite RCT comparing DBT to individual and group drug counseling (IGDC) among 125 men and women with BPD and co-occurring opiate dependence. Participants in both conditions received opiate replacement mediation (buprenorphrine–naloxone). Results from urinalysis (UA) indicated that patients in both groups had similar reductions in opiate and cocaine throughout the study and follow-up in person. Due to inconsistent results from interviews and missing UA results, DBT may have been superior in reducing the use of other drugs. DBT was significantly more effective at reducing depression and anxiety than IGDC. Findings from this study suggest that while DBT-SUD may be comparable to gold-standard multimodal substance abuse treatments, it is superior to simultaneously targeting mental health outcomes.

In an RCT comparing DBT to TAU, 25 women with co-occurring SUD and eating disorders (ED) were evaluated on disordered eating, substance use, and depression. Participants randomized to DBT evidenced superior retention rates and clinical outcomes. However, individuals randomized to TAU saw worsening ED and SUD symptoms, which resulted in the authors terminating recruitment early (Courbasson, Nishikawa, & Dixon, 2012).

In an open trial of DBT for SUD, Axelrod and colleagues (2011) sought to investigate whether improvements in emotion dysregulation accounted for improvements in substance use frequency among individuals receiving DBT. The authors found that emotion regulation accounted for improvements in the substance use, highlighting the role of improvements in emotion regulation as a mechanism of change for substance-using individuals.

### *Novel Applications of DBT to Target Addiction*

When key DBT skills were added to the Brief Alcohol Screening and Intervention for College Students (BASICS) for depressed and/or anxious and heavy drinking college students, the DBT-enhanced BASICS intervention outperformed the BASICS and a relaxation-controlled condition on alcohol-related problems at 3-month follow-up. DBT-enhanced BASICS outperformed the relaxation control on anxiety, depression, coping drinking, and emotion regulation at 1- and 3-month follow-ups (Whiteside, 2010).

Rizvi, Dimeff, and colleagues (2011) pilot-tested a mobile application of the DBT skill "opposite action" among 22 individuals with BPD-SUD in an effort to increase the generalizability of DBT skills. Participants in the study rated the app as highly useful and helpful. In addition, average ratings of urges to use substances decreased within each app usage.

To increase treatment access to individuals out of touch with evidence-based treatment, an Internet-delivered DBT skills-training intervention specifically designed for suicidal and heavy episodic drinkers was developed and preliminarily evaluated on 59 individuals. Individuals were randomized to receive access to the online skills-training intervention immediately or after an 8-week waiting list. The online intervention lasted 8 weeks and consisted of mindfulness, addiction, emotion-regulation, and distress-tolerance skills. Participants randomized to receive the treatment immediately

had significantly faster reductions in alcohol quantity as well as suicide ideation scores (Wilks, Lungu, Ang, Matsumaya, & Linehan, 2018).

## Whom Is DBT Designed to Treat?

DBT was originally developed for the treatment of chronically suicidal individuals with multiple and severe behavioral problems. The specific adaptation for substance dependence was designed and evaluated as a treatment for similarly severe substance-dependent individuals with BPD. The population of individuals with BPD and SUDs for whom this adaptation was based is largely heterogeneous in terms of drugs of abuse and demographic variables (e.g., race/ethnicity, gender, education, marital status). The majority of individuals who participated in the above-noted RCTs on which the adaptations are based were polysubstance-dependent with extensive histories of substance abuse and multiple unsuccessful attempts at getting off drugs prior to beginning DBT.

Might DBT be useful for other substance-dependent individuals without BPD? No studies have been conducted to date evaluating DBT's efficacy for substance-dependent individuals without a concurrent diagnosis of BPD. As clinical decisions are often required before findings are available from controlled clinical trials, a few principles may assist in determining whether DBT may be an appropriate intervention. First, clinical decisions and treatment planning should be guided by what is known from the empirical literature. Is there an already proven treatment for the particular problem(s) your patient has? Second, be parsimonious. All things being equal, consider beginning with a more simple and efficient treatment than one as complex and comprehensive as DBT. While DBT no doubt contains elements that will be therapeutic for most patients, it is also likely that it is considerably more extensive than most patients with SUDs require. Third, consider the extent to which emotion dysregulation plays a role in the individual's continued use of drugs. Because DBT was developed specifically for individuals with pervasive emotion dysregulation, it may be a good fit for people whose use of drugs is associated with affective dyscontrol. But DBT may be ineffective for individuals whose emotions contribute little, if any, to the sustained use of drugs. Finally, given that it was developed for a population of usually difficult-to-treat patients with multiple Axis I and Axis II problems, DBT may be well suited to address the problems of the patient who though non-BPD is a multi-diagnostic SUD patient who has failed on multiple occasions in other evidence-based SUD therapies.

## What Is DBT for Concurrent SUDs and BPD?

The standard DBT protocol was developed by Linehan (l993a, 1993b, 2015a, 2015b) for the treatment of BPD. In DBT for the treatment of BPD and SUDs, an integrative approach to treatment is adopted to concurrently address addiction problems and other behavioral problems that are unique to individuals with BPD. DBT for concurrent BPD and SUDs differs from standard DBT in only one respect: It provides more focus on addictive behaviors and associated problems. Otherwise, the treatments are identical. It is designed for the treatment of multidisordered individuals with

concurrent BPD and substance abuse problems. Consistent with the standard DBT treatment, the overarching goals of treatment are (1) to reduce serious behavioral dyscontrol (e.g., substance abuse, suicidal behavior, nonsuicidal self-injurious behaviors, excessive and extreme behaviors that interfere with therapy, and other behaviors that significantly interfere with the patients' quality of life) and (2) to promote more adaptive, skillful behaviors for functioning in life. As with other impulsive behaviors associated with BPD, addictive behaviors are conceptualized as learned behaviors that function as a means to regulate emotions and that may occur in the midst of the chaos of dysregulation. All modes of the treatment protocol (i.e., individual therapy, skills group, telephone coaching, therapist consultation team) are delivered just as they are in standard DBT.

Several additional features were incorporated into DBT for patients with both BPD and SUDs to facilitate the treatment of substance abuse. The treatment modifications are drawn from interventions discussed in the substance abuse treatment literature, as well as from clinical experience gained from applying DBT to substance-using individuals with BPD in a number of settings. DBT for patients with BPD and SUDs is distinguished from standard DBT only by the addition of (1) a conceptual framework for understanding the overlap between BPD and substance abuse, (2) a dialectical philosophy to define treatment goals related to addictive behaviors and to address relapse, and (3) a modified treatment target hierarchy that includes a focus on substance abuse. In addition, a number of special treatment strategies were added to address the unique needs of patients with concurrent BPD and SUDs, including a set of attachment strategies developed to enhance treatment engagement and retention in this notoriously difficult-to-engage population and specific examples of the DBT skills tailored to the SUDs population.

## Dialectical Abstinence

DBT stresses the message that to get the most satisfaction in life, abstinence from drug use is the most appropriate ultimate goal in a Stage 1 treatment. Why? Because drug use significantly interferes with building a life worth living in severely disordered individuals, including those with BPD and SUDs. However, focusing solely on abstinence often leaves a real gap when patients fall short—a phenomenon described initially by Marlatt and Gordon (1985) as the "abstinence violation effect" (AVE). The intense negative emotions that patients typically feel in response to a slip or relapse can themselves create the very conditions for continued drug use. Particularly among severely disordered individuals with problems of pervasive emotion dysregulation, addressing the AVE often requires support and coaching from the therapist to help them safely return to abstinence. A dialectical stance on drug use was developed in recognition of the findings that, on the one hand, cognitive-behavioral relapse prevention (RP) approaches based largely on harm-reduction principles (Marlatt & Donovan, 2005) are effective in reducing the frequency and intensity of drug use following a period of abstinence from drug use, and that, on the other hand, "absolute abstinence" approaches are effective in lengthening the interval between periods of use (Hall, Havassy, & Wasserman, 1990; Supnick & Colletti, 1984). "Dialectical abstinence," which seeks to balance these positions, is a synthesis of unrelenting insistence on total abstinence before any illicit drug

abuse and radical acceptance, nonjudgmental problem solving, and effective relapse prevention after any drug use.

While the ultimate goal in DBT is to get and keep patients completely free of their problem drugs of abuse, for many individuals the goal of abstinence seems out of reach. The essence of the absolute abstinence end of the dialectic involves teaching clients specific cognitive self-control strategies that allow them to turn their minds fully and completely to abstinence. Specifically, patients are taught how to anticipate and treat willfulness, hopelessness, and the waffling on one's commitment to get off drugs that commonly arises and complicates treatment once an individual makes a commitment to give up a dysfunctional habit. Patients learn that the key to absolute abstinence lies in making a strong commitment to rule out drug use entirely. This can be best accomplished by making a commitment to stay abstinent for a specified period that is no longer than they can commit to with 100% certainty that abstinence will be maintained. Like the popular 12-step slogan "Just for Today," the commitment to 100% abstinence may be for only 1 day, or for a whole month, or just for 5 minutes, depending on what the individual can commit to with 100% certainty of success. The commitment, then, is an act of mental "slamming the door shut" for that specified period of time. Upon expiration of the original commitment period, the individual recommits again to abstinence. In this sense, absolute abstinence is achieved by a series of recommitted "slamming the door shut." Hence, abstinence is sought only in the moment and only for a given set of moments. Like pearls that comprise a pearl necklace, a lifetime of abstinence is achieved a moment or a day at a time—just this one moment, then the next, and so on. The ultimate goal of this strategy is to block the ability to make half-hearted commitments (or to deny the reality that one has been made), while simultaneously limiting the commitment duration to a period that is perceived by the person's brain, so to speak, as achievable.

Other absolute abstinence cognitive self-control strategies used to trick the individual's brain during this phase include immediate "adaptive" denial of desires and options to use during the specified period of commitment, practicing radical acceptance of the absence of drug use and the difficulties involved, making an inner deal with oneself that the option to use drugs is left open for the future, as well as the promise to oneself of using drugs when close to death or upon learning of a terminal illness. Individuals with SUDs are also taught how to look ahead, plan for danger, and be proactive in order not to use again. For example, they are coached to "burn bridges" so they no longer have access to drugs; they learn what cues are dangerous for them and how to avoid those cues; and they learn skills for tolerating urges and cravings, as well as skills for changing their social environment to be more conducive to staying drug-free. Determining which strategy to utilize depends on which is most effective in promoting abstinence and the willingness to maintain it.

While remaining fully committed to abstinence, DBT, like RP, recognizes that all new behaviors, including those associated with abstinence, take time and practice to solidify, and that as a consequence of this reality, slips are likely to occur along the way. While maintaining that a commitment to abstinence is essential, the therapist simultaneously prepares the patient for doing the least amount of damage if and when a slip does happen and provides assistance for returning to abstinence as quickly as possible. As in RP, a lapse is viewed as a problem to solve, not as a treatment failure. Instead, the emphasis is on acquiring and strengthening the skill of "failing well," which involves admitting that drug use has occurred and learning from one's

mistakes by conducting a thorough chain analysis and identifying solutions for future use should the event that prompted use of drugs occur again. In teaching how to fail well, emphasis is placed on "what if" and "just in case" skills should a crisis occur. Consistent with RP (Marlatt & Donovan, 2005), the therapist and the patient discuss realistic skills and game plans the client can use should they face with a similar situation in the future. Rather than be caught off guard by an inevitable high-risk situation that could threaten an individual's hard-earned abstinence, DBT, like RP, focuses on precaution, planning, and preparedness as means of enhancing the individual's behavioral control, resulting ultimately in better treatment outcomes. Much like how a flight crew prepares their passengers for *the unlikely event of* a loss of cabin pressure or a water landing, DBT and RP prepare people to effectively manage the inevitable high-risk situation, including a potential slip, so that the response is swift and effective (e.g., a slip is indeed only a slip and does not progress to a full-blown relapse). Such "drop and roll" emergency strategies include calling the DBT therapist, having reminders about why they want to get clean, and getting rid of drugs so they cannot use them again. Failing well includes analysis of and reparation for the harm done from using drugs. The emphasis on correcting the harm caused to others and to oneself is similar to making amends in 12-step programs.

Other harm-reduction strategies (Marlatt, 1998) incorporated into DBT include educating patients about HIV/AIDS and hepatitis C transmission, infections related to IV drug use, and other ways to minimize harm should they use drugs. In this respect, DBT helps patients to use drugs more safely when they do use, but this approach is taken only on an as-needed basis, always working toward returning to abstinence.

The concept of dialectical abstinence is similar to the actions of a running back in football. In each play, the running back is never fully content to obtain a few extra yards for a first down: He is always striving to score a touchdown. Once the play is initiated, all his efforts are oriented toward moving the ball the full distance to the goal (abstinence) unless he is tackled. The DBT therapist adopts a similar approach, "running" with the patient like mad in the direction of abstinence, stopping only if the patient falls and even then only long enough to get the patient back on their feet, and then running again with the full intent to score a touchdown on the next play.

## Hierarchy of Targets in the Treatment of Concurrent BPD and SUDs

The hierarchy for DBT with patients with SUDs remains the same as in traditional DBT. While there are special considerations to be made regarding prioritizing substance use and related behaviors, the hierarchy remains a guide to treating patients with multiple, high-risk, difficult behaviors.

### *Pretreatment*

In DBT, the therapist communicates the expectation of abstinence by asking the patient to commit to stop using in the very first session. This commitment is strengthened via the DBT commitment strategies and discussed frequently during treatment. Obtaining initial commitment in the first few sessions can be accomplished with the standard DBT commitment strategies. In brief, the patient and the therapist explore the patient's goals and values, and the therapist points out that the patient cannot

accomplish those goals or live within those values while the patient is abusing substances. At this point, the therapist asks for a commitment to complete abstinence. Using the "door in the face" (asking for a very large commitment, such as "Do you agree never to use again?," which can increase the likelihood of agreement to smaller goals) and "foot in the door" (obtaining a relatively small agreement, which then opens the door for the therapist to ask for more) techniques strategically, the therapist can eventually elicit the longest period to which the patient will commit to abstinence. This initial commitment may be for the course of treatment (a year) or just for 24 hours. What is important is that a commitment to abstinence—the goal of Stage 1 DBT—is made, and that the therapist conveys the message that this commitment will be taken very seriously.

In the initial commitment to treatment, the therapist seeks a commitment to abstinence: Is the patient willing to get off drugs, is abstinence the goal of DBT? Or, is the client expecting and preferring a pure harm-reduction approach, where the goal is *not* necessarily to get off drugs but to experience fewer negative consequences while using drugs? As with trip planning, you want to be sure you know your destination before you purchase your airplane tickets. Better that you and your patient are clear what DBT will and won't offer than discover a fundamental difference in preferred approach during the midst of treatment. Only after a patient has committed to abstinence would the therapist make use of the "absolute abstinence" commitment strategy (e.g., committing to a period of abstinence that the person knows they can achieve with absolute certainty). This specific strategy is designed to help the individual achieve their goal of abstinence by breaking down the task into smaller and more manageable steps.

In DBT, a patient remains in pretreatment until they make a commitment to work on eliminating all life-threatening behaviors and to engage in treatment. The same expectation is true in DBT with patients with SUDs. But should a patient be expected to make a commitment to abstain from all illicit problematic substances prior to starting DBT? With patients with BPD, abstinence is the most appropriate choice of goals since teaching controlled use is not likely to lead to positive results. However, the problem with requiring abstinence before treatment begins is that some people will initially refuse such a goal. For example, a patient beginning DBT for opiate dependence may be unwilling to stop using marijuana, though eager to begin treatment for opiates. In such situations, requiring abstinence from all substances is not necessarily effective. Instead, the therapist may focus on obtaining a commitment to abstain from the substance that presents the greatest threat to the patient's quality of life (and any others that the patient can be convinced to give up), while obtaining an agreement that other, lower-priority substances will be negotiated later in therapy. It is often the case that once patients have had success with one problematic substance, they become much more engaged in addressing another. Because the others are lower on the treatment hierarchy, they can be focused on at a later point. In other cases, complete abstinence may not be essential. For example, individuals who do not meet the criteria for alcohol dependence but express concern over their drinking may be able to learn to control their use of alcohol. Similarly, individuals maintained on methadone may not seek abstinence from methadone but may be able to dramatically improve their quality of life.

Upon obtaining a commitment from a patient to abstain, the therapist then moves to the role of devil's advocate. The therapist points out all of the reasons why

one might want to stay on drugs, and asks, "Why on earth would you want to make this commitment?" This helps the patient pinpoint reasons why they use, and generate reasons why it would be worthwhile to give up those "benefits" (e.g., short-term emotion regulation). Getting the patient to generate these arguments is important so they can re-create these reasons when alone and faced with temptation. More on commitment strategies can be found in Linehan (1993a).

In the first several sessions, the therapist and the patient may return to this discussion many times. Until the patient actually stops drug use for any length of time, the patient is considered to be in the "pretreatment commitment" phase and the commitment strategies are the main focus of the sessions. During this period, the therapist focuses heavily on the patient's values and priorities—their "wise mind" reasons to get off drugs. Many times, these patients have never looked toward the future or considered what their values are. But with sufficient discussion, patients generally can determine at least some of their own values. The consistent message from the therapist is that a person cannot live in line with their values, or meet their life goals, while they are living the life of someone who is addicted to substances. This lays the groundwork for increasing investment in abstinence when the patient may falter later in treatment as well. Linehan (2015a, 2015b) has developed a series of skills handouts and homework sheets aimed at elucidating patients' values and helping them determine priorities to work toward those values, which are used in the initial phases and throughout treatment.

For example, one adolescent patient had not been drug-free for any period of time in his late childhood or adolescent years. He had never given any thought to what he valued or what he wished to work toward. With coaching from his therapist, he realized that he strongly valued his family relationships (which he had neglected for several years). He became very motivated to become drug-free to nurture these ties. This discussion strengthened his investment in the treatment and changed his focus from drugs to his family. After this discussion, the therapist reminded him of his values and related goals when he was not in wise mind, which helped him return to effective behaviors in many cases.

As soon as the patient has stopped drug use (even if only for a very brief period of time, such as a week), the therapist then switches strategies from commitment to problem solving following a lapse. Should a slip occur, chain analysis and solution analysis are the primary tools. In the spirit of failing well, an effort is made to determine the factors that led to the slip as a means of generating alternative, effective solutions to avert another slip. A common treatment error in DBT and other substance abuse treatments is to use maintenance strategies (i.e., chain analysis) *before* cessation of the behavior has occurred. We have found that moving to chain analysis prematurely, before a commitment has been secured, is much less effective because the patient is less likely to implement the solution. Given this reality, it is only *after* patients are abstinent and "throwing themselves into treatment" that therapists move to problem-solving, change-focused strategies. This is not to say that the therapist does not analyze patterns and assess the functions of the behaviors in the commitment phase, but the therapist does so in the service of helping the patient see the pros and cons of using drugs, as well as the consequences of doing so. Only once the patient and the therapist are functioning as a team in the service of the same goals, as evidenced by commitment and at least a brief cessation of drug use, does the dyad move into traditional DBT treatment strategies.

### Stage 1

Treating a Stage 1 patient with concurrent BPD and SUDs typically involves targeting multiple, extreme problems. This can overwhelm the therapist and contribute to an unfocused treatment in which the emphasis is on the "crisis of the week," with little progress on any goals. To address this problem, DBT follows the target hierarchy delineated in the standard protocol (refer to Linehan, 1993a, for a more detailed description). The therapist is not expected to focus on only one behavioral target in each session; rather, the hierarchy is used to set session agendas and prioritize behavioral foci. This targeting system allows the therapist to attend to the problems that are of utmost importance without getting drawn off track by the unremitting crises that arise between sessions.

In DBT, substance abuse is considered a quality-of-life behavior and therefore ranked below life-threatening and therapy-interfering behaviors. This means that in a given therapy session, a patient's substance abuse behavior may not be the top priority. For example, if a methamphetamine user becomes suicidal, the therapist may choose to target the drug use only briefly, or even to postpone discussion of it, to assess and minimize the risk of suicide. As long as the patient is refraining from engaging in life-threatening and therapy-interfering behaviors, the substance abuse behavior can take top priority. If there is a concern that the patient may not survive until the next session, or is behaving in a manner inconsistent with the progress of treatment, substance abuse must take a back seat to these other targets. This does not mean the therapist should ignore substance use in any session with higher-order targets. Rather, the DBT therapist needs to stay mindful of keeping the patient alive and participating in treatment rather than placing the main focus of the session on substances. While this may be an implicit rule of thumb in most other evidence-based therapies for addictive behaviors, it is made explicit in DBT because of the severity of patients treated in DBT.

If careful analysis reveals that lower-order targets are closely related to higher-order primary behavioral targets, the lower-order targets may take on more importance early in treatment as well. For example, a therapist may discover that drinking is a precipitant to suicide attempts. In this case, alcohol intake would be targeted immediately in an attempt to change the chain of events toward suicide. Similarly, cigarette smoking would generally be placed lower on the treatment hierarchy; however, if it were closely linked to illicit substance abuse, it would take higher priority. One of us (L.D.) had a heroin-dependent patient who often arrived late (more than 1 hour late in most cases) to nearly all his sessions. Targeting the tardiness by conducting chain analyses and problem solving was not yielding any changes. The consultation team discussed the problem and decided that because the patient's heroin use was nearly always related to his tardiness, the heroin use needed to be considered as therapy-interfering behavior. Targeting heroin use instead of one outcome of heroin use (tardiness) was more effective in this case.

In another case, one of us (S.M.) had a patient who drank one or two beers a day, a problem behavior that in ordinary circumstances might be very low on the treatment hierarchy. However, this patient had pancreatitis and had been informed by her doctor that a single beer could actually kill her. In this case, we chose to move the "drinking beer" target up to "life-threatening behavior" (any time a dangerous behavior becomes *imminently* life-threatening, it moves up the hierarchy; for this

particular patient, the behavior was also intentional self-harm in that the pain from drinking functioned to regulate her emotions), meaning that it took precedence over all else except her other self-harm behaviors. By using the data we had regarding pancreatitis and alcohol intake as our guides, we could tailor the hierarchy to her needs much more successfully.

Prioritizing various substances of abuse can be a challenge as well. Decisions regarding which problem substances are higher priority and which are lower priority should be made on a case-by-case basis. A focus on effectiveness and on the treatment hierarchy helps the therapist and the patient make decisions regarding priorities. Illicit substances are targeted first in most cases because they present a more significant threat to an individual's quality of life (not only the sequelae of the abuse specifically, but also the threat of legal problems). Replacement medications, particularly for opiates, are recommended if the severity of the drug use warrants their use. Although they may compromise quality of life somewhat, treatment outcome studies suggest that this is less of a risk than having no replacement (Dole, 1988). Decisions on how to prioritize substance targets with polysubstance users are made based on a patient's individual situation, taking into account the severity of abuse and the extent to which the substance increases the chances of a compromised quality of life (with substance abuse and in other areas of the patient's life as well).

### *The Path to Clear Mind*

Using drugs is but one behavior targeted under the general category of decreasing substance abuse; other behaviors related to substance abuse must be prioritized as well. Within the behavioral target of substance abuse, DBT has additional targets specifically aimed at behaviors needed for getting off drugs. These targets related to decreasing substance use are collectively known as the *DBT path to clear mind*. The path begins with the overarching substance abuse target of decreasing substance abuse, then places equal focus on other important steps necessary in becoming and staying clean. In contrast to the standard DBT hierarchy, the targets that form the path to clear mind are *not* hierarchically arranged with the exception of the first, logical target: to decrease substance abuse. The path to clear mind targets include:

- *Decrease substance abuse*. This is the first step in the path to clear mind. This target includes stopping all use of illegal drugs and all abuse of prescribed drugs.

- *Decrease physical discomfort*. This target is particularly focused on decreasing discomfort due to withdrawal symptoms, but also includes other causes of physical discomfort. Because most people are not fully aware of the physical and psychological withdrawal symptoms that correspond to their specific drugs of abuse, it is critical to educate them about the effects of each substance used. For example, one woman who was dependent on crack believed that her use was under control because she managed to abstain for 3 days between each period of use. She didn't realize that her crack use corresponded to intense feelings of withdrawal, including insomnia, irritability, and emptiness. Despite being committed to the goal of abstinence, whenever she experienced the first hint of withdrawal, she would run out to use crack to alleviate her discomfort. DBT readily incorporates replacement medications such as methadone, buprenorphine, or ativan when appropriate, in an effort to reduce the

physical discomfort due to withdrawal while maximizing the chances of abstinence. Non-opiate forms of pain management may be effective as well.

- *Decrease urges, cravings, and temptations to use drugs.* Research has demonstrated that urges—in particular, urge intensity from the previous day, duration of urge, and urge intensity upon awakening—are predictive of lapse (Shiffman, Engberg, Paty, & Perz, 1997). Patients are taught a variety of skills (Linehan, 2015a, 2015b) to help them tolerate urges, cravings, and temptations and to be more proactive in preventing lapses. Strategies include observing and labeling an urge as "only an urge," reviewing the long-term pros and cons of using, and using distress-tolerance skills. Examples of distress-tolerance skills for SUDs include imagining oneself being effective and not using; distracting oneself from urges and cravings; soothing oneself; focusing on one moment at a time; immersing one's face in ice water to elicit the "dive response" (Hiebert & Burch, 2003), which may help to regulate emotion (Porges, Doussard-Roosevelt, & Maita, 1994); and reminding oneself that urges and cravings are temporary and do not need to result in action (Porges et al., 1994).

- *Decrease the option to use drugs.* This target involves decreasing the likelihood that the patient will be able to turn to psychoactive substances even when the temptation is great. To achieve this, the patient is coached to systematically eliminate opportunities to use drugs—to "burn (their) bridges" to their previous life of using drugs. Actions taken may include moving away from dealers, destroying phone numbers for drug contacts, changing one's phone number to prevent those people from making contact, stopping all lying and stealing, making public commitments to be clean, telling others (particularly one's therapist) how to detect signs of use, and identifying oneself as someone who has quit using. Coaching patients in how to assert themselves effectively by using interpersonal effectiveness skills is important at this stage. Coaching distress-tolerance skills, too, is important to help patients purposefully end destructive, drug-focused relationships. For example, one patient purposefully angered a former boyfriend so that he would stop dropping by unannounced with free drugs. Breaking completely with this former boyfriend was extremely difficult but necessary for her to obtain abstinence. This approach can help patients prevent drug use even when they temporarily lose their commitment and decide to use again. It is similar to removing lethal means for suicidal patients. The objective is to help prevent the individual from acting when in a state of "emotion mind." This is a state during which the patient's thoughts, desires, and behaviors are ruled only by emotion (Linehan, 1993a), and they are less inclined to follow through with commitments. Cutting off options forces the patient to find other ways to tolerate urges and distress, rather than falling off the wagon.

- *Decrease contact with cues for drug use.* These cues serve to remind the patient of previous drug use (often out of the individual's awareness). Additionally, drug use cues may actually elicit withdrawal symptoms, in turn increasing the likelihood of relapse (Siegel & Ramos, 2002). Cues that have been paired repeatedly with drug use can actually operate to make the individual "expect" the drug. The brain then reacts as if the drug has been administered and counteracts the drug's effects to maintain homeostasis. When such counteraction occurs in the absence of the drug, withdrawal sensations are experienced, increasing the likelihood of use to alleviate physical discomfort (Siegel & Ramos, 2002). It is important to carefully assess what the patient's

cues for drug use are, as they vary according to each person's drug use pattern. Examples for such cues may include particular individuals, locations, thoughts, music, or even sitting in the back row of a Narcotics Anonymous meeting. By helping patients avoid contact with cues for drug use, their urges, cravings, and actual use can be reduced. Patients are coached to get rid of drug paraphernalia and other reminders of drug use, not to enter situations related to previous use, and to avoid individuals who may be associated with drugs. For example, one patient realized that she had an overwhelming urge to use cocaine whenever she was in her bathroom. It was important to help her understand that her bathroom was a cue because it was the place she escaped to for privacy to use crack. Changing the cues in the bathroom by painting the room another shade, placing soaps with a new fragrance, and hanging different-colored towels was instrumental in decreasing her urges to use.

- *Increase reinforcement of "clear mind" behaviors.* Patients who succeed in getting clean will not stay clean if their new, skillful behaviors are not reinforced. It is important for them to arrange their environments such that they receive reinforcement, not punishment, for engaging in these changes. A patient who manages to get clean, but still spends time with friends who use, will likely experience punishers (such as "I can't believe you're seeing a therapist" or "This won't last") that can threaten treatment success. This target focuses on helping the patient find new friends, social activities, vocational settings, and other environments that will provide support for clean behaviors, and withdraw support or even punish behaviors related to drug use. The interpersonal effectiveness skills (Linehan, 1993a, 2015a, 2015b) are particularly important to help in building these new relationships.

- *Clear mind.* "Clear mind" is the ultimate goal of the substance abuse targets in DBT. It is a prerequisite to getting into "wise mind" (Linehan, 1993a, 1993b), in which the patient can synthesize the poles of "reasonable mind" (where one is influenced only by logic without the benefit of emotion) and "emotion mind" (where one is influenced only by emotions without the benefit of logic) to incorporate all ways of knowing. Wise mind is by definition a state where one is able to make the wisest decisions possible, knowing just what is needed in any given moment. Clear mind is itself a dialectic: It is the synthesis of "addict mind" and "clean mind." Substance-abusing patients start treatment in addict mind, in which their thoughts, beliefs, actions, and emotions are controlled by craving drugs, finding drugs, and using drugs. This is the state where one is "chasing the bag," impulsive, and willing to sacrifice what is important just to obtain and use the desired substance. After some clean time, patients often move to clean mind. In clean mind, the patient is not using, but forgets that they may be in danger of using again. This state can be thought of as being "blinded by the light," or having one's judgment clouded by the fact that one has finally managed to get off drugs. Patients in this state may become reckless, thinking they are immune from future problems because they have succeeded in getting clean. As a result, they may fail to manage pain appropriately, ignore temptations or cues that increase vulnerability to use, and keep options open to use drugs.

In clear mind, the patient has achieved a state of clean mind *and* remains very aware that addict mind could return at any time. Cues may still lead to intense cravings and, without intervention, to actual drug use. The patient not only stops to enjoy success, but also prepares for future problems and has plans for what to do if staying

clean becomes difficult. A metaphor that may help patients understand this point is as follows: Being in clear mind is like going for a hike up a mountain. As you near the peak, you may get excited and feel the hard work is done. When you get to the top, you stop working, rest, and enjoy the view. Without taking away from the thrill and relief of reaching the top, to be effective, you need to remember that a return trip lies ahead: You will need to leave the peak while there is still enough daylight to get back to the car; you will need to make sure you have enough food and water for the return trip; and you will need to be sure you have enough energy to get back. The point is, while you are enjoying your success, you must remember and prepare for the remaining challenges of hiking down the mountain. Thus, in clear mind, you work hard at *getting clean* and really appreciate the success of *being clean,* but you do not forget that getting clean isn't the end point. There is still a journey after getting clean that involves *staying* clean. Additionally, the planning for the return trip can't be put off until you reach the top of the mountain. If you make it to the peak and *then* realize you don't have enough food for the return trip, you will be in trouble. Planning for *staying* clean needs to begin *now,* just as planning for the entire hike begins before you leave home.

Balancing the many targets on the path to clear mind can be challenging. Therapists may find many of the targets in this hierarchy are intertwined. As with the standard DBT treatment hierarchy, the path to clear mind, coupled with detailed assessment, can provide much-needed structure. For example, one patient had committed to stop using, and in fact had successfully switched from heroin to suboxone and maintained several weeks of clean urine samples (i.e., she had successfully decreased her use and her physical discomfort associated with withdrawal). However, she was in a very tumultuous relationship and was raising two small children with very little money. She continued to have strong urges that were most commonly associated with strong emotions related to her boyfriend and the stresses of parenting and poverty. Even when she was experiencing no urges, she had friends who would "check in" on her, and often bring her free heroin and cocaine. To the therapist, this was an overwhelming set of problems to tackle (i.e., strong urges related to her conflict with her boyfriend, poverty, stress of parenting, visits by drug-using friends). Using the path to clear mind lent some order to their sessions, as they would choose one or two targets to focus on at any given time. At times, their assessment would lead them to put high priority on items lower in importance—for example, they discovered that her strongest urges arose whenever she was presented with the cue of her boyfriend's crack pipe. As there was a relatively simple solution to the problem (having him hide his pipe elsewhere), this target was given precedence over others. The path to clear mind is meant to provide structure, not to add to the confusion of complex problems or create unnecessary rigidity.

## Special Treatment Strategies

The specific intervention strategies that were added to DBT for concurrent BPD and SUDs can be grouped into three main categories: (1) a set of attachment strategies designed to address the increased difficulties with becoming attached to treatment (the "butterfly" problem); (2) specific examples for the DBT skills for dealing with urges, cravings with attendant slips, or relapses (the "addiction" problem); and (3)

self-management strategies to deal with the consequences of having a lifestyle built on a foundation of substance abuse (the "getting a normal life" problem).

### *Attachment Strategies*

Engaging patients in the treatment process is vital to successful therapy. While the retention of any patients with BPD in treatment is notoriously difficult (Linehan, 1993a), it is even more difficult with those who have concurrent substance abuse problems. Though some patients will attach to treatment readily, Linehan et al. (1993a) characterize others as "butterflies" who attend sessions intermittently, fail to return phone calls, and "flit" in and out of treatment unexpectedly. A number of factors can contribute to problems with treatment engagement. Many substance-abusing individuals with BPD lead chaotic lifestyles as a consequence of their pervasive drug use: They may be unemployed, unable to support themselves financially, and have resorted to criminal activities. Some individuals lack adequate housing and may live on the street or in crack houses. Some may stay in dysfunctional and even abusive relationships because they lack the financial means to move to a new environment. Drug abuse can interrupt the organization of routines in day-to-day living, making it difficult to attend scheduled appointments. Further, it usually involves denial and lying about one's behavior. Patients often minimize their problems and are reluctant to acknowledge problematic behaviors to themselves or others because of their ambivalence about change. For example, one woman, only after being treated for months, revealed that she was working as a prostitute. A general reluctance to discuss problematic behaviors can stem from fear about disclosing illegal activities or shame about drug use.

Anecdotally, many DBT therapists who begin treating substance abusers have found this to be a difficult adjustment. Therapists often comment that they feel they have much less leverage with their patients with SUDs. Whereas in standard DBT, they are often the sole source of reinforcement for their patients, including warmth, encouragement, praise, and validation, with patients with SUDs they feel as if they need to "compete" with the drugs. Traditional DBT patients often become very attached to the therapeutic relationship, but patients with SUDs may not, at least at the start of treatment. Drugs simply offer more powerful, immediate changes in emotion than the therapist can. Attachment strategies can counteract this problem when applied diligently, early in treatment.

A primary treatment task in DBT is to enhance the patient's motivation and engagement in treatment. Lack of motivation or disengagement is viewed as a problem to be solved, rather than as an obstacle that needs to be resolved before treatment can be initiated. The therapist is challenged to engage the patient and must be prepared to assume an active role in doing so. Similar to a skilled fisherman, who must use different bait, rods, and lines, and eventually may need to grab a net to reel in the catch, the therapist must be steadfast and patient in these efforts. Ideally, the process of catching the fish will be as gratifying as the victory of the catch. However, if it is a long wait without a catch, the process may be experienced as arduous and frustrating. Like the fisherman, the DBT therapist may require support from others to continue the pursuit.

DBT incorporates a number of specific attachment strategies (see Table 11.1) to facilitate treatment engagement with substance-abusing patients with BPD, in order

to influence the probability of their entering, engaging in, and successfully completing treatment. The therapist must begin by orienting the patient to the problem. During this orientation phase, it is crucial to openly discuss potential barriers to treatment engagement, including anticipating the obstacles right away, discussing the early warning signals, and developing a plan for handling these when they arise. Meeting jointly with other treatment providers (e.g., a pharmacotherapist) should occur during the orientation phase, to ensure that everyone is working together to support the patient. Supportive family or friends should also be engaged early into treatment to ensure that they are reinforcing effective behaviors. For example, one of our patients was under strong pressure from her father to enter a 60-day residential substance abuse facility, which would have meant that she would miss 4 consecutive sessions of DBT and therefore would have been dropped from the program. It was important to have a joint family meeting to discuss the rationale for her remaining in an outpatient DBT program. It is also necessary during the orientation phase to develop a crisis plan with the patient, including details of where the patient may go if they "get lost" (are in danger of missing 4 consecutive sessions), and who may be called on to pull the patient back into treatment. In the first few sessions, the therapist can find out where the patient typically goes when they are using; where they will sleep, eat, take showers, and the like; and who will know how to find them. The therapist can also get written permission to talk to key people in the patient's life, in the event the patient stops attending sessions.

In the first several months of therapy, it is helpful to have as frequent contact with the patient as possible, to increase the patient's positive feelings about therapy and the therapeutic relationship. Furthermore, early on in treatment, extra contact can help patients reduce the chaos in their lives more quickly. Increasing contact by scheduling extra sessions, lengthening sessions, or adding phone and/or text messages can help patients manage multiple crises when they may not be able to wait a week for help, and can help them feel that there is a supportive community available to help. Some patients may benefit from shorter, more frequent sessions.

If the patient "gets lost," the primary therapist and the team must actively work to reengage them. This may involve pursuing the patient by sending cards or a token gift (e.g., a packet of forget-me-not seeds), or even searching for the patient in their own environment such as a neighborhood or a favorite coffee shop. For example, with one patient who failed to show up at sessions, the therapist took some glue to the patient's workplace, a strip club, and attached a note saying, "Stick with us." It is critical to try and prevent deleterious consequences from building while the patient

**TABLE 11.1. Strategies to Enhance Attachment to Treatment**

- Orient the patient to the problem.
- Increase contact.
- Provide therapy *in vivo*.
- Build connections to the social network.
- Provide shorter or longer sessions as necessary.
- Actively pursue patients when they get lost.
- Mobilize the team when the therapist gets demoralized.
- Build the patient's connection to the treatment network.

remains out of contact. For example, one patient, who missed 3 weeks of sessions because he went on a crack binge, ended up in a physical altercation with police that led to eviction from his apartment, criminal charges, and jail time. In our experience, actively pursuing patients in their own environment if they become lost often has a powerful impact, with patients typically surprised that anyone cares enough to pursue them.

With patients who are difficult to engage, it is not uncommon for therapists to feel burned out and to lack the energy to actively find the patient. The treatment team needs to remain alert to the fact that hard-to-engage patients are likely to demoralize even the most skilled therapist, and to work actively to support the therapist. The entire team goes into alert and mobilizes when a patient misses 3 consecutive sessions. For example, when we were about to lose a patient due to the 4 missed sessions rule, many members of the team tried to visit the patient at home and bring her a dose of suboxone so she would not use again. The therapist coordinated the effort, but several team members attempted to make contact with the patient, which energized the therapist and strengthened team relationships.

### *Using Skills to Cope with Urges and Cravings and to Reduce Risk of Relapse*

The standard DBT treatment protocol for BPD includes four core skills modules (Linehan, 1993b, 2015a), which are as relevant to the treatment of addictive problems as they are for other problems associated with BPD. A full description of the DBT-SUD skills is available in Linehan's *DBT Skills Training Manual* (2015a).

#### *Clean Mind*

The concept of clear mind was described above, in "The Path to Clear Mind" section. Essentially, the therapeutic task is to help the patient facilitate the synthesis of two poles: (1) being clean (clean mind) and (2) staying wary of the dangers of addictive thoughts, emotions, and behaviors (addict mind). To do so, the skills trainers and individual therapist highlight moments when the patient may be in "addict mind," when they are seeking drugs and not working toward abstinence, or in "clean mind," when they are clean and believe the struggle is over. Our patients helped to generate examples of these poles. Examples of addict mind behavior included any behavior that involved looking for, buying, or otherwise seeking drugs; lying; stealing; not making eye contact; "acting like a corpse"; "not having any life in my eyes"; avoiding doctors; glamorizing drugs; and thinking, "I don't have a drug problem." Examples of clean mind behaviors included thinking it is not dangerous to dress like a drug addict; returning to drug environments and relationships; believing one can handle the problem alone; stopping medication; believing, "I can use just a little"; carrying around extra cash; and thinking, "I can't stand this." Individual therapists and skills leaders who are vigilant to these signals can help move the patient back into clear mind, where the patient is abstinent and acutely aware that without skills and vigilance, temptation and intense urges can return at any moment.

#### *Mindfulness Skills*

Mindfulness skills are essential for treating addiction. An example of tailoring mindfulness skills is the use of the observe and describe skills to help patients acknowledge

and deal with their cravings and urges to use substances. Urges and cravings to use substances are among the primary precipitants to substance use. Not uncommonly, there is tremendous anxiety associated with urges and cravings because they are perceived as a sign of failure or an indication of inevitable relapse. In an effort to cope with overwhelming anxiety and discomfort, and to reduce the risk of relapse, the addicted individual may try to ignore or avoid thoughts and feelings related to substance use. Unfortunately, although this strategy can reduce anxiety in the short term, it generally intensifies urges to use and increases the risk of relapse in the long run.

Patients are taught that urges are natural occurrences of chronic substance abuse that typically last no longer than an hour and diminish in intensity over time if they are simply noticed, and not resolved via substance use. "Urge surfing," a technique described by Marlatt (1985), is a metaphor for the observe and describe skills used to reduce the anxiety associated with urges and thereby decrease vulnerability to relapse. The skill involves helping patients detach from their urges by using observe and describe skills in a nonjudgmental, effective way, which makes the urges more tolerable and reminds the patient that the urge will simply pass with time. The surfing metaphor captures the strategies necessary to successfully cope with urges. Surfing requires keen alertness to every feature of the constantly changing wave. The surfer must make constant subtle adjustments to stay on the crest of the wave without being "wiped out" by it. If one can stay on top of the wave, the wave will eventually die out as it nears the shore. Denial is the opposite of mindfulness, and is analogous to surfing with one's eyes and ears closed while ignoring physical, emotional, and cognitive changes. Ignoring the waves will not make them go away. By accepting the inevitability of urges and cravings, the patient can develop a capacity to observe urges in a detached manner and can learn to wait for the wave to crest and pass.

Alternate rebellion, an effectiveness skill, involves helping patients to effectively satisfy their urge to rebel without "cutting off one's nose to spite one's face." Alternate rebellion involves remaining focused on doing what works and staying focused on long-term goals while satisfying the wish to rebel. Patients are instructed that rebellion against conventionality is not inherently bad, and that one can indeed rebel in a way that does not destroy one's ability to achieve a life worth living. "Rebelling well" (effectively) might take the form of changing one's style of clothing, getting a tattoo or body piercing, dyeing one's hair blue, or finding new "hip" (and safe) places to hang out. Alternative ways of expressing rebellion can be effective particularly if they are secret. For example, a young woman who went to Disney World with her friends was refused admission for wearing a Mickey-the-Rat T-shirt. She returned to the car and put a blouse over her T-shirt so that she could still feel that she was expressing contemptuous rebellion but was now able to enjoy the day with her friends.

### *Distress-Tolerance Skills*

Distress-tolerance skills are key early on in treatment to help manage intense extreme physical and emotional pain as a person begins to abstain. The DBT-SUD skill of "burning bridges" involves teaching patients to cut off all options to use drugs as the patient moves from clean mind to clear mind. This involves, of course, *assessing* all the many ways drugs remain accessible to the patient, including their secret stash of "just in case" drugs (should they change their mind and decide to resume use). Other examples of bridges requiring burning include selling drugs, working or living with others who use them, selling "artesian" drug paraphernalia at community craft

shows. DBT therapists directly inquire about what bridges need to be burned, knowing that most patients are reluctant to volunteer this information.

"Adaptive denial" is an example of "pushing away" that turns the hallmark weakness of substance use—self-deception, or the ability to fool oneself—into an asset. One of the biggest challenges faced by substance abusers is that they are being asked to refrain from something they intensely desire. Abstaining requires the patient to replace maladaptive behaviors with behaviors that are less immediately rewarding. Adaptive denial involves blocking out or pushing away potentially accurate but distressing information through self-deception. One patient who loved the act of preparing to smoke a joint and missed both the *process* of rolling her joint as well as the "high" became a fan of selecting and preparing tea. When urges would hit, with a steel trap mind, she would act as if the urge was for tea, not pot, and would proceed to elaborately prepare a cup of tea.

Reviewing wise mind "pros and cons" is another skill that can help patients manage intense cravings. When overcome by powerful urges, substance abusers typically have difficulty recalling the negative consequences of their drug use and tend to experience strong euphoria associated with the physiological and psychological aspects of addiction. Patients are encouraged to make a written list of the negative consequences of substance abuse and the positive consequences of abstinence. This list can be a useful concrete reminder not to act on the urge.

### *Emotion-Regulation Skills*

Just as in standard DBT, where many target behaviors function to regulate emotions, substance abuse behaviors with patients with BPD can be quite similar. As a result, emotion-regulation skills remain central to DBT treatment with substance-abusing patients. Many of our patients use drugs at the first sign of difficult emotions, so a strong focus on mindfulness to current emotions is essential. "Opposite action" to emotion is also helpful to keep individuals from "falling into the abyss" when they begin experiencing these difficult emotions. And the PLEASE skills are important to address problems with physical pain, malnutrition, sleep, and the many other vulnerabilities these patients often acquire.

For example, one patient had such strong tooth pain, she used opiates (heroin as well as pain medication) to tolerate it. Focusing on PLEASE skills became a high priority because the pain was consistently a cue for using. Getting her to visit a dentist, regularly attend to dental care and nutrition alleviated her pain, which in turn reduced her drug use.

## *Interpersonal Effectiveness Skills*

With patients with SUDs, the main focus of interpersonal skills tends to be altering one's environment so effective changes are supported. A great deal of time is spent role-playing how to say "no" to drugs in a variety of situations, from strangers on the street, known dealers, significant others, and any other source of substances one may find. Helping patients burn bridges, as mentioned above, is also beneficial, ensuring that they do not lose their self-respect in the process.

Interpersonal effectiveness skills also help one to create opportunities and increase the frequency of reinforcement for effective behavior. Rehearsing how to build new

drug-free relationships and how to impress interviewers when applying for a new job are excellent examples of how these skills can help move a patient toward abstinence. DEAR MAN can also help one to "train up" loved ones to reinforce effective behavior. Environmental support for substance-free behaviors is an extremely powerful intervention in and of itself (e.g., Myers & Smith, 1995), and interpersonal effectiveness skills are essential to making the environment more conducive to clean behavior.

For example, the patient mentioned above with consistent, intense tooth pain also spent a great deal of time practicing DEAR MAN, so she could tell her dentist she did not want opioid pain relievers. She and the individual therapist rehearsed how to tell the dentist without providing too much information and while keeping the dentist invested in treating her. She also practiced telling her heroin dealer "no" at various levels of intensity. The therapist provided guidelines for knowing how intense to be in the face of different responses.

### *Self-Management Strategies*

Too often, substance abuse leads to an array of problems that impact all aspects of a person's life, including a lack of W-2/1099 earnings statements (vs. drug dealing), interpersonal relationships, time management, leisure activities, health, finances, and family. In our experience, individuals vary dramatically in the extent to which their lifestyle is dominated by substance use problems: Some lead chaotic lifestyles (e.g., selling drugs and sex on street corners), whereas others function well in stable jobs while actively pursuing their drug habit privately. Most substance abuse treatments recognize that the recovery of addicted individuals goes beyond helping them simply abstain; it is often essential to help them actively build a healthy lifestyle—one step at a time. This necessitates assessing the extent to which an individual's current lifestyle supports or impedes the recovery process. Helping a patient get a "normal" life often requires providing them with assistance in reentering the job market (e.g., helping them anticipate challenging questions they may get during the interview process about their lack of recent employment), safely leaving a problematic, violent relationship, and/or seeking financial counseling.

Increasing self-management includes teaching the patient how to apply the principles of behavior change to oneself, as is essential in standard DBT. DBT patients are essentially taught to be their own behavior therapists, implementing change strategies out of session just as their DBT therapist does in session. For this reason, DBT patients are encouraged to record each time they reinforce their own effective behavior, in an effort to strengthen that behavior. For example, one patient would place a large check mark on her diary card (a reinforcer itself) and allow herself time to read a novel (a luxury she had rarely indulged in prior to this intervention) every time she used a skill in response to an urge.

Consequences are not the only area of intervention when implementing change principles; managing the antecedents/cues to urges and cravings to use drugs is also an important self-management strategy on the path toward building a drug-free lifestyle. For example, one woman had cravings to smoke marijuana every evening. Over the past several years, she had smoked pot every day after returning home from work. Although she removed the drugs and drug paraphernalia from her apartment, she continued to experience strong urges to use every day after work. It was important to help her schedule activities every evening as a way of distracting herself from her

urges. She signed up for kick-boxing classes and started going to the gym after work. As long as her cravings were not followed by substance use, the association between the cues and substances would diminish over time. In this regard, it was important for the therapist to discuss the concept of extinction. These strategies are all methods of helping the patient understand ways of applying self-management tools.

Lifestyle interventions may also consist of helping patients build structure, as in securing a safe place to live, developing healthy relationships, gaining education/employment, and attending to physical health issues. It may not be possible for the primary therapist to assist with all patient problems. The patient may be best served by enlisting the help of an ancillary case manager who is a resource to the therapist or who consults directly to the patient. For example, one opiate-addicted individual who was employed as a health-care aide had resorted to stealing pain medications from her patients. She was advised to leave her job and pursue work in a less risky setting. Unable to think of alternative career choices, she was referred to an employment counselor who assisted her in identifying a more appropriate job. In DBT, the primary goal is to coach the patient on handling crises and accessing essential supports. Developing self-management skills and structuring the environment are inextricably related since they involve being mindful of and reducing the factors that lead to substance use.

## Comparing DBT to Other Standard Addiction Treatments

DBT shares much in common with therapeutic approaches that have stood the test of time and rigorous scientific scrutiny, including three prominent approaches to treating drug dependence: cognitive-behavioral relapse prevention (Marlatt & Gordon, 1985), motivational interviewing (Miller & Rollnick, 1991), and the 12-step-based approaches (Alcoholics Anonymous, 1981). The key similarities and differences between DBT and these three approaches are highlighted in Table 11.2.

With its strong basis in cognitive-behavioral and problem-solving principles, DBT shares much in common with Marlatt's *RP approach* (Marlatt & Gordon, 1985) and, more recently, *mindfulness-based* RP (MBRP; Bowen, Chawla, & Marlatt, 2011). Both are principle-driven approaches that focus on targeting and treating the controlling variables, including the proximal (i.e., immediate high-risk) and distal vulnerability factors that prompt and maintain alcohol and/or drug use problems. In both models, addiction is viewed as a complex process involving multiple interacting determinants (e.g., genetic, biological, learning history, sociocultural norms) that vary in their influence over time. Both models view behavioral change as a continuous process. There is an emphasis on developing new behavioral skills to replace maladaptive behaviors, while also attending to other important variables, such as cognitive expectancies and environmental factors that may trigger substance use. Treatment is focused on identifying the problematic links in the chain that led to substance abuse or other problematic behaviors. Treatment strategies include the teaching and modeling of coping skills, development of self-monitoring, behavioral assessment, didactics, cognitive restructuring, relapse rehearsal, the identification of early warning signals for relapse risk, and the development of prevention plans. Like DBT, MBRP incorporates mindfulness practice into treatment, with the goal that cravings and urges can be observed and tolerated rather than helplessly acted on.

**TABLE 11.2. DBT Contrasted with Major Addiction Treatment Models**

| Model | Similarities with DBT | Differences from DBT |
|---|---|---|
| Relapse prevention | • Development and maintenance of drug dependence is based on biopsychosocial model.<br>• Based on cognitive-behavioral, problem-solving approach.<br>• Idiographic, principle-driven treatment that arises out of thorough behavioral (functional) analyses of problem behaviors.<br>• Attends to proximal factors (attending to "high-risk situations" is similar to use of chain analysis following drug use or other problem behavior in DBT); proximal factors (global lifestyle imbalance in RP is like vulnerability factors in DBT). | • RP was developed initially as an "aftercare" maintenance treatment for substance abusers who had achieved abstinence; DBT is a comprehensive, integrated psychosocial treatment for cessation of maladaptive behaviors and maintenance of those behaviors.<br>• RP principles can be applied to both the goal of abstinence and the goal of harm reduction (e.g., moderation); DBT emphasizes abstinence for Stage 1 multidisordered patients. |
| Motivational interviewing | • In MI, treatment focuses on enhancing motivation to change; in DBT, attention to patient motivation and the factors inhibiting motivation permeate treatment. Both treatments include similar strategies for managing ambivalence or reluctance to make behavioral changes. For example, "psychological judo" in MI is similar to extending in DBT; use of self-motivational statements in MI is similar to use of "devil's advocate" in DBT; both treatments use evaluation of pros and cons.<br>• MI is rooted in Rogerian, patient-centered therapy; DBT's validation strategies similarly involve adherence to Rogers's core concepts of empathy and acceptance of the individual. | • MI was developed as a brief intervention for unidisordered substance-using patients; DBT was developed for multidisordered people with BPD.<br>• MI is typically conducted within a few sessions; standard DBT lasts a minimum of 1 year.<br>• In MI, motivation is understood as an internal state; in DBT, motivation refers to the constellation of variables controlling whether behavior is emitted in a particular context.<br>• MI offers a nonconfrontational approach and is opposed to confrontation; DBT is a synthesis in which the therapist is benevolently confrontational. |
| 12-step approach | • Both treatments emphasize abstinence as the goal of treatment.<br>• In both treatments, there is a focus on enlisting the support of the therapeutic community to facilitate the recovery process.<br>• Both approaches draw from spiritual traditions, with AA being an outgrowth of the Christian Oxford Group movement, and DBT emphasizing aspects of Zen Buddhism. The spiritual dimensions of 12-step programs that emphasize "change what you can and accept the rest" intersect with the Eastern philosophical influence in DBT and the concept of radical acceptance when a "person, place, thing, or situation" cannot be changed.<br>• Both models include an emphasis on initial behavior change, development of activities incompatible with drinking and drug use, and identification and change of dysfunctional behaviors and cognitions (McCrady, 1994). Both make use of contingency management and operant learning strategies, including the use of reinforcers to increase abstinence (e.g., keychains to recognize different lengths of sobriety). | • In DBT, substance abuse is a learned behavior that is precipitated by multiple and sometimes unrelated factors; 12-step approaches conceptualize substance abuse as a disease characterized by denial and loss of control.<br>• In contrast to 12-step approaches, DBT does not require that patients contract to stop all drug use as a condition of starting treatment, nor are patients required to label themselves as an addict or an alcoholic.<br>• Twelve-step approaches strongly advocate abstinence as the only reasonable treatment goal, since any return to use will result in relapse because it triggers the latent disease; DBT is not opposed to harm reduction approaches, including moderation. DBT emphasizes the dichotomy of abstinence versus harm reduction.<br>• Twelve-step approaches focus on removing patients from the environment associated with drug use to a residential treatment facility to get clean; DBT favors eliciting change in the natural environment.<br>• In 12-step approaches, the fellowship is considered an important, if not the primary, agent of change; in DBT, the individual is considered the agent of change. |

Specific coping strategies include helping patients make changes in their lifestyle to support their recovery, such as balanced daily living, replacing unhealthy habits with healthy ones (e.g., jogging, playing piano, meditation), developing a social network that supports recovery, substituting "adaptive wants" (e.g., recreational activities) for dysfunctional indulgences, labeling apparently irrelevant decisions as warning signals, and using avoidance strategies (Dimeff & Marlatt, 1995). In both models, difficult situations such as slips or relapses are reframed as opportunities for learning from one's mistakes. A main distinction between the models is that RP, which was developed as an aftercare program to promote maintenance of abstinence from addictive behaviors, does not include a specific program for the initiation of abstinence. In contrast, DBT was developed as a comprehensive treatment and incorporates a range of interventions to treat individuals with multiple problematic behaviors.

Similar to *motivational interviewing* (MI; Miller & Rollnick, 1991), DBT has always addressed patients' motivation to make changes. The fundamental difference between MI and DBT concerns the definition of "motivation." In MI, motivation is conceptualized as an internal state, whereas in DBT it is defined behaviorally as the constellation of variables controlling an individual's behavioral repertoire in a particular context that relate to the probability of a behavior. Despite these conceptual differences, attention to motivational factors permeates the delivery of treatment in both models. Both treatments offer creative strategies for effectively managing a patient's ambivalence or reluctance to make behavioral changes. In DBT, the clinician focuses on getting a commitment from the patient to participate in treatment and abstain from problematic substance use. Both incorporate similar strategies, including evaluating pros and cons and using devil's advocate to strengthen the client's own reasons for change. Both approaches have deep roots in Rogers's client-centered approach (Rogers & Wood, 1974), which forms the bedrock of MI and of validation strategies in DBT. Unconditional positive regard (e.g., radical acceptance of the patient in DBT), genuineness, and accurate empathic understanding are necessary and essential aspects of both treatments. How these treatment strategies are applied, however, varies considerably. A significant difference is that MI involves a non-confrontational approach with the patient in which the therapist decidedly avoids confrontation, whereas in contrast, a DBT opts for a synthesis: The DBT therapist communicates warmth to and acceptance of the individual but is simultaneously benevolently confrontational, often "going belly to belly" with the patient to elicit a commitment to stop using drugs and to participate in treatment.

*Twelve-step approaches* include the program initially developed by Alcoholics Anonymous (1981) and later adapted by fellowships such as Narcotics Anonymous, Cocaine Anonymous, Gamblers Anonymous, and many others. Also included here are 12-step facilitation therapy and 12-step counseling. Similar to these programs, DBT emphasizes abstinence from problematic substance use. The basic premise of 12-step approaches is that addiction is a chronic and progressive disease, and denial and loss of control over the use of drugs are the hallmarks of the disease process. In contrast, DBT, like RP, holds that the initiation and maintenance of the problem are caused by many complex and transacting factors, with biology being simply one of many factors. Where 12-step approaches often assume that a person is always "recovering," DBT assumes full recovery from addictive behaviors is possible.

Many 12-step-based treatment approaches recommend the removal of the patient from the environment associated with substances, and a retreat to a residential environment in order to "get clean." In contrast, DBT generally favors helping patients

make changes within the context of their natural environment. This approach is based on considerable data indicating that drug-dependent individuals often quickly resume drug use once they return to their own environments (Marlatt & Gordon, 1985), as well as on the knowledge that the most powerful method of learning occurs when individuals develop new behaviors in the context in which they are expected to apply those behaviors.

Similar to 12-step approaches, DBT is an abstinence-based treatment. DBT adherents recognize the value of harm-reduction approaches, including moderation, but are aware of strong empirical evidence suggesting that the people most likely to fail at moderation efforts are those with the vulnerabilities typical of BPD (i.e., a high degree of psychopathology and high impulsivity; Klein, Orleans, & Soule, 1991). While DBT discourages substance use, DBT practitioners also carefully examine instances of use to discover the relevant contextual factors that are involved in maintaining drug use behaviors. Because behaviors learned in a particular state are recalled and used with greater success in similar states, DBT encourages patients to practice behavioral skills even during states of intoxication. Thus, the patient who arrives at a skills group under the influence of drugs is encouraged to remain in the group and to use skills to stay alert and engaged throughout the session. In DBT, patients are not required to contract to stop all drug use as a condition of starting treatment, nor are they expected to label themselves as addicts or alcoholics, as is the practice in 12-step approaches. The DBT therapist works on gaining a verbal commitment to total abstinence during the first session. However, like other commitments obtained in DBT, this commitment is viewed as a public act that increases the probability of the behavior in the future, not as a contract that if violated threatens the continuation of treatment.

Both approaches draw from spiritual traditions. Alcoholics Anonymous is an outgrowth of the Christian Oxford Group movement, while DBT emphasizes aspects of Eastern and Western contemplative practices. Similarities include a common philosophical base that emphasizes radical acceptance when a "person, place, thing, or situation" cannot, in fact, be changed, and a perception that the current moment is indeed the perfect moment (Alcoholics Anonymous, 1976). Here, the spiritual dimensions of 12-step programs intersect with the Eastern philosophical influence in DBT. The Serenity Prayer, with its change what you can and accept the rest premise, speaks to this common basis.

Another area of overlap between the two models is that both emphasize the importance of the therapeutic community (for therapists and patients alike) to derive support from others in the recovery process. Additionally, in both approaches, there is an emphasis on initial behavior change, development of activities incompatible with drinking and drug use, and identification and change of dysfunctional behaviors and cognitions (McCrady, 1994). Both make use of contingency management and operant learning strategies, including the use of reinforcers to increase abstinence (e.g., chips and medallions to recognize periods of sobriety of different lengths).

## Summary

In recent years, an effort was made to modify DBT to address the unique needs and capacities of substance-using individuals with BPD. DBT for individuals with BPD and SUDs incorporates the essential elements of the standard DBT protocol in

addition to specific techniques designed to address problems associated with problematic substance use. DBT for substance abusers assumes that, similar to other dysfunctional behaviors associated with BPD, an individual's substance use functions as a means to regulate negative mood states. Consequently, the focus of treatment is to help the individual eliminate problematic substance use through the development of more effective strategies to regulate their emotions. The goals of DBT-SUD include eliminating problematic substance use, reducing other maladaptive behaviors (e.g., self-harm behaviors), building structure, eliminating environmental stressors, and improving overall life functioning. DBT-SUD includes modifications such as a SUD-specific target hierarchy, attachment strategies, dialectical abstinence, as well as additional behavioral skills. DBT has been used in the treatment of individuals with BPD and diverse types of substance use problems. Research on DBT has shown it to be generally effective in reducing substance use and enhancing adaptive functioning in many troubled substance-using individuals diagnosed with BPD.

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CHAPTER 12

# Treating Posttraumatic Stress Disorder during DBT

## *Applying the Principles and Procedures of the DBT Prolonged Exposure Protocol*

MELANIE S. HARNED and SARA C. SCHMIDT

Dialectical behavior therapy (DBT) was developed to treat chronically suicidal individuals with multiple mental disorders and pervasive emotion dysregulation. From its inception, DBT has highlighted the role of trauma as a common etiological factor and posttraumatic stress disorder (PTSD) as an important treatment target for many clients who receive this treatment. However, the first two decades of DBT treatment development and research primarily focused on Stage 1 DBT to address behavioral dyscontrol, and DBT's Stage 2 in which PTSD is targeted was left largely undeveloped. As a result, formal treatment of PTSD during DBT has been the exception rather than the norm. The DBT Prolonged Exposure (DBT PE) protocol (Harned, Korslund, Foa, & Linehan, 2012; Harned, Korslund, & Linehan, 2014) was developed specifically to provide a structured method of treating PTSD within DBT. In this chapter, we will provide a rationale for integrating formal PTSD treatment into DBT and an overview of the integrated DBT and DBT PE protocol treatment. Then we will describe the principles underlying the treatment and focus on how to apply the core procedures of the DBT PE protocol in a principle-driven manner to flexibly address the needs of high-risk, complex, and multi-diagnostic clients with PTSD. Finally, we will present a case example to illustrate the application of this principle-driven protocol.

## Why Apply DBT to the Treatment of PTSD?

DBT is intended to be a comprehensive treatment that can address the full range of complex problems exhibited by high-risk and multi-diagnostic clients. While DBT

has been shown to be efficacious in treating many problems common in this client population, its effects on PTSD are limited. Indeed, although PTSD is one of the most common disorders among clients receiving DBT (~50%; Barnicot & Priebe, 2013; Linehan et al., 2006), it has the lowest rate of diagnostic remission of any disorder during and in the year after DBT (35%; Harned et al., 2008). This remission rate is also lower than those typically found in psychotherapies for PTSD (56–67%; Bradley, Greene, Russ, Dutra, & Westen, 2005). Furthermore, some research indicates that clients with PTSD have poorer outcomes during DBT in terms of suicidal and self-injurious behavior and borderline personality disorder severity (Harned, Jackson, Comtois, & Linehan, 2010; Barnicot & Crawford, 2018; Barnicot & Priebe, 2013), suggesting that PTSD is likely to complicate the treatment of other functionally related problems. Taken together, these findings highlight the importance of improving DBT's effects on PTSD.

## Approaches to Addressing PTSD in DBT

Faced with a suicidal, self-harming, and multi-diagnostic client for whom PTSD is just one of many problems in need of treatment, what should a DBT clinician do? According to DBT's stage model, treatment should begin in Stage 1 with the goal of achieving behavioral control and acquiring skills before PTSD can be treated in Stage 2 (Linehan, 1993). In clinical practice, however, DBT has typically been delivered with a primary focus on Stage 1 goals and has not progressed to directly or formally treating PTSD. Instead, the approach to addressing PTSD has often been to teach clients behavioral skills to effectively manage PTSD behaviors (e.g., nightmares, flashbacks, physiological and emotional reactivity to trauma cues) without treating the underlying disorder. There are many understandable reasons for this indirect, skills-focused approach, including the lack of information in the DBT manual about exactly when and how to treat PTSD, insufficient clinician training in evidence-based PTSD treatments, concerns about client worsening during PTSD treatments, and potential client-related barriers (e.g., ambivalence about engaging in PTSD treatment).

A second approach is to provide sequential treatment in which DBT is completed first (e.g., for 1 year) before referring clients to a different program or clinician for formal PTSD treatment. Such sequential treatment may be clearly articulated in the initial treatment plan, or may evolve as treatment progresses and the need for targeted PTSD treatment becomes evident. Although preferable to not receiving any formal PTSD treatment, this sequential model may unnecessarily delay PTSD treatment given that many clients are likely to achieve the stability necessary to engage in PTSD treatment during the time they are receiving DBT (Harned et al., 2010). In addition, this discontinuous care model creates a risk that clients may still not receive PTSD treatment due to potential challenges related to finding or transferring to a new clinician after they have completed DBT.

A third and preferred approach is integrated treatment that allows for targeting of PTSD, co-occurring problems, and their common mechanisms in the same treatment (Najavits et al., 2009; Rizvi & Harned, 2013). Of note, Linehan (1993) provided two recommendations for how to treat PTSD during Stage 2 of DBT, both of which are consistent with an integrated treatment approach. These include either

(1) utilizing DBT's existing exposure-based strategies in a focused fashion to address PTSD during DBT, or (2) inserting or concurrently applying a well-developed PTSD treatment into DBT (Linehan, 1993, p. 344). The integrated DBT and DBT PE protocol treatment described in this chapter is consistent with the latter recommendation and reflects DBT's typical approach to addressing severe co-occurring disorders more broadly. In particular, clinicians are expected to integrate other disorder-specific treatment protocols into DBT when needed to enhance targeting of co-occurring disorders.

## Selecting a PTSD Treatment for Integration into DBT

With this general approach to targeting PTSD selected, the task became to identify an established PTSD treatment to integrate into DBT. Prolonged exposure therapy (PE; Foa, Hembree, & Rothbaum, 2007; Foa, Hembree, Rothbaum, & Rauch, 2019) was selected for several reasons. First, exposure therapy has the strongest evidence for the treatment of PTSD (e.g., Cusack et al., 2016; Foa, Keane, Friedman, & Cohen, 2009; Institute of Medicine, 2008; American Psychological Association [APA], 2017) and, of the exposure-based PTSD treatments, PE is the most well researched. Among adults and adolescents receiving PE, approximately 60–78% achieve diagnostic remission from PTSD (e.g., Foa, Dancu, et al., 1999; Foa, McLean, Capaldi, & Rosenfield, 2013) and 93% exhibit a reliable improvement in PTSD severity (Jayawickreme et al., 2014). Second, Linehan (1993) specifically recommended the use of exposure to treat PTSD, which is consistent with DBT's heavily behavioral orientation. Third, PE has been found to be readily transportable to community settings where clinicians with minimal prior cognitive-behavioral training have achieved outcomes comparable to those of experts (Foa, Hembree, et al., 2005). Finally, contrary to common clinical lore, PE is well tolerated by clients. Reliable worsening at posttreatment is exceedingly rare (0–1%; Jayawickreme et al., 2014), treatment dropout rates are low (20%; Hembree et al., 2003), and these potentially adverse outcomes are comparable to those found in non-exposure-based PTSD treatments. In sum, PE was selected because it is both a gold standard treatment for PTSD and highly compatible with DBT.

Of note, although PE was selected as the basis for the approach described in this chapter, it is possible that other PTSD treatments may also be effective when integrated into DBT. Other treatments with low to moderate strength of evidence for PTSD include cognitive therapy, cognitive processing therapy, mixed cognitive-behavioral therapies, eye movement desensitization and reprocessing, and narrative exposure therapy (Cusack et al., 2016; Foa et al., 2009; APA, 2017). To date, however, no other PTSD treatments have been researched when delivered in combination with standard DBT. Although several PTSD treatments have been developed that incorporate aspects of DBT, including DBT for PTSD (DBT-PTSD; Bohus et al., 2013; Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011) and Skills Training in Affective and Interpersonal Regulation–Narrative Therapy (STAIR-NT; Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2010), these treatments utilize adapted versions of DBT prior to initiating various trauma-focused interventions.

## Overview of the DBT PE Protocol

The DBT PE protocol is an adapted version of PE (Foa et al., 2007; Foa et al., 2019) that was developed specifically to be integrated into standard DBT. The DBT PE protocol utilizes the same treatment structure and core procedures as standard PE while incorporating adaptations intended to increase compatibility with DBT and better address the characteristics of a high-risk, severe, and multi-diagnostic client population. Consistent with a protocol-based approach, treatment is delivered in a structured format in which each session includes required components. Table 12.1

**TABLE 12.1. Structure of the DBT PE Protocol**

Session 1

- Review DBT diary card[a] and set session agenda.
- Present overview of the treatment rationale and procedures.
- Conduct Trauma Interview and select first target trauma.[b]
- Strengthen commitments to control higher-priority behaviors.[a]
- Complete postexposure DBT skills plan.[a]
- Assign homework.[b]

Session 2

- Review DBT diary card[a] and set session agenda.
- Review homework.
- Psychoeducation on common dialectical reactions to trauma.[b]
- Orient to the rationale for *in vivo* exposure.
- Introduce SUDS and establish anchor points.
- Construct *in vivo* exposure hierarchy.[b]
- Orient to the Exposure Recording Form.[a]
- Assign homework.[b]

Joint session

- Optional session with client and support person(s).[a]

Session 3

- Review DBT diary card[a] and set session agenda.
- Review *in vivo* exposure homework.
- Orient to the rationale for imaginal exposure.
- Conduct imaginal exposure.
- Conduct processing of imaginal exposure.[b]
- Assign *in vivo* and imaginal exposure homework.

Session 4+

- Review DBT diary card[a] and set session agenda.
- Review *in vivo* and imaginal exposure homework.
- Provide rationale for and select hotspots (if needed).
- Conduct imaginal exposure.
- Conduct processing of imaginal exposure.[b]
- Assign *in vivo* and imaginal exposure homework.

Final session

- Review DBT diary card[a] and set session agenda.
- Conduct brief imaginal exposure.
- Review treatment progress.
- Discuss relapse prevention handouts and complete worksheets.[a]

[a]This component is not included in standard PE.

[b]This component was modified from standard PE.

provides an outline of each session of the DBT PE protocol and specifies which session components were added to or modified from standard PE.

As in standard PE, the treatment occurs in three phases. During the preexposure sessions (1 and 2), the therapist provides the client with a rationale for the treatment, conducts a formal trauma assessment, provides psychoeducation on common dialectical reactions to trauma, and constructs the *in vivo* exposure hierarchy. In addition, an optional joint session may be conducted with the client and a family member or friend to orient the person to the treatment and discuss how they can provide support. During the exposure sessions (3+), the therapist conducts imaginal exposure followed by processing of the thoughts and emotions elicited by the exposure. Between-session homework includes *in vivo* exposure and repeated listening to a recording of the in-session imaginal exposure. Lastly, during the final consolidation session, the therapist reviews progress in imaginal and *in vivo* exposure and teaches relapse prevention skills.

Importantly, although DBT PE is a structured protocol, it is delivered within DBT, a principle-driven treatment that requires therapists to flexibly select treatment strategies based on the principles underlying the treatment and the client's in-the-moment responses. Optimal delivery of the DBT PE protocol involves a synthesis of these two approaches; namely, clinicians deliver the required elements of the DBT PE protocol in a principle-driven manner. At a high level, this means that clinicians remain grounded in DBT's principles of change, acceptance, and dialectics, and flexibly utilize the strategies of these paradigms as needed to optimize outcomes. For example, the required elements of the DBT PE protocol are augmented with DBT strategies when clients are unwilling or unable to engage in required treatment tasks in a manner likely to be effective and/or improvement is slow or insufficient. Stated simply, clinicians continue to "do DBT" while delivering the DBT PE protocol: The goal is to be adherent to both treatments simultaneously. In this way, PE is not only integrated into DBT, DBT is also integrated into PE to achieve a true synthesis of these two highly effective treatments.

## The Theoretical Foundation of the DBT PE Protocol

PE is based on emotional processing theory (EPT; Foa & Kozak, 1986; Foa & McLean, 2016), an extension of behavioral learning theory that provides a conceptualization of how PTSD is maintained and how exposure works to reduce PTSD.

### *How PTSD Is Maintained*

EPT specifies two factors that maintain PTSD over time: avoidance and problematic beliefs. *Avoidance* includes persistent efforts to avoid thoughts and memories of past trauma as well as situations that are reminders of trauma. This avoidance is typically fueled by certain types of *problematic beliefs,* including beliefs about danger (e.g., "The world is dangerous" and "People can't be trusted") and negative beliefs about the self (e.g., "I am weak and incompetent" and "It is my fault the trauma occurred"). Although avoiding trauma-related thoughts and situations works to reduce painful emotions in the short term, it maintains these painful emotions in the long term by preventing new learning. In particular, avoidance prevents people with PTSD from

encountering corrective information that would change their problematic beliefs, which is necessary to reduce painful emotions in the long run.

As an example, consider the case of a woman who was sexually abused by her older brother throughout her childhood and adolescence. As a result of this abuse, she now avoids wearing form-fitting clothing because she believes she will be raped if she does. She is also afraid of many other situations that activate this same belief (e.g., talking to men she does not know well, walking outside at night, going to a bar). As a result, she tries to avoid these types of situations as much as she can or, if she does find herself in them, she utilizes a variety of avoidance behaviors to make herself feel safer (e.g., bringing a friend, not making eye contact, dissociating). This avoidance works to decrease her distress during and immediately after encountering these feared situations, but maintains her distress in the long run by preventing her from learning that the actual likelihood of being raped in these situations is extremely low.

### *How Exposure Works to Reduce PTSD*

Based on this formulation of PTSD, EPT specifies that there are two conditions necessary for PTSD to be reduced: (1) The emotion must be activated (*emotional engagement*), and (2) information that is incompatible with the expected aversive outcomes must be present (*belief disconfirmation*). Exposure is a method of approaching avoided but nondangerous stimuli in order to activate emotions and change the problematic beliefs associated with these stimuli. In the prior example, this might involve having the client interact with men in a variety of everyday contexts (e.g., in stores, on the street, on the bus) while wearing nonbaggy clothing in order to learn that the actual likelihood of being raped is very low. Repeated exposure to avoided stimuli in the absence of feared consequences will eventually lead to a reduction in the intensity of emotions over time (referred to clinically as "between-session habituation"). Consistent with EPT, research has found strong evidence for the role of belief change and between-session habituation, and moderate evidence for the role of emotional engagement, as mechanisms of change in PE (Cooper, Clifton, & Feeny, 2017).

## The Core Procedures of the DBT PE Protocol

The DBT PE protocol includes three core procedures: *in vivo* exposure, imaginal exposure, and processing of imaginal exposure. These procedures are individually tailored to target the specific avoidance behaviors and problematic beliefs that are maintaining PTSD for a given client. Effective delivery of these core procedures requires clinicians to have a thorough understanding of the rationale for the procedure as well as the mechanics of conducting the procedure itself.

### In Vivo *Exposure*

People with PTSD often live very restricted lives due to efforts to avoid a wide variety of situations that elicit painful trauma-related emotions. This behavioral avoidance often greatly interferes with building a life that is experienced as worth living, as it frequently limits the person's ability to engage in pleasurable activities, develop and maintain meaningful relationships, and pursue school and work-related goals.

*In vivo* exposure is designed to counteract this behavioral avoidance by approaching avoided but objectively safe people, places, and things *in vivo* (i.e., in real life).

### *The Rationale*

*In vivo* exposure is intended to achieve several important goals. By approaching feared but nondangerous situations, people will have a chance to learn that these avoided situations are actually safe. In this process, they also learn that intense emotions, although uncomfortable, are not dangerous and can be tolerated. By breaking the habit of relying on avoidance to achieve short-term relief from painful emotions, they instead learn that emotions do not last forever and will become less intense as time passes. Overall, *in vivo* exposure functions as a way to build mastery and increase the person's belief that they are competent and can do difficult things.

### *The Procedure*

*In vivo* exposure and exposure procedures more generally have four key steps. First, the specific cues that are avoided, the emotions the cues elicit, and the feared outcomes of confronting the cues must be identified. As in standard PE, *in vivo* exposure tasks include cues that are (1) perceived as dangerous (e.g., crowds, talking to strangers, sleeping with the lights off); (2) reminders of the trauma (e.g., sounds, smells, and objects that were present at the time of the trauma); and (3) avoided due to depression (e.g., hobbies, exercise, social events). In addition, given that shame is a particularly common and impairing emotion among DBT clients, the DBT PE protocol uses *in vivo* exposure to target cues that elicit unjustified shame (e.g., making a mistake, sharing personal information, saying "no" to a request). Guided by the case formulation, the therapist and client collaboratively identify *in vivo* exposure tasks that will test the client's specific problematic beliefs and most improve their quality of life. Selected *in vivo* tasks are arranged in a hierarchy from least to most distressing.

Second, a specific cue is intentionally approached so that the problematic emotions and associated beliefs are activated. *In vivo* exposure is typically done gradually by starting with tasks that are moderately distressing before progressing to the most distressing tasks. In addition, approaching *in vivo* exposure cues in a way that maximizes variability enhances its effectiveness. In particular, varying the exposure cues, the contexts in which cues are approached, and distress levels during exposure has been shown to reduce the likelihood of later relapse (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014).

Third, urges to avoid the cue are blocked. The effectiveness of *in vivo* exposure is enhanced when tasks are completed with mindful awareness of the cue in the present moment. This requires the client to notice when avoidance occurs and nonjudgmentally return their attention back to the cue. Similarly, for *in vivo* exposure to work, the client must allow rather than avoid the uncomfortable internal experiences (emotions, thoughts, physical sensations) it elicits.

Fourth, the client repeatedly confronts the cue until their expectancies about the frequency and/or severity of feared outcomes are disconfirmed (referred to clinically as "corrective learning") and associated emotions decrease in intensity. In general, *in vivo* exposure tasks can be viewed as real-world experiments designed to test hypotheses about the likelihood and severity of specific feared outcomes. For example, a

man may be afraid that looking at reminders of his son who died in an accident will cause him to experience intense sadness and that this will be unbearable. In such a case, *in vivo* exposure tasks can evaluate this hypothesis by having him approach reminders of his son (e.g., photos, personal belongings, letters) in order to learn that the intense sadness these reminders elicit is tolerable and can be coped with effectively. In general, there should be a rationale for each *in vivo* exposure task that is selected in terms of the specific beliefs it is designed to test and, ideally, disconfirm.

### Imaginal Exposure

People with PTSD also avoid thinking about the traumas they have experienced and try to push away trauma memories when they arise. This cognitive avoidance is understandable, as thinking about trauma elicits painful emotions that most people would prefer not to have. However, avoiding trauma-related thoughts makes it impossible to process these events and maintains suffering in the long run. Imaginal exposure is designed to counteract cognitive avoidance by approaching rather than avoiding memories of past trauma.

#### The Rationale

Imaginal exposure is intended to help people get a new perspective on what happened before, during, and after a trauma, and to organize these events into a more coherent narrative. By focusing on the details of a specific trauma, the person also becomes better able to differentiate between the traumatic event and similar but safe events in the present day. As with *in vivo* exposure, imaginal exposure also increases people's belief in their ability to tolerate intense emotions and allows them to learn that emotions do not last forever and will eventually decrease. In this process, people learn that trauma memories are not dangerous, and that remembering a trauma is not the same as being retraumatized. Over time, repeatedly approaching painful trauma memories rather than avoiding them will also increase the person's sense of mastery and competence.

#### The Procedure

Similar to *in vivo* exposure, imaginal exposure consists of four key steps. First, the client and therapist select specific trauma memories that will be approached via imaginal exposure. In the DBT PE protocol, a thorough trauma assessment is conducted in Session 1 and up to three trauma memories are identified and prioritized based on the degree to which they are contributing to PTSD and general impairment. Typically, the most distressing trauma is selected as the focus of the first imaginal exposure, as this is likely to yield the greatest reduction in PTSD most quickly. However, clients may opt to begin with a less distressing event if they prefer.

Second, the selected trauma memory is approached by having the client repeatedly describe the event out loud in the present tense and in as much detail as possible with eyes closed. During imaginal exposure, the therapist assesses the client's level of emotional activation on a 0–100 scale (i.e., Subjective Units of Distress Scale [SUDS]) about every 5 minutes. It is important for clients to achieve an effective level of emotional engagement during imaginal exposure as either extremely low or

high emotional activation is likely to interfere with corrective learning. For clients struggling with underengagement, therapists may coach them to upregulate emotions using mindfulness and reality acceptance skills, whereas clients who are overengaged may be coached to downregulate emotions using crisis survival or emotion regulation skills.

Third, both the client and the therapist remain vigilant for avoidance and work to block it when it arises. Imaginal exposure requires clients to mindfully focus their attention on a trauma memory while describing in detail their internal and external experiences at the time the trauma occurred. Clients often begin imaginal exposure by focusing on certain, often external, details of the traumatic event and leaving out other important, often internal, details of their experience. Over time, clients are coached to fully describe all aspects of the traumatic experience without leaving out or changing any details. In this process, it is important that clients allow rather than avoid or suppress the painful emotions that arise when thinking about the trauma.

Fourth, imaginal exposure is done in a prolonged (20–45 minutes) and repeated (multiple times per week) manner to allow corrective learning to occur. For many clients, the most direct hypotheses tested by imaginal exposure relate to their perceived ability to tolerate thinking about past trauma. For example, many clients receiving the DBT PE protocol believe that thinking about past trauma will cause them to lose behavioral control (e.g., attempt suicide, self-injure, use substances), cognitive control (e.g., become stuck in negative thoughts), and/or emotional control (e.g., cry endlessly). Ideally, imaginal exposure will disconfirm these beliefs and allow clients to learn that trauma-related thoughts and emotions are painful but not dangerous, and can be tolerated. After multiple sessions of imaginal exposure have been conducted on a trauma memory and habituation is beginning to occur, the focus shifts to doing imaginal exposure on a "hotspot" (i.e., the most distressing part of the memory). Once habituation to the hotspot(s) occurs, imaginal exposure to the full memory is done one more time to be sure there are no parts that continue to elicit high distress before moving on to a new memory if needed.

### *Processing of Imaginal Exposure*

Immediately following imaginal exposure, clients engage in a 15- to 30-minute discussion (i.e., "processing") of the emotions and beliefs that were elicited by the exposure. As with imaginal exposure, the overall goal of processing is to facilitate corrective learning. However, these two procedures follow different pathways to achieve this goal. Imaginal exposure is similar to the concept of "emotion mind" in DBT, as it involves activating intense emotions and allowing these emotions to drive one's experience of reality. In contrast, processing is more like "reasonable mind" as it focuses on logic, analysis, and reflection as a means of understanding reality. Together, the two procedures are used to help clients find their "wise mind" by integrating both emotion and reason to find a new, more balanced perspective on their trauma.

#### *The Rationale*

In the DBT PE protocol, processing has three main goals: the acquisition, strengthening, and generalization of new learning. As a starting point, therapists must help clients to acquire more adaptive beliefs. Sometimes these new beliefs develop naturally

as a direct result of the imaginal exposure; for example, a client may immediately recognize that his feared outcomes of having a panic attack and fainting as a result of thinking about his trauma did not occur. For other beliefs, particularly negative beliefs about the self (e.g., "I'm bad and disgusting") and self-blame about the trauma (e.g., "It was my fault I was abused"), the acquisition of more adaptive ways of thinking may occur more slowly and require extensive effort on the part of the client and therapist. Once a new, more functional belief is present and at least partially endorsed by the client, the therapist moves quickly to strengthen this new learning. This is often done by validating and reinforcing the client's more adaptive belief. Over time, the goal is for the new learning to become stronger than, and therefore inhibit, the original maladaptive learning. Finally, the therapist and client actively work to generalize new learning to other similar events (when the trauma was recurrent), to other nonrelated traumas, and to the person's life narrative more broadly. In this way, PTSD can be effectively treated among multiply traumatized clients by targeting only a few traumatic events via imaginal exposure (typically, two to three) and ensuring that the learning generalizes to multiple events during processing.

### *The Procedure*

Processing is structured to include three general phases. First, the therapist sets the stage by offering immediate reinforcement to the client for completing the imaginal exposure and coaching them to use DBT skills as needed to regulate sufficiently to engage in productive discussion. Second, the therapist elicits the client's perspective by asking open-ended questions such as "What did you learn from doing the imaginal exposure?" or "What are you thinking now about this event?" The therapist continues to assess and normalize the client's perspective while working to shift problematic beliefs that may be evident. Finally, after the client has had sufficient time to verbalize their reactions, the therapist shares their own observations and asks targeted questions about important things that came up during the exposure.

DBT strategies from the paradigms of change, acceptance, and dialectics are used during processing to achieve the goal of corrective learning. Indeed, the processing portion of DBT PE sessions could essentially be considered DBT that is targeting the reduction of problematic posttraumatic beliefs and emotions. Accordingly, cognitive modification strategies from DBT's change paradigm are frequently used to help clients observe and describe their thoughts, evaluate and challenge specific beliefs, and generate more adaptive ways of thinking. Therapists use Socratic argument when possible to help clients self-generate new beliefs, and will directly generate and sell more adaptive beliefs when needed. Stylistically, therapists may at times use irreverent communication strategies to directly confront dysfunctional beliefs and provide unexpected, irreverent, or humorous responses that help clients get unstuck from rigid patterns of thinking.

The acceptance paradigm also provides useful strategies for helping clients to accept and build a compassionate understanding of their traumatic experiences. Validation strategies are frequently used during processing to normalize the client's behavior and communicate that it is understandable. Validation can be particularly useful in helping clients to understand their reactions at the time of the trauma in a non-judgmental way. For the sexually abused child who at times initiated sexual contact with an adult perpetrator, how does this behavior make sense? For the victim

of intimate partner violence who loved her partner despite his abusive behavior, how is this emotion understandable? For the client who thought it would be dangerous to disclose his physical abuse, how is this thought reasonable? To further communicate acceptance of the client, therapists' default style is based in DBT's reciprocal communication strategies, including being responsive to the client, expressing warm engagement, and maintaining a non-judgmental attitude. Therapists also regularly use self-disclosure to strategically share their own thoughts and feelings about the traumatic event and the client's responses to it. For example, self-disclosure is often used to model adaptive ways of thinking (e.g., "I wouldn't have fought back against an armed assailant either") and counteract unjustified shame (e.g., "I do not think you are disgusting").

From the dialectical paradigm, processing often focuses on helping clients identify nondialectical thinking and work for a synthesis. Examples of common dialectical dilemmas that arise include (1) wanting the trauma to be real and not wanting it to be real, (2) wanting to view oneself positively and not wanting to view the perpetrator negatively, and (3) wanting to get better and not wanting to act as if the trauma was not damaging. In addition, processing focuses on helping clients to develop a more holistic understanding of their traumatic experiences by actively calling attention to details that are being left out. For example, clients commonly overfocus on the elements of the event that they believe make it their fault (e.g., going limp while being raped), and do not attend to other things that happened before or after (e.g., repeatedly expressing their nonconsent). This systemic perspective is also applied to generalize the learning from one trauma to other traumas; for example, how did the sexual abuse a client experienced as a child influence her behavior during a rape that she experienced as an adult? Finally, when clients get stuck in rigid patterns, dialectical strategies such as metaphors, extending, devil's advocate, and making lemonade out of lemons can help achieve movement and progress toward change.

## Integrating the DBT PE Protocol into DBT

The integrated DBT and DBT PE protocol treatment adheres to DBT's stage model of treatment. Specifically, the treatment begins in Stage 1 by using standard DBT to stabilize problems that are a higher priority than PTSD. Once higher-priority behaviors have been sufficiently addressed, treatment progresses to Stage 2 during which the DBT PE protocol is integrated into ongoing DBT to directly target PTSD. The final stage of treatment focuses on addressing any problems in living that remain after PTSD has been treated.

Of note, there is ongoing debate about how to define Stage 1 versus Stage 2 of DBT. Some argue that Stage 2 requires a period of sustained behavioral control and the absence of severe or disabling problems in any life domain. Others argue that if a person has recently achieved behavioral control and has the skills necessary to complete PTSD treatment, they are by definition in Stage 2. Given the lack of consensus on this issue, for many years we described the DBT PE protocol as occurring in a middleground called "Stage 1B." More recently, however, we describe the DBT PE protocol as occurring in Stage 2 based on the fact that the DBT manual (Linehan, 1993) clearly specifies that PTSD treatment occurs in Stage 2. Regardless of the exact stage language that is used, it is important to understand at a high level that (1) the

present treatment progresses in stages; (2) to be eligible to begin the DBT PE protocol, clients must have achieved sufficient control over behaviors that would make engaging in PTSD treatment likely to be unsafe or ineffective; and (3) clients are not required to eliminate all severe and potentially disabling problems before progressing to the DBT PE protocol. The trajectory and structure of the treatment stages are described below.

### *Stage 1 DBT: Achieving Behavioral Control and Acquiring Skills*

This integrated treatment is intended for individuals with PTSD who require stabilization prior to being able to effectively engage in PTSD treatment. Accordingly, treatment begins with Stage 1 DBT targeting, in hierarchical order, life-threatening behaviors, behaviors that interfere with therapy, and behaviors that interfere with quality of life. While Stage 1 DBT is delivered without any adaptations according to Linehan's (1993) manual, it is broadly conceptualized as being in the service of preparing clients to safely and effectively engage in the DBT PE protocol in Stage 2. To that end, therapists begin orienting clients to the DBT PE protocol during pretreatment of DBT and work to build motivation to engage in this treatment throughout Stage 1. In addition, Stage 1 explicitly focuses on decreasing behaviors that are likely to make the later DBT PE protocol unsafe (e.g., acute suicidality) or ineffective (e.g., severe dissociation during sessions, consistent treatment noncompliance), while increasing skills that are likely to enhance its effectiveness (e.g., mindfulness, distress tolerance, emotion regulation).

### *Determining Readiness for the DBT PE Protocol*

The decision about when to progress to the DBT PE protocol is made collaboratively using a set of six principle-driven readiness criteria that align with the Stage 1 target hierarchy. In the life-threatening behavior domain, clients are required to (1) not be at imminent risk of suicide (e.g., serious suicidal ideation [SI] with intent and a plan), (2) not have engaged in suicidal or nonsuicidal self-injury for at least 2 months, and (3) be able to control urges to engage in suicidal and nonsuicidal self-injury *when in the presence of cues for those behaviors*. The 2-month period of abstinence from life-threatening behaviors (Criterion 2) was determined using an iterative treatment development process that initially began by requiring 4 months of abstinence and, based on the low rate of relapse of these high-risk behaviors during the DBT PE protocol, was progressively decreased to 2 months.

In the therapy-interfering domain, clients are required to (4) not be engaging in any serious therapy-interfering behavior. The guiding principle here is that the client must not be engaging in any behavior that is serious enough that it would be likely to make the DBT PE protocol ineffective. This may include serious nonattentive behaviors (e.g., regularly cancelling appointments, leaving sessions early, or arriving at sessions under the influence of drugs or alcohol); noncollaborative behaviors (e.g., frequent unwillingness to engage in treatment tasks or constant hostility); and noncompliant behaviors (e.g., routinely failing to complete homework or refusing to keep treatment agreements).

Finally, two readiness criteria fall within the quality-of-life domain, including (5) PTSD must be the client's highest priority goal, and (6) the client has the ability

and willingness to tolerate intense emotions without escaping. The fifth criterion is consistent with DBT's general approach of allowing clients to determine the order in which quality-of-life problems are targeted. The final criterion is intended to optimize outcomes during the DBT PE protocol given that emotional avoidance is likely to undermine the treatment. Clients' ability to effectively experience emotions is often determined via behavioral observation of clients' naturally occurring emotion during therapy sessions as well as behavioral tests designed to induce emotions (e.g., describing a sad but nontraumatic event).

Overall, these readiness criteria can be conceptualized as a formal contingency management plan that is collaboratively developed with clients early in Stage 1. In particular, therapists and clients work together to clearly define the specific behaviors that must be increased or decreased in each criterion domain to be able to begin the DBT PE protocol. Given that a majority (76%) of suicidal and/or self-harming clients with PTSD and borderline personality disorder (BPD) report a preference for a combined DBT and DBT PE protocol treatment over DBT alone (Harned, Tkachuck, & Youngberg, 2013), the DBT PE protocol often functions as a reinforcer that helps motivate clients to quickly achieve control over higher-priority behaviors during Stage 1.

### *Stage 2: Treating PTSD with the DBT PE Protocol*

Once these readiness criteria are achieved, the client progresses to Stage 2 in which the DBT PE protocol is integrated into DBT individual therapy sessions. Clients receive either 1 combined individual DBT + DBT PE session per week (90–120 minutes) or 2 separate individual therapy sessions per week (one 60- to 90-minute DBT PE session and one 60-minute DBT session). The length and structure of individual therapy sessions are determined by client and therapist preferences and pragmatic constraints, but it is expected that all clients continue to receive some amount of DBT individual therapy in addition to the DBT PE protocol. In addition, all other modes of standard DBT continue to be delivered without adaptation, including DBT group skills training, between-session phone coaching, and therapist consultation team.

While progress through this stage-based treatment is linear for some clients, for others it may include multiple transitions between Stages 1 and 2. Therapists use a set of principle-based guidelines to make decisions about when to pause the DBT PE protocol to address higher-priority behaviors (e.g., a recurrence of suicidal or self-injurious behavior), when to resume the protocol after pausing, and when to end the protocol because sufficient improvement has been achieved. In this way, the treatment is delivered in an idiographic manner, with the timing and duration of Stages 1 and 2 varying depending on the client. Once the DBT PE protocol is complete, clients typically continue to receive standard DBT to address any remaining treatment targets and goals, which are often related to improving psychosocial functioning (e.g., work, school, relationships).

## Evidence Base

To date, DBT + DBT PE has been evaluated as a 1-year outpatient treatment in an open trial ($n$ = 13; Harned, Korslund, Foa, & Linehan, 2012) and a randomized controlled trial (RCT) comparing DBT with and without the DBT PE protocol ($n$ = 26; Harned,

Korslund, & Linehan, 2014). Both studies involved adult women with PTSD, BPD, and recent and recurrent suicidal and/or nonsuicidal self-injury. Across both studies, 60% of clients started the DBT PE protocol after an average of 20 weeks of DBT; of these, 73% completed the protocol in an average of 13 sessions (range = 6–19). More than 70% of clients who completed the DBT PE protocol achieved diagnostic remission from PTSD and, in the RCT, the addition of the DBT PE protocol doubled the rate of remission of PTSD compared to DBT alone (80% vs. 40%). These improved PTSD outcomes were achieved without increased risk to clients; indeed, RCT clients who completed the DBT PE protocol were 2.4 times less likely to attempt suicide (17% vs. 40%) and 1.5 times less likely to self-injure (67% vs. 100%) than those who completed DBT alone. In addition, both studies found large pre–post improvements in dissociation, depression, anxiety, guilt, shame, and social and global functioning; in the RCT, these improvements were larger than those found in DBT alone.

Studies of the timing and mechanisms of change during the integrated DBT and DBT PE treatment have found that (1) PTSD is unlikely to improve until it is directly targeted in Stage 2 (Harned, Gallop, & Valenstein-Mah, 2016); (2) between-session habituation in trauma-related emotions (Harned, Ruork, Liu, & Tkachuck, 2015) as well as trauma-related beliefs and experiential avoidance (Harned, Fitzpatrick, & Schmidt, in press) are critical targets for reducing PTSD; and (3) reducing PTSD severity leads to subsequent improvements in numerous mental health and functional outcomes (Harned et al., 2018; Harned, Wilks, Schmidt, & Coyle, 2016).

Finally, one effectiveness study evaluating the treatment in a routine care setting has been completed (Meyers et al., 2017). It found that a combined DBT and PE treatment had promising effects when delivered as a 12-week intensive outpatient treatment with 33 male and female veterans with PTSD, BPD traits, and prior dropout or exclusion from standard PTSD treatments in the Veterans Affairs (VA) system. At posttreatment, 91% of clients showed reliable improvement and 64% were below clinical cutoffs for PTSD, and significant reductions were also found in BPD, SI, anxiety, and depression. Additional effectiveness studies have recently been completed or are in progress.

## Putting It All Together: The Case of Molly

To further illustrate the application of the principles and procedures of the DBT PE protocol, we will present the case example of a client who received this treatment. To protect identifying information, this client is a hybrid of several we have treated.

"Molly" was a 30-year-old, single Caucasian female who lived alone. Her parents divorced when she was 2, and her mother remarried when she was 5. She has two younger half-siblings. Molly was sexually abused by her stepfather between the ages of 6 to 12, at which point her mother discovered that he was having an affair and they divorced. At 13, Molly began engaging in nonsuicidal self-injury (cutting with a razor blade) multiple times per week. After several months, Molly's mother walked in on her cutting her arm, "freaked out," and took her to the emergency room. It was at this point that Molly disclosed the abuse by her stepfather. Molly reported that upon learning of it, her mother became intensely sad and angry, demanded to know why Molly had not told her sooner, and begged her not to talk about it anymore or to tell her younger siblings. After this incident, Molly said that she "buried the memories" of her stepfather "down deep" and never spoke of the abuse again. Molly

reported that she has always felt the pressure to be "perfect." For example, when her mother was struggling with depression in the aftermath of her divorce, she would seek out advice and comfort from Molly and often expected her daughter to care for her younger siblings. Over time, Molly developed the belief that her own needs were less important than those of others, and that she needed to be the one who "held it together" in her family.

Throughout her teens and 20s, Molly continued to cut herself regularly, began to restrict her food intake as a way to numb out, and experienced chronic depression. Despite these struggles, she was a good student and was accepted to attend her first-choice college. In college, she often felt very overwhelmed and began to think about killing herself during periods of particularly high stress. In her second year, she told a roommate she was considering suicide and ended up being psychiatrically hospitalized after her roommate shared this information with their resident advisor. As a result of this experience, Molly decided she would keep her suffering to herself and always try to act as if she was "fine." She threw herself into school and work, graduating with a master's degree at 25. When Molly was 27, a male friend came to visit her from another state. One night when she was asleep in her bedroom, she awoke to find him naked on top of her. She pretended she was still asleep as he raped her, and for the remainder of his visit she acted as if the incident had not occurred.

Soon after this incident, Molly noticed an increase in PTSD symptoms related to the abuse by her stepfather, including frequent distressing, intrusive memories and images of the trauma, and avoidance of situations that reminded her of the abuse (e.g., she stopped watching a favorite television show in which a character bore a physical resemblance to her stepfather). It was at this point that she decided to seek treatment. At intake, Molly reported self-harming with a razor blade an average of once per week, engaging in high-risk sexual behavior (unprotected sex with men she did not know) a few times per month, drinking most days and until she blacked out at least twice per month, and restricting her food intake during periods of stress. Additionally, while Molly said that she had several acquaintances, she often spent extended periods of time isolating herself in her apartment or working long hours to avoid interaction with others, and that she tended to "lose track of time." She met criteria for PTSD, BPD, major depression, alcohol use disorder, and eating disorder NOS (not otherwise specified).

### *Stage 1 DBT*

During pretreatment of DBT, Molly identified treating PTSD as one of her primary treatment goals. Her therapist oriented her to the basic rationale and procedures of the DBT PE protocol, and Molly said that although it sounded really difficult, she would be willing to try the protocol if her therapist thought it would help. While orienting Molly to the DBT target hierarchy, her therapist linked this to the readiness criteria for starting DBT PE; namely, that Molly would have to stop all forms of suicidal and nonsuicidal self-injury for at least 2 months and eliminate any serious therapy-interfering behavior before she could start DBT PE. Given that treating PTSD was an important goal of Molly's, these contingencies helped to increase her motivation to quickly gain control over her self-harming behavior.

Stage 1 of DBT began by focusing on decreasing life-threatening behavior by teaching Molly skills to use to manage these urges. Molly initially relied heavily on

crisis survival skills to tolerate periods of high distress and over time became more able to utilize emotion regulation strategies to reduce her emotional vulnerability and change unwanted emotions. Molly cut herself once per week during the first 3 weeks of treatment, but then stopped self-harming altogether. She displayed no major therapy-interfering behaviors, completing all homework and diary cards, and attending skills group regularly. While she was initially hesitant to use phone coaching, she did so appropriately and with increasing frequency as treatment progressed.

In addition to standard Stage 1 tasks, the therapist also began to identify Molly's trauma-related problematic beliefs about herself and others, as well as her patterns of avoidance in order to develop an initial case formulation. Through chain analysis and ongoing assessment, Molly's therapist identified key problem emotions of sadness and shame, and several cognitive (dissociation; thinking about self-harm), emotional (suppression of emotions; numbing out), and behavioral (restricting; self-harm; high-risk sex; drinking; avoiding conversations that cue painful emotions) avoidance strategies. Additionally, the therapist hypothesized that Molly's beliefs about herself ("I am inadequate"; "I will not be able to control my emotional response if I think about the trauma") and others ("I can't rely on other people"; "You never know who will hurt you") contributed to both deeply rooted self-loathing and to desperate attempts to control both herself and her environment. As a result, Molly vacillated between rigid perfectionism and overcontrol, and impulsive and reckless behaviors.

While Molly was still engaging in several quality-of-life interfering behaviors (restricting food intake, drinking, and high-risk sex) during Stage 1, they decreased in frequency as Molly increasingly used skills to manage urges to engage in these behaviors. Molly also was making more social plans and joined a running club. In the third month of treatment, as Molly gained more control over her problem behaviors and demonstrated greater use of a range of DBT skills, she and her therapist began to develop behavioral tests for assessing her readiness for DBT PE. To assess her ability to tolerate intense emotions without escaping, the therapist asked Molly to tell a non-trauma-related story that elicited intense emotion. Molly told her therapist about the time her high school boyfriend broke up with her midway through their senior prom, during which she experienced the associated sadness that arose. She recorded herself telling the story and listened twice more at home. Molly also purposefully put herself in situations that historically prompted self-harm, including having a long (20-minute) phone call with her mother and leaving work earlier than her colleagues. After Molly successfully completed each of these behavioral experiments, both she and her therapist determined she was ready to begin the DBT PE protocol—this occurred after 18 weeks of DBT. Given Molly's rigorous work schedule, she and her therapist agreed to conduct DBT and DBT PE in one 2-hour session per week. They decided to conduct DBT PE in the first 90 minutes of each session and use the last 30 minutes for DBT as Molly believed this change of topic would help her feel more regulated before she left the office.

### *Stage 2: Targeting PTSD via the DBT PE Protocol*

#### *Preexposure Sessions*

During Session 1, the therapist completed a formal trauma history interview to identify and prioritize target traumas. At this point, Molly reported that the rape by her

friend at age 27 was causing the most current distress, followed by a particularly shame-eliciting incident of sexual abuse by her stepfather at age 10 and her mom's reaction to her disclosure of the sexual abuse at age 13. Molly and her therapist collaboratively decided to target the rape first given that it was most distressing. As part of the Trauma Interview, the therapist obtained information about whom, if anyone, Molly blamed for the rape. Molly reported that she primarily blamed herself (90%), but assigned some blame to "society and gender norms" (10%). She did not assign any blame to the perpetrator. Molly was also asked to rate the intensity of current emotions she had about the trauma on a scale of 0–100. She reported high levels of guilt (70), disgust (70), and shame (90), moderate levels of fear (50), and low levels of sadness (20) and anger (10). Molly said that she "almost" disclosed the trauma to a friend earlier in the year but "chickened out," and had not told anyone other than the therapist. As part of the postexposure DBT skills plan, Molly agreed that she would not engage in any quality-of-life interfering behaviors (drinking; having high-risk sex; restricting) for at least 2 hours after completing any exposure task.

During Session 2, Molly's therapist reviewed common dialectical reactions to trauma, and Molly endorsed elements of each of the extremes of under- and overcontrol, including vacillating between emotional flooding and numbness, reckless disinhibition and rigid control, and desperate connection and detached independence. Her therapist then presented the rationale for *in vivo* exposure, and they began to construct the *in vivo* hierarchy, selecting tasks that would maximally violate Molly's trauma-related beliefs about safety. These included tasks such as riding public transportation, going on a date, and taking a run by herself around her neighborhood. To test her beliefs about needing to "appear perfect" and be in control, they also included situations that would elicit unjustified shame, such as purposefully making a mistake at work and telling a friend about the trauma. Molly's first *in vivo* exposure homework was assigned, including going for a run by herself in her neighborhood (three times) and initiating a conversation with a male coworker (three times).

### *Exposure Sessions*

Session 3 began with the therapist reviewing Molly's *in vivo* exposure homework. Molly had successfully completed the three runs, but had only approached a male coworker once. The therapist reinforced Molly's efforts and used DBT's missing links analysis to briefly assess and problem-solve what got in the way of fully completing the homework. The therapist then presented the rationale for imaginal exposure and oriented Molly to the procedures. Molly then began imaginal exposure by describing the details of the rape. Initially, she had difficulty engaging emotionally, reporting SUDS scores between 30–50, and her therapist addressed this by reiterating the rationale and prompting her to include more details of her internal experience during the retelling of the trauma narrative.

In subsequent exposure sessions, Molly achieved more optimal levels of emotional engagement during imaginal exposure, with SUDS scores ranging from 70 to 100. Molly's therapist continued to monitor her progress using the PTSD Checklist (PCL; Blevins, Weathers, Davis, Witte, & Domino, 2015) as well as obtaining pre- and postexposure ratings of specific emotions and radical acceptance of the trauma using the Exposure Recording Form. After 5 sessions of imaginal exposure, Molly showed a large decrease in fear (85 to 10) and guilt (100 to 50). However, Molly's

shame remained at a 90 and her radical acceptance that the trauma occurred hovered at a 10. Additionally, Molly was still reporting significant PTSD symptoms. During processing, her therapist asked Molly what was causing this high shame and low acceptance. Molly became quiet and then began to sob. She revealed to the therapist that she was "making the whole story up." Upon further assessment, the therapist learned that Molly initiated consensual sex with her perpetrator two times in the days following the rape. While Molly was increasingly aware that she was not to blame for the rape, she was feeling intense shame and self-loathing about having had sex with the perpetrator later and having "tricked" her therapist into believing she was worthy of compassion.

Molly came into session the following week refusing to do exposure. She had not completed any imaginal or *in vivo* exposure homework and was minimally responsive to her therapist's attempts to assess what got in the way. The therapist hypothesized that Molly might be anticipating rejection based on the previous week's session, offered her some reassurance that she was not viewing her critically, and encouraged her to continue with the planned exposure to gain additional information about whether her shame was justified. Molly became angry and said that the treatment was not working, was too difficult, and perhaps the therapist did not know what she was doing. She refused to do the planned exposure and left the session early. Two days later, Molly utilized phone coaching to repair her relationship with the therapist and agreed to continue DBT PE as planned.

For the next 5 sessions, Molly's therapist specifically targeted shame and radical acceptance. She assigned *in vivo* tasks to target unjustified shame by having Molly disclose the rape to her sister and a friend who both responded with support and care. During imaginal exposure, Molly was coached to use opposite action to shame by making eye contact with the therapist and speaking in a confident tone of voice. The imaginal exposure also progressed to focusing on the most shame-eliciting hotspot of the rape: when Molly had pretended to be asleep. During processing, the therapist targeted shame by helping Molly develop a compassionate, non-judgmental interpretation of her responses during and after the rape. Molly came to recognize that pretending to be asleep was a strategy she had used as a child that sometimes worked to keep her stepfather from abusing her. With this broader systems perspective, she was then able to recognize that pretending to be asleep was actually a strategic response that she had hoped would deter her friend from raping her. Similarly, Molly eventually understood that she had later consented to sex with the perpetrator in an effort to regain a sense of power. She also began to let go of her nondialectical thinking that the later consensual sex had somehow nullified the rape, and to instead acknowledge that both could be true ("I was raped and I later consented to sex"). Once these cognitive changes occurred, Molly's radical acceptance of the rape increased to a 90, her shame decreased to a 10, and guilt decreased to 0. Instead, she was feeling the justified emotions of sadness (80) about the impact of the rape and anger (20) at the perpetrator. Her PTSD symptoms had also decreased by 12 points on the PCL but still remained above threshold.

Molly then progressed to targeting her stepfather's sexual abuse and her mother's subsequent invalidation when she disclosed it. She and her therapist identified a specific incident of this recurrent abuse that was particularly distressing to Molly: an event in which her stepfather caused her to have an orgasm as a "gift" for her tenth birthday. As a result of the learning that had occurred when targeting the rape, Molly

began this exposure with low fear and minimal guilt or self-blame for this event. Therefore, processing focused primarily on reducing her shame and self-directed disgust for having experienced sexual arousal during the abuse as well as anger at her mother for not being more supportive when she disclosed the abuse to her. After 6 sessions, Molly's shame had decreased from 70 to 5, anger toward her mother had decreased from 80 to 20, and she no longer met diagnostic criteria for PTSD. She and her therapist then completed the final DBT PE session focused on consolidation and relapse prevention. Once the DBT PE protocol was complete, Molly continued in DBT for the remainder of her 1-year treatment contract, during which she focused on building new friendships, dating, and reducing her perfectionistic demands on herself.

## Conclusion

The integrated DBT + DBT PE protocol was developed to facilitate routine targeting of PTSD during DBT with high-risk, multi-diagnostic clients. While DBT PE is a structured protocol, it flexibly incorporates the principles and strategies of DBT to address problems that occur and optimize outcomes. Thus, effective delivery of the DBT PE protocol requires therapists to stay grounded in the principles of DBT while delivering the core procedures of *in vivo* exposure, imaginal exposure, and processing. Furthermore, the DBT PE protocol is delivered in an idiographic manner by tailoring the core procedures to optimally target client-specific mechanisms, with the ultimate goal of helping clients find relief from PTSD and build a life they experience as worth living.

## DISCLOSURE

Drs. Harned and Schmidt are paid to provide training and consultation in DBT and DBT PE.

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CHAPTER 13

# DBT and Eating Disorders

LUCENE WISNIEWSKI, DEBRA L. SAFER, and SARAH ADLER

Dialectical behavior therapy (DBT) has been widely adapted to address many behaviors associated with emotion dysregulation. Eating disorders (EDs) may involve behaviors that function to manage strong emotions, making DBT an interesting focal point for researchers and clinicians alike. The aim of this chapter is to illustrate ways DBT may be used to treat clients with EDs. We introduce two models of comprehensive DBT (C-DBT) adapted for EDs, while illustrating how DBT can be applied to clients with EDs who have a range of quality-of-life interfering behaviors. These two models—the multi-diagnostic eating disorder DBT (M-ED DBT) and the Stanford model (SM)—were designed to meet the varying needs of clients presenting to ED treatment while using the treatment targets of a traditional DBT framework. While variations exist, generally the M-ED DBT model was developed to address Stage 1 clients with EDs whose symptoms may warrant a higher level of care (i.e., with life-threatening suicidal or eating behaviors), while the SM was developed to treat later-stage clients with EDs and skills deficits in emotion regulation whose ED behaviors interfere with quality of life. Both models are aligned with general DBT, specifically enhancing coping skills, improving motivational factors, assuring generalization, and promoting therapist motivation and efficacy by structuring the treatment environment. In this chapter, we provide detailed descriptions of the above models as well as concrete examples of how to employ DBT with clients with EDs presenting with varying degrees of symptom complexity.

## Why Apply DBT to the Treatment of Clients with EDs?

For adults, cognitive-behavioral therapy (CBT) and interpersonal psychotherapy, and for adolescents, family-based treatment, are considered the first-line treatments for

EDs (National Institute for Health and Care Excellence [NICE], 2004), yet are effective for only about 50% of clients with bulimia nervosa (BN) and binge eating disorder (BED; Keel & Brown, 2010). Treatment effects for anorexia nervosa (AN) are even more modest (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007). Predictors of poor outcome in standard, evidence-based treatment models for EDs include severity of ED symptoms, less symptom change early in treatment, and comorbid personality disorders or other Axis I disorders (for a detailed review, see Vall & Wade, 2015).

DBT may be a viable option for those clients who have not been helped by evidence-based treatments. DBT, unlike other ED treatments, is based on an emotion-regulation model of ED symptoms. There is evidence that affect is a frequent precursor to binge eating (e.g., Lavender et al., 2016), and that binge eating and other types of eating pathology (e.g., vomiting, restrictive eating) may provide a means, albeit maladaptive, of regulating emotions (see, e.g., Waller, 2003; Telch, Agras, & Linehan, 2000; Haedt-Matt et al., 2014). The fact that DBT is specifically designed to teach adaptive affect regulation skills and to target behaviors resulting from emotional dysregulation provides a theoretical rationale for applying DBT to treating EDs (Telch, Agras, & Linehan, 2001).

The *rationale* for applying DBT to the treatment of EDs has been thoroughly described elsewhere in the literature (e.g., Bhatnagar, Martin-Wagar, & Wisniewski, 2017; Chen & Safer, 2010). Thus, this chapter will focus primarily on the *application* of DBT to ED treatment.

## Theoretical Adaptations to the DBT Model When Treating EDs

### *Adaptation of DBT's Biosocial Theory to EDs*

There are no current data examining DBT's biosocial model applied to individuals with a primary diagnosis of an ED. Conceptualizing EDs as a problem of pervasive emotion dysregulation is both applicable and relevant to certain clients, though the standard biosocial requires some adaptation. First, in addition to its grounding in a belief in the individual's biological vulnerability to pervasive emotion dysregulation, the DBT biosocial model for understanding the development of EDs includes an awareness of a special nutritional vulnerability (Wisniewski & Kelly, 2003; Bankoff, Karpel, Forbes, & Pantalone, 2012). Nutrition-related vulnerabilities that may increase the risk for developing an ED include a disruption in the body's ability to effectively signal hunger and satiety. This disruption, which may occur prior to or be a result of disordered eating behavior (e.g., Wisniewski, Epstein, Marcus, & Kaye, 1997), may make it particularly difficult to regulate eating.

The emotionally invalidating environment for a client with an ED may be expanded to include body-shape- and weight-related teasing by peers and family (Puhl et al., 2017) and the culture at large. As obesity rates increase worldwide (Ng et al., 2014), there simultaneously exists the ubiquitous message that "thin is good" and "fat is bad" and obese people can experience shaming, prejudice, and even abuse due to their weight status. The difference between the reality of a lived body experience and cultural expectations for thinness may result in societal expectations for beauty that may be experienced as invalidating to some individuals. Furthermore, in clients with comorbid borderline personality disorder (BPD) and ED, dysregulation of the self—an important criterion behavior for BPD—may make clients particularly

vulnerable to turning to body image–focused environments as sources of information about what the self "should" be. Finally, clients with EDs may also experience invalidation with respect to their specific ED symptoms, as when asked, "Why can't you just stop eating?" or, conversely, "Why can't you just eat?" This conceptualization of the invalidating environment, although untested, may explain the greater degree of self-dysregulation often seen clinically in clients with both BPD and ED. Possessing both BPD and an ED may set the stage for clients to engage in more extreme behaviors (e.g., purging at very low weights) as a way of eliciting attention and positive reinforcement.

### *Adaptations of Standard DBT Treatment Targets for Clients with EDs*

#### *Target 1: Life-Threatening Behaviors*

As in standard DBT, suicidal and other imminently life-threatening behaviors are the first targets addressed in treatment. ED behaviors are considered Target 1 when engaging in the behavior poses an *imminent* threat to the client's life. Examples include fluid restriction or exercise in a bradycardic client, vomiting despite electrolyte imbalance, and insulin manipulation in an insulin-dependent diabetic client, as all of these conditions can lead to imminent, whether intentional or not, death.

Difficulties arise when determining if a particular ED behavior meets criteria to be considered Target 1, because although high rates of morbidity and mortality are associated with EDs, no definitive guidelines to designate which ED behaviors pose *imminent* danger to life exist. In addition, medical risk for a particular problem behavior may vary across clients. For example, multiple daily purging episodes can result in electrolyte disturbances in one individual but not in another. When deciding in which target a particular behavior falls, it is important to consider the function, lethality, imminence, degree of disability, and complexity of the behavior for a particular individual, while also taking into account the behavior's history. For instance, ipecac abuse may be immediately life-threatening in a client with bradycardia (independent of the client's *intent* to die or harm themself; Target 1), or may constitute "therapy-interfering behavior" (Target 2, see below) if it occurred with a client without electrolyte imbalances as a "legitimate" excuse for missing a group skills session. Finally, the same behavior could be a quality-of-life interfering behavior (Target 3) in a client who infrequently abuses ipecac as a means of inducing vomiting (Mehler & Frank, 2016).

Given the difficulty of predicting risk, it is important that the decision to include an ED behavior as Target 1 is made on an individual basis and that the decision adheres to the behavioral definition of this class of behaviors (i.e., imminent risk of death). Consultation with medical professionals will often be required to determine whether a particular behavior is indeed an imminently lethal behavior within the context of relevant laboratory results and findings. The clinician's or institution's tolerance of risk should not be considered a relevant factor in considering whether the behavior is a Target 1 behavior.

#### *Target 2: Therapy-Interfering Behaviors*

Common therapy-interfering behaviors that may occur within the context of ED treatment include not completing food diary cards; an inability to focus during the

session due to a malnourished state; refusing to be weighed; falling below an agreed-upon outpatient weight range; engaging in behaviors to surreptitiously alter weight; exercising against medical advice; absence from treatment due to the need for medical intervention; and/or engaging in purging that interferes with medication efficacy.

### *Target 3: Quality-of-Life Interfering Behaviors*

ED behaviors that are not associated with an imminent risk to life are classified as Target 3. Examples of specific ED behaviors can include restricting, binge eating, vomiting, laxative use, diuretic use, diet pill use, excessive or compulsive exercise, and other eating-specific targets. The bulk of treatment for clients with EDs who are not suicidal or at imminent risk of death will fall within Targets 2 and 3.

For clients who have numerous quality-of-life interfering behaviors across multiple classes of behavior (e.g., EDs, substance abuse, legal problems), it is important to determine the hierarchy of behavioral targets within this domain. Unless otherwise specified below, principles from standard DBT (Linehan, 1993a) should be applied, resulting in the following considerations:

1. The immediacy of the problem (e.g., not having a place to sleep that evening is a more pressing target compared to binge eating).
2. The solvability of the problem: Trying to solve the less difficult rather than the more difficult problems yields greater chances of reinforcing a skill's use and generalization.
3. The functional relationship of behaviors to higher-priority targets (e.g., suicide crisis behaviors and nonsuicidal self-injurious behaviors; therapy-interfering behavior; suicide ideation and sense of "misery"; maintenance of treatment gains and other life goals).
4. The client's goals.

Consider the client who, for example, engaged in binge eating, but also had a hoarding problem, resulting in an apartment so full of belongings that it was difficult to move from one room to the next. The client's inability to eat at her dining room table, or invite others to her home to eat with her, creates shame that leads to increased suicidality. In this case, the client's hoarding, not her binge eating, is leading to imminent danger and therefore indicates a higher-order treatment target. In practice, therapists should be aware that although the client may present for treatment with binge eating, functionally, the hoarding may be a higher priority due to the distress it is causing the client. In fact, addressing the binge eating and ignoring the higher-order target (and the client's distress) may lead to the client feeling invalidated and increase therapy-interfering behaviors (such as resistance or dropout).

## DBT for Multi-Diagnostic EDs

The M-ED DBT treatment model was developed to address the needs of clients who were not helped by other evidence-based ED treatments, or who were diagnosed with comorbid disorders that could interfere with or complicate their ED treatment—in particular, those with BPD or who have had significant suicidality or nonsuicidal

self-injury (NSSI). While the literature on using DBT with multi-diagnostic clients with EDs is still evolving (see, e.g., Chen, Matthews, Allen, Kuo, & Linehan, 2008; Courbasson, Nishikawa, & Dixon, 2012; Federici & Wisniewski, 2013; Kröger et al., 2010; Lenz, Taylor, Fleming, & Serman, 2014; Palmer et al., 2003), clinicians need guidance with this population. This section hopes to fill that need.

Although the M-ED DBT treatment described here may theoretically be used with any adult client with an ED, Table 13.1 delineates admission criteria that are being developed by Wiesniewski to determine whether or not a client may be an ideal candidate for M-ED DBT treatment. In using these criteria, we first consider if a client has received, and has not been helped by, an adequate trial of CBT. Data suggest that response to a course of CBT for an ED will be evident within the first 6 sessions (Mitchell et al., 2002). Treatment nonresponse to standard CBT may therefore be identified fairly quickly.

Next, we consider if the client carries diagnoses that could interfere, or have interfered, with the implementation of CBT for ED, since adults with multi-diagnostic, complex clinical pictures (e.g., a dual diagnosis of BPD, substance abuse disorder [SUD], or recurrent suicidality or NSSI) may not benefit as greatly from CBT (e.g., Chen et al., 2008; Wilfley et al., 2000).

Finally, if a client describes ED symptoms as being used for emotion regulation, engages in NSSI, experiences chronic suicidality, or has a history of engaging in behaviors that interfere with treatment, we strongly consider M-ED DBT treatment (Federici & Wisniewski, 2013; Federici, Wisniewski, & Ben-Porath, 2012). We have been using this model and have decided clinically that a client meeting 3 out of the 5 criteria listed above would be a client who could benefit from M-ED treatment.

### *Assessment of Multi-Diagnostic Clients with EDs*

When determining the course of treatment for multi-diagnostic and complex individuals with EDs, it is important to consider both level of medical compromise and state of nutritional insufficiency. Psychological interventions including DBT may have limited effectiveness if a client's physical health and cognitive processes are underfunctioning due to ED-related symptoms. All potential M-ED DBT clients should receive an initial assessment to determine the appropriate treatment level of care,

**TABLE 13.1. Criteria for M-ED DBT Treatment**

| Criteria | **Explanation and examples** |
|---|---|
| 1. Previous attempts at evidence-based ED treatment | Treatment nonresponse within the first 6 sessions of an evidence-based ED treatment, such as CBT. |
| 2. Multi-diagnostic | BPD, SUD |
| 3. Suicidality or self-harm present | Recurrent suicidality or NSSI behaviors |
| 4. ED behaviors are utilized to regulate mood/ manage emotions | ED behaviors mainly serve the function of regulating emotions, such as bingeing and purging when feeling hurt. |
| 5. Therapy-/treatment-interfering behaviors | A history of engaging in behaviors that interfere with treatment, such as repeated lateness, missing treatment, sleeping during treatment, medication noncompliance, and incomplete diary cards. |

given the severity of the disorder and the degree of functional impairment. This is best executed when the client participates in a semi-structured clinical interview designed to assess eating pathology as well as other comorbidities and the therapist uses the level-of-care criteria outlined in the *Practice Guidelines for the Treatment of Patients with Eating Disorders* (American Psychiatric Association [APA], 2006) to make level-of-care recommendations. These guidelines suggest the use of a multiaxial evaluation that includes weight, the presence of bingeing and/or purging, and access to treatment to determine level of care. It is recommended that these guidelines be consulted prior to initiating DBT (or any other outpatient psychological treatment approach) with clients with EDs.

### *Orientation to M-ED DBT Treatment*

As with standard DBT, clients beginning M-ED DBT are oriented to the structure of treatment, such as the use of a consultation team, telephone skills coaching, and the 4 missed sessions rule. At the initial assessment, clients are asked to make an appointment with their own medical professional for a physical exam and any necessary tests (e.g., bloodwork, electrocardiogram) to screen for electrolyte imbalances or cardiac abnormalities associated with purging or restriction, or medical problems associated with obesity (e.g., Type II diabetes). Many general therapists and physicians have limited expertise in the medical evaluation and assessment of EDs and may be directed to the Academy for Eating Disorders' (AED's) *Eating Disorders: A Guide to Medical Care,* often referred to as "the purple brochure" (Academy for Eating Disorders, 2016). This document provides resources that will aid in recognition and risk management in the care of EDs and may be given to a client using the consultation to the patient strategy of DBT. The client can bring this brochure with them to their medical appointment, so the medical professional has information to help adequately assess and manage the pertinent ED issues.

#### *Individual Sessions in M-ED DBT Treatment*

Individual therapy sessions in M-ED DBT are conducted with the same structure as standard DBT with one exception: At the start of each session, clients are weighed by the individual therapist. The client may be weighed by an ancillary treater outside of session if adherence to the consultation to the client rule (e.g., if the client agrees to having the weight communicated to the individual therapist each week) is followed. Weighing weekly provides exposure to the number on the scale and, together with psychoeducation about how weight fluctuates, can be particularly helpful for clients who avoid weighing themselves. For clients with EDs who check their weight frequently, learning to weigh themselves only once a week can also be useful.

Taking the weight and talking about the numbers are integral parts of CBT for clients with EDs (Fairburn, 2008; Waller, Stringer, & Meyer, 2012). Not taking or talking about the weight of a client with an ED would be similar to a therapist who does not ask about a depressed client's suicidality. It may be difficult to make progress in addressing a problem if you are unable to talk about it. If you are uncomfortable with this aspect of the treatment, it will be important for you to get support, feedback, and skills from your DBT consultation team.

### Group Skills Training in M-ED DBT

M-ED DBT group skills training involves teaching all four standard skills-training modules. Since there are no modules devoted entirely and specifically to EDs, discussions pertaining to ED treatment, issues, and experiences must be woven throughout the teaching of the DBT modules. The use of DBT skills is modeled using ED behaviors as an example (e.g., doing pros and cons with urges to restrict a planned meal). This example may be discussed in a group setting as the discussion of eating behaviors, unlike discussion of suicidal behavior, does not appear to have a negative contagion effect on clients. With emotion-regulation PLEASE skills and crisis-survival distract (ACCEPTS) skills, those who restrict their intake or who overexercise are asked to use more adaptive alternatives. In applying crisis-survival distract skills to stop binge eating, clients are asked to find alternatives incompatible with binge eating, such as crocheting or knitting. Mindfulness exercises around eating and body awareness, including the raisin exercise described by Kabat-Zinn (1990), may also be added. That being said, as in any skills group practice, clients may be encouraged, but not forced, to participate in group practice activities.

### A Word about Mindfulness and Mindful Eating

In our consultation to other DBT colleagues, we are often asked about the role that mindful eating may play in the treatment of EDs. The answer to this question depends on the specific eating disorder diagnosis and stage of treatment. In M-ED DBT, clients are encouraged to use mindfulness to begin to monitor their hunger and fullness sensations at the very start of treatment, since by definition clients with EDs do not respond to these cues (e.g., they do not eat although hungry, or they do not stop eating although full). In ED treatment, regular eating is prescribed as a strategy both to increase and to limit intake. During early stages of treatment, clients are asked to eat at a prescribed time, even if they are not hungry and to stop eating after a prescribed amount, even if they feel overly full (in the case of AN) or not full enough (in the case of BN or BED). Thus, using a dialectical approach, clients learn to attend effectively to hunger and satiety *and* that eating according to the meal plan must occur regardless of hunger or fullness at the start of treatment, because "food is medicine" and these systems are often disrupted in clients with EDs (see Wisniewski et al., 1997).

Mindfulness of body sensations (i.e., hunger and fullness cues), however, is different from mindful eating. An individual may practice mindfulness skills by mindfully eating a piece of chocolate or a single raisin. But mindful eating may also be thought of as eating with intention and attention. There are data to suggest that clients who engage in binge eating benefit from a mindful approach to eating with a focus on awareness of hunger and satiety cues (Allen & Craighead, 1999; Kristeller, Wolever, & Sheets, 2014). However, research from Wisniewski and colleagues (Marek et al., 2013) has found increased negative affect postmeal in clients with AN and BN when practicing mindful eating. We therefore encourage AN and BN clients early in treatment to act opposite or to use distractions during therapeutic meals to aid in the establishment of a regular eating pattern or weight restoration. Over time, when these clients show mastery over the act of eating per se, and their ED symptoms decrease, they can be encouraged to approach the therapeutic meal more mindfully.

### *M-ED DBT Skills Group: Structural Issues*

M-ED DBT skills groups may be highly heterogeneous, including clients with any ED diagnosis, clients with and without BPD, and clients ranging in body size from underweight to obese. As described by Linehan (1993b), the trick to conducting skills-training groups with a heterogeneous group of clients is to focus on the shared problem of emotion dysregulation that precipitates a number of problematic behaviors. As clients with EDs have a tendency toward social comparison (e.g., Tiggemann & Polivy, 2010), it may be necessary for individual therapy sessions to underscore or practice the use of skills to effectively manage the tendency toward social comparison in a group setting.

### *M-ED DBT Consultation Team*

There are no differences in the function or structure of the M-ED DBT consultation team; however, it is recommended that all members of the team have training and expertise in assessing and treating clients with EDs and knowledge regarding weight and obesity. Consistent with the therapist's agreement in standard DBT, when members of the consultation team lack competency in EDs, we suggest that they receive training or find consultation. Where there may not be an ED specialist available to lecture or consult on cases, therapists can invite a consultant to provide a series of talks, either in person or by teleconferencing. Suggestions for finding a consultant include contacting the Academy for Eating Disorders, the National Eating Disorders Association, or a behaviorally oriented graduate training program in psychology. A less costly alternative would include conducting a journal club during the training hour devoted to the reading and presentation of articles on eating disorders.

### *M-ED DBT Telephone Consultation*

Phone coaching in M-ED DBT follows the same principles and protocol as standard C-DBT with a modification around the 24-hour rule. The application of the 24-hour rule is problematic for use with targeting ED behaviors, given that food, eating, weight, and shape stimuli are omnipresent. The goal of the 24-hour rule is not to be overly punitive but to shape the client to call before, rather than after, a crisis, and to prevent the potential reinforcement of the dysfunctional behavior by increasing contact with the therapist immediately following the dysfunctional behavior (assuming the therapist is a reinforcer for the client). Using the 24-hour rule with ED behaviors would make it extremely unlikely for a client to be able to use the telephone consultation if they engaged in any ED behavior at all! In response to this dilemma, we developed the next meal/snack rule (NM/S rule) (Wisniewski & Ben-Porath, 2005). The NM/S rule posits that a client call for consultation prior to engaging in a targeted ED behavior. If the client does engage in a targeted ED behavior, however, they may call for coaching at the *next scheduled meal or snack*. If a client purges at lunch, for example, she may (and is expected to) call for coaching if she is having difficulty with the afternoon snack. The focus of that afternoon call, however, is only on the *current* episode (i.e., urges to restrict the afternoon snack), not the purging episode at lunch.

Consistent with standard DBT, clients are encouraged to use crisis-survival strategies when intense urges arise to engage in dysfunctional behaviors *before* contacting

their individual therapist. Dependent on the client's skill level, the individual therapist may specify a number of skills to try before contacting the individual therapist. Once the client calls and the specific reason for the call is identified, the individual therapist should ask, "What skills have you tried to get yourself to eat?" or "What help do you need to use skills to refrain from purging?" Occasionally, it is difficult to assess whether change-based skills (e.g., crisis-survival strategies) are required, or if acceptance-based strategies would be more beneficial. Sometimes clients with EDs who are new to DBT are reticent to coaching. In such cases, phone calls can be assigned as homework and practiced to increase the probability that the client will call during an actual crisis situation.

### *Ancillary Treatments in M-ED DBT*

Ancillary treatments are important in treating EDs because the most lethal problems associated with EDs are often ones that medical professionals, not therapists, are qualified to assess and monitor. For this reason, we require clients in M-ED DBT treatment to have a full medical workup before they start treatment and to submit to ongoing monitoring by medical professionals over the course of treatment (e.g., regular assessment of electrolytes). Attendance at these appointments is monitored by the M-ED DBT individual therapist. Nonattendance is targeted as therapy-interfering behavior and may even be therapy-destroying if the client is medically unstable.

Working with a nutritionist may be useful to those clients who are new to ED treatment and who could benefit from being taught self-management skills. In these sessions, clients may be taught specific skills to promote balanced eating, including basic nutrition education and meal planning skills, as well as how to complete their DBT diary card. The goal of these meetings would be to educate (or reeducate) clients with EDs about topics such as portion size, meal planning, metabolism, the function of a varied diet, and the effects of food restriction and compensatory behaviors on weight control and mood. Other topics that can be addressed during these meetings include myths about dieting, advertising and cultural reinforcers for dieting behavior, psychoeducation regarding eating disorders, weight regulation, and medical issues.

Other common ancillary programs utilized by M-ED DBT are those for weight management or related medical issues (e.g., consulting with a personal trainer, attending a weight control program, and consulting with chronic pain or diabetes specialists) or for other psychological treatment (e.g., attending Narcotics Anonymous, tapering off psychotropic medications with a pharmacotherapist). Allowing clients to see ancillary providers keeps the M-ED DBT program focused on teaching skills to manage emotions. As described earlier, it is important that the individual therapist have knowledge of the relative efficacy of interventions for obesity to provide clients with guidance in choices of weight management programs. However, typically clients have tried numerous weight and exercise programs but have had limited benefit or discontinued them due to difficulty regulating their emotions (e.g., frustration, anger, and anxiety) and negotiating the interpersonal difficulties that may arise. Thus, coaching clients how to make the most of these programs can be addressed in treatment.

Most clients with EDs and those who treat them are accustomed to the use of a multidisciplinary approach that involves many treatment professionals. It is important that the M-ED DBT therapist orient both the client and the treatment network

to the DBT approach, including the consultation to the client (vs. environmental intervention strategies) as well as the general treatment model (e.g., biosocial theory, stages and targets of treatment).

### *Dialectical Dilemmas for M-ED DBT Clients*

Relating a client's goals to secondary targets and dialectical dilemmas can be a helpful introduction to the notion of dialectics. In M-ED DBT, clients are encouraged to find the dialectical synthesis between the extremes of overcontrolled/rigid eating and absence of an eating plan (Wisniewski & Kelly, 2003). Using DBT language, this synthesis is discussed within a framework of "effective eating." Effective eating can be described as eating when hungry, stopping when full, and using a variety of foods to achieve these goals. This model also allows for eating more than usual at special social occasions without experiencing a loss of control. Discussing eating within the DBT concept of effectiveness can help a client become unstuck from whether or not a particular food, or even eating, is "good or bad." An example of this is the client who eats a high-calorie, fast-food lunch and so skips dinner because she feels that she has "eaten too much already." This client may then become hungry in the evening, setting her up for a binge eating episode. Eating a fast-food lunch and skipping dinner, therefore, may be viewed as ineffective with helping the client to meet her goal of stopping binge eating. The therapist and client might jointly come up with a more effective plan that includes a moderate lunch so that the client feels able to eat dinner as well. Note that the language of effectiveness can help the client stay away from stating that she was "bad" or that the food she ate was "bad" or fattening.

## *Core Therapist Strategies in M-ED DBT*

### *Diary Card and Chain Analyses*

The diary card for M-ED DBT clients includes a food diary consisting of time of day when food/liquid is consumed, quantity, and description of the food and liquid consumed. This diary card may be conceptualized as including standard DBT components of self-monitoring target behaviors (modified to include ED behaviors) as well as recording dietary intake. The recording of intake is included in this diary card as it reflects the CBT tradition of meal planning and expects that following a regular pattern of eating will help decrease ED and other targeted behaviors. Regular and balanced eating is an important component of emotion regulation as well. For example, a client who follows a prescribed pattern of eating three meals and two snacks per day will likely be less hungry and feel less deprived, decreasing the likelihood of heightened feelings of hunger and deprivation leading to a binge. In addition, both meal planning and self-monitoring of intake are essential when treating a client with low body weight, as increased intake is a primary goal of treatment. It is important to note that this particular diary card assumes that the client has received a meal plan as a result of a meeting with a dietician who understands EDs. The meal plan is designed to help the client eat normally and effectively and may reflect the goal of the client gaining or maintaining weight. This monitoring allows the client and the therapist to become aware of what the client is able to eat and in what context, and can be useful in the individual DBT context as long as the therapist is knowledgeable about its use.

### In vivo *Exposure: Eating in Session*

Given the trouble many clients with EDs have initiating or stopping a meal, eating in session is an important treatment strategy. Clients can bring whole meals or specific trigger foods to session for *in vivo* exposure work. The meal context functions as an exposure for many clients, who often prefer to eat alone and/or in secret. Moreover, since the therapeutic meal gives the staff member *in vivo* observation of client behavior, interventions can be designed in the moment for a particular client. For example, a client who excessively cuts up their food can be asked to use a specific DBT skill appropriate to the client, the behavior, and the context to stop this behavior in the moment (e.g., act opposite to emotion, practice pros and cons, urge surf). A client who is having difficulty finishing their meal may receive cheerleading and suggestions of skill use from the therapist. Of note, the therapist may choose to eat a meal or specific food with the client in session. The therapist's meal choice and eating behavior can serve to model effective behavior for clients.

## The Stanford Model

The second model presented in this chapter was developed to target clients whose primary focus is gaining control over eating disordered behaviors that are significantly interfering with their quality of life. Such clients are typically, but not always, in Stage 3 (see Koerner, Dimeff, & Rizvi, Chapter 1, this volume). The Stanford model (SM) for clients involved a number of adaptations to standard DBT that reflect this client population, their diagnoses, and their level of disorder consistent with a focus on quality of life versus higher-order targets. Given that the SM was developed specifically for such clients, this model is not appropriate for suicidal clients or clients with other out-of-control behaviors (e.g., substance abuse or dependence). Indeed, such individuals were excluded from the original research on which this model is based.

Although this section is intended to provide the "nuts and bolts" of how to implement DBT according to the SM, additional resources describing this model are available, including a published therapist treatment manual (Safer, Telch, & Chen, 2009).

### *Research Supporting the Stanford Model for Clients with BED and BN*

The SM is manual-based and was researched using 20 outpatient sessions with adult women and men who met the criteria for BED or BN. The SM is currently one of the few adaptations of DBT for EDs supported through randomized trials. To date, seven studies (four randomized controlled studies, one uncontrolled study, and two case reports) have been published (Telch, Agras, & Linehan, 2000, 2001; Telch, 1997; Safer, Telch, & Agras, 2001a, 2001b; Safer, Robinson, & Jo, 2010; Masson, von Ranson, Wallace, & Safer, 2013). Results from these are promising to date. For example, abstinence rates from randomized trials were 64–89% after 20 sessions of DBT-BED (Telch et al., 2001; Safer et al., 2010) and 28.6% after 20 sessions of DBT-BN (Safer et al., 2001b). More recently, a guided self-help version of the SM was developed and tested. Abstinence rates after receiving 13 weeks of guided self-help (including up to six 20 minute-phone conversations with a therapist) were 40% (Masson et al., 2013).

### *A Word before Getting Started*

It is noteworthy that in most of the research conducted to date, the SM for clients with BED was conducted in a group session format and in an individual session format for clients with BN. The rationale for this distinction is more an artifact of the research process (difficulty recruiting sufficient numbers of clients with BN at one time for a group format) than for any clinical reason. We do not anticipate that changing the delivery format (i.e., group or individual) would adversely affect clinical outcomes. Hence, while the present content focuses on BED, it is fully transferable to BN.

### *Target Hierarchy*

The SM targets clients whose primary treatment focus includes problematic BED and BN eating behaviors interfering with quality of life. In the absence of data on applying the model for clients with life-threatening behaviors and the plethora of data on DBT's efficacy for such clients, we strongly discourage application of the SM for BED or BN clients engaging in suicidal and/or eating behaviors that pose an *imminent* threat to the client's life. When such clients wish to enroll in our program, they are instead referred to a higher level of care according to standards presented earlier in this chapter.

### *Treatment Structure: Combining Functions of Individual Treatment with Skills Training*

There are two distinct features of the Stanford model for binge eating and bulimia that differ from both the M-ED DBT model and standard DBT. First, the SM combines functions of both individual therapy and group skills training. Specifically, where enhancing motivation in standard DBT is typically done in individual psychotherapy and acquiring/strengthening new skills occurs within a skills-training group, these functions are combined in this adaptation. Second, whereas standard DBT is typically provided in no less than a year, this model consists of 20 sessions. These adaptations were made primarily for pragmatic purposes. For example, the other efficacious treatments for BED and BN against which DBT would be compared during the research trials, such as CBT and interpersonal therapy (IPT), typically run no longer than 20 sessions. The decision to remove interpersonal effectiveness was also made primarily for research design purposes: to avoid criticism that the treatment was "powered" by this module, given that numerous studies have demonstrated IPT is efficacious (e.g., Wilfley et al., 2002; Wilson, Wilfley, Agras, & Bryson, 2010). For clinicians and programs that are not limited by the constraints of time, resources, or research, there is no research-based reason not to add back the interpersonal effectiveness module.

The covered modules in the SM, in sequence, are the mindfulness module (Sessions 3–5), emotion-regulation module (Sessions 6–12), and distress-tolerance module (Sessions 14–18). Sessions 1 and 2 are introductory (orientation to the treatment model and treatment targets, group rules and agreements, group commitment to stop binge eating), while Sessions 19 and 20 are devoted to review and relapse prevention. As described below, participation in group treatment is preceded by a pretreatment orientation visit.

### Pretreatment Orientation Visit

An essential component of the SM for clients with binge eating and bulimia is that every participant meets individually with one of the co-therapists (or, for BN, the individual therapist) for 30–45 minutes prior to beginning therapy. The major goals of this pretreatment visit involve orienting the participant to the DBT emotion-regulation model of binge eating and the targets of treatment, describing the expectations of group members (e.g., regular timely attendance, listening to tapes of any missed sessions, completing homework assignments), and eliciting commitments from the client to stop binge eating and to address any treatment-interfering behaviors that may arise.

The therapist conducts this session and obtains a commitment using the same strategies applied by the individual therapist in standard DBT. In addition to the standard DBT agreements (e.g., agreement to attend all sessions and do all homework, work with therapist on problems in the therapeutic relationship should they arise), the therapist also seeks a commitment from the client to specifically give up behaviors associated with their ED (e.g., binge eating).

### Format of Group Sessions

Groups for clients with BED treated according to the SM are made up of eight to ten members with two co-therapists: a leader and a coleader. The length of the group should be no less than 2 hours and no more than 2.5 hours (or 50 minutes, if treatment is conducted individually). The format is divided evenly into two halves, with a brief (5- to 10-minute) break. The first half, which contains elements common to individual therapy sessions in standard DBT, focuses on skills strengthening and involves review of client diary cards, chain analyses, and assigned homework. The second half, which contains elements common to skills-training groups in standard DBT, is devoted to teaching new content (skills acquisition) and practice of those new skills. During the homework review, each group member will have between 5 and 10 minutes to report on their use of new skills in the past week and to describe specific successes or difficulties in applying the skills to replace the targeted problem eating behaviors. The length of time each member has varies based on the total amount of time allocated to group and the number of clients in attendance so that everyone has sufficient time to share. Group members are encouraged to help one another identify solutions to problems encountered in using the skills and to "cheerlead" efforts made.

### Therapeutic Pointers for Homework Review

It is important to assign group members the homework of completing at least one chain analysis each week for at least the first 15 sessions. Even if they do not engage in binge eating, clients should use the chain to address another target behavior (e.g., mindless eating). If they have had absolutely no eating-related problem behaviors a particular week, they might describe a past binge or a non-eating-related problem behavior. The rationale for requiring that no less than one chain be conducted per week for the first 15 sessions is that clients must practice using the chain to understand it sufficiently to continue using it on their own once treatment ends. By Week

16, clients can begin to fill out chain analyses only as needed for any problem eating-related episodes.

Clients are oriented to the importance of making maximal use of the allotted time by coming to sessions prepared to discuss their completed diary card, a chain analysis (including all relevant elements of the chain, especially where they might have intervened with a skillful alternative that would have eliminated the problem behavior), and specific skills homework sheets. Group members are asked to focus on their highest-order targets first (e.g., a binge episode rather than a mindless eating episode).

### *Session 1: Obtaining the Group Commitment to Stop Binge Eating*

A major task of Session 1 is to obtain a group commitment to stop binge eating. After initial introductions by each group member and the co-therapists, it is key that therapists create a groundswell of motivation and commitment from group members by flexibly utilizing the commitment strategies of standard DBT. Therapists might begin by using a devil's advocate strategy (Linehan, 1993a). In a somewhat puzzled and challenging manner, for example, they might say:

> *OK, we're assuming that you're all here because you want to gain control over your eating behavior. Specifically, we're assuming that you want to stop binge eating, right? We're also assuming that you want to enjoy your life—that is, you want a quality of life in which you enjoy your relationships, feel a sense of mastery, and feel good about yourself most of the time. And as we understand it, BE is a problem because it interferes with feeling good about yourself and having the quality of life you desire. What isn't clear to us and what we'd like explained now is: Why can't you have a quality life and stay a binge eater? Why can't you do both? Explain that to us. (Safer et al., 2009)*

The point is for therapists to draw group members into arguing that it is imperative for them to stop binge eating to lead a quality life. Therapists must be sure to polarize the argument by describing the quality of life they believe the group members can attain as one that is deeply rewarding, one in which group members are fully alive and feel very *very* good about themselves—a seeming impossibility to many clients with BED. In other words, therapists must ensure that group members understand that by "quality of life," one is not referring to simply existing, getting by, or minimizing pain.

Therapists then use the group members' arguments as a starting point for eliciting the pros and cons of continuing life as a binge eater and list these on the board. Therapists might next assert:

> *OK, based on what we've just heard from you, there is absolutely no other choice than to stop binge eating. You've convinced us. So let's face it and put this on the table before we get any further. Binge eating is over. Whenever you last binged, that was the last one. You simply can't have the kind of life you want to lead and continue BE and problem eating. So we're all in agreement, right? We're all committed, right?*

The intention is to obtain a verbal commitment from each group member. Some clients may fear committing because of worries that they will fail. One of the therapists might say:

> *Are you worried about BE in this moment or are you worried about the future? We're not talking about the future but about this one moment. Can you make a commitment to try your absolute hardest to never ever binge again in this one moment, right now? [door in the face]*

If a client insists "It's impossible" or that making a commitment would be a "set-up," the therapist might offer:

> *Would it literally be impossible? I mean, it would likely be very, very difficult and scary—but are you saying that you think there is no way for you to physically survive unless you were binge eating?" [using a matter-of-fact tone, irreverence]*

If the client concedes that it actually would be *possible,* one of the therapists can say:

> *So it sounds like you agree it might actually be possible to stop bingeing but you are very certain that you would fail in the attempt. Therefore, it feels easier to tell yourself that stopping BE is more impossible than to try to stop. Because if you were to try your best but fail, you would have to feel awful about yourself not only for having binged but for failing in your attempt to stop. I can understand that kind of thinking. [validation] Yet, we know from research on commitments that when people don't make a commitment or say they will accept less—when, right from the beginning they say there's no hope—the likelihood of success is very low.*

Other tasks of Session 1 include orienting group members to (1) the emotion-regulation model of binge eating; (2) the treatment targets and group agreements; (3) the biosocial model including an explanation of the invalidating environment (see the adaptation of DBT's biosocial theory to EDs); and (4) the diary card (described below) and chain analysis.

### *Session 2: Explaining the Concept of Dialectical Abstinence*

In Session 2, therapists introduce clients to the concept of dialectical abstinence, a concept originally developed in DBT adapted for substance use disorder (DBT-SUD; Linehan & Dimeff, 1997). Dialectical abstinence is a synthesis of a 100% commitment to abstinence and a 100% commitment to relapse management strategies. Before a client engages in problematic behaviors (e.g., binge eating), there is an unrelenting insistence on total abstinence. After a client has binged, however, the emphasis is on radical acceptance, non-judgmental problem solving, and effective relapse prevention, followed by a quick return to the unrelenting insistence on abstinence (Linehan et al., 1999).

Therapists might introduce this concept with an explanation that a "dialectical

view" recognizes that for every force or position there exists an opposing force or position: a thesis and an antithesis, yin and yang. For example, the yin and yang symbol is black and white, yet the synthesis of these is not merely the color gray. This leads to discussion of a problem as well as its solution. On the one hand, group members have all made a 100% commitment to binge abstinence. Anything short of that would be failure. When faced with the urge to binge, one cannot have the idea that it is "OK" to binge and fail and to "just try again." Such thinking is undermining and will make it more likely one will decide to binge-eat. On the opposite side, it is clear that in not anticipating and preparing for a slip, clients will be less likely to handle such an event effectively, should it occur. This is the problem that therapists and group members are faced with and that is presented for discussion: How can one deal with these two opposing forces of success and failure?

The metaphor of the Olympics becomes quite useful at this point (Safer et al., 2009). The therapists suggest that group members are like Olympic athletes and the therapists are like coaches. Clients are participating in an incredibly important event, improving their lives by putting an end to binge eating. Absolutely nothing is discussed before a race in the Olympics except winning, or "going for the gold." Similarly, the only thing group members can possibly allow themselves to think about and discuss is absolute and total binge abstinence. But, of course, athletes and group members must be prepared for the possibility of failure. The key is to be prepared to fail well. The dialectical dilemma is that both success and failure exist. The dialectical abstinence solution involves 100% certainty that binge eating is out of the question and 100% confidence that one will never binge again. However, simultaneously, one keeps in mind ("Way, way back in the very farthest part of your brain so that it never interferes with your resolve") that if one slips, one will deal with it effectively by accepting it non-judgmentally and picking oneself back up, knowing one will never slip again.

### *Sessions 3–5: Mindfulness Skills*

The mindfulness skills are introduced in these 3 sessions and reviewed in Session 12. These skills are the same as in standard DBT—mindful eating, urge surfing, and alternate rebellion—that are discussed in more depth below. Urge surfing and alternate rebellion were borrowed from DBT-SUD (Linehan & Dimeff, 1997).

#### *Mindful Eating*

Mindful eating, as opposed to mindless eating, is the experience of full participation in eating. It is eating with full awareness and attention (one-mindfully) but without self-consciousness or judgment.

#### *Urge Surfing*

Urge surfing involves mindful, nonattached observing of urges to binge or eat mindlessly. Mindfulness skills teach one to accept the reality that there are cues in the world that will trigger the urge to binge-eat. Clients are educated about how urges and cravings are classically conditioned responses. Mindful urge surfing involves awareness without engaging in impulsive mood-dependent behavior. One simply notices

and then describes the ebb and flow of the urge. One is "letting go" or "detaching" from the object of the urge, and "riding the wave" of the urge. Though bearing similarities to mindfulness of the current emotion, urge surfing is a mindfulness skill that involves non-judgmental observing and describing of urges, cravings, and food preoccupation.

#### *Alternate Rebellion*

This mindfulness skill involves using the "how" mindfulness skill of *effectively* to satisfy a wish to rebel without destroying one's overriding objective of stopping binge eating. The purpose is not to suppress or judge the rebellion but to find creative ways to rebel that do not involve "cutting off your nose to spite your face." Many clients with BED have described the desire to "get back" at society, friends, and/or family whom they perceive to be judgmental about their weight. Rather than compromising one's goals and consuming even more food as a means of "getting back," alternate rebellion involves finding effective ways to rebel so that long-term goals are honored. Clients are encouraged to observe their need to rebel, label this urge as such, and then, if they decide to act on the urge, to do so effectively. Group members can be creative. For example, a client who feels judged by society for being obese might "rebel" by buying and wearing lacy lingerie.

### *Sessions 6–12: Emotion-Regulation Skills*

These sessions cover the emotion-regulation skills taught in standard DBT, without any specific adaptations for Stage 3 clients with BED except when they involve a focus on the problem-eating treatment hierarchy.

### *Sessions 13–18: Distress-Tolerance Skills*

These sessions cover the distress-tolerance skills of standard DBT. The one skill added, burning bridges, was borrowed from DBT-SUD (Linehan & Dimeff, 1997).

#### *Burning Bridges*

This skill involves accepting at the deepest and most radical level the idea that one is really not going to binge-eat, or eat mindlessly, or abuse oneself with food ever again—thus, burning the bridge to those behaviors. One accepts that one will no longer block, deny, or avoid reality with binge eating.

### *Sessions 19–20: Relapse Prevention*

Session 19 begins with a review of mindfulness, emotion regulation, and distress tolerance. In addition, clients fill out a worksheet for Session 20 asking them to:

1. Detail their specific plans for continuing to practice the skills taught.
2. Outline their specific plans for skillfully managing emotions in the future. They must identify the circumstances and emotions that previously set off binge eating. Outline their plans for dealing with the emotions that will

prevent any problem eating behaviors. Write about at least three different emotions.
3. Explain in writing the next actions they need to take in life to continue building a satisfying and rewarding quality of life.

Session 20 includes each group member reviewing their worksheet as well as final good-byes. Like standard DBT, many groups come up with rituals to mark the end of treatment.

### *DBT Consultation Team*

Therapists meet weekly with the treatment team to confer with regard to the progress of treatment and adherence to DBT principles. However, these consultation teams lack the exchange between individual and skills therapist because, unlike standard DBT, clients are only treated in a group context. Because the SM for clients with binge eating and bulimia was researched at a site where members of the treatment team were all highly familiar with eating disorders but not all were familiar with DBT, it was often useful to have an expert DBT therapist who was not identified as an eating disorder specialist as a member of the treatment team.

### *Telephone Consultation*

Although clients are encouraged to call therapists if they have questions during the week (e.g., for clarification of a particular skill, for dealing with uncertainty on how to apply a skill in a particular situation), telephone coaching as practiced by individual therapists in standard DBT is not used in DBT for binge eating and bulimia. Skills generalization is addressed during the first hour of the group treatment and through written feedback on weekly homework assignments by the therapists. As with other components of DBT for binge eating and bulimia, this decision to not implement standard DBT telephone skills coaching was made for research purposes so that the treatment would be comparable to other short-term (e.g., 20-week) outpatient therapies for this population in terms of clinicians' time demands. Standard DBT telephone coaching might well be indicated in other settings.

### *Diary Card and Chain Analyses*

DBT strategies are used without modification, as described in the treatment manual for standard DBT (Linehan, 1993a), with the exception of the diary cards and ED-specific targeted behaviors. In other words, the chain analyses are those used in standard DBT (Linehan, 1993a) with maladaptive eating behavior (e.g., binge eating, mindless eating) as the targeted problem behavior for these Stage 3 clients.

## Summary

This chapter discussed how and why to adapt DBT to clients with EDs. We presented two models independently developed that were influenced by both their client populations and treatment setting. DBT for multi-diagnostic EDs, for example, was

specifically developed for clients with EDs and out-of-control behaviors that may meet criteria for comorbid BPD. An advantage of this model is its appropriateness for clients who are suicidal and/or engaging in NSSI, and/or engaging in substance abuse in conjunction with their ED. It is also appropriate for clients whose serious, complex, and/or treatment-resistant ED, as well as possible medical and psychiatric comorbidities, may require an intensive outpatient and partial hospital setting. If needed, this model may include CBT components within a DBT framework. DBT for clients with multi-diagnostic EDs requires a suitable infrastructure in which standard DBT components can be provided, such as group and individual DBT, a consultation team for therapists, and a 24-hour on-call system.

The second model presented, the Stanford model, was specifically designed for clients with BED and BN in an outpatient clinical setting. Elements of standard DBT, such as weekly individual sessions and weekly skills-training groups, were combined into a single format (e.g., 20 sessions of 2-hour weekly group therapy for BED). The SM for clients with BED and bulimia has the advantage of having the most empirical support at present. By using the information provided in this chapter as a foundation, greater clarity in implementing ED-specific adaptations suitable for other treatment settings and target client populations can be gained.

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CHAPTER 14

# DBT beyond Stage 1

## *An Overview of Stages 2, 3, and 4*

CEDAR R. KOONS

When Marsha Linehan developed dialectical behavior therapy (DBT) as a treatment for borderline personality disorder (BPD), one of many valuable contributions she made was delineating the stages of treatment. Linehan described four stages of treatment that correspond to four levels of the disordered behavior of clients. She also prescribed goals and targets for each stage, including a pretreatment period (Linehan, 1993). By delineating stages of treatment and the treatment targets for each stage, Linehan gave therapists a clear road map for how to progress through treatment in a defined path rather than becoming lost in the ever-arising crises presented by the client.

The level of disorder that corresponds to Stage 1 of treatment includes suicidal attempts and nonsuicidal intentional self-harm, behaviors that could potentially doom therapy, and behaviors inconsistent with an adequate quality of life, such as abusing alcohol or being homeless. These behaviors are not caused by one discrete problem such as addiction or depression, but are theorized to be caused by pervasive emotion dysregulation and lack of behavioral skills. The goal of Stage 1 treatment is to eliminate suicidal and self-harming behaviors, reduce behaviors that interfere with therapy, establish basic behavioral control, and increase behavioral skills.

The level of disorder apparent in Stage 2 includes emotional avoidance, numbness, and symptoms of posttraumatic stress contributing to "quiet desperation" and poor quality of life. The goal of Stage 2 treatment is to reduce posttraumatic stress and increase normative emotional experiencing, including of love and joy. Clients in Stage 3 level of disorder, while having overcome behavioral dyscontrol and quiet desperation, continue to have "ordinary problems of living," such as limited or conflicted interpersonal relationships, self-care deficits, or protracted difficulties with work or finances. These problems, though likely partially addressed in previous stages, are the main targets of Stage 3. The level of disorder associated with Stage 4 includes lingering problems with meaning, emptiness, and a lack of joy and freedom. Stage 4's

goal is achieving greater life satisfaction, joyful awareness, emotional flexibility, and freedom from rigidity and attachment. Stage 4 treatment, when it occurs in therapy, often includes efforts to strengthen mindfulness meditation practice.

Stage 1 of DBT is well described in Linehan's 1993 treatment manual and is summarized by Comtois, Elwood, Melman, and Carmel, Chapter 10, this volume. In some treatment settings, Stage 1 is the totality of DBT offered. For many years, Stage 2 was less well described beyond what was in Linehan's text, though notable work described the terrain and dilemmas of Stage 2 (Wagner & Linehan, 2006; Rizvi & Linehan, 2005), including some research (Bohus et al., 2013). Recently, the DBT prolonged exposure (DBT-PE) protocol and other DBT-compatible exposure treatments are showing promise and providing more guidance for how to conduct formal exposure and other interventions geared to this stage of treatment (Harned, Korslund, & Linehan, 2014; for a discussion of DBT-PE, see Chapter 10). How to conduct Stages 3 and 4, however, has received little attention in both the clinical and research literature. Since the work of Stage 1 will only take a client so far toward a life worth living, being able to provide treatment targeted to get them "all the way" may reduce the likelihood of relapse and also improve satisfaction for the therapist.

In settings where resources are limited, clients may be referred out after a prescribed period of time, or at the end of Stage 1. For many DBT clients, the risk of relapse to Stage 1 behaviors may be reduced by keeping their therapist in later stages, as this person understands their particular strengths and vulnerabilities and knows their history. In all outpatient settings, however, therapists should be prepared to conduct treatment beyond Stage 1, to avoid continuing Stage 1 treatment strategies beyond when they are needed or overlooking new goals and targets as they emerge. If unprepared, therapists may default to conducting unfocused sessions without a clear treatment plan or target hierarchy. This chapter will describe the basics of how DBT may be conducted in Stages 2 and 3 and will offer some suggestions for Stage 4, utilizing a fictional case example.

## Is My Client in Stage 2?

Movement through the stages of DBT is not a factor of time, though time does play a role. To determine whether a client has arrived at Stage 2, we evaluate whether they have made significant progress in each of the four main targets of Stage 1: elimination of suicidal risk, reductions in behaviors that significantly interfere with therapy or with an adequate quality of life, and acquisition of behavioral skills (Wagner & Linehan, 2006). A client who is not actively suicidal or self-harming and is not engaging in other severe behaviors in the presence of cues that previously evoked suicidal and other severely dysfunctional behaviors, and who already possesses basic behavioral skills may be at or near Stage 2 at the outset of treatment. However, most clients referred to DBT, even those without severe behaviors, require some time to acquire and strengthen the basic skills of Stage 1 prior to entering Stage 2.

Clients who are actively suicidal or engaging in nonsuicidal self-harm are, by definition, in Stage 1, even if they have been in treatment longer than a year. So are clients whose therapy-interfering behaviors are severe enough that the therapeutic relationship is under constant stress, or whose quality of life is not adequate due to severely dysfunctional and repetitive high-risk behaviors or a high-risk environment

over which they have no control. Clients who refuse to use skills to manage their severe targeted behavior should be considered to be in Stage 1, even if they know the skills so well they could teach them to others. And, no matter how long they have been in DBT, clients who have abrogated the basic commitments to therapy should be considered to have returned to pretreatment, the goal of which is recommitment to the stage of treatment and targets they were in prior to losing commitment.

At the beginning of Stage 2, clients should be collaborating with their therapist and tolerating group well enough to attend and participate. They should have acquired some skills in each of the modules, especially distress tolerance, and thus have improved their ability to experience strong emotions without resorting to self-destructive or addictive behaviors. Clients who have eliminated suicide attempts and nonsuicidal self-harm have taken a giant step toward Stage 2, even if they still have the occasional suicidal wish, thought, or expectation. Because suicidal thoughts may have been habitual for years and probably reinforced negatively and positively, the thoughts may persist for some time, even after the person no longer endorses any actual desire to kill themself (Linehan, 1993).

The client in Stage 2 of disorder will often still look and feel miserable. While no longer behaving in ways that appear out of control to others, they may *feel* out of control—of emotions, relationships, and life. Nonetheless, they typically attend therapy, come to group, and comply with what the therapist asks them to do, such as homework, diary card, coaching calls, and other assignments. Clients may look as if they are only "going through the motions" because they remain emotionally and experientially avoidant and socially isolated. While they perhaps no longer dissociate frequently, they may report feeling numb. They may also describe feelings of anhedonia, emptiness, boredom, and meaninglessness. A primary goal of Stage 2 then is to increase normative emotional experiencing; this awareness can also reduce feelings of emptiness and boredom (Wagner & Linehan, 2006; Fruzzetti, 2016).

### *What Do I Need to do to Begin Stage 2 Treatment?*

To conduct competent DBT in Stage 2, therapists should first revise their case formulation to align with the client's current goals and problems, keeping in mind the biosocial model of DBT and the secondary targets from Stage 1 (Wagner, Rizvi, & Harned, 2007). Many clients continue to have significant problems, which either may have received insufficient attention in Stage 1 or recur in Stage 2, including poorly treated depression, panic attacks, obsessive–compulsive disorder (OCD), social isolation, sleep disorders, and the like. Evidence-based protocols available can be learned from manuals or from expert training.

If unable or unwilling to learn or apply treatments that the client clearly needs, the DBT therapist will need to make a referral to someone who can offer the best available methods at the end of Stage 1. These protocols are usually not developed for individuals with BPD, however, and the expert therapists who apply them may not have experience treating persons with BPD and thus might be unwilling to treat them or have judgments and fears about their emotional intensity or history of suicidal behavior. Thus, ideally, the DBT therapist will be willing to learn evidence-based treatments for the most common problems Stage 2 clients experience, including formal and informal exposure methods.

Like Stage 1, Stage 2 requires clear and appropriate targets, an emphasis on skills

generalization, the continued use of a DBT consultation team, and staying up-to-date on the latest research (Wagner et al., 2007). These basics of DBT, plus reliance on a dialectical approach, help therapists remain effective with clients in Stage 2 (Fruzzetti & Payne, 2015).

### *Should My Client Remain in Skills Class?*

Stage 2 clients may benefit from remaining in skills class beyond the requisite first year or from participating in an advanced class if one is available. Different models of advanced classes exist for beyond Stage 1, from therapist-led to peer-led and from those that focus on skills review and generalization, such as the Accepting the Challenges of Employment and Self-Sufficiency (ACES) program (see Chapter 10), to those that increase interaction among participants through peer teaching and process interactions. Therapists should assess their client's skills mastery and needs to determine whether they would benefit most from remaining in a regular skills class, participating in an advanced group, or taking a break from group in Stage 2 (Harned & Linehan, 2008).

Each DBT skills module also has specific applications for the tasks of Stage 2. For example, mindfulness skills can help clients reduce dissociation and increase sensory experiencing, both of which help them attain normative emotional experiencing (Harned, Ruork, Liu, & Tkachuck, 2015). Interpersonal effectiveness skills, which may not have been acquired sufficiently in Stage 1, are strengthened in Stage 2, as the isolated client increases their self-expression, learns how to approach relationships, and practices being more mindful of others (Linehan, 2015). The client in Stage 2 can make greater use of the reality acceptance skills from the distress-tolerance module. No longer using crisis-survival skills just to get through the day, they can begin to practice and grasp the skills of turning the mind, willingness, and radical acceptance, and to use those skills in a generalized way. Finally, learning to observe and label emotions, as well as to understand, embrace, and regulate them, has new meaning for Stage 2 clients who have practiced emotional avoidance for such a long time, possibly even during their first exposure to the emotion-regulation skills in Stage 1. Emotions become less frightening, more tolerable, and more acceptable throughout Stage 2. Clients begin to grasp the importance of reducing their vulnerability to strong emotions and problem solving around emotional situations, rather than avoiding them.

### *Starting Stage 2*

When a client moves between stages in DBT, the therapist should consider revisiting orientation and commitment. A good way to begin is to highlight the progress already made and connect that progress to the work that lies ahead. For example, if the client worked hard in Stage 1 to tolerate distress from intense emotions, they can use those same skills in the upcoming work of increasing normative emotional experiencing. Thus, the client who in Stage 1 was paralyzed by fear when invited to a neighborhood potluck dinner—attending, if at all, in intense discomfort—in Stage 2 will attend despite feeling mild to moderate anxiety, and will fully participate and perhaps even enjoy the party.

Highlighting progress in this way naturally leads to a discussion of what the client would like to work on next. The therapist asks about the client's goals now and

how those goals might be met, and provides information on what treatment methods could be used and the evidence of their effectiveness. Stage 2 clients should be prepared to participate in exposure for posttraumatic stress disorder (PTSD), panic attacks, social anxiety, OCD, simple phobia, and other anxiety disorders that are characterized by avoidance behaviors; or in the absence of a specific disorder, learn to fully experience emotions rather than avoid or blunt them in some way. Stage 2 is also a time to recommend activities that help the client reengage with their community, such as taking academic, fitness, or vocational classes or participating in volunteer work.

The therapist and client should come to agreement about the structure for Stage 2, such as weekly sessions of DBT individual therapy and possible participation in a skills-training class or an advanced group for a stage-specific purpose. Just as in Stage 1, the client will be asked to complete a diary card and homework assignments in both individual and group therapy.

The next task is to get specific about the targets of Stage 2 and what might interfere with achieving those goals. For example, for a client who is socially isolated but wants more relationships, the therapist might target obstacles such as anxiety in social settings, the avoidance of social settings, and automatic and self-defeating self-appraisals, while also strengthening a set of skills to overcome them (Fruzzetti, 2016). The more specific and clearly defined the obstacle, the easier it will be to overcome.

Some clients are eager to take on marital therapy or family therapy in Stages 1 or 2, perhaps before they have the skills needed to manage the cues present in the conjoint sessions. The DBT therapist should consider the timing of marital and family therapy in the target hierarchy, especially for clients who are temperamentally or emotionally vulnerable and who have more difficulties being interpersonally effective when profoundly aroused emotionally (Fruzzetti & Payne, 2015). Marital and family therapy sessions, especially those conducted outside a DBT framework, may cause interruptions in work on other targets, should a client need to use their session to talk about what happened in a conjoint session and reregulate. Thus, the therapist and client should come to an agreement about which targets to prioritize. If the client and therapist agree that marital work takes precedence, it can be done in Stage 2 prior to exposure work. However, in many cases, conjoint therapy sessions can be postponed until later in Stage 2 or even put off to Stage 3, to give the client and their therapist time to complete exposure and gain more stimulus control before undertaking conjoint sessions.

### *Case Example: Melissa*

"Melissa," a single, white, heterosexual woman with no children, entered DBT at age 24 after her second psychiatric hospitalization. She had completed 2 years of college and worked in a wholesale supply company as a data entry clerk. Melissa was diagnosed with recurrent major depression, social anxiety, and BPD. Melissa also reported problems with dyslexia, colitis, and acne.

Melissa is the younger of two daughters born to an insurance salesman and a self-employed bookkeeper. Melissa's older sister, Victoria, a nurse, is married with two young children. Melissa has no memory of sexual or physical abuse or neglect in her childhood. However, from her earliest memories, she felt subjected to intense

and traumatic invalidation from her parents. For example, at about age 5, Melissa overheard her mother telling her grandmother that she felt "cursed to have Melissa for a daughter." She also remembers being told she was the cause of her father's frequent depressions and that her "emotional demands and tantrums" contributed to his suicide attempt when she was 14. These feelings of being blamed contributed to her making a suicide attempt and being hospitalized for the first time when she was 15. Melissa also experienced bullying, taunts, and repeated rejections from her peers beginning in childhood and throughout adolescence.

Even though Melissa's IQ is in the high normal range, her learning disability interfered with her achieving the academic success expected in her family. Melissa always believed that her parents preferred her sister to her. Victoria was pretty and a good student. According to Melissa, Victoria never missed an opportunity to point out her superiority. Shortly before Victoria's wedding, Melissa had an acne outbreak and Victoria expressed dismay that Melissa would have a "pineapple face" for the occasion. Melissa attempted suicide and missed the wedding.

Melissa lived in her parents' guesthouse on their property from the time she dropped out of college. After several years of unemployment, she finally got the data entry job, which she struggled to keep. Fights with her parents revolved around her lack of goals, her financial dependency and impulsive spending, the disarray of her apartment, and her appearance. Melissa had few friends and spent most of her time outside work alone.

Melissa's hospitalization just prior to entering DBT resulted from an overdose of medications after an argument with her parents. She spent a night in intensive care followed by a week in an acute care psychiatric unit. Her doctor prescribed an atypical antipsychotic and an antidepressant and also renewed two problematic medications, Ativan and fentanyl, the ones she had used to overdose.

Melissa entered DBT and quickly developed a strong attachment to her individual therapist, Robert. During the first 6 months, she had difficulties completing her diary card and skills homework. Melissa struggled to attend skills class due to social anxiety. Melissa's Stage 1 targets included suicidal thoughts and urges, fights with her parents, poor personal hygiene, social isolation, impulsive spending, and procrastination. Robert also focused on trying to increase her use of phone coaching, decreasing as-needed use of Ativan and reducing and eliminating fentanyl. Robert had Melissa rate daily her self-invalidation, sadness, avoidance, and shame, and they explored the intermittent reinforcement she received from her parents when she voiced suicidal thoughts.

After 15 months in treatment, Melissa's progress included marked decreases in suicidal thoughts and urges; improvement in attendance, homework, and diary card completion; and improvement in skills use, especially distress-tolerance and mindfulness skills. Melissa had stopped using fentanyl and decreased her use of Ativan. She improved her hygiene and grooming. She also asked for and received a raise at work, started budgeting her money, moved out of her parents' guesthouse and into a studio apartment, and began attending a monthly book club organized by a coworker.

Still, Melissa remained socially isolated, struggled with depression, procrastinated at work, and avoided friends and acquaintances during her time off. She continued to have occasional suicidal thoughts and arguments with her parents and sister when she felt attacked and misunderstood. Sometimes these arguments contributed to a colitis flare, which could result in her missing work and staying in bed. Melissa

had serious doubts about her self-worth that stemmed from the invalidation of her childhood.

### *Melissa's Stage 2 Targets*

Robert, Melissa's therapist, began Stage 2 with a session focused on the progress she had made in Stage 1. Together, they revisited the progress she had made and her new goals: to feel more enjoyment in life, be more stable financially and more productive at work, have more friends, and make efforts to meet a life partner. Robert expressed support for these goals, and they made a list of the behaviors that still could get in the way of pursuing them, including avoidance of her emotions and of other people, self-loathing thoughts, impulsive spending, boredom, and problems with sadness and shame. Robert gave Melissa an overview of the kinds of treatment he recommended, including exposure to cues that elicit strong emotions and to emotionally traumatic events from her childhood. He advised her she would be expected to tolerate strong emotions, listen to recordings of their sessions, approach a series of situations that provoked anxiety for her, and continue to practice skills. Melissa agreed to the treatment plan, and she and Robert committed to another 12 months of weekly sessions. Then they discussed the skills Melissa still needed to acquire, strengthen, and generalize. When Robert offered her a chance to participate in an advanced skills group, Melissa agreed to participate for at least 6 months to increase her interpersonal interactions and improve her grasp of the other skills.

Melissa and Robert agreed their first target would be to increase her capacity to experience strong emotions, especially sadness and shame, without acting on or blocking them. The second task was exposure to the intense invalidation she experienced in childhood. The third task was to increase her social interactions, with the goal of making friends and starting to date. Robert suggested they also target Melissa's avoidance at work and her impulsive spending. Finally, Melissa wanted to increase her interest in life (decrease boredom) and increase enjoyment on a day-to-day basis.

## *Secondary Targets in Stage 2*

The six secondary targets identified in Stage 1 of DBT (see Chapter 10) continue to influence clients and interfere with progress in Stage 2 (Wagner et al., 2007). The difference is that when the patterns assert themselves in Stage 2, the client is less likely to engage in high-risk behavior, as was the threat in Stage 1. Recognizing prominent secondary targets can help both the client and therapist to anticipate and respond to problematic behavior patterns before they precipitate a crisis. Highlighting the role of secondary targets encourages self-observation and correction in the client (Fruzzetti, 2016).

For example, the person who experiences exquisite emotional vulnerability and responds with the learned behavior of self-invalidation will probably continue this transaction in Stage 2. The more intense the emotional distress, the crueler the self-invalidation, and so it goes in a vicious cycle. In such a case, the client must learn to interrupt the cycle with mindfulness to current emotion, self-validation, and encouragement. The therapist in Stage 2 emphasizes mastery of emotion-regulation skills, especially those that reduce emotional vulnerability and intensity and enable the client to notice and step aside from self-critical and perfectionist thoughts.

Similarly, clients who avoid emotions and then find themselves acting impulsively and creating crises will likely still struggle with this in Stage 2. Although the impulsive behaviors will not be as severe as those of Stage 1, they often create crises for the client, such as damage to an important relationship due to ineffective anger expression or not having money for a necessity because of impulsive spending. A pattern still apparent in Stage 2 is the tendency to avoid emotions by becoming numb, called *inhibited emotional experiencing* or *inhibited grieving* (Linehan, 1993). Avoidance of emotion makes the person more vulnerable to disregarding the next crisis developing or the next impulse arising. The therapist helps the client identify and skillfully manage urges targeted in Stage 2, such as an urge to withdraw when sad, resulting in a weekend spent alone, thereby precipitating a depressive episode. The ability to tolerate emotional experiencing without impulsive action is crucial to Stage 2, especially during exposure when the client must be able to tolerate strong emotion without acting on urges.

Finally, the client whose problem-solving style is passive and avoidant but who appears quite competent on the surface will continue to evince this problematic pattern, though to a lesser degree, in Stage 2. To address active passivity in Stage 2, the therapist will encourage effective use of the mindfulness skill, the skill of coping ahead when problems are anticipated, and problem-solving skills for problematic emotions when they are justified and opposite action when they are not—all toward the goal of trying to encourage a more active problem-solving approach. In Stage 2, better problem-solving and interpersonal skills, especially the ability to say "no" when needed, will help move the client from apparent-only competence to actual competence.

### *Melissa's Stage 2 Secondary Targets*

In Stage 1, Melissa had specific difficulty with the secondary targets of inhibited emotional experiencing and crisis-generating behavior. As Melissa gained skills in distress tolerance, she stopped dissociating and thus began to observe and describe her emotions instead of avoiding or reacting impulsively to them. The observe and describe skills helped Melissa to become more aware of her inner state and take steps to reduce crisis-generating behaviors such as missing work or canceling social plans. Once Melissa had more emotion-regulation skills, she was less vulnerable to her emotions than in Stage 1. When she became emotionally aroused, however, she still resorted to self-invalidation and severe self-criticism. For example, when attending her book club, she sometimes was so afraid of saying the wrong thing that she would become paralyzed and unable to speak. Afterward she would criticize herself mercilessly for remaining silent. Before Robert undertook formal exposure work with Melissa, he wanted her to decrease this self-invalidation, increase access to her wise mind, and use skills like encouragement and mindfulness to current emotion more effectively. Robert hypothesized that when Melissa learned to tolerate her fear and disappointment without resorting to self-invalidation, she would be more open to her *essential validity,* that is, the ability to appreciate her value as a human being without reference to her accomplishments or the appraisals of others. Robert discussed this idea with Melissa as a potential goal. While Melissa was hesitant to embrace her essential validity at first, she did agree to work on reducing self-invalidation.

In Stage 2, Melissa most struggled with active passivity and apparent competence.

Robert helped her focus on active problem solving as one of the solutions to her ongoing depression. He worked with her to increase acknowledging her problems, rather than avoiding them and becoming depressed. For example, when she worked hard on an important project at work, she was disappointed that her supervisor appeared not to notice. Melissa started to feel sad and hopeless. With Robert's encouragement, she scheduled a meeting with her supervisor to discuss her work. The supervisor praised her work, and after this meeting she paid more attention to Melissa's efforts. The more success Melissa achieved in actively solving her problems, the more actual competence she started to show, increasing her ability to complete tasks. Because Melissa's passive problem-solving style had become firmly established in childhood, Robert anticipated that work on these behavior patterns would need to continue in Stage 3.

Many of Melissa's biggest challenges arose out of her tendency to avoid contact with sensory and emotional experiencing. Because her mild dissociation began as a young child, it remained Melissa's most practiced coping mechanism and contributed to numbness and isolation. In Stage 1, Melissa's go-to skills were the crisis-survival skills, which, while more adaptive than her problem behaviors, are largely based on avoiding emotions by distracting from them or decreasing them without directly confronting the cues (Linehan, 2015). Melissa needed to practice skills to *approach* her experiences, both pleasant and unpleasant. The path to Melissa's Stage 2 goals led to increasing her contact with her inner experiences and practicing skills that increased her awareness of what she was feeling. Robert hypothesized that emotional and experiential avoidance contributed greatly to her anhedonia and sense of meaninglessness.

### *Emotional Exposure*

Therapists treating Stage 1 clients rarely strive to increase the sensations, experiences, or expressions of strong emotion. In contrast, in exposure sessions, clients are asked to set aside the skills of distracting from emotions, avoiding emotions, and sometimes even self-soothing. Instead, they learn to sense their emotions fully without resorting to extreme, problematic, or escape behaviors (Rizvi & Linehan, 2005). Emotional exposure can be uncomfortable both for the client, who has learned to be emotion-phobic, and for the therapist, who fears the fire of the client's emotion burning out of control. The client must learn to distinguish the primary emotion, which is sometimes suppressed, and the secondary emotions that occur in response to the primary emotion and that may function to avoid feeling the primary emotion (Fruzzetti & Payne, 2015). The client must also be aware of the accompanying urges and not act on them, while enduring the associated bodily sensations until the emotion subsides. Further, they must be able to behave, speak, and interact effectively under the influence of strong emotions.

Depending on the case formulation, both formal and informal emotional exposure techniques may be used late in Stage 1 or early in Stage 2 (Harned et al., 2015). Informal exposure can be used very effectively "on the fly" whenever a therapist notices emotional avoidance in the session, beginning in Stage 1. When conducting planned informal exposure to emotions, the therapist focuses on having the client describe in detail the "emotional landscape" of the week. The therapist helps the client focus on the emotions felt before, during, and after any problematic interaction, distinguishing between primary and secondary emotions. The therapist also attends

to the emotions the client is feeling *within* the session, when reviewing events of the week or when the therapeutic relationship is discussed. Before turning to problem solving to reduce the emotions, as would be prioritized in Stage 1, the therapist lingers with the client's emotions in an effort to help them feel, identify, describe, and understand how the emotions function, radically accept them, and allow them to pass. In this way, the client learns how to experience strong emotions, continue to function effectively, and return naturally to a less aroused state. It is helpful during informal exposure for the therapist to ask the client these questions: "What emotion are you feeling right now?" "How strong is the emotion on a scale of 1 to 10, with 1 being very, very mild and 10 being as strong as you ever feel that emotion?" "Is this the main emotion you feel or is another emotion present? Which one do you think is primary?" When the client uses nonspecific words like "overwhelmed," "tired," "bored," or "empty" to describe emotions, the therapist should probe to find the simplest true emotion that describes best what the client is feeling.

### *Emotional Exposure with Melissa*

Melissa entered Stage 2 depressed, anxious, and struggling to regulate the emotions of shame and anger. She was most likely to feel depressed on weekends when she isolated, avoiding social situations. She frequently experienced sadness when she felt judged by her family or treated unfairly at work. Shame was Melissa's most problematic emotion. Melissa felt ashamed of her appearance, her lack of achievement, her mental and physical health difficulties, her life problems, and her lack of friends and lovers.

Robert oriented Melissa to the tasks of emotional exposure and obtained commitment to proceed. He began by exploring Melissa's depression. Although Melissa intellectually knew she must be experiencing sadness, she found it difficult to identify the sensations that accompanied her sadness and frequently resorted to words like "boredom" or "emptiness" to describe her inner state. She could readily describe her sad thoughts, most of which had to do with loneliness. For example, she would say, "At the beginning of the weekend, I think about how I'll not talk to anyone for two whole days. My phone won't ring. No one will visit. My apartment is dead quiet, like a tomb. I have nothing to do and nowhere to go. Nothing interests me." She stated this with a blank expression, which Robert associated with suppressed emotion.

As Melissa talked about her lonely weekends, Robert helped her observe and finally describe the bodily sensations she felt, including her stomach sinking, the lump in her throat, and something she described as a cold sensation in her chest. Robert encouraged her to notice all these sensations and any urges that arose. One session they had the following interchange:

MELISSA: I feel like lying down on the couch. I don't want to go anywhere or do anything, but I also don't want to feel this way.

ROBERT: Can you rate your sadness on a scale of 1 to 10?

MELISSA: It's a 7. Today is Friday, and when I go home, I have nothing to do all weekend. I feel like I can't endure another weekend like this. (*Blank expression on her face.*)

ROBERT: Let's focus on your sensations of this sadness right now. Do you feel like you can tolerate the emotion right now?

MELISSA: Yes, but you're here.

ROBERT: What if I wasn't here?

MELISSA: (*Sobbing.*)

ROBERT: Do you feel it at other times during the week?

MELISSA: Yes, sometimes in the evenings. It gets worse as we get close to the weekend.

ROBERT: What is the urge when you are sad?

MELISSA: I just want to go to bed. And sometimes I do. I stay inside, watch TV.

ROBERT: Does that help?

MELISSA: No, it gets worse. I can hardly stand it.

ROBERT: What about going out?

MELISSA: You mean acting opposite?

ROBERT: Yes, tolerating the sadness but getting active.

MELISSA: I keep telling myself I feel too bad. I feel too anxious.

ROBERT: Are you anxious now?

MELISSA: No. (*Clenched jaw.*)

ROBERT: How do you feel right now?

MELISSA: I'm starting to feel angry! Why do I keep doing this?

Robert brought her back to the discussion of her loneliness, which continued for about 20 minutes, during which Melissa sobbed. She talked about feeling trapped in her loneliness and how she wanted to escape it. "This is why I would get suicidal," she said, "But I don't want to go back there." Eventually, Melissa calmed down. She blew her nose and sat up straighter. "Whew," she said, "That was quite a little tantrum." Robert admonished her for self-invalidating. "You're right," Melissa said, "It was actually helpful!" Melissa rated her sadness as a 3. She observed that the cold feeling and the lump in her throat were gone, although she still felt queasy.

"I hardly ever let myself cry like that in front of anyone," she admitted.

Robert talked about the pattern of avoiding emotions only to be overwhelmed by them later and the goal of normative emotional experiencing. As he spoke, Melissa's tear-streaked face took on an expression of resolve.

"I just realized something," she said. "I forgot I have my book club on Sunday! I've read the book and we're meeting at my friend's house. I'm going!" The rest of the session consisted of making plans for Melissa to go to her book club on Sunday and how to make herself go even if she wanted to back out at the last minute.

Robert and Melissa explored all of Melissa's problematic emotions in this same deliberate way. With fear, Melissa noticed her overwhelming urge to escape, especially in social situations in which she feared being judged. Fear caused Melissa's heart to race and her neck and face to become hot and blotchy. In social situations, she also noticed automatic thoughts, such as "I have no friends," "I am ugly and disgusting," and "I am worthless." Robert highlighted for Melissa how these thoughts

seemed to spring from the emotion of shame, which Melissa began to realize often followed fear. Because fear and shame felt similarly, she had a hard time distinguishing between the two. Melissa and Robert explored all the ways in which shame afflicted her, and as they talked about the emotion and she felt it, she learned to identify it, describe it, and evaluate whether her shame fit the facts of the situation. Robert encouraged her to describe all the bodily sensations she felt with shame and all the situations that prompted her to feel shame.

One day in session, Melissa told Robert about an encounter with a high school acquaintance who had spoken to her in her neighborhood coffee shop that week. The woman, who was with an attractive man, called her by name and said hello. She was visiting from out of town and wanted to know if Melissa still lived there. Melissa felt intense shame and could hardly speak. She believed the woman was condescending to her. She thought, "She'll think I'm ugly and disgusting." She mumbled "yes" and left the shop abruptly. Then she felt strong regret and anger at herself.

MELISSA: I felt my heart beating very fast. My face was hot and I started to sweat. My throat locked and I couldn't speak. I wanted to hide.

ROBERT: How strong was the shame?

MELISSA: A 10.

ROBERT: How about now?

MELISSA: About an 8. I don't know why it was so bad. She was very sweet and she even remembered my name! I couldn't remember hers! But I kept thinking she has this handsome husband and I have nothing. I don't know if he was her husband or not! I realized later that I felt really envious of her. I've noticed that sometimes when I feel strong shame, I also feel envy. Sometimes it's hard to tell which one came first.

As therapy progressed, Melissa became more comfortable acknowledging shame. She also improved in identifying the emotion in the moment and then acting opposite to shame when she determined it did not fit the facts. She told Robert that she had come to believe that shame was not always the first emotion she felt but one that quickly overpowered whatever primary emotion she was feeling. And then shame, even as a secondary emotion, prompted other emotions such as fear, anger, envy, and sadness. "I feel like if I can act opposite to shame, I can identify all the other emotions and manage them better. If I don't always fall into shame, I won't feel as anxious or as sad. At least I hope that is true." Melissa's hard work reducing self-invalidation was starting to pay off.

For several months, Melissa and Robert worked on identifying and acting opposite to shame. At first, Melissa felt flooded with shame most of the time, but gradually she began to catch it arising and use breathing and imagery to bring it down quickly. She also learned to use self-validation to help her counter automatic thoughts associated with shame.

During this phase of Stage 2, Melissa continued in skills group and Robert continued to consult regularly with his DBT team about her progress. The consultation team helped Robert remain focused on his case formulation, targets, and treatment plan as well as make use of the combined resources of his colleagues to fine-tune his application of exposure techniques.

### *Exposure to Traumatic Events in Stage 2*

How do we treat clients who report extremely painful events in childhood or adulthood but who do not meet the criteria for PTSD? Trauma treatment in DBT is grounded in DBT principles and is best practiced in harmony with those principles (Wagner et al., 2007). But complex traumas such as childhood sexual abuse or severe invalidation may not lend themselves to protocol-driven treatments (Decker & Naugle, 2008). First, the therapist must consider the individual's case formulation and assess what about the past event the client is avoiding, and why they are avoiding it. Then the therapist should explore what methods will be most effective with a client to reduce their fear, shame, and suffering, and to promote new understanding and acceptance. Each client in Stage 2 deserves an opportunity to talk about anything that happened to cause them to feel deeply invalidated as well as to be heard, understood, and have their pain validated by the therapist.

Exposure treatments have some features in common: (1) sessions may last longer and require time for wind-down; (2) the therapist often gives homework, such as asking the client to review a recording of the session or write about the session; (3) the client is encouraged to avoid "safety behaviors" that block exposure by distracting from the distress; and (4) the therapist may postpone the exposure if the client becomes suicidal or has a major crisis that temporarily must take precedence (see Chapter 12, this volume). If the therapist stops the exposure out of fear that the emotions themselves will be harmful to the client or due to the therapist's own distress, however, they risk reinforcing the client's belief that the traumatic event cannot be accepted or is too dangerous to think about or discuss (Decker & Naugle, 2008). Thus, once exposure begins, it should continue until completed, even if pauses must be taken when the client is in crisis.

#### *Melissa's Exposure to Severe Invalidation*

In his initial assessment, Robert had determined that Melissa did not meet the diagnostic criteria for PTSD, but she did experience intense pain and discomfort when discussing events in her childhood that she experienced as extremely invalidating. Robert had Melissa write down as many of these events as she could remember and then rate them from low to high with regard to how much distress they caused her. Melissa came up with a list of 16 instances of intense invalidation, beginning at around age 4 and culminating with her second hospitalization. Melissa's most distressing events tended to occur in developmental clusters, beginning with ages 4 to 7, then from ages 12 to 16, and then from 19 to 24. Each cluster contained at least one of her most highly distressing events. Robert and Melissa decided that rather than going from least distressing to most distressing in a traditional hierarchy, they would approach her experiences in chronological order. Melissa expressed some nervousness about proceeding but remained willing to do so.

Robert explained to Melissa the methods they might use: prolonged exposure (PE) and expressive writing. He disclosed his training and experience using these methods and data on their effectiveness. Robert thought that PE might not be the best method for Melissa, whose history, while intensely painful and invalidating, did not include specific, discrete events with threats to life or bodily integrity. Melissa expressed a strong desire to find new understandings about her experiences that

would increase acceptance for herself and her family. Together, they decided to use expressive writing (Pennebaker & Seagal, 1999), a modality Robert had used with other clients with histories of traumatic invalidation and emotional avoidance that did not meet the criteria for PTSD. After reading about the method, Melissa said she felt satisfied it was a good one for her.

Each week, Melissa was instructed to engage in free, uncensored writing about the next event on her list, with an emphasis on writing the facts and her reexperiencing the event in as much detail as possible, including emotions. Melissa agreed to set aside 30 minutes for writing that first week. At age 5, Melissa had a particularly painful memory. This is what she wrote about it:

> *I had been crying after a fight with Mother and fell asleep on the couch. I woke up and heard voices in the kitchen. I got up and walked toward the kitchen. I was going to ask for a cookie. I heard my mother and grandmother talking. Mother said, "She is such a bad girl." My grandma laughed and said, "Melissa is the price you pay for having Victoria." I was the price Mother paid? I didn't know what that meant exactly, but I knew it was not good. I already knew my mother didn't love me. But I thought my grandma did. Hearing my grandma say that made me want to die.*

Robert and Melissa discussed this event and its meaning for Melissa for several weeks. Each week, Melissa rewrote the story and more small details emerged. Melissa remembered she was home sick from daycare that day, and her mother was taking care of her. "She must have had to cancel clients," Melissa said. "I bet she hated that." She remembered the sound of her grandmother's laugh. "I think that day was the beginning of thinking I was worthless," she said. "Even my grandmother didn't love me." Robert asked if Melissa was sure about that interpretation—that her grandmother didn't love her. "I don't know. My grandmother had always been really sweet to me. She died suddenly of a heart attack when I was 7." Melissa's memory about her grandmother led her to experience grief she'd never really felt before about this loss. "I think I'd loved her until I overheard that conversation." Conversations about this incident and Melissa's writing helped her feel an important grief and understand more about herself as a young child. "I was really so sensitive to rejection even then," Melissa said, wiping away tears, "and the message I always got was, 'What is wrong with you, or just get over it like Victoria does.' " As Melissa explored the story, she felt more compassion for herself. "I didn't know how to just get over it. Everyone in my family except me is kind of nonemotional. I'm the one who feels everything." Robert reviewed the biosocial model with Melissa to help her understand more about what she experienced. "My poor mother didn't know what to do with me," Melissa finally said. "I know it wasn't easy for her either. I have always thought of her as a monster but she wasn't. She just didn't get me at all."

A second cluster they reviewed included events surrounding her father's suicide attempt when Melissa was 14. Here is what she wrote about that incident:

> *That year, I was having a lot of problems in school with my learning disability. The day he attempted, we were taking tests and I was sure my scores would be really bad. I came home from school and the house was empty. The phone rang and it was Mother. She said Dad had an accident and was at the hospital.*

*I started crying, really sobbing. She said to watch TV, and she and Victoria would be home soon. She said not to "cause her more problems." I remember wondering why Victoria was at the hospital and I wasn't. I figured Dad wanted to see her and not me. I watched TV for hours and it became dark. I was scared and hungry. I went into the kitchen to find something to eat and went back to the TV. I was eating spaghetti, and I spilled some sauce on the new couch where I'd been sitting. I tried to get the stain out, but I just made it worse. I felt panicky. Mother would be furious. Actually, I don't remember her even noticing. When Dad got out of the hospital, she said he was overtired from worrying about me and that was why he was in the hospital. Later Victoria told me he had overdosed on his medications and would have died if Mother hadn't found him.*

This story included many elements characteristic of the invalidation Melissa experienced in her family, including being blamed for family problems, lack of support for dealing with her learning disability, repeated experiences of feeling her sister was preferred over her, and feeling abandoned by her father. In adolescence, Melissa began to experience more anxiety, especially at school, including panic attacks. She started having acne outbreaks that she found profoundly embarrassing. "No one really noticed how much I was struggling," she said. "Except my Dad, off and on. He would sometimes listen and try to help. Then he tried to kill himself. No wonder I was so attracted to suicide."

When Melissa discussed this event, most of what she felt was anxiety. "When I think of that time of my life, all I can feel is dread," she said. "I think I cut my wrists to try to escape the feeling. Now, looking back, I feel mostly sad, but for years all I could feel was sickening anxiety. That was when my colitis got out of control."

Robert helped Melissa move through her anxiety, which he interpreted as avoidance, to feel her sadness over the many painful experiences of her childhood. As she found the strength to actively grieve these experiences, Melissa became much less likely to appear blank or numb during sessions. Her self-invalidation decreased markedly as well. "I just don't feel like I need to escape my feelings as much. I don't like feeling the way I do, but I don't blame myself for it and I can accept it." Robert pointed out how this represented progress. "You can look back and see that you were a brave kid, really, doing your best under really difficult situations," he said. "Well, I wouldn't go that far," Melissa teased.

After nearly 6 months in Stage 2, Melissa felt ready to focus on an event from her final cluster of painful memories, the loss of her virginity at the age of 24, which led to her final hospitalization. Here is what Melissa wrote about that event:

*Chad was a boy I knew from college who I saw in a bar one night. He was there with some guy friends, and I was there with my friend Kelly. They invited us over to their table and I sat next to Chad. He was kind of drunk already, I remember. We drank for a while and one thing led to another, and he invited me over to the apartment he shared with this guy named Todd. Kelly went home. Anyway, Todd was in the living room watching TV, so we went into Chad's bedroom and started making out. I had been kissed before, but no guy had ever touched me below the waist. So we start fooling around and taking off our clothes, and before long Chad is on top of me and trying*

*to get inside me. I start to panic a little and it starts to hurt. I had a hymen, but I didn't really realize it. So he's pushing on my hymen, and the next thing I know it hurts like hell. I screamed. Chad breaks my hymen, and right away he comes and it's all over. "What was that all about?" Chad said, getting up. "What do you mean?" I asked, "Why did you scream?" "It hurt," I said. Chad laughed. "She's a fucking virgin," he yelled through the door to Todd. Todd yelled something back and they both laughed. "I want to go home," I said. "There's the door," Chad said. There was a bloodstain on the bed. I put my clothes on quickly and ran out the door. I didn't know where I was or how to get home. I called my father, and he came and picked me up. He said going to a guy's apartment was "kind of slutty." We had a fight in the car. Once I got home, I took all my fentanyl and some Ativan. I really wanted to die. But then I told my father, and he took me to the hospital. He didn't want Mother to know anything, but she found out everything. I felt so ashamed.*

When Melissa first shared this story, her shame was at a 10. Not only was it difficult to share with a male therapist, but also Melissa had long avoided contact with how humiliated she had felt, first by the two young men, then by her father, and then at the hospital. Melissa had only had sex on two other occasions since, and while neither experience was as painful as this one, neither had been pleasant either. Robert and Melissa spent many weeks exploring this experience and the intensity of the shame she felt. They explored the many ways shame had harmed Melissa's expression of sexuality and sense of self. During the first 2 weeks when they worked on this cluster, Melissa experienced a relapse of depression and a colitis flare, which resulted in lost workdays. At first, Melissa wanted to take a break from therapy, but Robert encouraged her to continue the exposure work. After about 6 weeks, the intensity of her shame was reduced and she once again found herself grieving the loss of her virginity to a man who was uncaring toward her. She also grieved that her choice at the time had been to harm herself. "Actually, attempting suicide was really against my values, even then. I just didn't know what else to do to deal with how I felt." Through exposure to these events, Melissa's acceptance of the choices she'd made increased, as did her compassion for herself in the past, as well as her hope for the future. "I don't think I will ever choose to harm myself again," she said.

Six months after beginning Stage 2, Melissa completed her advanced skills group with Robert's approval. She had increased her skills use markedly. At 10 months, Melissa and Robert finished the discussion of her entire list of painful events. They reflected on all that Melissa had learned from her work in Stage 2. Robert noticed an increase in Melissa's willingness to tolerate strong emotions until they decreased naturally and increased skill at understanding her emotions. Melissa noticed she was more fully feeling and acknowledging her emotions, both pleasant and painful ones. Robert and Melissa discussed beginning Stage 3.

## Understanding Stage 3 of DBT

According to Linehan, the goal of Stage 3 DBT is to achieve "ordinary happiness and unhappiness." Ordinary happiness includes having a positive sense of self, some close relationships, a sense of meaning in life, good self-care, regular pleasant events, and

enough resources to live with relative independence and comfort. Ordinary unhappiness could be described as having the kinds of problems people have in life that can be solved or accepted without becoming overwhelmed and relapsing into Stage 1 behaviors. The difference between Stage 3 DBT and other cognitive and behavioral treatments lies primarily in the individuals who complete the first two stages of DBT. The DBT client may have more emotional vulnerability but also may have mastered more skills. Most treatments used in Stage 3 DBT come directly from other evidence-based cognitive and behavioral therapies.

When a client moves from Stage 2 to Stage 3 of DBT, it is a good time to step back and take stock. Have the goals of the individual changed? For example, do they still want to go back to school, apply for a different job, move, leave a marriage? Clients at this phase may be questioning old beliefs and either rekindling or ending old relationships. The beginning of Stage 3 offers opportunities for the client to explore new territory and possibly chart a new course. Alternatively, the beginning of Stage 3 can be a time when a client wants a break from therapy to rest a bit on their own laurels. Thus, the sessions that begin Stage 3 can also be termination sessions if the client desires a referral or is ready to exit therapy.

At the outset of Stage 3, the therapist again reconsiders the case formulation and works with the client to revise the diary card and obtain commitment to the new treatment plan. Does the client still lack satisfying intimate relationships? Do they remain somewhat isolated and lonely? Are there lingering addictive patterns with food, overworking, spending, media, avoidance, or substances? Are there problems with anhedonia or dysthymia? Do they display black-and-white thinking and cognitive distortion? Once again, the therapist will need to consult and learn relevant treatments to assist Stage 3 clients. What treatments can be offered that will address this specific client's most problematic patterns? DBT therapists can borrow from some elegant treatments with good evidence, including functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012), mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990), mindfulness-based cognitive therapy for depression (MBCT; Segal, Williams, & Teasdale, 2002), and other treatments in harmony with DBT principles. Stage 3 can also be a good time for a process group formed around DBT skills and focused on pursuing each member's stated goals, thus "turning up the heat on skills generalization" (Comtois et al., 2007).

### *Stage 3 with Melissa*

Melissa's Stage 3 problems included ongoing loneliness, social anxiety, and depression. She agreed on 6 more months of treatment. Her sessions went from weekly to once every other week, at her request. After 2 years in treatment, Melissa was experiencing some fatigue with therapy and wanted to make time for other activities. Robert probed for any signs that Melissa's decision was prompted by avoidance and felt confident it was not. She expressed a desire to take more responsibility for her long-term mental health and place less reliance on therapy. Melissa also wanted to get off psychotropic medications, which she felt she no longer needed.

While continuing to see Robert, Melissa enrolled in an 8-week course of MBCT and began a daily mindfulness practice toward the goal of reducing depressive relapse. She also started taking a weekly class in restorative yoga. On her retooled diary card, she kept track of her mindfulness practice, colitis symptoms, depression, anxiety, and

activities toward her goals, especially social interaction. With her raise at work and use of skills, Melissa worked to keep her spending under control and was mostly succeeding. Now that she was living on her own, she had less contact with her family.

About 3 months into Stage 3, Melissa made a momentous decision. She wanted to go back to school to get a bachelor's degree in accounting to earn more money and improve her job prospects. "I'd like to be a CPA one day," she said. "And I think I can." She applied for and received grants and loans to attend the local university the next fall. At Robert's suggestion, Melissa also joined the Sierra Club and started going on weekly guided hikes. The hikes got her out of her apartment on weekends, introduced her to a circle of other hikers, and improved her fitness. Eventually, two men asked her for dates. "Neither of them really interests me romantically," she told Robert, "but I *like* them both." She also made a good friend in yoga class and continued to enjoy her book club. Melissa was enjoying a lot more about her life than she ever thought possible. "I'm hardly ever bored these days."

Melissa's relationships with her mother and sister remained difficult, but she grew closer to her father. He was now retired and sometimes joined her on her Sierra Club hikes, and they enjoyed each other's company. Melissa decided that she would probably never be close with either her mother or sister. "For now, I'm just going to have to radically accept the way I feel." she decided. "I can gently avoid them most of the time and I'm decent the rest of the time."

By the time that Melissa was ready to start school, she was off psychotropic medications, practicing mindfulness daily, involved with the Sierra Club, and dating an engineer. One day in August, she said, "With school coming up and everything, I'm going to be really busy. Can we go to monthly appointments?" Robert asked if she felt ready to end therapy and Melissa said "no," but repeated her desire to rely more on herself as she progressed toward her goals.

Robert saw Melissa about once per month for another year. They worked on helping her remain focused on the use of skills to make sure old problems such as depression didn't recur. Her colitis was stable. Melissa struggled some with procrastination with her schoolwork and whether to break up with her boyfriend; she found him boring, but he kept her loneliness at bay. A few months after she finally broke up with him, Melissa met someone new, Michael, a graduate student in neuroscience, who was 2 years her junior. It was the first time Robert ever heard Melissa talk excitedly about a man. "I'm really in love, finally," Melissa said, smiling. "And I'm finally enjoying sex. I'm glad I didn't miss this part of my life!" Melissa and Michael were married that summer, and Robert attended the wedding. After her wedding, Melissa canceled three appointments in a row. "I'm just so busy and doing so well," she said in a final message. "I'm not ready to quit therapy, but can we just take a break?"

## Stage 4: Do You Believe in Magic?

Little has been written about Stage 4 of DBT, beyond describing it as a time when a client who has completed the arduous work of the previous three stages may still seek therapeutic support for the problem of "incompleteness" and toward the goal of "increasing [her] capacity for joy and freedom" (Linehan, 1993; Van Nuys, 2004). In this context, joy is different from ordinary happiness derived from a good relationship or decent work. The joy of Stage 4 is the present moment of joy that arises out

of simply being alive (Koons, 2016). Freedom in Stage 4 does not mean not having ordinary life problems. Rather, it means freedom from clinging to getting what you want and not getting what you don't want, and is a basis of equanimity.

People may toggle between Stages 3 and 4 for months or even years. At this time in DBT, the behavioral criteria that define BPD are no longer present, but the sensitive temperament remains. The sense of essential validity developed in DBT therapy may still be somewhat fragile. With Stage 4 clients, a therapist's main role is to encourage the practice of mindfulness skills while providing a setting where skills, progress, and goals are referenced, acknowledged, and reinforced (Koons, 2016). At this stage, many clients also seek deeper meaning for their lives, a spiritual connection, or a way to make a contribution to society. Many are drawn to pursuits that are about relieving the suffering of others. Stage 4 is a time when a strong, positive relationship with their therapist remains key for some clients. Throughout treatment, the therapist ideally has been a model of mindful presence, compassion, and acceptance. Many clients approach bringing the therapeutic relationship to a close with a bittersweet mix of emotions.

Other clients readily turn to other ways to find the support they need in Stage 4. In a new family, with a sangha or religious community, a writing group, graduate school, training as a yoga teacher, a rock climbing club, as a hospice volunteer, or by learning to create art, many DBT graduates enter Stage 4 outside of therapy and never look back—unless something they want to share with their therapist brings them briefly back, often a success of some kind or a loss they are managing but want to discuss.

### *Stage 4 with Melissa*

After her marriage to Michael, Melissa did not return to therapy for 2 years. One day she called Robert, asking to come in to talk about her father, who had just died after a struggle with cancer. Melissa reported feeling well. She had a new job working in state government that paid well and allowed her to study toward her CPA. She and Michael had decided not to have children, but they had bought a house with a big backyard and had two dogs they adored. They were also attending a meditation circle at a local Unitarian church.

The death of Melissa's father caused her intense grief that she wanted to better understand. "I realized Daddy was the only person who really got me, more or less, until I met Michael. I think he might have been borderline, too. I know he struggled with depression. Anyway, for so many years I was so caught up in myself, and I really couldn't be there for him until a few years ago. I was definitely there at the end. And now he is gone. The sadness is overwhelming." Robert and Melissa spent most of their every-other-week sessions discussing her newfound awareness of the preciousness of life, its impermanence, and exploring how to increase her compassion for herself and for her mother and sister. She hoped she'd now be able to become more involved with them, at least with her mother, who was struggling with widowhood and seemed to want more contact with Melissa. Robert looked forward to these sessions, which often closed with a few minutes of mindfulness practice. After this final 6 months of sessions, Melissa felt ready to terminate her treatment with Robert. They spent several sessions saying goodbye. "You've helped me so much," she said in a beautiful card she gave him at the end. "You and DBT saved my life."

Melissa and Robert had the good fortune to have a long therapeutic relationship that progressed through all four stages of DBT. Robert had the wisdom to remain in reserve for Melissa in case she needed him by avoiding becoming her friend prematurely after she stopped attending regularly. While we don't know empirically the importance of a long therapeutic relationship like the one between Robert and Melissa, most of us have felt the lasting value of such a relationship.

The first day a DBT client walks into our office, a journey begins that can feel fraught with obstacles and even peril. Our clients are often highly distressed, afraid, and hopeless, evincing multiple complex problems. We may not know where to begin or what to prioritize. The DBT road map of levels of disorder and stages of treatment focuses us on clear priorities and helps us stay on course. Like Melissa in the case example, our clients change dramatically from stage to stage. As they give up old problematic behaviors and gain new skills, their lives also change, presenting new dilemmas and opportunities. The skills clients learned in Stage 1 are put to use in more sophisticated and complex ways as treatment progresses. For therapists, too, providing competent treatment for new targets continues to pose challenges in learning.

While we cannot always see clients through all the stages of DBT, we can be guided in each stage by a sense of their essential validity. This sense arises in the early days of treatment, even as we watch them struggle with dire problems. Through each stage of treatment, the sense can grow, becoming a vision of their unique value and worthiness. Under the best circumstances, we hold this vision in safekeeping until they can hold it for themselves, however long that takes.

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CHAPTER 15

# An Overview of DBT for Preadolescent Children

## *Addressing Primary Treatment Targets*

FRANCHESKA PEREPLETCHIKOVA
and DONALD NATHANSON

Dialectical behavior therapy for preadolescent children (DBT-C) was developed to address severe emotional dysregulation and associated behavioral dyscontrol in a pediatric population (Perepletchikova, 2018; Perepletchikova, Axelrod, et al., 2011; Perepletchikova & Goodman, 2014; Perepletchikova, Nathanson, et al., 2017). DBT-C retains many of the theoretical model, principles, and therapeutic strategies of the adult DBT model, and includes most of its skills-training curriculum and corresponding didactics (Linehan, 1993). To accommodate developmental and cognitive levels of the target population (children ages 7–13), and the family-oriented treatment approach (children are seen in treatment together with their parents), the presentation and packaging of the information have been considerably modified, and an extensive parent training component has been added. Modifications (i.e., duration of treatment, engagement of parents) are made to accommodate the unique developmental and cognitive adaptations, as consistent with other evidence-based practices (EBP) for children (Becker et al., 2018; Dowell & Ogles, 2010; Fawley-King et al., 2013; Haine-Schlagel & Walsh, 2015; Noser & Bickman, 2000; Zima et al., 2005). In contrast to work with teens, young adults, and adults, a central goal of DBT-C, like other EBPs for children, involves strengthening both the motivation and capability of the child's *parent or guardian* to treat the child. This chapter has three main objectives: (1) to provide an overview of the DBT-C model, including adaptations to the DBT framework to address primary treatment targets; (2) to describe the target population; and (3) to detail the differences and similarities between DBT-C and standard DBT.

## Treatment Structure

The main goals of DBT-C are (1) to teach parents how to create a validating and change-ready environment; (2) to empower parents to become coaches for their child so as to promote adaptive responding during treatment and after therapy is completed; and (3) to teach parents and their children effective coping and problem-solving skills. In service of these goals, outpatient DBT-C retained all of the modes of the comprehensive DBT model, including individual therapy, skills training, consultation team meeting for therapists, and phone coaching between sessions, and has added a comprehensive parent training component. Further, DBT-C retained the five main functions of DBT. The corresponding functions of treatment are as follows:

1. *Improve client's motivation.* Although the goal of the treatment is to improve the child's level of functioning, the family as a unit is the client in DBT-C. Thus, motivation for engaging in therapy and continued participation is a target for all family members. The child and parents are provided with their own individual therapy time. The outpatient DBT-C model includes a 90-minute session once per week, done with families on an individual basis. The sessions are divided roughly into three main components: (1) a 30-minute individual session with the child, (2) a 20-minute parenting session, and (3) 40-minute skills training with both parent(s) and child present. Table 15.1 details the treatment structure of DBT-C.

2. *Enhance client capabilities.* In an outpatient setting, DBT-C provides skills training individually within each family unit, as opposed to a group format in standard DBT or a multifamily group done in adolescent DBT. This also means that in DBT-C, the individual therapist and skills trainer is one and the same. The developmental and cognitive ages of the children seen in DBT-C (ages 7–13 years) are too varied to have the children of various ages plus their parents seen for group skills training. Individual skills training also allows better tailoring of the material being presented to the developmental and cognitive levels of the child and family needs, including which material is covered and to what degree, the amount of time spent on specific skills, the presentation of didactics, and so on.

3. *Assure generalization.* Generalization is assured via homework assignments, mandated daily skills practice with parents in hypothetical situations, and phone coaching. In DBT-C, only parents are required to call the individual therapist between sessions. The child is invited to call the therapist, but is not required to make coaching calls. Instead, the child is instructed to use the parent as her skills coach. Of course, it cannot be realistically expected that a young child will call a therapist for coaching. Therefore, the main function of structuring phone coaching in this manner is to establish parents as the main coaches for the child. As these children grow, new developmental tasks and challenges will arise and parents need to become a consistent and reliable source of help long after treatment ends.

4. *Structure environment.* Structuring the environment is one of the most important functions of DBT-C. Working with children offers a significant advantage to targeting psychopathology, as the invalidating environment can be targeted directly and concurrently with treating the child. Indeed, parents are seen in treatment by themselves for the first 6 weeks to help create a validating and change-ready

**TABLE 15.1. DBT-C Treatment Structure**

Assessment

Assessment with parents:

- Conduct assessment of the child's symptoms.
- Conduct assessment of parental readiness to engage in treatment.
- Start orientation of parents to treatment (e.g., your child's behavior is irrelevant until the environment is ready).
- Incorporate teaching parents 1–2 coping skills (give them a diary card).

Assessment with the child

Therapy phase (90-minute sessions)

Weeks 1–2: Pretreatment with parents only (2 sessions)

Weeks 3–9: Treatment with parents only (4–6 weeks to help them create a validating and change-ready environment, training on material up to ignoring); safety planning session with child, if child has suicidal ideation or NSSI

Weeks 10–12: Child starts therapy when parents are ready to support their child's progress:

- Biosocial theory (with child only)
- Orientation and commitment (with child only)
- Optional to see parents concurrently if needed for a portion of the child's session (separately from the child)

Weeks 13–18: Child and parents come together for therapy:

- Together, child and parent receive psychoeducation on emotions during the child's individual part of session (30 minutes).
- Parents receive individual counseling, focusing on the implementation of the learned techniques, feedback, and troubleshooting problems (20 minutes).
- Together, child and parents do skills training (start with the mindfulness module; 40 minutes).

Week 19: Child and parents come together for therapy:

- Child's individual therapy follows treatment target hierarchy (30 minutes).
- Parents receive individual training component (20 minutes).
- Skills training with child and parents takes place (40 minutes).

environment in preparation for the child entering treatment. During that time, they are provided with psychoeducation, and learn contingency management, validation, dialectics of parenting and emotion-regulation skills. Once parents cover this material and have sufficient emotion-regulation skills, the child starts treatment. Parents continue to be seen, to help them apply what they learned in the first phase and to improve their emotion regulation. Treatment is usually terminated *not* when all of the child's problems are addressed, but when the therapist is confident that the parents are able to consistently implement the learned strategies and procedures *and* can maintain their own emotional regulation to sustain the change-ready and validating environment.

5. *Enhance therapist capabilities and motivation.* Like standard DBT, DBT-C involves a community of clients and families receiving treatment from a community of therapists. Therapists participate in weekly consultation team that serves as a "therapy for therapists" and a forum for discussing aspects of their clients' treatment when needed.

## Target Population

DBT-C targets primarily children ages 6–13 years with severe emotional dysregulation and corresponding behavioral dyscontrol. As in standard DBT, DBT-C defines emotional sensitivity in terms of the following components:

1. *Emotional reactions have a low threshold for occurrence*. For these children, prompting events may involve just a thought, a memory, an association, or an external event so minute that others may not notice its occurrence.

2. *Emotional reactions are intense*. Children often describe their emotional reactions as tsunamis that are hard to withstand.

3. *Emotional reactions happen fast*. Parents and children alike describe these reactions as going from "0 to a 100" in a millisecond.

4. *Emotional reactions take a long time to subside*. Once an emotional reaction starts, it takes considerable time for the reaction to go back to baseline. At times, it may take hours before a child calms down.

Clinical observations indicate that emotional sensitivity frequently co-occurs with most of these patterns of behavior:

- Emotionally sensitive children frequently *look for ways to avoid effort*. These children are constantly overwhelmed by their own emotional experiences and may be less inclined to face more challenges. They need to withstand not only the impact of a challenge but also the impact of their intense emotional reaction to it. This is an important consideration for parents who might believe that their emotionally sensitive children are "lazy." Instead, parents need to remember that their children may be in a constant state of emotional overload.

- These children are usually *hyperreactive* and may exhibit behaviors such as anxiety attacks, physical aggression, verbal outbursts, temper tantrums, suicidality, and nonsuicidal self-injury (NSSI) like cutting.

- These children *generally dislike change*. They respond well to structure, sameness, and security. Anything new is met with reluctance; having to transition from one activity to the next is problematic for them.

- They are *more easily bored*. Although these children usually avoid engaging in difficult new activities, they require a high level of stimulation and need a constant source of enjoyable events. However, parents also must keep in mind that these children rapidly lose interest even in fun activities.

- These children tend to have *a lower tolerance for delayed gratification*. Because of their high excitability, they experience the inability to satisfy their wishes right away as painful.

- Frequently, these children have *more difficulty with concentration and rapidly shift their attention* compared to peers.

- Since emotionally sensitive children are overexcitable, they tend to have a *surplus of physical energy* and may be viewed as hyperactive.

- They frequently display *impulsive behaviors*. Sensitive children may often do things without thinking. The intensity of their emotional reactions is so high that they may not be able to fully process their urges before they act on them. This may also be related to their difficulty with delayed gratification, and with feeling pain because they are being blocked from immediately achieving a goal.

- Emotional sensitivity is frequently associated with *sensory sensitivity,* or a low tolerance for sensory stimulation. Some or all of the senses may be affected (i.e., touch, smell, taste, sound, and vision). Even putting on a new pair of socks may cause a high level of discomfort for some of these children.

- These children frequently have *severe interpersonal difficulties* with siblings and parents, and may have problems with peers and friends. Their reactivity often greatly interferes with developing and maintaining stable relationships.

- They tend to have an *extreme thinking style,* such as black-and-white thinking and catastrophizing. They also tend to perseverate and ruminate. This is quite understandable, given that under high arousal, attention narrows down and thoughts become more rigid.

- These children often have *difficulty with personal hygiene,* such as brushing their teeth, taking showers, and the like. This may stem from such activities being perceived as unpleasant, boring, or demanding effort and, in some cases, from sensory processing problems. Sensitive children have difficulty with all of these, as discussed above.

A child who is emotionally sensitive brings unique demands to the environment, such as parents, teachers, and therapists alike. However, emotional sensitivity also brings with it certain unique advantages. DBT-C includes a standard psychoeducation on the dialectics of emotional sensitivity and discusses associated challenges alongside the advantages:

- Emotionally sensitive children can *experience positive emotions at a higher level*.
- Emotionally sensitive children are quite *adept at reading other people's emotions*.
- They are *empathic* and very likely to be caring, supportive, and understanding of other's pain.
- Emotional sensitivity has been linked to *increased creativity* (see Kaufman & Gregoire, 2015).

Unfortunately, the word "sensitive" has acquired the negative connotation of one being "touchy," defensive, uptight, paranoid, or neurotic. To avoid the common derogatory terms associated with sensitivity, in DBT-C, we use the expression "supersenser" to describe children and adults with emotional sensitivity. An analogue is the term "supertasters" that describes people with heightened sensitivity to sensory perceptions. When the challenges and advantages of the emotional sensitivity are discussed with parents and children, it is underscored that sensitivity has its challenge and advantages and, in itself, is not a problem to correct but a special ability that the child needs to learn to control. Communicating this point to the child is critical. This

helps children feel understood, validated, and not judged, which decreases their self-critical thinking and increases their willingness and interest to learn what we term "superskills" to help control their "superabilities."

## Biosocial Model

DBT-C retains the DBT strategies, procedures, and theoretical principles to address the needs of the target population. In her landmark *Cognitive Behavioral Therapy for Borderline Personality Disorder* (Linehan, 1993), Marsha Linehan outlined an etiological theory on how a person develops borderline personality disorder (BPD) throughout their life span. According to Linehan's biosocial model, BPD has its origins in a maladaptive transaction that occurs between a biologically emotionally vulnerable person and an invalidating environment that leads to pervasive emotional dysregulation. Emotional vulnerability is seen as an inborn dysfunction in emotional processing, where a person has a low threshold for emotional reactivity, reacts quickly and intensely to stimuli, and experiences a slow return to baseline.

It is quite a challenge to parent a supersenser. A poor match between the child's needs and parental ability to satisfy these needs may lead to the development of an invalidating environment. An invalidating environment is characterized by pervasive and indiscriminate rejections of the child's experiences (e.g., feelings, thoughts, behaviors) as invalid (e.g., "Stop acting like a baby, there is nothing to be scared about!"); oversimplification of the ease of solutions (e.g., "Just stop this!"); and intermittent reinforcement of escalations (i.e., the child learns that while lower levels of dysregulation are invalidated, the coveted support and care can be achieved by engaging in self-harm or threatening suicide; Linehan, 1993).

An invalidating environment is not necessarily abusive or neglectful. On the contrary, in most cases, parents are indeed caring and supportive, and attempt to deal with situations to the best of their ability. They may be quite competent in providing "good enough" parenting to other children in the family who may not be as emotionally sensitive. However, good enough parenting is simply not good enough for supersensers. The poor fit between the child's needs, and parental capacity to satisfy these needs, may lead to a pervasive transaction where the child's demands stretch the environment's resources, and the environment invalidates the child in response. This transaction dysregulates the child further, resulting in further demands on the environment, and so forth. As a result, these children fail to learn self-regulation, and often have problematic relationships with parents, siblings, peers, and teachers, and persistent difficulties in multiple settings. The negative feedback may lead to the development of negative self-concept in affected children; impede their emotional, social, and cognitive development; and increase the chance of psychopathology in the future (Althoff, Verhulst, Retlew, Hudziak, & Van der Ende, 2010; Okado & Bierman, 2015; Pickles et al., 2010).

As noted, for supersensers, "good enough" parenting may not be sufficient to meet their needs. *Supersensers require what can be called a superparent*. One of the most important goals of DBT-C is to help parents learn to become superparents. A superparent can be compared to a firefighter. Just like a firefighter:

- A superparent does not start fires (e.g., does not model verbal or physical aggression, does not provoke or invalidate the child, does not retaliate, and does not use ineffective parenting techniques).
- A superparent is not afraid of fires (e.g., is not scared of the child's outbursts and does not accommodate the child in an effort to avoid problems).
- A superparent calmly and skillfully puts fires out and works on preventive measures (e.g., ignores their child's dysfunctional behaviors, validates the child's suffering, models skills use, prompts and reinforces adaptive behaviors, uses effective parenting techniques, helps the child to cope ahead of problematic situations, does daily reinforced practices with the child, and encourages the child's self-management).

## Treatment Target Hierarchy

As detailed above, DBT-C is a family-oriented approach, where family as a unit is treated as the client. Parental involvement, participation, and commitment to the treatment are required, while a child's commitment is only preferred, regardless of the child's age. Commitment from a child is elicited *only* if a therapist is sure that the commitment will be given, after the initial orientation. Preadolescent children may not have sufficient cognitive and developmental maturity to fully understand commitment, so this aspect is less relevant for DBT-C than for standard DBT, for the function of treatment engagement.

In DBT-C, parental emotion regulation and ability to create an environment conducive to change are prioritized. To incorporate these goals, the hierarchy of primary treatment targets was greatly extended in DBT-C as compared to standard DBT and DBT for adolescents. In the original model, the treatment target hierarchy consists of three main categories, in order of priority: decreasing life-threatening behaviors, decreasing therapy-interfering behaviors, and decreasing quality-of-life interfering behaviors, all while simultaneously increasing skillful responding. DBT-C has a target hierarchy that includes 3 main categories, divided into 10 subcategories.

I. Decrease current severe psychopathology and risk of psychopathology in the future:
   1. Decrease life-threatening behaviors of the child.
   2. Decrease therapy-destroying behaviors of the child.
   3. Decrease therapy-interfering behaviors of the parents.
   4. Improve parental emotion regulation.
   5. Teach effective parenting techniques.

II. Target the parent–child relationship:
   6. Improve the parent–child relationship.

III. Target the child's presenting quality-of-life and therapy-interfering behaviors:
   7. Decrease risky, unsafe, and aggressive behaviors.
   8. Decrease quality-of-life interfering problems.

9. Provide skills training.
10. Decrease therapy-interfering behaviors of the child.

The following sections briefly describe each target category and how each target is addressed in treatment.

### *Decrease Current Severe Psychopathology and Risk of Psychopathology in the Future*

Children with severe emotional dysregulation are at high risk to develop psychopathology. Irritability and impulsivity that are highly prevalent in this population are associated with poor functioning and severe impairment during childhood and adolescence, as well as in adulthood (Althoff et al., 2010). These include significantly impaired functioning at home, school, and with peers; clinical-level anxiety and depression; attention-deficit/hyperactivity disorder (ADHD); impulsive–aggressive behavior; negative affect; and cognitive problems (Althoff et al., 2010; Roy et al., 2013). Further, emotional dysregulation and irritability symptoms are associated with adult personality disorders, substance abuse, and mood disorders (Althoff et al., 2010). These behaviors are also a significant predictor of suicidality in adulthood (Stringaris, 2011). Thus, the main goal of DBT-C is to target the present psychopathology and to reduce the risk of psychopathology in the future.

#### *Target 1: Decrease Life-Threatening Behaviors of the Child*

As has been stated, the priority in DBT-C is to reduce the risk of severe psychopathology now and in the future. To that end, the highest target remains the same as with standard DBT: life-threatening behaviors. These include suicidal and NSSI acts, urges, communications, ideations, expectations, beliefs, and affect. In the preadolescent population, suicidal and NSSI behaviors are less common than in adult or adolescent populations. However, risk assessment and safety planning are integral parts of treatment from beginning to end. A therapist must continue to assess the level of risk that a child presents to inform their decisions. For example, it is quite common for emotionally sensitive children to make remarks such as "I wish I were dead!" or "I'm going to kill myself!" during a verbal outburst. Whether these communications are actively ignored or attended to depends on the risk level of the child, and the function that these comments serve. In most cases, such verbalizations are ignored in the moment, followed by processing of a situation, when the child is in a neutral state, to figure out how to handle a similar situation in the future. It is often very difficult for adults to ignore a child threatening to cut themself, yet most often that is precisely what is needed to preclude reinforcement of the behavior with attention.

#### *Target 2: Decrease Therapy-Destroying Behaviors of the Child*

As will be discussed later, DBT-C is very tolerant of behaviors on the part of the child, in and out of session, that may be therapy-interfering (e.g., yelling, cursing). However, children can engage in behaviors that may destroy the treatment process. In session, therapy-destroying behaviors are those threatening the safety of participants

or the therapist, such as physical aggression, property damage, or running away from the office (unless it can be safely assumed that the child will remain in the vicinity of the office and will return shortly). As a general rule, any physically aggressive acts in a session are treated as therapy-destroying and are typically addressed with a time-out procedure (administered by a parent). Measures can also include ending the session or, if possible, ending just the child's portion of the session. Ending a session may be particularly problematic as there is a risk of reinforcing such behaviors, if the function of a behavior is to end a session. Yet, ensuring participants' safety takes precedence. Such matters are best resolved by prevention as opposed to intervention, including building a strong therapeutic alliance, use of reinforcement of opposite desirable behaviors, and coping ahead strategies.

Therapy-destroying behaviors on the part of the child that occur between sessions include dangerous levels of aggression or destruction at home, school, or elsewhere, such as choking a sibling or breaking windows. Such behaviors are therapy-destroying, as they preclude the effective use of behavior modification techniques like planned ignoring and, therefore, progress cannot be achieved. Therapy-destroying behaviors that are frequent and interfere with progress may necessitate the consideration of medication management to reduce reactivity. In severe cases, a higher level of care may be needed before beginning a course of outpatient DBT-C.

### *Target 3: Decrease Therapy-Interfering Behaviors of Parents or Therapists*

While therapy-interfering behaviors of the child are considered a lower priority in DBT-C (Target 10), therapy-interfering behaviors of parents or caregivers are placed high on the hierarchy. Significant and lasting treatment gains cannot be achieved without parental engagement. Therapy-interfering behaviors on the part of caregivers may include frequently missing or re-scheduling sessions; failing to follow the therapist's recommendations; and continued use of prolonged, harsh, or unnecessary punishment techniques.

To help reduce such occurrences, parental orientation to the treatment begins at the first point of contact. Often, orientation starts at the introductory phone call, outlining the requirements in a direct and clear manner: This treatment involves a lot of work on the part of caregivers. Parents are expected to learn and model the use of coping skills and elicit them from their children. They are expected to ignore annoying behaviors. They are expected to provide validation and praise adaptive behaviors. Also, frequently the therapist will be asking parents to do what may be counterintuitive or contrary to the expectations of how a parent and child "should" interact (e.g., don't reprimand your child during an outburst when he is swearing at you). From the very beginning, parents are oriented to the complex structure of the treatment, and to the idea that it will take time before they understand the treatment model and appreciate how different components are designed to address the specified targets. Thus, parents are instructed to "act as if" they trust the method before they fully understand it and begin seeing therapeutic gains. As mentioned above, parental commitment to treatment is necessary, while the child's commitment is just preferred, and providing parents with full disclosure of what may be involved before such a commitment is elicited helps decrease the risk of therapy-interfering behaviors.

### *Target 4: Improve Parental Emotion Regulation*

Attempting to help the child achieve emotion regulation in a dysregulated environment is a rather futile task. Parental emotion regulation is critical in all aspects of treatment. Parents need to have a vast repertoire of emotional coping skills to model effective coping, reinforce adaptive behaviors, ignore dysfunctional behaviors, and suppress dangerous behaviors, all while validating a child's distress. Thus, bolstering parental emotional coping capacity is one of the main goals of treatment. Thus, during the initial 4 to 6 weeks of therapy, only caregivers are seen in treatment to help establish a change-ready and validating environment. This includes parents learning emotion-regulation skills themselves.

### *Target 5: Teach Effective Parenting Techniques*

Closely related to increasing parental emotion-regulation ability is the goal of increasing effective parenting skills. Typically, when families seek DBT-C, the child's maladaptive behaviors are at a severe level, and parents rely mostly on punishment to force compliance and to regulate their own distressing emotions. Instead, they need to learn how to rely primarily on reinforcement of desired behaviors, validation, behavioral shaping paradigms, and planned ignoring. Parents are instructed to use punishment techniques very sparingly and strategically to suppress only potentially unsafe behaviors of their child.

## ***Target the Parent–Child Relationship***

Families often enter into therapy with high-conflict households, where the parent–child relationship is characterized by active opposition and hostility rather than compassion. The high-conflict relational pattern is usually a result of a poor fit between the child's needs and parental capacity to satisfy these needs, as discussed above. In such households, parents frequently use retaliation to achieve perceived vindication and also to regulate their own emotional distress. Unsurprisingly, children respond in kind to their parents, so the cycle continues. When the parent–child relationship has been corroded to this point, any meaningful changes can hardly be expected of the child. Parents are the main tools of therapeutic change in DBT-C, and a loving relationship between children and parents is the driving force for the desired changes.

### *Target 6: Improve Parent–Child Relationship*

Having a healthy and loving relationship between children and parents is the foundation on which change can be built. Therefore, parents are instructed to take active steps toward building, mending, and maintaining the relationship with their children. Heavy reinforcement schedules, validation, and building reciprocity between members of the family are the main methods for addressing this target. To build reciprocity, parents are instructed to actively participate in joint activities with their children. The choice of activities is driven by the child's, not the parents', interests and frequently includes watching videos or playing video games. The goal is for parents to be involved in what their child likes to do and promote their child feeling happy, loved, and accepted.

A positive parent–child relationship serves several important functions toward ameliorating the child's problem behaviors. It models a relationship that is based on trust, reinforcement, shared interest, and mutual respect. It helps instill in the child a sense of self-love, safety, and belonging that are necessary for adaptive, independent, and prosocial functioning. It increases the child's desire to spend time with their parents, which in turn means that parents have more time to elicit, model, and reinforce adaptive coping behaviors, and practice the use of skills with their child. A positive relationship also augments the child's motivation to behave in a way that will please their parents and make them proud, as opposed to making them miserable. Indeed, reinforcement from parents becomes more effective if the child wants to make their parents happy, which cannot be taken for granted. Finally, a healthy parent–child relationship helps to build pathways in the child's developing brain that are associated with adaptive behaviors.

### *Target the Child's Presenting Problems*

The third major category on the hierarchy consists of problems that usually bring families to treatment, yet they are relatively low on the target hierarchy as meaningful and lasting changes cannot be achieved in an environment that is dysregulated, invalidating, and unable to support the child's progress.

#### *Target 7: Decrease Risky or Unsafe Behaviors of the Child*

Target 7 includes physical aggression and property destruction at home, school, and other settings. These behaviors are mild to moderate in severity (e.g., kicking, pushing, shoving), as compared to the Target 2 therapy-destroying behaviors (e.g., choking a younger sibling, or using a heavy object aggressively). Parents are instructed to use punishment techniques to suppress Target 7 behaviors (e.g., reprimands or a time-out). Although responses in Target 7 also represent quality-of-life interfering behavior, they are placed in a separate category, as they have to be addressed before targeting other quality-of-life interfering problems and events. It is frequently countertherapeutic to address them simultaneously with some of the Target 8 behaviors. For example, when physical aggression is placed on a shaping paradigm, there is frequently a temporary increase in verbal aggression.

#### *Target 8: Decrease Quality-of-Life Interfering Events or Behaviors of the Child*

Target 8 includes the quality-of-life interfering behaviors of the child and events that affect the child's functioning. This category subsumes a broad array of behaviors, including comorbid disorders such as ADHD, anxiety, verbal aggression, interpersonal difficulties, impulse control issues, and struggles maintaining personal health and hygiene. Further, this category includes addressing school problems and parent/family issues (e.g., divorce).

Level 8 behaviors usually happen more frequently than life-threatening behaviors, therapy-destroying behaviors, or risky and unsafe behaviors. However, it may take time before they are consistently targeted as such might be countertherapeutic to address them at the same time as higher-level issues. For example, targeting a decrease in physical aggression (Target 7) may temporarily trigger an increase in

verbal aggression (Target 8). Parents can easily agree that targeting a risk of self-harm or suicide is more important than addressing school refusal or that hitting a sibling is more problematic than cursing at him. However, due to the sheer frequency of the level 8 behaviors and their impact on family life, it is usually quite difficult for parents to continue to accept the need to tolerate these behaviors until more pressing issues are addressed. Therefore, continued validation of parental struggles balanced with increasing their mindfulness of therapeutic priorities is a leitmotif of parent sessions.

### *Target 9: Provide Skills Training*

DBT-C, as in all forms of DBT, offers a variety of coping skills that can be used to replace maladaptive behaviors that supersensers display. The skills are presented in an animated, simplified, child-friendly way. Parents learn all the didactics that their child is learning, as they need to use these same skills to regulate their own emotions, as well as model, elicit, and reinforce the skills use of their child. Skills-training sessions are ideally done with all participants (parents and children) together. With some families, this may be problematic, particularly at the beginning of therapy, if the child cannot tolerate their parents being present. In such cases, skills training is done separately with parents and the child until the parent–child relationship has been sufficiently improved for cotraining to occur.

### *Target 10: Decrease Therapy-Interfering Behaviors of the Child*

Therapy-interfering behaviors (as distinguished from therapy-destroying or risky/unsafe behaviors described above) are the lowest on a target hierarchy in DBT-C. These include in-session verbal aggression, threats, cursing, screaming, attempts to distract parents or the therapist, being distractible oneself, devaluing treatment, among many other behaviors. Sometimes the entire session can consist of the child screaming, yelling, and threatening. These behaviors are hard to tolerate, yet they are target-relevant and informative of what happens outside of sessions.

Target 10 behaviors are addressed primarily with contingency management (e.g., ignoring maladaptive and reinforcing adaptive behaviors in session). They provide great opportunities to refine the use of parental emotion-regulation skills and parenting techniques in the moment (Targets 4 and 5). The therapist also has a chance to observe and assess parent–child interactions for further interventions (Target 6). Further, the therapist can continue to teach skills to parents while a child is having an outburst (Target 9), assigning the parents to later discuss the learned techniques with the child. These behaviors additionally allow the therapist to model effective coping (Target 9) and application of contingency management procedures (Target 5). Finally, ignoring a child's disruptive behaviors in sessions as well as at home helps to extinguish such responses in multiple settings (Target 8).

## Pretreatment Phase

In DBT-C, pretreatment is usually conducted over 2 sessions separately with the child and 2 sessions separately with the parent(s). The same topics are covered. During this phase, the therapist discusses the biosocial model and assumptions about clients who

need DBT-C, orients the family to the treatment model, sets treatment goals, and connects how treatment components will address the specified targets. As has been referenced above, in DBT-C, parents are asked to commit to treatment at the outset of therapy, while children are not required to formally make such a commitment. The child's commitment is only elicited if a therapist is confident that the child will commit. This may require the child to have sufficient experience with therapy to trust that the treatment might indeed help.

## Individual Therapy

Individual therapy with the child consists of two phases: psychoeducation on emotions and therapy following DBT-C targets. Psychoeducation on emotions includes a discussion of what emotions are, their functions, myths about emotions, the emotion wave, the emotion-regulation model, the behavior change model, radical acceptance, willingness and willfulness, and the STOP skill. DBT-C introduced the emotion-regulation model to help elucidate how one's emotion is amplified, sustained, and transformed into a mood. This model indicates that there are three main sources that fuel emotions: doing what an emotion wants us to do, thinking what an emotion wants us to think, and maintaining tension (or energy) that an emotion brings with an action urge. To stop experiencing an unwanted emotion, all three sources have to be cut off. The behavior change model is also unique to DBT-C. It includes three components: *awareness* (i.e., an ability to catch an action urge or thought before it is realized in action); *willingness* (i.e., motivation to not follow an urge if it is not justified by a situation); and *capability* (i.e., adaptive coping skill, problem solving, cognitive restructuring, self-management). Willingness is the most important aspect, as without motivation to engage in a competing response, knowledge of skills and other strategies becomes useless. A lot of time is devoted to enhancing the child's motivation during individual sessions with the therapist and in-between sessions with parents.

In DBT-C, chain analysis is simplified by following the sequence of emotion wave steps: vulnerabilities, event, thought, feeling, action urge, action, aftereffects. A three-headed dragon of chain and solution analysis game is used for younger children to motivate engagement and help sustain their attention. Children write about events, feelings, thoughts, and behaviors on specifically designated cards or links in a chain, and place them on a drawing of a three-headed dragon. The middle neck of the dragon represents what actually happened, and the other two necks are used to discuss what other actions could have been taken instead. Once alternative responses are developed, the child and the therapist role-play the use of generated adaptive solutions.

Individual treatment with the child following DBT-C targets includes regular DBT tasks, such as the application of learned skills, development of self-management, problem solving, cognitive restructuring, behavioral activation, exposure, modeling, coaching and shaping behaviors, and consultation to the client. In DBT-C, the main tasks during an individual session are to improve motivation for change; conduct thorough assessments of emotions, thoughts, and actions to understand functions of responses; and help clients effectively use change strategies (e.g., skills, problem solving, cognitive restructuring

## Skills Training

DBT-C retains the vast majority of the skills used in standard DBT, with many of the skills having been condensed, and only a few completely omitted. The mindfulness module has been retained completely, while other modules have experienced significant modifications. For example, in the standard DBT interpersonal effectiveness skills module, there are three sets of skills used to balance and maintain one's wants, relationships, and self-respect when dealing with others. These are the DEAR MAN, GIVE, and FAST skills, respectively, with each letter in the acronym standing for an aspect of the skill used. In, DBT-C, these skills have been concentrated into the DEAR and FRIEND skills (be **F**air and **R**espectful, act **I**nterested, use an **E**asy manner, **N**egotiate, and be **D**irect).

In DBT-C, the differences in the distress-tolerance and emotion-regulation modules are discussed functionally from the perspective of the emotion-regulation model. Distress-tolerance skills function to reduce the risk of making the situation worse without the goal of changing how the person feels or the situation. Thus, the majority of these skills are designed to cut one or two foods for an emotion. For example, the DISTRACT skill (a combination of standard DBT wise mind ACCEPTS and IMPROVE the moment) includes **D**o something else (cuts *the doing food* from the emotion), **T**hink about something else (cuts *the thinking food*), and so on. Emotion-regulation skills, on the other hand, function to modulate an emotional experience and are thus designed to cut all three food sources from an emotion. For example, the opposite all the way skill includes opposite action, opposite thinking, and opposite tensing. As mentioned, some skills are omitted from the DBT-C distress-tolerance and emotion-regulation modules on the basis that they are less relevant for a pediatric population, such as sticking to values, comparing oneself to others less fortunate, finding meaning in suffering, and using prayer. For a more complete summary of DBT-C skills curriculum, please refer to Table 15.2.

## Parent Training Component

DBT-C, as compared to standard DBT, has a unique advantage: an ability to directly intervene in the environment to stop the dysfunctional transaction described in the biosocial model. Parents have to learn everything the child is learning (i.e., didactics on emotions and skills), plus additional components (i.e., creating a change-ready and validating environment, behavior modification techniques, and the dialectics of parenting).

DBT-C maintains an emphasis on training parents to become therapists for their children, with the goal of promoting the parents' ability to model, elicit, and reinforce skills use and problem solving with their children long after therapy ends. From the very beginning, parents are given a message that their child's behaviors are *irrelevant* until parents are able to create a stable, change-ready, and validating environment. However, the tasks of the parent training component are not limited to just helping parents attain their own emotion regulation and teaching them how to reinforce, ignore, validate, and model adaptive responding. Adequate and consistent application of these strategies is just the foundation for helping parents promote in their child a sense of self-love, sense of safety, and

**TABLE 15.2. DBT-C Skills**

| | |
|---|---|
| | **Mindfulness** |
| Introduction | Meaning, importance, and goals of mindfulness skills. |
| Emotion mind and reasonable mind | "Emotion mind" occurs when thoughts and behaviors are controlled mostly by emotions and it is hard to think straight.<br>"Reasonable mind" occurs when thoughts and behaviors are controlled by logic and rules, and emotions are not considered. |
| Wise mind | "Wise mind" occurs when we take into account information from our feelings and thoughts. and add intuition when making decisions. Steps to connect to wise mind are discussed. |
| What skills | Observing, describing, and participating with awareness. |
| How skills | Don't judge; stay focused and do what works. |
| Review | Review and discussion of the learned mindfulness skills. |
| | **Distress tolerance** |
| Introduction | Meaning, importance, and goals of distress-tolerance skills. |
| DISTRACT | Controlling emotional and behavioral responses in distress using the acronym DISTRACT: **D**o something else, **I**magine pleasant events, **S**top thinking about it, **T**hink of something else, **R**emind yourself that feelings change, **A**sk others for help, **C**ontribute, **T**ake a break. |
| TIP | When at a breaking point, use TIP skills: **T**ense and relax, **I**ntense sensation, **P**aced breathing. |
| Self-soothe | Tolerating distress by using the five senses: vision, hearing, taste, smell, and touch. |
| Review | Review and discussion of the learned distress-tolerance skills. |
| | **Emotion regulation** |
| Introduction | Meaning, importance, and goals of emotion-regulation skills. |
| Surfing your emotion | Decreasing the intensity of emotional arousal by attending to sensations the emotion produces in the body without distracting or ruminating. |
| Opposite all the way | Changing an emotion by acting and thinking opposite to the action urge and releasing tension that emotion brings into the body. |
| PLEASE skills | Reducing emotional vulnerability: Attend to **P**hysica**L** health, **E**at healthy, **A**void drugs/alcohol, **S**leep well, and **E**xercise. |
| LAUGH skills | Increasing positive emotion: **L**et go of worries, **A**pply yourself, **U**se coping skills ahead of time, set **G**oals, and **H**ave fun. |
| Review | Review and discussion of the learned emotion-regulation skills. |
| | **Interpersonal effectiveness** |
| Introduction | Meaning, importance, and goals of interpersonal effectiveness skills. |
| Worry thoughts and cheerleading | Goals of interpersonal effectiveness: what gets in the way of being effective and cheerleading statements. |
| Goals | Two kinds of interpersonal goals: "getting what you want" and "getting along." |
| DEAR skills | How to "get what you want": **D**escribe the situation, **E**xpress feelings and thoughts, **A**sk for what you want, **R**eward or motivate the person for doing what you want. |
| FRIEND skills | How to "get along": Be **F**air, **R**espect the other person, act **I**nterested, have an **E**asy manner, **N**egotiate, and be **D**irect. |
| Review | Review and discussion of the learned interpersonal effectiveness skills. |

sense of belonging. Parental vulnerability in these senses is also explored and targeted during sessions.

Frequently, parents are seen in treatment without the child for the first month or two to give parents the necessary training to be able to model, reinforce, and shape the adaptive responding of the child and develop sufficient emotional regulation to withstand the unavoidable increase in maladaptive behaviors once the child starts therapy. DBT-C, like most therapies, disrupts the established ways in which parents and children interact with each other and changes patterns of responding. Children and their parents need time to adjust to such changes, and lack of parental preparation can make the situation for the family worse. For example, if parents don't yet have sufficient emotional regulation and start to implement planned ignoring, there is a very good chance that they may not be able to withstand extinction bursts and will attend to a behavior (e.g., scream back at the child) at the height of escalation. Thus, rather than extinguishing a maladaptive behavior, a higher severity level of this behavior will be reinforced with attention.

## Research on DBT-C

The outpatient study examined the provision of DBT-C and treatment-as-usual (TAU) to 43 children diagnosed with disruptive mood dysregulation disorder (DMDD; Perepletchikova et al., 2017). In this sample, 55.8% of children had active suicidal ideation and 37.2% engaged in nonsuicidal self-injurious behaviors. The study demonstrated the feasibility and efficacy of DBT-C, with no dropouts from therapy in the DBT-C condition as compared to 36.4% in the TAU condition, and families in DBT-C expressed higher treatment satisfaction. Further, 90.4% of children in the DBT-C condition responded to treatment, a rating of "much improved" or "very much improved" by blinded clinicians on the Clinical Global Impression Scale (Guy, 1976) as compared to 45.5% in TAU. These outcomes were demonstrated despite three times as many children in TAU as compared to DBT-C receiving psychiatric medications. The outcomes were clinically significant and sustained at follow-up.

An adaptation of DBT-C for a residential setting was also examined as compared to TAU in a sample of 47 boys ages 7–12 (Perepletchikova et al., 2020). The sample exhibited severe and diverse psychiatric problems, with the majority being diagnosed with ADHD, disruptive behavior disorders, and mood disorders and 61.8% engaging in suicidal behaviors and/or experiencing suicidal ideation. DBT-C was shown to be significantly more effective than TAU in reducing externalizing and internalizing psychiatric problems on all subscales of the Child Behavior Checklist staff report (Achenbach, 1991), with the differences being clinically significant. There were no significant differences, however, recorded in the parent and teacher reports. This could result from the fact that the milieu staff at the residential program were trained in DBT-C in the same manner as caregivers in the outpatient DMDD study, described above, while teachers were not trained in the approach (as they were in contact with both groups) and the majority of parents failed to consistently participate in trainings (on average, attending less than a third of prescribed sessions). Thus, the significant difference between groups was only observed with the caregivers (i.e., milieu staff) who were trained in the model, highlighting the importance of caregiver involvement in treatment to elicit and maintain treatment gains.

## Conclusion

DBT-C retains the main therapeutic strategies and procedures of standard DBT. Yet, the implementation of these procedures varies between the models. For example, providing psychoeducation, conducting extensive behavioral chain analyses, and doing consultation to the client are not emphasized in therapy with children as much as with adult patients. On the other hand, contingency management (e.g., use of a heavy reinforcement schedule, ignoring, shaping); stylistic strategies (e.g., validation, irreverence); and environmental interventions take center stage.

Dialectical strategies (e.g., magnifying tension, using a balanced style, dialectical thinking, speaking in metaphors, as well as movement, speed, and flow) bear particular salience to the therapeutic process within DBT-C. Moving with speed and flow to keep the client slightly off balance is key to sustaining the child's attention. Therapists have to be alert to changes in the child's mood and levels of engagement, as they happen frequently and usually quite abruptly. For example, the higher the severity of the child's behavioral outburst, the more relaxed the therapist has to be; the more withdrawn the child, the more enthusiastic, lively, bubbly, and funny the therapist has to become so as to bring and maintain momentum in the session. To encourage the child's participation, a therapist has to be prepared to play games, watch cartoons, sit on the floor in a lotus position, learn how to plié, eat a lot of candy, and become a comedian and a magician (if nothing else works, performing some sleight of hand for a mindfulness exercise can do the trick). A DBT-C therapist needs to have an ability to use a variety of strategies and switch swiftly between them, depending on the requirement of the situation. A rapid-fire delivery of validation, irreverence, reinforcement, and ignoring within each brief segment of a session is a rule, rather than exception, when doing therapy with children.

A therapist also has to be vigilant about parents' responses in session to ensure that they are able to tolerate the child's outbursts, maintain their own emotion regulation and engagement, learn skills, and assist the therapist during the session, as opposed to contribute to escalations. Orientation to the treatment model, goals, hierarchies, strategies, and parental role in therapy is paramount in DBT-C. Of similar importance is training parents (ahead of starting therapy with the child) on behavior modification and validation techniques, and having them practice coping skills to be able to withstand behavioral escalations. Parents have to be prepared to function as co-therapists during the interactions with the child in sessions and as the main therapists outside of sessions.

Further, there are significant differences between DBT-C and standard DBT in the treatment targets' hierarchy, individual therapy, skills training, and treatment structure, as well as the addition of an extensive comprehensive parent training component.

Marsha Linehan (1998) compared providing DBT to playing jazz, where a therapist must adapt and react to a patient in the same way a musician's fingers do when they fly rapidly over the keys of an instrument in response to what notes were just played a moment before. DBT-C can be compared to an interactive theater performance, where the therapist is at once the director, an actor, a props master, and a stagehand. A DBT-C therapist has to combine a scripted performance with spontaneity and improvisation, while setting the stage and closely monitoring, instructing, and directing other players to ensure that the performance unfolds collaboratively yet within the boundaries of the session's goals.

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CHAPTER 16

# DBT for Adolescents

ALEC L. MILLER, JILL H. RATHUS,
ELIZABETH T. DEXTER-MAZZA,
CHAD S. BRICE, and KELLY GRALING

The prevalence rates of mental illness among youth are staggering, with approximately one in five children in the Unites States diagnosed as having a mental health disorder (Merikangas et al., 2010). In addition, nearly one in five youth has seriously considered suicide in the past year (Centers for Disease Control and Prevention [CDC], 2015) and the rates of completed suicide among children ages 10–19 have increased. Suicide is now the second leading cause of death among young people in this age group (CDC, 2015; Perou et al., 2013). Furthermore, 15–30% of adolescents in community studies reportedly engaged in nonsuicidal self-injury (NSSI), leaving some clinical researchers to wonder if this has become the "coping strategy" of our youth in the 21st century (Miller & Smith, 2008).

Teens with repeated self-injury or suicidal ideation (SI) are often brought to emergency rooms and admitted to psychiatric in-patient units only to be rapidly discharged back to their traditional outpatient services not necessarily equipped to treat these high-risk behaviors. Over the past 20 years, dialectical behavior therapy (DBT) with suicidal multiproblem adolescents has been found to be an effective alternative to treatment-as-usual (TAU), cognitive-behavioral therapy (CBT), supportive and psychodynamic psychotherapies (Miller, Rathus, Linehan, Wetzler, & Leigh, 1997; Rathus & Miller, 2002; Miller, Rathus, & Linehan, 2007; Mehlum et al., 2014; Rathus & Miller, 2015; McCauley et al., 2018). DBT for adolescents (DBT-A) began as a treatment for suicidal and self-harming youth, but has evolved into a more transdiagnostic treatment for adolescents presenting with a range of emotional and behavioral problems (Miller et al., 2007; Ritschel, Miller, & Taylor, 2013).

In this chapter, we begin by discussing the rationale for DBT with adolescents. We then summarize our learning from developing our own DBT programs for adolescents, focusing on the adaptations, additions, and areas of emphasis we consider important to the developmental level of this population. Throughout, we describe

how to maintain the principles of DBT in developing and running an adolescent DBT program. Finally, we present a clinical vignette to illustrate how to apply these principles with a multiproblem adolescent.

## Why Adopt DBT-A?

There are several reasons for adopting DBT-A: (1) to address a clear need for an evidence-based treatment for suicidal multiproblem youth; (2) to offer a biosocial theory that provides a compassionate theoretical framework to explain the etiology and maintenance of emotional dysregulation that also informs the treatment interventions; (3) to address various skills deficits, including emotion regulation, and teach new behavioral skills in group or classroom contexts compatible with typical youth learning, practicing and generalizing new skills; and (4) to utilize a multimodal intervention that allows for various intervention points, including individual therapy, multifamily skills-training group, intersession coaching for teens and parents, and family sessions and parenting sessions as needed.

During the early 1990s when the Surgeon General of the United States issued a "call to action" to address the increasing rates of suicide, there was not a single evidence-based treatment for suicidal adolescents to offer adolescents. A clear need existed for a comprehensive treatment that could address skills deficits while increasing motivation for change and for staying in treatment, and also teaching caregivers the skills to interact effectively with their teen. Additionally, treatment providers conducting outpatient treatment with this high-risk population also needed support and help maintaining motivation (Miller et al., 1997).

Applying DBT to suicidal and self-injuring adolescents proved a logical fit to achieve these goals. DBT was explicitly designed for individuals who are chronically suicidal or self-injuring and who have multiple serious mental health problems. DBT not only directly targets life-threatening behavior, it also aggressively targets treatment noncompliance, an enormous problem among suicidal adolescents. For example, in one early study, 77% of adolescent suicide attempters who presented to an emergency room failed to attend or complete outpatient treatment (Trautman, Stewart, & Morishima 1993). Another benefit of DBT is that of a multimodal approach, which includes individual therapy; a consultation team, also known as "therapy for the therapists"; a phone consultation for patients; and group skills training. Group skills training is a particularly effective treatment modality for adolescents due to peer relationships promoting the development of social skills and identity formation (Brown, 1990). The flexibility of a multimodal approach allowed room to adapt necessary new modes that we describe below, including intersession coaching for caregivers, family interventions as needed, new skills for the multifamily skills group (MFSG; e.g., Walking the Middle Path skills, THINK skills), and a graduate group for teens.

## Modifications to Standard DBT for Adolescents

Before modifications are made to any evidence-based treatment, it is incumbent on providers to first apply the exact treatment that is supported by the evidence and

to assess the outcomes and difficulties. As clinical researchers, Rathus and Miller piloted the adult manual with cohorts of adolescent patients and their caregivers to gain clinical information before making adaptations. However, several modifications were necessary to address adolescents' developmental needs that differed from adults, include family members who also demonstrated skills deficits, and simplify content from Linehan's original skills-training materials. Adolescent developmental literature coupled with direct participant feedback and clinical observations informed the initial modifications (Miller et al., 1997; Rathus & Miller, 2002). Rathus and Miller continued to make minor modifications based on developmental and family contextual needs and their research (Rathus & Miller, 2000, 2002), as reflected in their treatment and skills-training manuals: *Dialectical Behavior Therapy with Suicidal Adolescents* (Miller et al., 2007) and *DBT Skills Manual for Adolescents* (Rathus & Miller, 2015). They maintained the essential principles and elements of DBT, including its dialectical underpinnings; biosocial theory of disorder; treatment functions; assumptions about patients and therapists; primary treatment targets and targeting procedures; change and acceptance procedures; treatment strategies (i.e., core, dialectical, stylistic, commitment, case management); and skills.

## Research on DBT with Adolescents

Early quasi-experimental design studies of DBT with adolescents suggested that DBT was effective in reducing numerous target behaviors found among suicidal multiproblem youth (Rathus & Miller, 2002; Katz, Cox, Gunasekara, & Miller, 2004; Fleischhaker et al., 2011). These studies demonstrated feasibility and promising outcomes that provided the foundation for subsequent randomized controlled trials (RCTs).

To date, three RCTs have been conducted and indicate the effectiveness of DBT in an adolescent population (Mehlum et al., 2014; McCauley et al., 2018; Goldstein, Axelson, Birmaher, & Brent, 2007). Mehlum and colleagues' study (2014) compared 19 weeks of outpatient DBT (with the adolescent materials translated to Norwegian) to enhanced usual care (EUC) for 77 suicidal and self-harming adolescents diagnosed with at least three borderline personality criteria. Treatment retention was generally good in both treatment conditions and use of emergency services was low. DBT was superior to EUC in reducing self-harm, SI, depression, hopelessness, and borderline personality disorder (BPD) symptoms. At 1-year follow up, Mehlum and colleagues (2016) found significant within- and between-groups differences of self-harm episodes from posttreatment to 1 year, with DBT faring significantly better than EUC.

A second large RCT, the Collaborative Adolescent Research on Emotions and Suicide (CARES) Study, compared comprehensive DBT (C-DBT) to a protocol-driven individual and group supportive therapy (IGST) for recent and repeated suicidal behavior in 173 adolescents with at least three BPD features (McCauley et al., 2018). The DBT intervention lasted 6 months. Preliminary results indicate a sharp decline in suicide attempts over the course of treatment and a significantly lower rate of suicide attempts at the end of the treatment in the DBT condition compared to the control group. Investigators also found significantly reduced NSSI behaviors and SI among adolescents receiving DBT compared to the control condition. These results lend further support for the efficacy of DBT in reducing suicidal behaviors, NSSI, and SI in youth.

A third RCT was smaller and specifically designed for adolescents with bipolar disorder (Goldstein et al., 2015). In this study, DBT ($n$ = 14) was compared to psychosocial TAU ($n$ = 6). The DBT condition included 36 sessions, 18 individual and 18 family skills-training sessions, alternating weekly over the course of 1 year. The TAU condition was an eclectic psychotherapy approach including psychoeducational, supportive, and CBT techniques. Results indicated that individuals in the DBT condition had greater treatment adherence and reductions in depressive symptoms over time. Additional results indicated trends toward greater reductions in SI and emotion dysregulation in the DBT condition; however, the small sample size precludes the ability to draw strong conclusions.

Results reported from nonrandomized studies indicate that adolescent DBT appears to reduce suicidal behavior, NSSI, depression, and BPD features, as well as have strong treatment feasibility, acceptability in several countries and cultures, and treatment retention rates (Cook & Gorraiz, 2016; Cooney et al., 2012; Goldstein et al., 2007; Groves, Backer, van den Bosch, & Miller, 2012; Rathus & Miller, 2002). In addition, clinicians and researchers have applied DBT to an ever broader range of adolescents, many of whom have never been suicidal (Groves et al., 2012). Hence, mental health practitioners can apply DBT with adolescents across a range of mental health disorders and behavioral problems who struggle to control their emotions and behaviors (Ritschel et al., 2013). Since adolescents fall along a continuum from typical, relatively asymptomatic (i.e., school settings), to severely emotionally and behaviorally dysregulated teens who may require a restrictive setting (i.e., inpatient or residential treatment), we believe DBT components, ranging from skills training only to comprehensive treatment, can be beneficial to all these populations, applied within a primary, secondary, and tertiary prevention framework (Rathus & Miller, 2015).

## Deciding Whom You Will Treat with DBT-A: Factors to Consider

One of the first decisions in developing an adolescent DBT program requires the clarification of inclusion and exclusion criteria for the program. An advantage of limiting the DBT program to a relatively homogenous group (e.g., presence of BPD criteria and recent intentional self-injury) is that individuals in the program resemble the *original* group for whom DBT was shown to be efficacious (Miller et al., 1997). The similarity of problems in a more homogenous group may create greater feelings of cohesion among youth in the program. On the other hand, the increasing evidence that DBT can be successfully adapted for a range of target behaviors (Miller et al., 2007; Rathus & Miller, 2015; Ritschel et al., 2013) makes it reasonable to consider mixed diagnostic groups that serve more clients. The trade-off, as entry criteria broaden, however, is that individuals' severity levels and treatment targets also broaden, and these differences may mean that the program and group skills training could lose their focus. Most outpatient adolescent DBT programs' inclusion criteria are the endorsement of at least 3 out of 5 of the DBT problem areas (e.g., emotion dysregulation, interpersonal difficulties, impulsivity, confusion about self-identity, and teenager/family challenges) with no suicidality or self-injury required for admission. Many youth selected for DBT programs typically have been given comorbid diagnoses, including mood, anxiety, substance and disruptive behavior disorders.

The key consideration regarding exclusion criteria is whether the patient is likely

to benefit from DBT or if more appropriate evidence-based treatments are available. For example, an adolescent whose primary problems result from a thought disorder should not be in DBT as a first-line treatment—other evidence-based treatments are more appropriate. However, one might consider DBT for an adolescent who is chronically suicidal and self-injuring and has psychotic features secondary to a major depression. Sometimes exclusion criteria must consider how well a client will function in group skills training. For example, current mania or psychosis, severe substance abuse, significant intellectual disabilities, and severe expressive or receptive language and reading disorders may interfere with the person's ability to learn and participate in group skills training. This may mean that admission to a DBT program is delayed until conditions are stabilized enough for the individual to benefit from group skills training, or skills training is delivered in an individual format that can accommodate factors that interfere with learning and participation.

In practice, exclusion criteria across programs vary based on program resources, choices about homogeneous versus heterogeneous diagnostic groups, and program limits. Most outpatient DBT programs also exclude adolescents unwilling to comply with the complete DBT program (i.e., attend individual and skills group) or refuse to discontinue other non-DBT psychotherapy. These programmatic limits arise from the practical obstacles to address partial participation or dual simultaneous therapy that may interfere with treatment progress. Gauging the appropriate level of care also factors into exclusion criteria. Teens are excluded from outpatient treatment when they are so behaviorally out of control (e.g., who are imminently suicidal or homicidal, or who after extensive attempts to obtain commitment to staying alive still exhibit no capacity or willingness to stay alive for the next week and make use of therapy to decrease suicidal/homicidal urges) that attempting to treat them in an outpatient setting would be dangerous to them or others (including family members). Ultimately, outpatient DBT is voluntary and if adolescents "refuse," they are not admitted to C-DBT until they offer at least some minimal degree of voluntary commitment to work on learning new skills to address some identified problematic behavioral or emotional difficulty. They may remain in "pretreatment" with an individual therapist working on commitment to C-DBT until the teen consents.

Inclusion and exclusion criteria are typically less stringent in inpatient and residential DBT settings that take on a wider set of presenting problems. In schools, however, the inclusion criteria for a comprehensive school DBT programs may be more narrowly focused on a combination of emotional and behavioral dysregulation. Many typical adolescents exhibit some degree of emotional dysregulation, and training in DBT skills, by itself, may benefit these teens. In schools, secondary prevention programs are intended to protect against the full blossoming of mental health disorders for at-risk individuals characterized by mild or early indicators of mental health needs (e.g., school difficulties, attentional problems, sad or anxious mood, family conflict). DBT skills, at a minimum, may be taught to these individuals, in schools or clinical settings, to address episodic or mild emotion dysregulation not necessitating a full DBT intervention (Rathus & Miller, 2015).

Like diagnostic criteria and presenting problems, age is another important inclusion criterion to specify. Adolescence is generally defined as ranging from 12 to 19 (e.g., Berk, 2004), and one must determine what age group(s) the DBT program will serve. The advantages to limiting treatment to specific age groups (early, middle, or late adolescence) include increased homogeneity in terms of developmental issues,

possibly leading to a greater connection to peers in group settings. However, constraints such as limited referrals or staff may necessitate a mixed-age program for adolescents. Most adolescent DBT programs we are aware of accept patients ranging from ages 12 to 18, mixed together in skills groups.

Another factor to consider is gender and whether to include both girls and boys together in groups. Some residential treatment settings are limited to treating one sex or else separating the sexes into different residences, but most other settings admit both boys and girls. Limiting skills group to a single sex allows for greater homogeneity of issues brought into group and perhaps greater comfort with self-disclosure. Further, it minimizes the degree of disruptive or distracted behavior due to factors such as heterosexual flirting or increased social anxiety due to the presence of the opposite sex. However, one potential disadvantage of separating the sexes is that clients have fewer opportunities to learn from and further enhance skillful behaviors with persons of the opposite sex. Further, keeping groups separated by sex limits the ability of the treatment program to fill the skills groups as easily, since there are typically fewer male referrals. Finally, teens who identify as trans, gender fluid, or gender queer or questioning may experience invalidation about their gender identity from the treatment team if forced into a single-sex group.

## The Key Role of Biosocial Theory in the Treatment of Adolescents

Linehan's (1993a) biosocial theory proposes that chronic problems of emotional dysregulation stem from a biological vulnerability to emotional dysregulation transacting with an invalidating environment. Using a life span developmental perspective, Crowell, Beauchaine, and Linehan (2009) extended the biosocial theory to consider the link between impulsivity and emotion dysregulation. These authors proposed that many biological correlates of BPD are similar to those observed across impulse control disorders, and highlighted the etiological overlap between borderline pathology and attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), substance use, and antisocial pathology. From a developmental perspective, they recommended considering the role of impulse control disorders as one of many pathways to BPD (Crowell et al., 2009). In DBT-A, we teach the biosocial theory to teens and their parents (see Rathus & Miller, 2015). Teaching the model non-judgmentally, we ask family members which parts of the model apply to them and elicit a discussion. As skills trainers, we often share stories that involve inadvertently invalidating our loved ones to show our own fallibility and to not assume a one-up position to those struggling to use validation strategies with their family members.

### *Biological Vulnerability*

Emotional vulnerability includes a high sensitivity to emotion-triggering stimuli, high reactivity (i.e., intense emotional responses), and a slow return to one's emotional baseline. Added to this vulnerability is difficulty modulating emotional reactions; that is, the adolescent lacks the requisite skills and capabilities to effectively cope. Over the past decade, increasing amounts of biological research have shed light on adults diagnosed with BPD and now some early research with adolescents. In adults, hyperreactivity in the amygdala (i.e., the emotion center of the brain) in individuals

with BPD compared to healthy controls has been widely demonstrated through functional magnetic resonance imaging (fMRI) studies (Goodman et al., 2014; Hazlett et al., 2012; Koenigsberg et al., 2014; Krause-Utz et al., 2014); however, to date, no fMRI studies have been conducted on amygdala activity in adolescents with BPD (Ensink et al., 2015). Amygdala activity is notable due to its key role in emotion processing and fear and stress responses. Other neurobiological studies have been conducted with adolescents with BPD, assessing volumetric abnormalities in the anterior cingulate cortex (ACC) and anterior cingulate gyrus (ACG), structures that functionally connect to the amygdala. Some evidence suggests a decrease in volume in the left ACC in adolescents with BPD (Whittle et al., 2009) and decreased ACG volume in adolescents with BPD (Goodman et al., 2011). These results provide preliminary evidence that neurobiological vulnerabilities may exist in the development of BPD in adolescents, and we highlight this in very broad strokes when teaching the biosocial theory to teens and families.

### *The Invalidating Environment*

The invalidating environment is defined as the tendency of people in the emotionally sensitive person's environment to pervasively dismiss, negate, punish, or respond erratically to the person's expression of emotions, thoughts, or behaviors. For teens, the invalidating environment may consist of parents, siblings, and other family members as well as peers, teachers, other school personnel, and even health professionals (Miller et al., 2007). Many teens experience bullying, social exclusion, or social media reactions that can be considered extremely invalidating or even traumatic (e.g., "You're a slut" or "We'd all be happy if you killed yourself"). In an invalidating environment, one's emotional experiences are not received as valid responses, and are instead trivialized, ignored, or attributed to unacceptable characteristics such as overreactivity, inability to see things realistically, lack of motivation, attention-seeking, or being dramatic. At times, however, individuals in the environment may inadvertently reinforce escalating communications of distress, by providing attention and soothing, giving in, or removing demands after suicidal communication. Invalidating environments emphasize controlling emotional expressiveness ("Stop worrying so much, as it's not such a big deal as you're making it seem!"), oversimplify the ease of solving problems ("Just study more for your next SAT and you'll do great"), and are generally intolerant of displays of negative affect ("Take off that sourpuss and smile, we're going to Uncle Johnny's house and he needs to see that we're one big happy family!"). Such environments provide little to no coaching in emotion regulation and instead the individual learns that "emotions are bad." "I shouldn't feel what I feel; my reactions are wrong so I cannot trust them," or "I can only be taken seriously if I *really* let them know how upset I am."

It is important for the teen, caregivers, and school personnel to be taught how the teen's biological emotional vulnerability and the invalidating environment reciprocally adversely influence each other over time. A teen with extreme emotional vulnerability may develop dysregulation in a family with "normal" levels of invalidation, and may even inadvertently elicit invalidation (e.g., a well-meaning parent who doesn't understand why only *this* child who has ADHD and trouble sitting still keeps fidgeting at the dinner table and interrupting others, until the parent finally snaps, "Enough! Go to your room!"). Or, a highly invalidating environment might transact

with a lower level of emotional vulnerability to yield persistent emotional dysregulation (e.g., the coach throughout high school who criticizes rest breaks as weakness, shames emotional displays, and tells the injured player to ignore the pain and "get back in the game"; Rathus, Miller, & Bonavitacola, 2017).

Because of the role of the biosocial theory in our understanding of teens' emotion dysregulation, and since many are minors still living in their parents' homes, it is useful to engage the caregivers in treatment, starting at intake. While in standard DBT for adults, family members or other social support tend to have a more ancillary role in treatment, we find it is critical to address the adolescent's social environment. We address adolescents' invalidating environments at home or school with added emphasis on environmental intervention. Further, we identified adolescent–family dialectical dilemmas and secondary treatment targets (Rathus & Miller, 2000). Due to the increased use of environmental intervention by having caregivers attend skills-training group, receive coaching, and participate in family sessions, we developed a new skills module called Walking the Middle Path (WMP) treatment, in addition to making several modifications to Linehan's existing skills and including some additional skills for teens and caregivers (Rathus & Miller, 2015).

### *Increasing Environmental Intervention to Target Invalidating Environments*

Given the invalidation many of our teenage clients endure as described in the biosocial theory, whether from peers, caregivers, and/or teachers, we believe it is important to target various members of the environment to decrease invalidating behaviors and help increase skillful behaviors (e.g., validation skills) that are likely to improve communication and relationships. It can be useful to orient and even train school staff in DBT (see Dexter-Mazza et al., Chapter 6, this volume) and to engage the staff in a collaborative manner by sharing (with the adolescent and caregiver's permission) treatment goals and effective strategies to reinforce skillful behaviors. For example, if a student with a history of panic attacks is permitted to leave class to speak with a school counselor each time they become anxious or emotionally dysregulated, there is potential to reinforce anxiety/leaving. Providing the counselor with effective strategies to not reinforce anxious behaviors can be advantageous for reaching the adolescent's goals more efficiently.

### *Inclusion of Caregivers in Various Modes, Including Multifamily Skills-Training Group*

We address the standard DBT treatment function, *structuring the environment,* through the inclusion of caregivers in treatment and through interfacing with school personnel whenever indicated. We include parents or caregivers in treatment through participation in DBT skills training (either MFSG or parallel parent skills group) and family sessions. Teaching DBT skills to parents and caregivers provides them with strategies to improve their relationships with their adolescents and to more effectively manage their own emotions and behaviors, ideally improving the family environment.

### *Walking the Middle Path Skills*

Walking the Middle Path (WMP) skills (Miller et al., 2007) teach adolescents and caregivers the following: (1) dialectics and adolescent–family dialectical dilemmas to

reduce extreme thinking/behaviors while enhancing perspective taking, (2) validation skills, (3) behavior change principles (along with parenting strategies).

A significant development in DBT with adolescents was adding the teaching of dialectics directly to teens and families in the WMP module. Dialectical truth, and thus change, emerge by considering elements of truth on both sides of an argument (the "thesis" and "antithesis"). This process results in a "synthesis," and rather than working to prove the merits of one side, a dialectical stance acknowledges the tension between sides—through this consideration, new solutions emerge. Replacing "either/or" thinking with a "both/and" perspective reminds teens and caregivers that ideas that seem at odds with each other can both be true (e.g., "You can be both firm and flexible"; "Your point of view makes sense *and* my perspective does too."). Adolescents often become polarized from their family members with regard to problems and potential solutions. Thus, we teach WMP skills and conduct family sessions to help work toward a synthesis.

Walking the Middle Path also addresses the extreme vacillating behavior patterns frequently observed between teens and caregivers that we labeled teen–family dialectical dilemmas (Rathus & Miller, 2000): (1) excessive leniency versus authoritarian control; (2) normalizing pathological behaviors versus pathologizing normative behaviors; and (3) forcing autonomy versus fostering dependence. For each pattern, we developed secondary treatment targets (Rathus & Miller, 2000): one to decrease the maladaptive behavior, the other to increase a more adaptive response. Table 16.1 lists the dialectical dilemmas for adolescents and parents, and the corresponding secondary treatment targets. These are explicated in the WMP skills, allowing families to identify personal patterns through the use of a family sculpture. Each family member is instructed by the skills trainer to physically position themself and the accompanying family members in a particular spot in the room to demonstrate where on the dialectical dilemma they typically land (e.g., too loose vs. too strict). Group members also practice finding syntheses to polarizing hypothetical family scenarios. The problem solving to reach "middle path" solutions for actual family conflicts is typically conducted in family sessions, where there is more time to address these behavior patterns.

To determine the impact of the WMP module, we evaluated its treatment acceptability in families receiving DBT (Rathus, Campbell, Miller, & Smith, 2015).

**TABLE 16.1. Adolescent Dialectical Dilemmas with Corresponding Secondary Treatment Targets**

| Dilemma | Targets |
|---|---|
| Excessive leniency versus authoritarian control | • Increasing authoritative discipline; decreasing excessive leniency<br>• Increasing adolescent self-determination; decreasing authoritarian control |
| Normalizing pathological behaviors versus pathologizing normative behaviors | • Increasing recognition of normative behaviors; decreasing pathologizing of normative behaviors<br>• Increasing identification of pathological behaviors; decreasing normalization of pathological behaviors |
| Forcing autonomy versus fostering dependence | • Increasing individuation; decreasing excessive dependence<br>• Increasing effective reliance on others; decreasing excessive autonomy |

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Adolescents and parents found the module acceptable, helpful, interesting, and relevant. Additionally, three of the five most highly rated skills in perceived helpfulness for both adolescents and their caregivers across the full DBT skills curriculum were WMP skills, with validation the most highly rated skill among both adolescents and caregivers.

### *Adaptations and Additions to Adolescent DBT Skills*

Adolescent DBT skills include the majority of Linehan's original (1993b) skills, those from our Middle Path module, and several additional skills. These additional skills, included in the adolescent DBT manual (Rathus & Miller, 2015), are either adapted from the second edition of Linehan's skills manual (Linehan, 2015) or developed specifically for teens and families. Adolescent skills adapted from Linehan's revised manual include the TIPP (change the Temperature, Intense Exercise, Paced Breathing and Progressive Muscle Relaxation) skills from distress tolerance, cope ahead, check the facts, problem solving, and wise mind values and priorities from emotion regulation. It should be noted that the look and number of words presented on handouts were modified to lower the reading level and make them more teen-friendly.

Several additions are original to our teen adaptation and are not included in the adult skills manual (Rathus & Miller, 2015). Parent–teen shared pleasant activities extend the emotion-regulation skill of accumulating positives in the short term to address the deficit in positive interactions that we have noted within many families seeking DBT. This skill aims to add ways to increase positive emotions while improving teen–parent relationships. We also include two supplemental handouts to the emotion-regulation PLEASE skill: one for managing eating (food and your mood) and the other on sleep (the best ways to get rest). To interpersonal effectiveness, we added the THINK skill (designed to increase empathy and taking the perspective of others). We developed this skill based on Crick and Dodge's (1994) social information processing model after noticing that teens and families often assumed the worst about one another's intentions, which increased negative emotions and ineffective interactions, and resulted in the need for more help with perspective taking. THINK skills have not yet been included in clinical trials.

### *Adding Family Therapy*

Another adaptation to DBT with adolescents is the addition of family work (Miller, Rathus, et al., 2007; Miller, Glinski, et al., 2002). Family intervention is important because it helps clarify how the contingencies and transactional nature of problem behaviors in the home environment maintain dysfunctional behavior. DBT therapists encourage caregivers to use the same skills as their teens to alter the way they respond. Often, family behavioral analysis provides an effective tool for highlighting adaptive and maladaptive family interactions and determining change strategies. The therapist conducts a family behavioral analysis when a family member is directly involved in an adolescent's life-threatening, therapy-interfering, or quality-of-life interfering behavior (Miller, Glinski, et al., 2002). These sessions offer an opportunity for skills strengthening and generalization. Regardless of the reason for a family session (see Table 16.2), the therapist treats family members as partners rather than targets in treatment. The family feels more connected to and supported by the DBT

**TABLE 16.2. Indications for Scheduling a Family Session as Part of Individual Therapy with an Adolescent**

1. A family member is providing a central source of conflict; the adolescent needs intensive coaching or support in attempting to resolve this conflict.
2. A crisis erupts within the family.
3. The case would be enhanced by orienting one or more family members to or educating them about a set of skills, treatment targets, or other aspects of treatment.
4. The contingencies at home continue to reinforce dysfunctional behavior or punish adaptive behavior.

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therapy team through significant amounts of validation and consistent family sessions (Miller, Rathus, et al., 2007). Many family members report having experienced judgmental attitudes and blame from their children's prior therapists over the years. Adopting a dialectical stance allows DBT treatment providers to develop a more synthesized and phenomenologically empathic view of family behavioral patterns, recognizing each family member's perspective, skills deficits, and capabilities (Miller, Rathus, et al., 2007).

### *Adding Parent Phone Coaching and Parenting Sessions*

Attendance in a DBT skills-training group and family sessions may still not provide sufficient support to caregivers who need help structuring the environment consistent with treatment goals. Caregivers may also need *in vivo* skills coaching and, ideally, proactively planned parent coaching sessions to help them more effectively and consistently generalize skills. We recommend that the parenting coach be one of the group leaders or any other therapist on the team who is not the adolescent's primary therapist to avert potential conflicts of interest that can jeopardize the therapeutic alliance with the teen.

Some parents are encouraged to arrange more formal individual parent coaching sessions to work more directly on their own behaviors that may be interfering with their adolescent's treatment progress. Overall, we have found that parent coaching is most useful when it focuses on increasing parents' dialectical thinking, validation, and contingency management. Although these are the skills taught in the Middle Path module, parents may need additional help generalizing these skills with their adolescent.

When practical obstacles arise to caregiver involvement, we suggest being creative and making the effort to nonetheless involve them. For example, sometimes family involvement is difficult because the family lives far from the DBT program (particularly for residential and inpatient settings). Programs have used the one family session that occurs during the initial intake to orient family member to DBT; they have scheduled weekly family sessions by phone; they have DBT program staff offer indirect support to families by coaching the adolescent patients to "teach" their parents the skills they learn. One program that we are aware of provides parents with a DBT skills manual as a method of orienting parents to the treatment. Including caretakers—whether weekly, monthly, or as needed—best addresses generalization and helps structure the environment to enable and strengthen treatment gains.

### *Not Enforcing the "24-Hour Rule"*

In standard DBT with adults, the 24-hour rule (i.e., the patient may not contact the therapist within 24 hours following any suicidal or nonsuicidal self-injurious behavior) is used so the therapist's behavior does not inadvertently reinforce life-threatening behavior. Given that adolescents under 18 are minors and not often aware of the medical and biological consequences of their actions, therapists conducting DBT with adolescents do not enforce the same 24-hour rule. While we also do not want life-threatening behavior to be reinforced, there is a greater medical-legal responsibility in telling a minor to not call after they have engaged in a life-threatening behavior. If an adolescent engages in suicidal or nonsuicidal life-threatening behavior, the DBT therapist will want to focus on assessing medical lethality, ensuring the adolescent receives any necessary medical attention, and when indicated, informing a family member, all while attempting to not reinforce life-threatening behaviors. The therapist can decrease the potential of reinforcing these behaviors by using a matter-of-fact tone and by not being overly soothing.

## Graduate Group and Other Follow-Up Treatment Options

Research studies with suicidal multiproblem adolescents have tested treatment lengths for outpatient treatment of 5–6 months (Mehlum et al., 2014; McCauley et al., 2016), and our manual proposes 6 months (Rathus & Miller, 2015). In practice, among adolescent DBT programs, the length of treatment varies from setting to setting. For example, some adolescent outpatient programs offer an abbreviated (e.g., 16 weeks) initial phase of treatment, others a year-long program. Some teens with BPD features may not need the longer-term treatments that adults with more entrenched personality and behavioral problems require. Further, therapists may more easily "sell" a shorter outpatient program to adolescents who are not always sure why they need any treatment right now, let alone long-term treatment. Yet, a shorter length of treatment might not be sufficient to treat those adolescents with severe emotional and behavioral dysregulation and suicidality. Because documented rates of relapse and recurrence among depressed adolescents are high, clinical researchers have recommended either booster or continuation treatment to address this problem in briefer treatments (Birmaher et al., 2000).

One solution to meeting these various needs is to offer a continuation phase of DBT treatment (e.g., a graduate or maintenance group; see Miller et al., 2007). For example, consider this possible sequence: An acute phase of 16 weeks of C-DBT is offered after which four options are reviewed for the adolescent. First, those who are still significantly struggling with Stage 1 targets are invited to repeat a second 16-week acute phase of treatment. Second, adolescents who have successfully completed the acute phase of treatment (i.e., reduced life-threatening, therapy-interfering, and severe quality-of-life behaviors) are awarded a diploma in a graduation ceremony for the multifamily skills-training group. These individuals are then invited to join the "graduate group" (for teens only) and may choose to discontinue individual therapy or fade out over time. Third, those in the middle, who have made some improvement yet still need more help gaining control with regard to Stage 1 target behaviors, have the option of repeating the acute phase of treatment, engaging in intensive family

therapy if more work is indicated there, or moving to the graduate group while continuing with individual therapy. This decision is made by the treatment team, including the therapist, adolescent, parents, and DBT consultation team. Finally, a fourth choice is to discontinue treatment altogether after 16 weeks, something that is rarely recommended.

Our graduate groups include adolescent graduates and one or two DBT therapists. We do not require two as, in theory, the graduates are better emotionally regulated and require less coaching during group time. This treatment phase is less time-intensive, consisting of 90-minute groups once per week for at least 16 weeks with the opportunity to recontract for an additional 16 weeks (and beyond) if the adolescent can identify clear treatment goals. While telephone consultation to adolescents is still used in this modality, individual therapy may be phased out over time. Adolescents who do not continue with a primary individual therapist are eligible for as-needed individual or family sessions led by one of the graduate group therapists. The primary goal of the graduate group is to prevent relapse by reinforcing the progress made in the first phase of treatment and to help patients generalize their behavioral skills. The group leaders encourage the adolescents to "consult" with, validate, and reinforce one another, with less emphasis on the therapist, to more effectively manage their current life problems. In fact, each group begins with a different adolescent leading a mindfulness exercise, while another teen reviews a skill for their peers. An agenda is then set and adolescents use peer feedback and support to address members' current life problems. This group tends to be highly engaging for adolescents, as they come to rely more on one another, depend less on the adult therapists, and increase their sense of mastery. These options of repeating the acute phase, moving to a maintenance phase that focuses on generalization with as-needed access to individual or family therapy, provide many ways to tailor treatment length to the adolescent's needs. While adjusting length of treatment is common practice in DBT with adults, such flexibility may be particularly important in meeting the needs of adolescents in DBT.

## Confidentiality and Treatment of Suicidal Adolescents

A DBT therapist working with adolescents is faced with all of the ethical challenges of working with a high-risk population as well as some additional complicating factors. Treatment of intentional self-injury in adolescents applies the same protocols and strategies used with adult/standard DBT. The common reaction to adolescent suicide ideation is to hospitalize, yet given the absence of data that hospitalization actually reduces suicidal behavior (Geddes, Juszczak, O'Brien, & Kendrick, 1997; Hunt et al., 2006; Isometsä, Henriksson, Heikkinen, & Lönnqvist, 1993), DBT favors an approach that will manage intentional self-injury on an outpatient basis (for many reasons, including avoidance of reinforcement for escalation of suicidal behavior). This represents a strong shift in thinking that may feel threatening and anxiety-provoking to some parents and caregivers as well as many clinicians and administrators. Because of the patient's age and the likelihood of family involvement in therapy, issues of confidentiality can be more pressing in working with suicidal adolescents using DBT.

Our guidelines for calls between a parent and the teen's primary DBT therapist clarify that the parent may share information with the therapist (of which the teen

will be informed), but the therapist will not share confidential information with the parent. Parents are urged to copy their teen on any email that goes to the therapist and notify their teen when leaving a voicemail message, so the teen is kept abreast of parent–therapist correspondence. Therapists typically protect teen privacy by not disclosing the teen's ongoing low-level risk behaviors or thoughts including passive SI and/or superficial self-injury; therapists inform teens and parents that to do so would violate trust and impede therapy. However, for any concerning escalation or new behavior/urge, or any event that indicates imminent risk, therapists assure the parents that they will be informed, often with the teen present and participating in the disclosure after therapist coaching and support. Moreover, DBT therapists can assure caregivers that they will be available 24/7 to the teen for coaching as needed, and also they will be closely monitoring the teen's diary card in individual sessions each week that explicitly monitor self-harm and suicidal urges and actions, in addition to other high-risk behaviors.

Direct explicit negotiation at the onset of therapy regarding the ground rules and agreements about other information that one is not required to report (e.g., substance abuse, sexual behavior, eating disordered behavior) and decisions related to disclosure of this information can be made on the basis of what is clinically indicated. Even in jurisdictions that provide the adolescent with a full right to invoke privilege, expectations and roles can be made clear and mutually agreed upon from the beginning to clarify the lines of communication. The development of confidentiality agreements and continued consultation with hospital/agency/practice lawyers can also be very important steps to successfully address such concerns.

## DBT-A in Action: The Case of Evelyn

"Evelyn" was a 16-year-old female who presented to outpatient DBT with preexisting diagnoses of ADHD, major depressive disorder (MDD), and a specific learning disorder (SLD) for mathematical reasoning. At intake, she also met the criteria for BPD. She was referred following an inpatient hospitalization for suicidal threats in the context of intense family conflict. Leading up to this hospitalization, Evelyn had been engaging in several high-risk behaviors that her parents became aware of from a concerned friend. For example, Evelyn had been using a dating app to meet older male teens and overnight would climb out of her bedroom window to meet them. These encounters typically included substance use and unprotected sex. When confronted, Evelyn responded with anger by yelling and blaming her parents for her behavior. As the conflict escalated and her parents were beginning to establish consequences, Evelyn disclosed that she had been engaging in NSSI for the previous 2 years and that she wanted to die. Her father continued to insist that her behavior was unacceptable and that there would be restrictions, while her mother comforted her and slept in Evelyn's room with her that evening. The next day, her parents took her to the emergency room to be evaluated.

At intake for the outpatient treatment, Evelyn disclosed that she had been feeling hopeless, empty, and lonely since she began high school at age 14 and that she considered suicide a few times per week with various plans, including taking over-the-counter medications or slitting her wrists. Typically, watching her favorite TV show would be

sufficient to distract her from suicidal urges. She had been struggling academically until she was diagnosed with SLD and was held back in ninth grade. Evelyn reported intense shame about her school performance and that she no longer felt accepted by her peers. As a result, Evelyn began using marijuana daily at school with older students to escape these intense negative emotions. Evelyn began spending time with substance-using older peers exclusively and started isolating from her former friends. At home, Evelyn would spend most of her time alone in her room and ruminate about every social interaction throughout the day while looking at social media. It was at this time that Evelyn would engage in NSSI in the form of cutting with razor blades, which she restricted to her upper thigh to hide the scars from her parents. Therefore, her parents only perceived the change in friends and the escalation of substance use. As a result, they attributed her hypersomnia, overeating, and withdrawal from the soccer team as substance-related and not related to depression or social difficulties. Evelyn's parents would become even more upset when Evelyn stated that she did not know why she engaged in problem behaviors. At the time of her hospitalization, Evelyn had been grounded for the past 3 months for stealing money from her parents, being under the influence of marijuana, and lying about being at the movies when she left the theater to go to a party. It was during this grounding that Evelyn started using the dating app to form connections and began taking harder drugs (e.g., MDMA and cocaine) with people she met online.

Evelyn identified a number of goals for treatment. She wanted to improve her relationship with her parents and earn more freedom, decrease her substance use, build meaningful friendships, stop NSSI and SI, and rejoin the soccer team. Her reasons for living at that time included not upsetting her parents any further, taking care of her younger brother, and the hope of pursuing first a college degree and then a career in forensic science.

When building her commitment in the first session, Evelyn's difficulties were broken down into the five adolescent DBT problem areas. She admitted to all of them:

1. *Reduced focus, reduced awareness, and confusion about self:* not knowing why she engages in problem behaviors (i.e., lack of awareness), rumination (i.e., having difficulty maintaining attentional focus)
2. *Impulsivity:* substance use, NSSI, risky sexual behaviors, stealing, lying
3. *Emotional dysregulation:* persistent negative mood (hopelessness, loneliness, emptiness, shame); inability to regulate emotions effectively; withdrawal from friends, family, and activities; and difficulties eating and sleeping
4. *Interpersonal problems:* unsteady friendships, sacrificing self-respect, feeling rejected/excluded
5. *Teen and family challenges:* family conflict, nondialectical thinking and acting, invalidation of lower levels of emotional expression, inconsistent and ineffective parental responses to problem behaviors

These behavioral difficulties were further sorted into the DBT target hierarchy:

**Decrease life-threating behaviors**

- Decrease SI/threats.
- Decrease/eliminate NSSI.

**Decrease therapy-interfering behaviors (see the "Course of Treatment" section below)**

- Withholding information about target behavior from the therapist (client).
- Not completing a diary card (client).
- Not conducting behavioral chain analyses consistently (therapist), arising later in therapy.

**Decrease quality-of-life-interfering behaviors**

- Decrease substance abuse, promiscuous and unprotected sexual behavior, stealing, and lying.
- Reduce negative moods.
- Reduce family conflicts and improve communication with family.
- Build stable friendships with non-drug-abusing friends.
- Decrease binge eating.
- Improve hours and quality of sleep.
- Experience emotions without engaging in mood-dependent behavior.

### *Course of Treatment*

The therapist oriented Evelyn to the comprehensive DBT program including weekly individual therapy, weekly 2-hour MFSG, 24-hour skills coaching for Evelyn, 24-hour skills coaching for the parents, and parenting sessions as needed. Evelyn initially said, "Sure, my parents are making me do this anyway." The therapist used commitment strategies including pros and cons, freedom to choose and absence of alternatives, devil's advocate, and foot in the door to get Evelyn to participate actively in treatment. Evelyn committed to weekly individual therapy with skills coaching and 24 weeks of MFSG with both of her parents; her parents engaged in biweekly parenting. Parenting coaching and parenting sessions were conducted by a skills group leader separate from Evelyn's individual therapist and focused on helping her parents support Evelyn's skills use, boost validation, and work on Middle Path skills (e.g., setting consistent wise mind limits for Evelyn).

Early in individual sessions, Evelyn would frequently attend without a completed diary card (therapy-interfering behavior) and report that her "dark period" was over and that everything was fine, and praise the therapist for helping so much (i.e., the secondary target of apparent competence was present). These sessions would often be followed by reports from the parents that Evelyn had been demonstrating an increase in problem behaviors. Conversely, in other sessions, Evelyn would report that "nothing is working" and that she needed to return to the hospital to feel better (secondary targets of active passivity and emotional vulnerability). In these moments, Evelyn would cry, shut down, engage in suicidal thinking, and disengage from the therapist. Evelyn's parents would be surprised when they were included in the session to discuss whether hospitalization was necessary (dialectical strategy of extending and contingency clarification).

The therapist consistently adhered to the DBT target hierarchy, prioritizing life-threatening behaviors, therapy-interfering behaviors (TIBs), and quality-of-life interfering behaviors in that order. For example, when TIB occurred (i.e., Evelyn came to

session without her diary card), the therapist engaged Evelyn in a behavioral chain analysis to determine the function of the TIB and to collaborate on a solution analysis to make treatment more effective. Due to chaining the TIB, the life-threatening behavior that the client had not reported was revealed. On this occasion when Evelyn did not complete her diary card (target behavior), Evelyn identified that she had been having trouble sleeping (vulnerability), was ruminating about a conflict with a friend (vulnerability), and engaged in NSSI in the form of cutting (prompting event). This led to intense shame (critical link), an urge to avoid treatment, worry about being hospitalized again if she disclosed to the therapist (critical link), and fear that her parents would punish her while she was feeling so upset (critical link). Evelyn said that she had previously cut herself and that the therapist did not notice the NSSI column of her diary card was blank, and although she felt guilty (consequence), she successfully avoided discussing the behavior (consequence).

It is noteworthy that this chain analysis initially focused on TIB revealed an instance of NSSI which otherwise might not have been exposed in the session. Upon completing the chain, the therapist and Evelyn collaborated on a solution analysis by identifying skills to apply to each critical link in the chain (see Figure 16.1).

The individual therapist and parent coach collaborated to help Evelyn's parents reduce the ways in which they might be maintaining Evelyn's problem behaviors and could alternatively intervene to increase her skillful behaviors. The parent coach consulted to the parents to develop a behavior contract that they could consistently enforce. This addressed the dialectical dilemma of being "too loose versus too strict" by reducing their tendency to set unenforceable limits and then setting no limit when Evelyn did not meet expectations. To foster Evelyn's autonomy, the individual therapist helped Evelyn utilize skills to help her meet parental expectations. Intermittent family sessions focused on family issues such as practicing validation together and to help her parents understand which of Evelyn's behaviors were more typical adolescent behaviors (e.g., wanting to stay out late) and which were more pathological (e.g., excessive withdrawal).

### *Outcomes*

By 6 months, when Evelyn and her parents were graduating from the multifamily skills-training group, Evelyn had been free from self-harm and SI for 4 months, and she was no longer engaging in risky sexual behavior. She was still using marijuana approximately once per month, which she was tracking on her diary card. She was committed to reducing marijuana use when the function was to regulate emotions, while she remained ambivalent about its use when it served a social function. Evelyn had fewer conflicts with her parents and her family was able to regulate their conflict more effectively by utilizing dialectical thinking and validation skills, with greater use of shaping and positive reinforcement and less reliance on pure punishment. To address her remaining quality-of-life interfering behaviors, Evelyn remained in individual therapy and joined a DBT graduate group to collaboratively generalize skills with other teens who had completed MFSG. Evelyn also had a job outside of school and took up rock climbing as part of her life-worth-living goals.

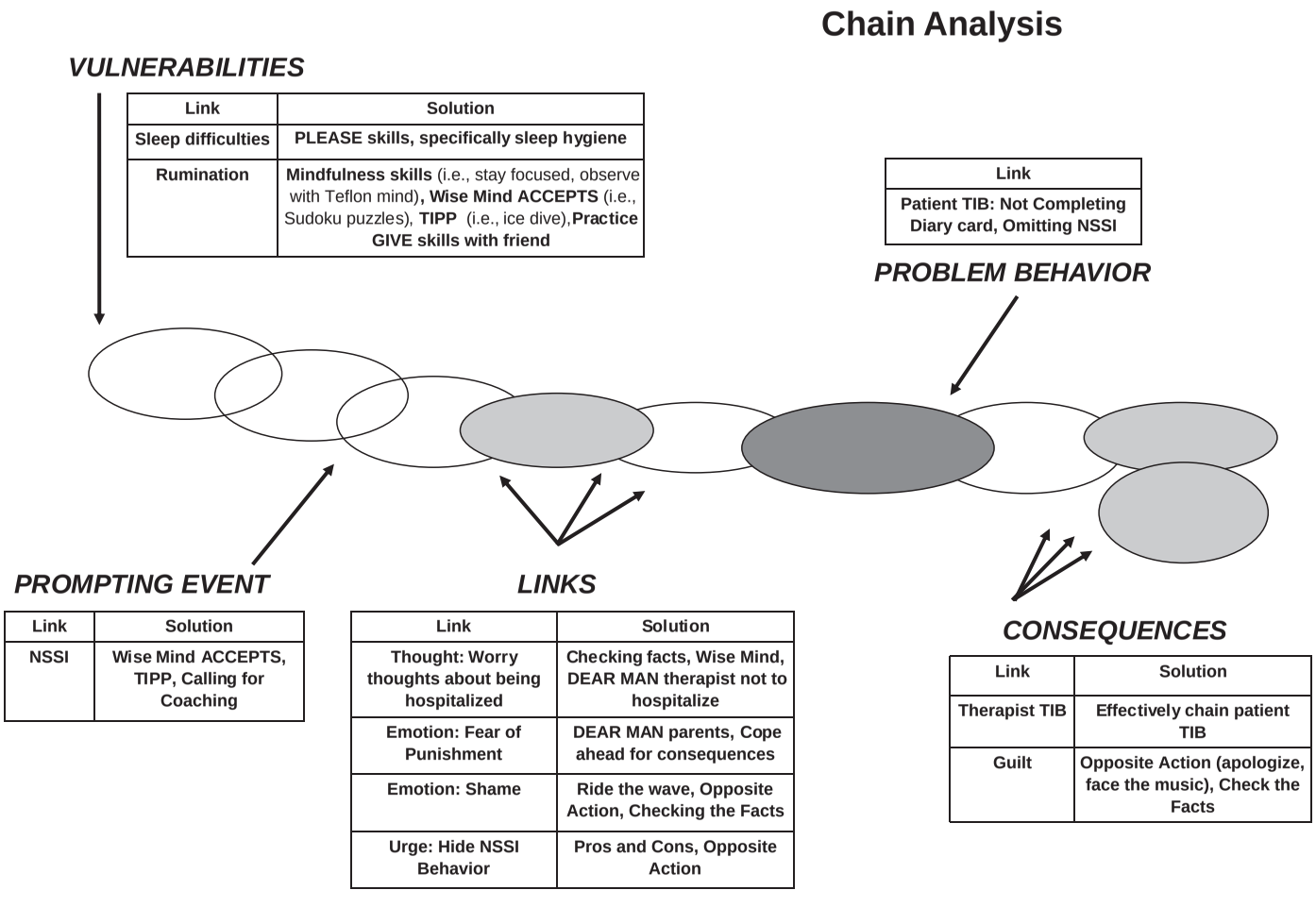


**FIGURE 16.1.** Behavioral chain and solution analysis.

## Conclusions

Many factors make working with suicidal, multiproblem adolescents challenging. DBT offers an evidence-based alternative to TAU that may reduce intentional self-injury, depression, BPD, and the use of expensive psychiatric services for this population. It is our belief that by paying particular attention to the functions of generalization and structuring of the environment (e.g., by incorporating caregivers, providing alternative lengths of treatment, using a graduate group), DBT can be modified to best meet the needs of adolescents. We hope that this chapter helps you consider how DBT makes sense in your setting and provides useful guidelines as you develop your DBT program for adolescents.

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CHAPTER 17

# DBT with Families

ALAN E. FRUZZETTI, LUCIANA G. PAYNE,
and PERRY D. HOFFMAN

Dialectical behavior therapy (DBT; Linehan, 1993) is founded on a transactional (or biosocial) model of borderline personality and related disorders that maintains a dialectical position: Disorders related to severe and chronic emotion dysregulation are the result of an emotionally vulnerable person transacting with others in a pervasively invalidating social and family environment (Fruzzetti, Shenk, & Hoffman, 2005; Linehan, 1993). However, most targets and strategies employed in DBT are designed to help individuals regulate their emotions, and direct interventions in the social and family environment are often not emphasized. Yet, there are several reasons to consider using family interventions to complement individual ones in DBT.

First, substantial literature supports the efficacy of augmenting individual treatments for severe psychopathology with family interventions (Fruzzetti, 1996, 2018). In fact, research evidence suggests that improvements in family functioning mediate treatment outcomes for individuals with borderline personality disorder (BPD; Fruzzetti, 2019) and augmenting DBT with programs designed specifically for parents can lead to better treatment outcomes for adolescent patients (Payne & Fruzzetti, 2020).

Second, the transactional model puts the social and family environment in a central role in the development, maintenance, relapse, and/or remediation of problems associated with severe and chronic emotion dysregulation (Fruzzetti, 2006; Fruzzetti, Shenk, & Hoffman, 2005). Because the behaviors of a parent and partner (and other loved ones) are often relevant to the chain of a patient's problematic behaviors, including family members in treatment creates direct opportunities to target problem behaviors in two new important ways: (1) Family interventions can effectively augment individual DBT, for example, by helping family members reduce prompting events for patient emotion dysregulation, and reducing reinforcement of their dysfunctional behaviors; and (2) by helping parents and partners understand their loved one's struggles (and their chains toward dysfunction), with family interventions providing a learning laboratory in which patients can practice new skills (with live

coaching, as needed) and be more likely to receive support for their improvements. It makes sense to intervene on *both* sides of the transaction (the individual's skills and others' responses), and data suggest that it is effective and efficient to do so.

Third, comprehensive DBT, of course, includes five functions (Linehan, 1993): (1) skill acquisition; (2) skill generalization; (3) enhancing client motivation; (4) skill and motivation enhancement of therapists; and (5) structuring the environment to promote (or at least not to interfere with) progress. Many family interventions typically include skill acquisition (in both individual and family DBT skills); thus, practicing skills in a family context provides opportunities for generalization. Family interventions that address problematic behaviors of family members, or problematic family interactions that contribute to patient target behaviors (i.e., are antecedents or consequences) therefore also address patient motivation. And, of course, intervening with families necessarily involves "environmental intervention." Thus, family interventions, in particular DBT family interventions, can be a highly integrated component of DBT that addresses all functions of the treatment.

Finally, data support the effectiveness of DBT family interventions for both individual clients and family members (e.g., Flynn et al., 2017; Hoffman et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007; Kirby & Baucom, 2007; Payne & Fruzzetti, 2018). For parents and partners, family interventions offer the opportunity to understand their relatives' experiences, diagnosis, and behaviors, as well as to reduce the stigma associated with the diagnosis (BPD) or a variety of behaviors (e.g., suicide attempts). Multiple studies suggest that family interventions alleviate stress, burden, grief, and depression in family members. DBT family interventions can be an avenue for parents and partners to learn skills and/or obtain support that may not be available otherwise. For patients, evidence suggests that family involvement has a salutary effect on their outcomes. Including partners or parents in treatment provides opportunities for skills generalization as well as opportunities to target the behaviors of family members that may contribute to the development and/or maintenance of the patient's problem behaviors (e.g., problematic family transactions, family member's inadvertent reinforcement of problem behaviors, or punishment of skillful behavior).

For our purposes, we will assume that families with a member with BPD (or other disorders related to chronic emotion dysregulation) are a heterogeneous group. In our clinics, we have found many family members to be competent, caring, loving, devoted, and willing to work very hard to do anything that might help their child or partner with BPD. We also have found that many family members can be quite distressed themselves (angry, depressed, fearful), sometimes needing treatment, sometimes blaming the patient identified with BPD for a host of individual and family difficulties, or they may be overwhelmed with guilt and fear, and might even have stress- and trauma-related problems (Ekdahl, Idvall, & Perseius, 2014; Fruzzetti, Harned, Liu, Valenstein-Mah, & Hoffman, 2020; Hoffman et al., 2005). Family members are often blamed, criticized, and maligned for their putative role in the development of BPD, and people with BPD are frequently blamed for the difficulties and burden that their families experience. Interventions will be most useful when all parties (patients, family members, professionals) eliminate or at least significantly minimize blaming. For this reason alone, DBT provides an effective template for family interventions. We find it useful to take a mindful and non-judgmental stance, and to avoid blaming anyone. The transactional model (Fruzzetti et al., 2005; Linehan, 1993) tells us that significant problems with emotion dysregulation can develop

whether the BPD family member started out with an extreme temperament or had a more normative one, or whether the family was disengaged or invalidating early on or was instead validating and caring. Regardless, the ongoing transaction means that emotion vulnerabilities and dysregulation create and/or exacerbate invalidating responses, and invalidating responses create and/or exacerbate emotion vulnerabilities and emotion dysregulation (Fruzzetti, 2006; Fruzzetti et al., 2005; Fruzzetti & Worrall, 2010). Consistent with other applications of DBT, having a non-pejorative way to understand families is essential to being effective when trying to engage family members and facilitate important changes in the family.

With this background in mind, this chapter will address a number of issues and problems relevant to family interventions associated with the delivery of DBT for adults and adolescents, with the hope that more DBT clinicians will learn and incorporate DBT family interventions into their practices. We will (1) discuss program issues relevant to family participation in treatment; (2) describe DBT family skills to complement individual DBT skills; (3) describe multifamily skill groups; (4) summarize the use of individual and family DBT skills in the Family Connections program (groups for family members, led by family members); and (5) explicate the steps involved in doing brief family interventions, or DBT family therapy, to augment individual outcomes and improve family functioning for DBT patients. For a comprehensive guide to assessing couples and families from a DBT perspective, that should precede DBT family interventions, see Fruzzetti and Payne (2020).

## Program Issues in Family Interventions in DBT

There are many issues that are important to consider when offering family interventions. This section will include discussions about who (which therapist) should be the therapist with a family, what modes of family intervention might be offered, how to structure groups (e.g., homogeneity vs. heterogeneity), and how to facilitate participation among family members.

### *Who Should Be the Family Therapist?*

DBT programs have several alternative ways to provide or facilitate the delivery of family interventions: (1) Individual DBT therapists can also provide DBT family interventions for their own clients and their families (i.e., the same therapist works with the patient and their family); (2) DBT therapists can treat the families of clients who are seen individually by other DBT therapists in the program (a different therapist interacts with the patient and their family, but both are on the same DBT consultation team); (3) the DBT program can develop a separate family DBT team with its own consultation group, which provides family interventions for the program; or (4) the program can consider referring family work to "DBT-friendly" family therapists.

There are pros and cons to each of these arrangements. For example, having the individual DBT therapist also provide family interventions allows the therapist to become very aware of the patient's patterns, their "chains" (factors that are related to treatment target behaviors such as self-injurious behavior, aggression, substance use, etc.), and how family responses have influenced these behaviors in the past. However, having therapists do double duty as both the individual and family therapist could

make it difficult for them to remain neutral, and/or for family members to perceive them that way in some cases. The perception of a therapist's biased alliance with the patient could reduce family members' motivation to participate fully in family interventions.

In contrast, utilizing another therapist may help to establish an alliance with partners or parents, but the therapist may be less knowledgeable about the details and patterns of the patient and the patient may perceive the therapist as siding with other members of the family. With both of these options, it is also important to consider that some teams do not have members with substantial family therapy training. In contrast, although having an entire team dedicated to family treatment (with concomitant family therapy training and experience) provides wonderful treatment options and expertise, this option can require a significant investment of time and resources. For example, family therapists would need at least some minimal training to work within the DBT model to provide good continuity of care in which the individual therapist and family therapist are not working at cross-purposes, or whose models for treatment are so different that it could be confusing for patients or their families.

Finally, referring families out to community family therapists is relatively easy and requires no resources on the part of the program, but the risks of working at cross-purposes, or having "too many cooks" doing too many different and likely incompatible interventions, are high. Also, in many communities few family therapists are well acquainted with DBT or the myriad problems associated with BPD, and it is possible that some models of family therapy are mostly at odds with DBT principles, resulting in confusion and possibly poorer outcomes for the patient. Thus, developing within-program DBT family resources are highly recommended, and as will become apparent below, some options are likely well within the reach of most DBT programs. Regardless of which course a program chooses, team members should try to prevent or mitigate potential problems associated with the particular structure they use.

### *Modes of Family Intervention*

Programs must decide what mode(s) of family intervention to offer. Family interventions can be delivered in a traditional, one-family-at-a-time mode (traditional family therapy), or may be delivered in a group mode with multiple families present concurrently. With groups, there are many additional choices. Groups can include family members only or both patients and family members. Additionally, programs have the option of offering more heterogeneous groups (i.e., mixing parents, partners, siblings, and children of patients), or more homogeneous groups (i.e., a group just for parents, a group just for couples). Again, resources and program specialty (adult, adolescent, etc.) may dictate the answer: A small program may have very few families to treat at a given time, so may need to see them individually, whereas a larger program might efficiently use a heterogeneous or homogeneous multifamily group. This can vary with the age of the patient and the program's focus. For example, adolescent DBT programs often include multifamily skills groups that bring together both parents and teens as part of treatment, as suggested by Rathus et al. (2014), and some programs may have enough resources to offer additional parent-only groups. Larger adult programs may have enough families seeking treatment at any given time to warrant separate groups for parents and partners.

The advantage to offering heterogeneous groups is high efficiency (every family member in treatment can participate in the same group), but that same heterogeneity may mean some family members feel left out because the group can easily become dominated by the problems of one particular type of family constellation, if not reasonably balanced or if the skills group leader does not effectively respond to the various needs of the group. For example, if most members are parents of adolescents, the problems of others, such as spouses, could become marginalized (or vice versa). Thus, if there are sufficient family members available, it may be preferable for parents to be in groups with other parents, partners with other partners, and the like.

### *Structuring Family Groups*

With multifamily groups, there is also the question of whether to include the patient in the group, or limit the group to family members of the patient. Programs with family components deal with this quite successfully in both ways. In part, the answer may depend on the targets of the group. For example, in an adolescent DBT program, one key target may be for parents to learn individual DBT skills to support and coach their child effectively in self-management skills (while also becoming more skillful themselves; Miller, Rathus, & Linehan, 2006). With this target, including the adolescent patient and parent(s) in the same group would likely afford the best outcome. However, if the goal is to provide psychoeducation, improve parent self-management, and improve parenting skills specifically, having the parents meet separately, without their children, would likely be preferable. The presence of the child may inhibit accurate assessment, demonstrations of strong support for the parent (others may fear offending the child or eliciting a negative reaction in the youngster), and strong pushing for change and improvement (others may fear "criticizing" the parent in front of the child, giving the youngster "ammunition" in conflict situations, etc.). Similar issues are present with spouses or partners, and other family members: The nature of the targets of the program may influence the modes of family intervention offered.

### *Enhancing Participation among Family Members*

With any type of family intervention, difficulties getting family members to participate may arise. Parents and partners are often stressed themselves, may feel "burned out" by their family member or by previous therapy experiences, might have been blamed for myriad problems by previous therapists or others in the mental health profession, and may not see the value in expending the time and money required to participate in any form of family intervention. Of course, standard DBT commitment strategies are a useful place to start. In addition, it is important to highlight just how essential it is to listen and to understand (assess) what might block active participation in whatever intervention mode you want to provide. Then it will be possible to collaborate right from the beginning with the family even in trying to decide whether family interventions make sense at that time. Clearly, validating their experiences is essential, as parents and partners often have had a very difficult time in helping and supporting their loved ones, and can suffer from stress- and trauma-related problems. In addition, many family members report having been judged and blamed within the mental health system, so highlighting the "no blame" component of any DBT intervention (individual or family) is essential: Neither parents nor partners (or anyone

else) will be blamed or judged in DBT. Similarly, doing a thorough "pros and cons" of treatment can be very helpful in identifying targets to validate, and to understanding the goals of treatment for family members, as well as individual treatment targets.

For very reluctant family members, it may be helpful to provide a clear sense of what will be expected, and perhaps to orient them toward a brief intervention (at least initially). We often find that family members believe they are being asked to participate in ongoing (even interminable) therapy, which they cannot afford in terms of time or money. However, when offered brief interventions (e.g., 3 sessions of family therapy, or a 6-session parent group), these same family members may agree to them. Of course, further interventions may be offered later on, if needed. Thus, beginning with a very brief commitment may be a version of the "foot in the door" strategy.

Similarly, some "burned out" family members may state that they have done all they can (or are willing to do) for their child or partner with BPD. It may be useful to point out (dialectically) that family interventions are also designed to help family members, not only the patient. In fact, family interventions can be designed primarily to benefit family members. Of course, the transactional model suggests that anything one family member can do to help another function more effectively will make their own life (and relationship with that person) a bit better, and vice versa. Thus, driving home this point to family members may enhance their willingness to give the intervention a try.

Some family members have a style that is more logical or cognitive. For these family members, it may be useful to appeal to the data. There are hundreds of studies documenting the beneficial effects of family involvement in treatment for a variety of disorders. Data concerning family interventions with BPD, although somewhat limited, are growing and are consistent with the larger body of data for other disorders. Conversely, other family members may have a more emotional style (sometimes similar to that of their loved one in individual DBT). In such cases, it is important to identify their emotions, assess and understand the origins of their strong feelings, and provide validating responses, before discussing how joining treatment may help improve these situations and/or ameliorate their negative emotions. Regardless of their style, being clear and honest about the rationale for treatment, expectations for participation, and minimizing blame, while validating concerns the family members may have, will maximize the chances of successful participation.

## DBT Family Skills

Several individual DBT family skills have been adapted specifically for use with families, and several new family skill modules have been developed (see Table 17.1; Fruzzetti, 1996, 2006, manuscript in preparation; Fruzzetti & Hoffman, 2004/2017). Below we will describe briefly these adaptations and developments. They are relevant to multiple DBT intervention modalities with families.

*Mindfulness,* of course, is the "core skill" in DBT. Although it is essential for family members to learn the basic skills of mindfulness, the specific application of mindfulness to relationships is particularly important and emphasized. Mindfulness skills help family members notice transactions, including increased arousal and problematic reactions to their relative's emotion dysregulation, creating opportunities for change in patterns of these transactions. Thus, the *relationship mindfulness*

**TABLE 17.1. Family and Relationship Skills Overview**

| |
|---|
| Emotion self-management |
| Utilize distress-tolerance, mindfulness, and/or emotion-regulation skills to reduce your negative emotional arousal and inhibit reactivity; inhibit negative, critical, or judgmental responses; don't make the situation worse. |
| Relationship reactivation |
| Spend more non-negative time together (reduce avoidance of each other when one has become an "aversive stimulus"), and engage in enjoyable activities together with awareness and connection. |
| Mindfulness |
| Pay attention. Notice and describe your wise mind goals and desires; be aware of your primary emotions; describe and don't be judgmental. |
| Accurate expression |
| Be descriptive; express accurately your primary emotions, and wise mind goals and desires. Describe what happens, rather than interpret events. |
| Relationship mindfulness |
| Bring non-judgmental awareness of, and open-minded attention to, the other person, while maintaining awareness of your wise mind relationship goals; remember to be aware of your love for and commitment to the other person. |
| Validation |
| Express accurately your understanding and acceptance, and the legitimacy, of the other person's experiences and behavior. |
| Radical acceptance |
| Let go of ineffective attempts to change the other person; this includes grieving the loss of desired changes and becoming aware of what you missed when you were intensively or singularly focused on trying to get the other person to change. |
| Collaborative problem solving |
| Utilize all the above skills; collaborate in solving the problems of one or both people in the relationship, or problems that create destructive conflict, pain, and distance, with an awareness of the legitimacy of both perspectives. |
| Dialectical parenting (parents only) |
| Balancing nurturance and validating responses with limits and demands for mature behavior. |
| Closeness and intimacy (partners in a couple only) |
| Utilize relationship activation, mindfulness, and relationship mindfulness as a foundation for deep and honest accurate expression and understanding/validating responses. |

skills module includes (1) awareness of oneself (especially emotions and desires), with particular attention to the importance of accurate (and non-judgmental) expression; (2) a focus on staying grounded in long-term relationship goals in the face of rising reactivity (e.g., "This is my child/partner, a person I love" that, of course, comes out of "wise mind"); and (3) bringing attention and curiosity to the other person in their everyday activities and interactions ("being together when you are together"). Special attention is placed on letting go of judgments and transforming anger into other more primary emotions (e.g., sadness, disappointment, fear, dislike), given how corrosive both judgments and strong anger are in close relationships.

Family members are encouraged to engage in active relationship mindfulness practice, which can include quietly observing their loved one during daily activities, simply noticing when nothing unpleasant or argumentative is happening, engaging in a conversation mindfully (i.e., with full attention and interest, without judgment), or purposefully participating in an activity together. These relationship mindfulness skills are designed, in part, to help reduce negative reactivity, which in turn helps to reduce aversive conflict, both hallmarks of problematic relationships (Fruzzetti, 1996). Therefore, both mindfulness and relationship mindfulness contribute to a reduction in invalidating responses and interactions.

Sometimes relationships have endured so much negativity and conflict that one or both parties begin to avoid the other. When that happens, opportunities for positive, or even neutral, interactions essentially disappear. However, conflicts continue, and negative interactions become the only kind of interactions they have. Simply focusing on reducing the negative reactions is not sufficient. When family members avoid each other, "relationship reactivation" provides an important additional skill. Basically, the idea is to block avoidance, facilitate exposure to each other in neutral or positive situations (opposite action), and use relationship mindfulness to notice that nothing awful is happening. Rather, the other person is most often doing things that are neutral or enjoyable.

*Communication* skills are also central in family DBT skills training. The transactional model of the development and maintenance of emotion dysregulation posits the reciprocal relationship between high emotional arousal (including secondary emotions) and judgments and inaccurate expression and invalidation as a core problematic *invalidating* transaction (Fruzzetti, 2006; Fruzzetti & Worrall, 2010). Figure 17.1 illustrates this transaction. A healthy relationship, in contrast, would include the identification of the primary emotion(s), accurate expression, followed by validating responses (and vice versa), as shown in Figure 17.2. Thus, additional skills include (1) identifying primary emotions and letting go of high anger in close relationships; (2) accurate expression; (3) validation.

*Validation* skills (Fruzzetti & Ruork, 2018; Fruzzetti, 2006; Linehan, 1997) focus on how to understand the other person's experience (and the ways in which it is legitimate), how to communicate genuinely that understanding, and how to reinforce accurate expression. In families, validation skills are key to helping family members get through conflict, build trust and closeness, as well as reduce negative emotional arousal. In fact, validating responses have been demonstrated to have a very significant positive impact on the other person's negative emotions. Shenk and Fruzzetti (2011) demonstrated that even under ongoing stress, subjects who were validated showed significant reductions in emotional distress and arousal, measured by both self-reports and psychophysiological indices. In contrast, subjects who were invalidated during the experiment maintained very high levels of negative emotional arousal.

One might think of validation skills as taking the "V" in the DBT GIVE skills (Linehan, 2015) and expanding it into a whole set of skills relevant to families. Validation skills require relationship mindfulness (non-judgmental awareness of another), which is also a "Level 1" validating response (paying attention, listening, and communicating interest and acceptance). Of course, listening mindfully, in turn, requires the ability to stay focused on the other person and negative reactivity that would interfere with listening, understanding, and ultimately, validating. Family members must also learn what to validate (targets) and how to validate.

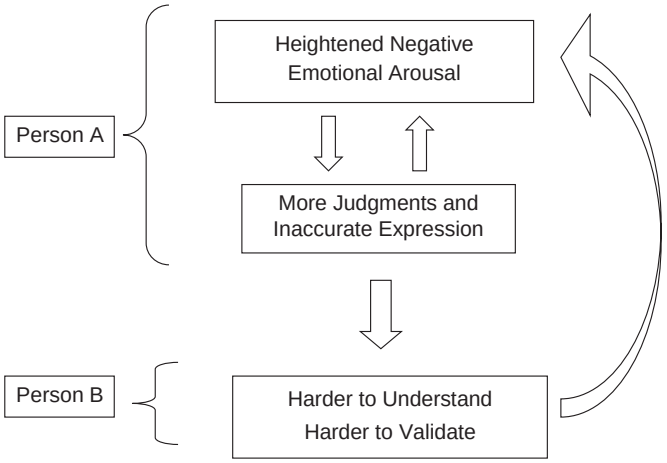


**FIGURE 17.1.** Invalidating transaction. Adapted from Fruzzetti (2006).

Just as there are many ways to validate in psychotherapy (e.g., Linehan, 1997), there are many ways to validate in family relationships (e.g., Fruzzetti, 2006; Fruzzetti & Iverson, 2004, 2006; Fruzzetti & Ruork, 2018). Although the validating responses of a therapist and those of family members overlap, there are important differences. Family validation may take many forms: (1) non-judgmental attention and active listening; (2) understanding and reflecting back (acknowledging) the other person's emotions, wants, or other disclosures; (3) engaging in behaviors that uncover more depth and accuracy in the other person's expression (especially if it is a different experience than you might have in a similar situation), especially asking questions to

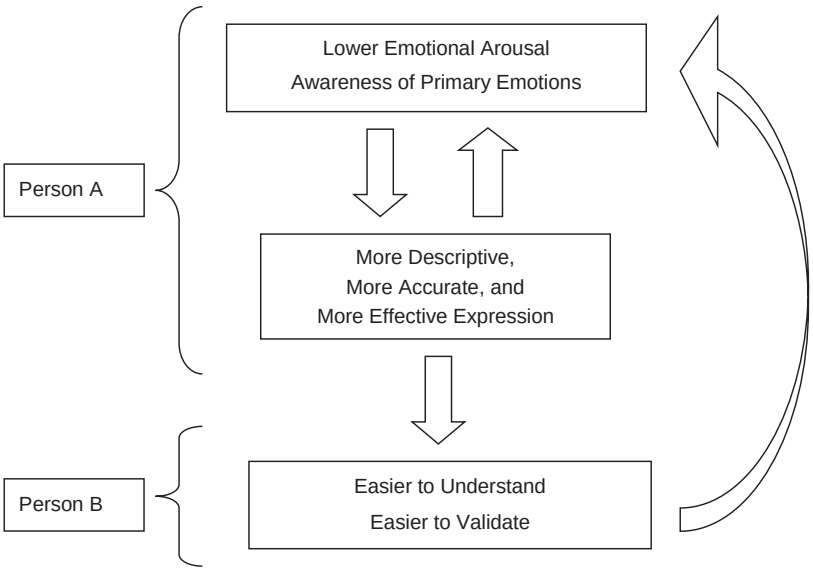


**FIGURE 17.2.** Validating transaction. Adapted from Fruzzetti (2006).

facilitate understanding what has not been articulated; (4) in the face of "problem" behaviors by a child or partner, putting their behavior in context to lessen its negative valence (i.e., understanding the behavior given the other's history or current level of functioning, or remembering other less problematic behaviors and including these as "context" to reduce invalidation); (5) "normalizing" normative behavior (e.g., "I'd feel that way too—anyone would"); (6) treating the family member with BPD as an equal human being, not as fragile (taking into account, of course, a child's developmental abilities); and (7) expressing reciprocal vulnerability, often by reciprocating self-disclosures of vulnerability (e.g., "I'm sad we haven't been getting along, too"). It is particularly important for families to practice validation skills in a wide range of situations, even those that include inaccurate self-expression, emotion dysregulation, and other behaviors that make it difficult to find what is valid. Skills also include teaching not only how to validate, but also what to validate, when to do so, how to build motivation to validate, and how to recover from invalidation.

In fact, understanding *invalidation* is also an important part of letting go of invalidating responses and increasing skills at validating (Fruzzetti, 2006). Invalidation can be obvious (e.g., hostile, angry tone, judgments, or severe criticism), but it may also be quite subtle (e.g., warmly reinforcing fragility), and the distinction between validation and invalidation is based less on the form of the behavior than its function. For example, gently supporting a family member who chooses not to go to school or work could be invalidating because it treats them as incapable (e.g., "Yes, I can see how tired you are. Of course, you're too tired to go" after the person was out late drinking, or up until 3 A.M. surfing on the Internet). In this example, acknowledging the person's fears, tiredness, sadness, and so on, and helping the child or partner skillfully get on with their day could be much more validating, although it might appear more "pushy" and less warm (e.g., "Yes, I can see how tired you are. Still, if you sleep all day, you're likely to be up all night again, and have the urge to stay home again tomorrow and be miserable. Let's take it one step at a time. How about you get up and get in the shower, and I'll get you a little breakfast. We can take it from there").

Of course, in a different context, accepting the partner or child's limitations and supporting them in staying home might also be validating. For example, they may have the flu and self-invalidate ("I should go anyway. Most people don't stay home just because they're sick to their stomach and have a low fever"). In this case, blocking the self-invalidation and supporting the person in going back to bed would probably be much more validating (e.g., "No, most people *do* stay home when they have a fever and the flu. Come on, you look like you feel awful. Listen to your body. It probably makes sense to go back to bed. I can make you some tea and bring it to you there"). The various types of validating and invalidating behavior that we look at in couple and parent–child interactions are summarized in Table 17.2.

In addition, many families lack skills in solving or managing problems. For these families, a collaborative problem-solving approach is needed (Fruzzetti, 2006, 2018; Fruzzetti & Hoffman, 2004/2020). This includes basic teaching in describing and defining problems accurately (without judgment), how to look at intersecting "chain analyses" (in which two family members' "chains" intersect in a problematic way), and collaboration in solution generation, contracting, and follow-up (see Fruzzetti & Payne, 2015). For example, Figure 17.3 shows a schematic chain analysis of two people interacting. This is similar to an ordinary chain analysis that is a standard part

**TABLE 17.2. Validating and Invalidating Behaviors**

| Validating responses | Invalidating responses |
|---|---|
| 1. Basic attention, listening, ordinary nonverbals; behaviors that communicate attention, listening, openness | 1. Not paying attention, distractible, changes subject, anxious to leave or to end the conversation |
| 2. Reflecting or acknowledging the other's disclosures; what they are thinking/feeling/wanting; or functionally responding to them by answering or problem solving | 2. Not participating actively, missing needed minimal conversational validation opportunities, not providing evidence of tracking the other person; functionally unresponsive |
| 3. Articulating/offering ideas about what the other might think/feel/want, in an empathic (not insistent) way; helping the other to clarify; asking questions to help clarify | 3. Telling the other person what they *do* think/feel/want (or insisting) even when the other provides contradictory statements; or telling that person what they *should* think/feel/want |
| 4. Recontextualizing the other's behavior (including feelings/desires/thoughts); putting a more understanding "spin" on it; acceptance because of history or conditioning; reducing the negative valence | 4. Agreeing with the other person's self-invalidation when behavior makes sense in terms of history (almost always) and could be spun differently; increasing its negative valence; "kicking when they're down"; includes making judgments about the other's problematic behavior (public or private) |
| 5. Normalizing the other's behavior (any type) given present circumstances; e.g., "Anyone (or I) would feel the same way in this situation" or "Of course, you would think/feel/want that" | 5. Pathologizing/criticizing the other's behavior when it is reasonable or normative in the present circumstances (remember, self-descriptions of private behaviors are assumed to be accurate unless evidenced otherwise); taking specific (may be valid) criticism and globalizing it, or overgeneralizing it; also includes making judgments about normative behaviors (public or private) |
| 6. Empathy, acceptance of the person in general; acting from balance about the relationship; not treating the other as fragile or incompetent, but rather as equal and competent | 6. Patronizing, condescending, and/or contemptuous behavior toward the other; treating the other as not equal (less than), as fragile or incompetent; character assaults/overgeneralizing negatives |
| 7. Reciprocal (or matched) vulnerability/self-disclosure in the context of the other's vulnerability, with the focus staying on the other person | 7. Leaving the other person hanging out to dry: not responding to (validating) their vulnerable self-disclosures, thereby assuming a more powerful position |

*Note:* Data from Fruzzetti (2006, 2018).

of DBT, except that the shaded "links" show public behaviors that are immediately relevant to both people (such as verbal statements or observable facial expressions and relevant body movements), and the open links show the participants' private behaviors (wants, thoughts, urges, emotions, etc.). Going over this chain can be helpful not only to identify targets for change (what skills each person could have used to facilitate a more effective outcome), but also to demonstrate how one person's behaviors influence another's, and to help each family member (and the therapist) begin to understand and validate the other's feelings and desires along the chain, increasing mutual understanding and communication.

Although similar to many forms of couple and family problem solving (e.g., Jacobson & Margolin, 1979), the DBT problem management skills set (or problem

solving) is predicated on having learned previous skills (relationship mindfulness, accurate expression, validation) and incorporates cumulative practice opportunities and recognizes that some problems cannot easily (or perhaps ever) be solved, and therefore must be accepted and managed.

*Closeness and acceptance* skills provide couples and parent–child dyads opportunities to transform conflictual interactions into understanding and connection, and were designed to help resolve the intimacy–independence polarity common in distressed couples and the dependence–autonomy polarity common among distressed adolescents and their parents. This skill module includes three steps that build, to some extent, from "radical acceptance" in the DBT skills manual (Linehan, 2015) and extends these skills to close relationships (Fruzzetti, 2006): (1) behavioral tolerance (stop nagging, no longer putting energy into changing the other person); (2) pattern awareness (becoming mindful of the consequences of conflict and the exclusive focus on the other person changing), including grieving the loss of desired changes; (3) letting go of suffering and instead focusing on what had been missing, while focusing exclusively on trying to change the other person (also called *recontextualization,* in which previously problematic behaviors are reconditioned or understood in a different context, leading to less conflictual, more genuine and validating responses).

*Parenting* skills can be extremely beneficial for both parents of adolescent DBT clients, and for parents who are themselves DBT clients. DBT parenting skills (Fruzzetti, 2018, manuscript in preparation) are tailored to the age of the child and may include (1) attending to child safety; (2) education about healthy child development across multiple domains; (3) relationship mindfulness; (4) reducing negative reactivity;

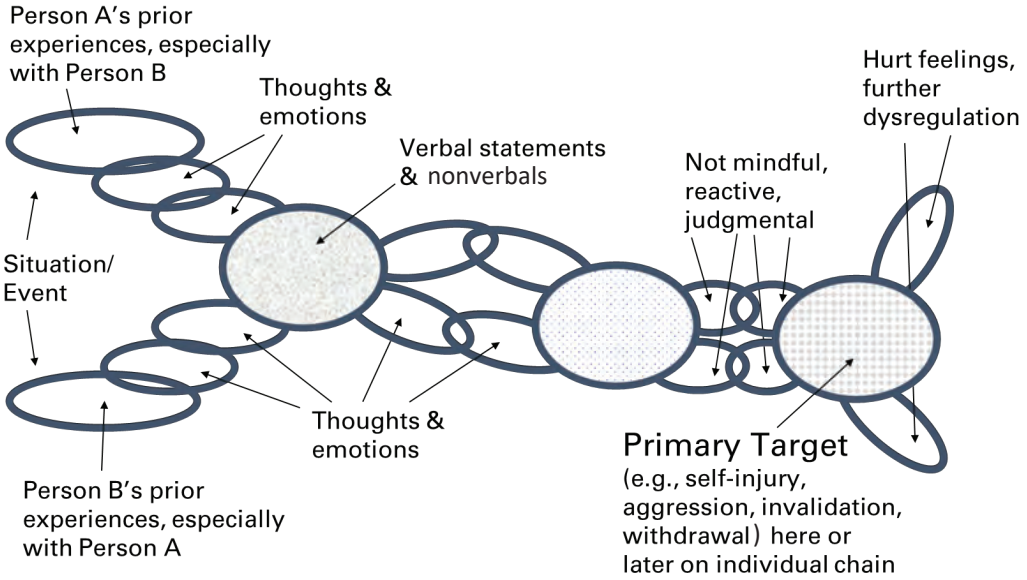


**FIGURE 17.3.** Double chain for understanding sequences of family interactions. Adapted from Fruzzetti (2006).

(5) rebuilding relationships and reconditioning relationships; (6) validation skills; (7) synthesizing parenting polarities and dialectics more generally; (8) effective limits; and (9) transforming conflict into understanding and closeness.

These skills can be used with individual families, or in multifamily groups, and may be offered alone (in skills groups) or as part of couples or family therapy. Studies have shown DBT family interventions to be effective with couples and with parent–child relationships. For example, in a 6-session treatment utilizing DBT family skills, partners demonstrated significantly increased validating and decreased invalidating responses, and reported significant reductions in individual distress and improvements in relationship satisfaction (Mosco & Fruzzetti, 2003). Similarly, Kirby and Baucom (2007) showed that a couples group intervention that taught emotion regulation, communication, and problem-solving skills had a significant impact on both individual and relationship distress. In addition, the Family Connections program (Fruzzetti & Hoffman, 2004/2017), described below, uses the skills described in this chapter as the core part of its curriculum and has been shown to help family members reduce grief, depression, and burden, while increasing mastery (Hoffman et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007; Flynn et al., 2017). Additionally, adolescents whose parents participated in a DBT parent skills program rated their parents as more validating and achieved greater treatment gains (Payne & Fruzzetti, 2020).

## Heterogeneous Multifamily Groups: DBT–Family Skills Training

In this section, a model for a DBT multifamily group, including clients and their family members, is presented. This multifamily model includes traditional skills training, group support, and an additional emphasis on family psychoeducation.

The treatment mode that historically has received the most recognition with psychiatric disorders (but not with BPD) is family psychoeducation (Fruzzetti, Gunderson, & Hoffman, 2014; Hooley & Miklowitz, 2018). Focusing on the key components of education and coping skills, the initial intention of the family psychoeducation model was to improve the patient's well-being. An additional point of interest, one that developed later, is the well-being or improved functioning of the family, and the well-being of nonpatient family members. Although family psychoeducation is not widely available, the value of psychoeducation for both the client and family member is now well acknowledged (Fruzzetti et al., 2014).

Multifamily psychoeducational groups may serve six to eight (or more) families at one time (and hence may include up to 20 participants in each group session). The information distributed includes facts about a variety of topics relevant to BPD, such as identifying the behaviors associated with the disorder, etiology, treatment options, medication issues, the disorder's impact on family members, and community resources.

Dialectical behavior therapy–family skills training (DBT–FST) is based largely on, and is compatible with, the theories and philosophy of the family psychoeducation model. This modality includes as a "family member" anyone the client chooses to invite over the age of 18. DBT–FST teaches DBT skills to family members and clients alike and targets emotional, cognitive/attitudinal, and behavior change for all participants. DBT–FST was developed in the early 1990s, and details of the program

have been published separately (Hoffman, Fruzzetti, & Swenson, 1999). Although the multifamily group was originally developed to be offered concurrently with individual DBT treatment, it may also be considered even when the individual with BPD is not in active treatment.

### Theory and Targets

The conceptualization of the DBT–FST modality grew from two basic hypotheses, one about patients and one about family members: (1) Increasing skill application for DBT patients in a setting with their family members offers a unique opportunity for skill generalization (and structuring the environment) in the context of what is often one of their most stressful environments (their family). (2) Both distress and skill deficits in family members can be ameliorated with DBT individual and family skills. Consequently, two overarching goals of DBT–FST were established: (1) to provide family members and patients with an opportunity to learn about BPD and (2) to teach specific self and relational skills to benefit each individual and to benefit family relationships.

Three of the central functions of standard DBT—skill acquisition, skill generalization, and structuring the family environment—are the foundation of the program. Skill acquisition and generalization are achieved through skill lectures and skill rehearsal along with the generalization of skills through in-session family problem solving among group members, and through practice between sessions. These standard DBT components are augmented by attention to structuring the family environment, in which changes among family members that may help reinforce skillful behaviors of the BPD patient are facilitated. This added component provides a unique opportunity to put skill acquisition and skill generalization practice directly into the family environment. Similar to standard DBT, "coaching" provides clients in-the-moment support to address a particular situation in their family environment, and the group may provide coaching concurrently to several family members. Group members work together on their own and relationship targets. The ultimate aim is to find a balance (synthesis) between what works (is desired and effective) for each individual and for the relationship.

There are four primary goals or targets of DBT–FST: (1) Provide information and education on the disorder; the diagnosis, its criteria, and accompanying behaviors are outlined and discussed as well as the etiological (transactional or biosocial) theory on which DBT is formulated. (2) Teach a new approach to and language for communication (based on mindfulness) that replaces judgments with description. (3) Create a no-blame environment: Often participants enter the group ready to express their feelings of blame toward themselves and other members in their family. A non-judgmental atmosphere is essential, along with a "no-blame" tenet. (4) Establish an effective forum that promotes discussion, family problem solving, and conflict resolution.

### Format

DBT–FST typically is conducted weekly for 6 months, but shorter or longer programs can be useful. Participants have the option to repeat the curriculum on an individual basis. However, a longer commitment might be a deterrent to family members participating, and 24 weeks allows for a full explication of skills. Led by two professionals

who follow the semi-structured manual, the 90-minute class time is divided into two components. The first 45 minutes is didactic, with lectures based on standard DBT skills or family DBT skills. The second part is called the "consultation hour" and is based, in part, on the DBT team consultation concept, described below. The weekly lectures include many of the skills traditionally taught in individual DBT treatment (Linehan, 2015), but the context in which they are presented is the family itself. For example, emotion mind is expanded into the concept of an "emotion family." The richness that evolves from such extensions offers dialogue that is non-pejorative, less provocative, and less antagonistic. In addition, DBT family skills such as accurate expression and validation (described earlier) are also presented (Fruzzetti, 2006; Fruzzetti, 2018), which build on the skills and language of traditional DBT skills.

The curriculum includes orientation; DBT phases of treatment; core mindfulness and relationship mindfulness skills; interpersonal effectiveness skills; emotion-regulation skills; distress-tolerance skills; accurate expression; validation; and consultation to the family (dialectical problem solving/problem management). In addition to teaching this curriculum of skills, there are suggested practice assignments that participants are encouraged to complete between sessions, which are reviewed.

The second component, of the DBT–FST consultation hour, provides multiple opportunities for skill application and problem-solving/management. Using skills, individual families work on problems specific to them. Both leaders and other group members provide coaching and input, with the dual focus of skill implementation and conflict resolution. Because family members have many common issues, all group participants can benefit from this process. Topics include financial issues, relationship responsibilities, family friction and communication, self-injury, fears of suicide, recovery from conflict, family roles, and observing limits.

The process in the consultation hour resembles that of a DBT consultation team and/or behavioral family therapy, and includes attention to sharing consultation time, keeping a dual focus on skill enhancement and support/validation, staying nonjudgmental, use of chain analysis, a role-playing or practice component, and opportunities for input from not just the therapists but also from others in the group. The group leaders work to establish a group "culture" that is supportive and noncompetitive. For example, because many others in the group share problems that come up with one family, the leaders try to provide validating responses to all and link solutions in one family to those in another. Thus, multiple family consultations can sometimes be addressed in one role-play or demonstration, and all group members can practice solutions separately as homework. This enhances the efficiency of the group and reduces stress due to time constraints.

Although more research is needed, a recent randomized controlled trial (Payne & Fruzzetti, 2020) showed that teaching DBT family and parent skills to parents of teens receiving DBT had salutary effects on both the teens' outcomes and on parent–teen relationships. Additional studies of comprehensive DBT that includes DBT-FST will help us understand further when and how DBT-FST augments individual DBT outcomes.

## Family Psychoeducation, Family Skills, and Family Connections

The effectiveness of professionally led patient and family psychoeducation has been demonstrated across a variety of disorders (Fruzzetti et al., 2014). However, despite

the considerable research showing that psychoeducation provided by professionals helps patients with major mental illnesses (e.g., schizophrenia, bipolar disorder), relatively few families actually participate in such programs because they are often not available (Dixon et al., 2006). Consequently, the actual number of participating families reported is less than 10% of those likely to benefit from this type of program (Lehman et al., 1998). Barriers to implementation include the limited number of clinicians interested in and trained to provide patient and family psychoeducation, the resources required (e.g., space, time), and the fact that third-party reimbursement rates are low, if available at all (Dixon, McFarlane, & Lefley, 2001). To address the above concerns, a variant of psychoeducation, family education (sometimes referred to as family psychoeducation), was created (Solomon, 1996).

Unlike patient psychoeducation, the focus of family education primarily is to address the needs of family members directly, rather than those of patients. Of course, patients are expected to benefit indirectly, and, as noted, recent research indicates that better treatment outcomes can be achieved when families participate in such programs (Payne & Fruzzetti, 2020). Family education programs are typically conducted by trained family members (or a combination of one family member and one professional) and generally housed in community settings; no fees are charged. Such programs typically are shorter in duration than professional psychoeducation programs and are not associated with the individual treatment of the patient. Rather, they are stand-alone programs, and the relative identified with the disorder does not attend. The model's goals are to educate participating family members (defined broadly) about psychological disorders, to teach them coping skills to enhance their own well-being, and to provide a network of family support. The most well-known is the Family-to-Family program conducted under the auspices of the National Alliance for the Mentally Ill (NAMI). The Family-to-Family course focuses on family members who have a relative with an Axis I disorder.

Family Connections (FC) is also based on the family education model but focuses on families with a relative with BPD or related problems (i.e., problems related to severe emotion dysregulation). FC is a free 12-week (or sometimes an intensive weekend) family psychoeducation program conducted in community settings (Fruzzetti & Hoffman, 2004/2020) led by family members (and sometimes by professionals, or a combination of professionals and family members) who have been trained to teach the course curriculum. The overall goals include psychoeducation, learning individual and family skills relevant to having a family member with BPD (reducing "quality-of-life interfering behaviors"), and creating a social support network, starting in the group. The targets include both increasing the participating family member's well-being directly, and indirectly, enhancing outcomes for the person with BPD. FC is increasingly available in the United States and has been implemented in at least 20 other countries.

### *Format*

FC has many similarities to DBT–FST. However, FC does not require professional leaders, and regardless of skill level, leaders do not function in the therapist's role, but rather serve as group facilitators. Thus, the emphasis is appropriately placed on education, skills, and social support. The FC program follows a clear curriculum, and the group typically runs for 2 hours each week. The group typically begins with

homework review, then turns its attention to an education segment (lecture or presentation on skills), and finally moves on to discussion and consultation. More time is devoted here than in DBT–FST to promoting the development of an ongoing support network (discussion and consultation) and thus the group meeting time is typically longer than in DBT–FST. A 2-day format for FC has also been developed to make the program accessible to families in settings where a 12-week commitment is not feasible.

### *Curriculum*

The course content is organized around six different curriculum modules. There is no specified length of time dedicated to each module; rather, time allotment is somewhat flexible and left to the discretion of the group leaders, based on the composition and specific needs of each group. Some groups require more time for support and discussion; other groups are more focused on the skills and are less interactive. The modules are (1) introduction; (2) education about BPD and emotion dysregulation; (3) relationship mindfulness and emotion self-management; (4) family environments; (5) validation; and (6) problem management. Practice assignments are given each week. Handouts are used, and group leaders also receive "teaching notes" to guide them and to help provide consistency from one location to another.

Group leaders must complete a FC group themselves (or an equivalent workshop) and then extensive group leader training provided by the National Education Alliance for Borderline Personality Disorder (NEA-BPD). Experienced group leaders assist in the development of the program, and in training and coaching new group leaders. There is no cost to group participants to attend an FC group, nor is there any charge for group leader training, to maximize access to these important resources.

For many people entering the program, FC is the first place where they have been together with other families that share common situations and problems associated with BPD. The fears of participating in a group quickly dissipate when members hear each other's experiences, and immediate connections are made among the participants. Often, the first group is quite emotional, with people drawn to each other in part because of the understanding and compassion they experience from each other.

The first two modules provide information about BPD and summarize the most current research that is available. Materials are updated regularly, in particular, via presentations at the annual Family Perspectives Conference on Borderline Personality Disorder, also sponsored by the NEA-BPD. In addition, FC participants are invited to request specific articles on topics of interest to them, which are provided by NEA-BPD staff.

The first skills module is next, relationship mindfulness and emotion self-management, in which the DBT "what" and "how" mindfulness skills are taught, framed in the context of relationships. Awareness of oneself, awareness of the other, adopting a non-judgmental approach, and managing one's own emotions effectively are the central themes of these skills. The next two modules, family environments and validation, build on prior skills, striving first toward the establishment of a no-blame environment and then teaching skills that promote a healthy family environment. Radical acceptance ends the module. Some groups have found it helpful to view a segment of one of Linehan's videos (e.g., the segment "Radical Acceptance" in *From*

*Suffering to Freedom: Practicing Reality Acceptance: Alleviating Suffering through Accepting the World as It Is*) or other videos produced to accompany the FC curriculum. Validation skills focus first on accurate expression and communication awareness, then on both validating another person and validating oneself. The final module, collaborative problem solving, borrows standard problem-solving steps from behavioral couples and family therapy, but also includes more options for acceptance of problems that are difficult or impossible to solve.

FC has been evaluated in several studies (Hoffman et al., 2005, 2007; Ekdhal et al., 2014; Flynn et al., 2017; Liljedahl et al., 2019; Payne & Fruzzetti, 2020). Results indicate that participants' levels of grief, burden, and distress/depression were reduced significantly from pre- to postgroup, while a sense of mastery was increased overall. These improvements were maintained at a 3-month follow-up assessment, suggesting that the FC program may provide significant and perhaps enduring benefits to family members. Additionally, evidence suggests that FC may influence DBT treatment outcomes for adolescent patients. Specifically, a study with adolescents in a residential DBT treatment program indicated that parent FC participation improved parental validation and was associated with greater improvements in adolescent emotion regulation and other outcomes during treatment (Payne & Fruzzetti, 2020). These studies provide encouraging evidence for the effectiveness of FC for patients and family members, and also point to the importance of family interventions in DBT more generally.

### *Conclusions about Family Psychoeducation and Skills*

Family members of those with BPD experience their own levels of distress, and education alone is not enough to provide relief (Hoffman et al., 2003). Whether led by a professional or a trained family member, programs that provide information, skill building, and a support network offer BPD family members the opportunity to learn to manage their own "emotional roller coaster" more effectively. As data show, high levels of emotional involvement are beneficial to persons with BPD (Hooley & Hoffman, 1998), but skills are required to achieve constructive, supportive, and sustained validating emotional involvement. DBT–FST and FC provide two promising vehicles to promote a healthy and validating family environment.

## Brief DBT Family Interventions to Augment Individual DBT Outcomes in Stage 1

When individual DBT therapists repeatedly find that the actions of family members, or patient–family member interactions, are an integral part of the patient's "chain" of dysfunctional behavior(s), bringing the family in for direct family intervention has many advantages. First, family assessment provides an efficient way to assess the importance of family behaviors vis-à-vis patient target behaviors. In addition, if relevant family behaviors are identified, brief family interventions can be used to augment individual treatment and to create safety and stability for the patient. In a series of difficult cases, even a few family intervention sessions have been shown to have a potent effect on reducing Stage 1 target behaviors (Fruzzetti, 2018). Targets for brief intervention are described below.

### *Target Safety*

Suicide attempts and self-harm are not the only safety-related targets in DBT. Unfortunately, many clients in DBT are victims of intimate partner violence or domestic abuse, and often are involved in ongoing aggressive and violent interactions with parents, partners, or children. We consider these behaviors (physical and sexual aggression and violence) to be life-threatening and are therefore among the highest-order targets in DBT, along with suicidal and self-injurious behaviors. When DBT clients are victims of battering or other domestic abuse, safety must be the first concern of any family intervention. Similarly, when the DBT client is engaging in aggressive and violent behaviors, these actions must be targeted immediately (see Fruzzetti & Levensky, 2000, and Iverson, Shenk, & Fruzzetti, 2009, for details concerning treating aggression and violence in DBT). Thus, the first target for any family intervention is ensuring safety. The implication of this is that safety must be thoroughly assessed.

Assessment of aggression and violence may be accomplished efficiently via the use of a combination of self-report (e.g., the use of the Conflict Tactics Scale–II; Straus et al., 1996) and a follow-up interview. Any self-reports should be administered in person, with partners or parents and children completing the forms in separate rooms to maximize the accuracy of information collected and to minimize threats and coercion. Aggressive or violent statements/behaviors that are endorsed by anyone in the family should then be followed up on in an individual interview to understand the frequency and danger of these behaviors, the level of fear or perceived threat experienced, as well as the relevant controlling variables (via chain analysis). If any safety-related behaviors are identified, they are the first treatment target.

The next assessment target is to identify any behaviors of family members that promote dysfunctional, especially suicidal and self-injurious, behaviors. Typically, a chain analysis already performed with the family member in individual DBT will identify some of the important links to be addressed. However, it may be useful to perform a "double" chain analysis to identify how one person's "chain" actually influences another's, and vice versa. This process was described earlier and depicted in Figure 17.3.

There are four common problematic family consequences to out-of-control patient behaviors to consider: (1) *positive reinforcement of dysfunctional behaviors* (providing warmth and caring following dysfunctional behavior); (2) *negative reinforcement of dysfunctional behaviors* (stopping criticism, threats, or other negative behaviors after increased patient suicidality); (3) *failure to reinforce self-management or skillful behaviors* (ignoring successful self-management); and (4) *punishment of skillful behaviors* (criticizing nascent skill development, immediately increasing expectations of the patient following early success). We have found that parents and partners frequently engage, often unwittingly, in these behaviors, and that changing these consequences can be essential to reducing and eliminating out-of-control behaviors of the patient.

For example, it is common for family members to feel "burned out" and to become detached from the patient, only to move in closer and soothe the patient (likely reinforcing dysfunction) following an escalation of suicidality (increased suicidal thoughts, urges, or actions) or other crisis behavior. In these cases, it is important to "move" rather than "remove" the warm, soothing, solicitous behavior. That is, if the patient is receiving very little nurturance, it is important to have the family

member(s) provide at least that amount, but either on a fixed, regular basis (x minutes every day) or contingent on the patient *not* engaging in dysfunctional behaviors. These interventions require the use of quick skills training, teaching whatever individual or family skill is needed on that chain, along with all of the usual DBT intervention strategies (see Fruzzetti, 2018, or Fruzzetti & Payne, 2015, for a more detailed explanation of this strategy).

Similarly, family members sometimes act in a highly aversive way toward the patient and only reduce those aversive behaviors when the patient responds with increasing suicidal behavior or other negative escalating behavior. For example, we have encountered many examples in which women are battered until they become suicidal or self-injurious, at which time their partners stop battering and even become warm, soothing, and solicitous.

Less dramatically, but not necessarily less importantly, verbal criticism and invalidation are common antecedents of patient dysfunctional behaviors, and suicidal and parasuicidal behaviors can function to escape from aversive, invalidating interactions. In such cases, the treatment target is the reduction or elimination of those destructive behaviors of the family member. It is important here to "remove" as many aversive behaviors as possible from the chain. This may require a lot of attention to helping family members increase their skillfulness in a variety of domains to reduce judgments and negative emotional reactions and increase mindfulness of their goals and the needs of their family member with BPD. These efforts are more likely to be effective, of course, if the family member with BPD reinforces the change (i.e., does not respond to a less aversive environment by increasing their own aversive responding).

Increasing validating responses of family members can be effective on the antecedent side of a patient's dysfunctional behaviors: (1) Validating wants and emotions may reduce negative arousal, making individual skills more likely to work in reducing arousal further), and (2) validating skill use may reinforce skill use, independent of the other effects of being skillful (in contrast to using previously learned, dysfunctional responses). Thus, validating the use of skills can be an important, if transient, source of reinforcement for skillful behavior, especially while the patient is learning the skills and they may not yet be very effective (they may not benefit much from skill use until they are skillful at it). Also, when a person is just beginning to learn a new skill, trying out the new behavior may surprise family members, who might respond by noticing the awkwardness or ineffectiveness of the skill, rather than the attempt to be skillful, and may punish the attempt. Consequently, it is important for family members to be alert to the emergence of newer skillful behaviors and to greet these new behaviors in a validating way. Practicing in the family session can help prevent family members from inadvertently punishing nascent skill use, and provides an opportunity for the therapist to model validation as an alternative, if necessary.

## Summary and Conclusions

There are many reasons to consider providing family interventions as an ordinary part of any DBT program: Outcomes may be improved and efficiency enhanced, and theoretically, family factors play a central role (the invalidating social and family environment) in the transactional model on which DBT is founded. Family interventions

may be successfully employed in multifamily groups or with individual families, and may utilize DBT principles and strategies or be integrated with common models of family therapy widely available in the community. This chapter has provided an overview of treatment targets and family skills, along with an overview of the emerging evidence that shows the utility of DBT family interventions. In summary, DBT family interventions can be an effective addition to any DBT program.

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PART IV

# SPECIAL TOPICS

CHAPTER 18

# Training and Supervision in Outpatient DBT Programs

JESSE HOMAN, JENNIFER H. R. SAYRS, and TRAVIS L. OSBORNE

Learning and mastering a highly complex treatment such as dialectical behavior therapy (DBT) can require significant resources, particularly time and money, to become an "expert." For many clinics and clinicians, the reality is that they simply do not have such resources. Despite these difficulties, it is critical that DBT providers obtain the necessary skills and knowledge, due to the high-risk, complex nature of the client populations they serve. The goal of this chapter is to provide structure and guidance for providing training and supervision in DBT, regardless of program size, location, and means, to help make expert care more feasible to provide and access.

## Obstacles to Effective Training

Training clinicians to competency has been identified as one of the greatest challenges of dissemination and implementation of effective treatments (McHugh & Barlow, 2010). In part, this is due to the fact that development and research on evidence-based practices (EBPs) are far outpacing the development and research on methods to effectively train clinicians to deliver EBPs in real-world settings (Lyon, Stirman, Kerns, & Bruns, 2011). Moreover, effective training methods that do exist are not well disseminated; many existing training practices are based on beliefs and procedures that do not necessarily ensure good clinical outcomes or provide evidence as to what knowledge and skills clinicians must possess to achieve good outcomes (Koerner, 2013). Additionally, the cost of being trained in an EBP can be prohibitive; workshop attendance is expensive and supervision by an expert can be even more costly (Fairburn & Cooper, 2011). The dearth of expert trainers in certain settings is yet another

obstacle to clinicians developing expertise in EBPs. Lack of access to supervision is also often cited by clinicians as a barrier to implementation (Dimeff, Koerner, et al., 2009; Dimeff, Harned, et al., 2015).

These obstacles have resulted in a significant gap between science and practice in the mental health field, in which an insufficient number of clinicians are adequately trained to deliver EBPs (Lyon et al., 2011; Wandersman et al., 2008). The field of DBT is not immune to these dissemination and implementation problems. As with all trainees learning EBPs, DBT trainees face multiple challenges. Mastery of DBT requires the clinician to learn myriad skills, strategies, principles, and protocols that are specific to DBT (Fruzzetti, Waltz, & Linehan, 1997). These difficulties may be compounded by the time-sensitive and intense nature of some DBT clients' problems, resulting in therapists trying to deliver DBT without sufficient expertise. This could lead to problematic outcomes, including clients receiving ineffective care, clients erroneously concluding DBT is not effective for them, or even suicide. Despite these difficulties, DBT can be effectively disseminated. Necessary strategies and suggestions for dealing with common obstacles are discussed below.

## Commitment to Training

Before any DBT training begins, commitment on the part of the trainee is an essential first step. The importance of commitment to the training process cannot be understated. Multiple DBT programs have found that lack of clinician orientation, preparation, and commitment has negatively impacted training efforts (Swenson, Torrey, & Koerner, 2002). The importance of training and supervision to deliver DBT to fidelity is communicated to anyone taking on DBT clients or joining a DBT team; this may even be discussed during the interview process, if relevant. This process includes committing to attending formal DBT training, in-house trainings, individual and/or group supervision, and DBT team, along with reading, skill rehearsal, and completing other related tasks. This commitment is conducted in a manner that parallels the process of commitment to DBT treatment, utilizing the same commitment strategies (e.g., pros and cons, connecting previous commitment to current commitment, devil's advocate, foot in the door/door in the face; Linehan, 1993; Sayrs & Linehan, 2019a).

## Skill Acquisition

After commitment is obtained, the focus will move to *acquisition* of new information and skills. Therapists must, in some manner, obtain the necessary knowledge to provide effective DBT. As is also true in DBT treatment, there are no rules or required procedures for acquisition; depending on resources and training needs, one may choose from a wide variety of methods for learning DBT. These methods can include online trainings, workshops, university classes, self-study, supervision/consultation, book clubs, formal or informal lectures, and observation of DBT experts.

For therapists who are new to therapy altogether, the list of training topics will be much more extensive and beyond the scope of this chapter. In addition to learning DBT, they will be learning basic therapy skills, ethics, behavioral science, and many

other topics that are relevant to learning to conduct psychotherapy more broadly. If one has some experience in providing therapy, the focus can narrow to learning DBT.

### Assessment

As with clients, it is imperative that trainers and supervisors accurately assess the actual knowledge and skill level of their supervisees. In some instances, new clinicians will have had little prior exposure to DBT, whereas in other circumstances, the knowledge and experience of new clinicians can be at an expert level. Clinicians also may rate themselves as possessing greater or lesser skills than they actually do.

Assessment is important in the skill acquisition phase to determine which topics to emphasize in trainings. Assessment of didactic knowledge can be conducted informally in group or individual settings. This can be done by asking questions that quickly assess trainees' knowledge. For example, "What are the six levels of validation?" or "List all the dialectical strategies you can," or "What are the components of a chain analysis?" This information can help supervisors aim their training topics effectively. Assessment should be an ongoing process, with adjustments in curriculum made as needed.

### Readings

There are many books and articles written on DBT. Unfortunately, not all follow the DBT manual closely; some researchers and writers have changed the treatment dramatically, without determining whether those changes are effective. It is for this reason we recommend starting with the DBT manuals written by the treatment developer (Linehan, 1993; Linehan, 2015a, 2015b). These books form the basis for adherence ratings and certification requirements and provide the best descriptions of adherent DBT.

One can then move to many other resources, from basic instructional material, to a more complex discussion of dialectical theory. There are many books that complement the DBT manuals well. Additionally, therapists must know the evidence-based treatments and manuals for the range of diagnoses and problems their DBT clients will need addressed (e.g., depression, substance use, anxiety disorders). These books and manuals make excellent topics for study groups, book clubs, and other organized efforts to acquire information about DBT, for new therapists as well as seasoned DBT providers. Examples are provided in Table 18.3 later in the text; additional readings may be found at *http://depts.washington.edu/uwbrtc, www.psychologicaltreatments.org, www.abct.org,* and *www.behavioraltech.org.*

Book clubs and study groups can be an excellent, cost-effective way for therapists to learn DBT and other evidence-based treatments. For study groups to succeed, both institutional and participant commitment are critical. A study group can quickly fall apart if other meetings or clinical tasks are scheduled at the same time and/or if members of the group do not fully participate (e.g., do not complete homework assignments, miss many of the meetings, do not participate in discussions). We offer tips for getting commitment from the institution and participants in Tables 18.1 and 18.2.

Learning about the data supporting DBT is also essential; when selecting studies to read, keep in mind the importance of a control condition, randomization, and replication. Linehan, Dimeff, Koerner, and Miga (2014) and Rizvi, Steffel, and Carson-Wong (2013) provide useful summaries of these data. This information is also

**TABLE 18.1. Tips for Obtaining Commitment from Administration for Study Groups**

In a clinic setting, negotiate with administration/management to use work time for training purposes. The following benefits may increase the likelihood that administration will agree:

- Link the study group to goals most important to administration (e.g., decrease hospitalization rates, decrease recidivism rates, increase staff morale).
- Inform administrators that a study group will allow for ongoing education and staff development without major losses in time/productivity.
- Offer administration something in return, such as developing learning materials for other staff based on the study group.

important for learning which populations are most likely to benefit from DBT and understanding when DBT may be a useful approach and when there might be better alternatives.

### *Workshops and Lectures*

Didactics (teaching, often through lecture and/or presentation) are essential. Researchers have found that without didactic trainings, supervision and future trainings are less effective (Chagnon, Houle, Marcoux, & Renaud, 2007; Herschell, Kolko, Baumann, & Davis, 2010; Hawkins & Sinha, 1998; Siqueland et al., 2000). Workshops are a very useful way to obtain didactics on DBT. They can, however, be very expensive and time-consuming. If one has the resources to attend a DBT workshop, there are many to choose from. We recommend presenters who follow the Linehan manuals (1993, 2015a, 2015b) and who have extensive experience teaching and implementing DBT.

Five- and 10-day DBT trainings are particularly common. They provide an overview of the history of DBT, theoretical and philosophical underpinnings of the treatment, data supporting DBT, as well as specific principles and strategies that comprise the treatment. These trainings are designed to be a multicomponent training package with a variety of teaching methods; in addition to didactics, they utilize experiential exercises, modeling, and homework assignments. They also often address DBT team cohesion and functioning and impediments to treatment implementation. Five-day foundational trainings are sufficient for training members of an established and highly experienced DBT team, where the shaping and maintenance of new skills can be provided within the clinical setting. For newly established DBT teams, teams without extensive DBT training, or teams without at least one expert in DBT, a 10-day

**TABLE 18.2. Tips for Developing and Maintaining a Study Group**

- Use DBT commitment strategies with each other. Get commitment for one book/topic at a time. It is better to have a very small group of highly committed people than a large group of moderately committed people. It is likely that over time others will see all the ways the group is valuable and will want to join it.
- Have an appointed group leader who is responsible for starting and ending meetings on time, following up with people when they miss a meeting, need to know what the assigned homework is, and the like.
- Take the homework seriously. As with clients, the group leader should assess the reasons for missing homework and attendance problems, and troubleshoot solutions.
- Have everyone read each chapter/paper. Discussions will be richer and more reinforcing than one person lecturing on the reading.
- Make it fun! Meet offsite, provide snacks, start with 5 minutes of chit-chat, and so on.

intensive training or long-term arrangement with an expert consultant may be a better fit to ensure that important components of the multicomponent training package are included and that knowledge is sustained over time.

Shorter workshops can also be useful, particularly if one is looking for an introductory overview of DBT, or to hone in on particular skills and strategies (e.g., addressing therapy-interfering behavior, mindfulness, or adaptations of DBT for particular populations). In our experience, a brief workshop such as a 1- or 2-day introductory training is not sufficient to prepare a therapist to start providing DBT; a 5- or 10-day training (or its equivalent), along with other acquisition strategies, will be necessary to truly learn the many components of DBT.

Classes and informal lectures may be a more cost-effective alternative to attending workshops. If a clinic, agency, or geographical area has a therapist experienced in DBT, that individual may be recruited to provide training. When feasible, we recommend that programs contact relevant professional organizations and go through the process of becoming eligible to provide continuing education (CE) credit to staff for attending in-house trainings (e.g., the American Psychological Association at *www.apa.org/ed/sponsor/become-approved/index.aspx* or National Board of Certified Counselors at *www.nbcc.org*). Doing so is a nice perk for therapists and will likely increase attendance at such events. Online lectures are also an option when one does not have in-person access to someone with expertise in the treatment.

In the absence of the structure of a formal workshop, it may be useful to build structure into self-study, didactics, or other curricula. Linehan's (1993) manual provides some guidance for this; the strategy checklist tables may be particularly useful as a study guide (e.g., Linehan, 1993, p. 206, Dialectical Strategies Checklist). It is also helpful to consider in what order therapists may need to learn these topics. If therapists are new to DBT, topics that must be well understood early in the treatment (e.g., biosocial theory) should be taught prior to topics that are needed later in treatment (e.g., termination). Table 18.3 offers a sample curriculum that provides the necessary topics to cover when training a new DBT therapist. Additional topics may be added, but these elements provide a solid foundation in DBT. All mention of chapters in Table 18.3 refer to Linehan (1993).

### *Other Resources*

Importantly, the acquisition process does not stop after reading a book or attending a workshop. Arranging some means to obtain ongoing information regarding DBT will be essential for all DBT therapists, not just those new to DBT. This might occur through supervision, consultation, or mentorship from an experienced DBT therapist; peer feedback; continuing education meetings; journal clubs; professional organizations such as the Association for Behavior and Cognitive Therapies (ABCT; *www.abct.org*) and the International Society for the Improvement and Teaching of DBT (ISITDBT; *www.isitdbt.net*); research updates, such as Google Scholar and PubMed alerts; and posted updates, such as *https://behavioraltech.org/research/updates*.

## Skill Strengthening and Generalization: Supervision in DBT

Acquisition alone is insufficient when training any therapist. For instance, some research indicates that didactic trainings result in an increase in therapist knowledge,

**TABLE 18.3. Sample Curriculum for DBT Training in Acquisition Phase**

1. Overview of the treatment (Ch. 4; Koerner, 2012)
2. Inclusion and exclusion criteria: Who will be included in the DBT program and who will not? This will include an overview of the research on DBT, focusing in particular on randomized controlled trials (RCTs) (e.g., Linehan, Dimeff, Koerner, & Miga, 2014). This will also include training the therapist in any agency policies regarding client populations.
3. Borderline personality disorder (BPD) and emotion dysregulation
   a. Biosocial theory (Ch. 2)
   b. DBT conceptualization of BPD and emotion dysregulation (Ch. 1)
   c. Assumptions about clients and therapists (Ch. 4)
4. Structure of DBT
   a. Modes and functions of DBT (Ch. 4)
   b. DBT team (Ch. 4; Sayrs & Linehan, 2019a)
   c. Outside-of-session contact (Ch. 4; Ch. 6; Ch. 15; Ben-Porath & Koons, 2005)
5. Risk assessment (Ch. 15; Katz & Korslund, 2020)
6. Commitment strategies (Ch. 14)
7. Diary cards (Ch. 6; Linehan, 2015a)
8. How to orient to DBT (Ch. 4; Ch. 14)
9. Basic structure of a DBT session (Ch. 14)
10. Targeting
    a. Primary targets (Ch. 5)
    b. Secondary targets (Ch. 3; Ch. 5)
    c. Target hierarchy (Ch. 6)
11. Assessment
    a. Behavior analysis (Ch. 9)
    b. Chain analysis (Ch. 9; Rizvi, 2019)
    c. Missing links analysis (Linehan, 2015a, 2015b)
12. Change strategies
    a. Solution analysis, task analysis (Ch. 9)
    b. Contingency management (Ch. 11; Pryor, 1999; Ramnero & Törneke, 2008, Chapman & Rosenthal, 2016)
    c. Exposure (Ch. 11; Abramowitz, Deacon, & Whiteside, 2019)
    d. Cognitive modification (Ch. 11; Dryden, DiGuiseppe, & Neenan, 2010)
    e. Skills (Ch. 11; Linehan, 2015a, 2015b; Swales & Dunkley, 2020)
13. Reciprocal strategies
    a. Validation (Ch. 8; Linehan, 1997; Linehan, 2015a, 2015b; Shenk & Fruzzetti, 2011)
14. Dialectics worldview and strategies (Ch. 2; Ch. 7; Koerner, 2012; Sayrs & Linehan, 2019b; Swenson, 2016)
15. Other strategies (stylistic: Ch. 12; case management: Ch. 13; orienting, didactic, insight strategies: Ch. 9)
16. Strategies for treating diagnoses and problems common among DBT clients. For example, Oxford's Treatments That Work series (e.g., Craske & Barlow, 2007) is extremely helpful when treating behaviors that interfere with quality of life. Other helpful treatment manuals include *The Mindful Way Through Anxiety* (Orsillo & Roemer, 2011); *Mindfulness-Based Cognitive Therapy for Depression* (Segal, Williams, & Teasdale, 2013), *Behavioral Activation for Depression* (Martell, Dimidjian, & Herman-Dunn, 2010), and *Overcoming Binge Eating* (Fairburn, 2013), to name a few. See "Readings" section (above) for websites with additional resources.
17. Observing limits (Ch. 10)

*Note:* Chapter cross-references here correspond to Linehan (1993).

but do not result in changes in therapist attitudes, knowledge application, or behaviors (Beidas, Edmunds, Marcus, & Kendall, 2012; Beidas & Kendall, 2010; Carroll, Martino, & Rounsaville, 2010; Dimeff et al., 2015; Harned et al., 2014; Fixsen, Blase, Naoom, & Wallace, 2009; Herschell et al., 2010). Herschell et al. (2010)

report that it is necessary for therapists to receive ongoing support to improve their skills. Additionally, when therapists receive ongoing consultation and/or supervision after didactic trainings, their skills continue to improve and behavior changes become more solidified (Beidas et al., 2012; Herschell et al., 2010).

The skills acquired through didactics, readings, and other means must be shaped, strengthened, and generalized to change therapist behaviors. The majority of such strengthening and generalization happens within the context of DBT supervision or consultation. This process is parallel to that of DBT therapy: Just as DBT therapists assist clients with rehearsing skills and troubleshooting instances in which they have difficulties using them in day-to-day life, DBT supervisors play a key role in helping therapists practice treatment strategies and generalize them to the therapy room. It is important for supervisors to remember that even if a therapist can produce a behavior in the supervisor's office, this does not guarantee that the therapist can do the same in a therapy session, or in response to specific client behaviors. Thus, any work on skill strengthening and generalization needs to begin with a detailed assessment to allow for accurate targeting.

### *Assessment*

Assessment is essential in the strengthening and generalization phases of training. Supervisors must conduct a thorough assessment of skills, understanding of didactic material, and most importantly, which therapist behaviors are (and are not) occurring during therapy sessions. Methods for such assessment are described below.

#### *Case Formulation*

Assessment of formulation skills can be done either during the supervision session or as a homework assignment. Case formulations and treatment plans with clients who have multiple complex and high-risk problems are critical for treatment success and can be difficult to develop (see Koerner, 2012, and Rizvi & Sayrs, 2020, for detailed information on case formulations and treatment planning). It is very easy for clinicians to lose track of treatment targets and goals, and for therapy to get bogged down and become ineffective; focusing on case formulation in supervision can help maintain the treatment's focus and precision. Such discussion also has the advantage of highlighting a trainee's strengths and weaknesses, which allows for increased precision in supervision. When reviewing the trainee's case formulation, key elements for the supervisor to look for are primary and secondary targets, biosocial theory, variables controlling the client's behavior, and obstacles interfering with more adaptive responses. This information is also valuable for the supervisor to have while listening to/watching recordings of therapy sessions (see below), as the supervisor will be able to assess if the formulation is accurate and if the supervisee is targeting the relevant behaviors in session.

#### *Direct Observation*

Although therapists' reports of their in-session behaviors are one potential source of assessment data, these are likely to be just as biased as all retrospective self-reports of behavior (Gunn & Pistole, 2012; Hantoot, 2000; Muslin, Thurnblad, & Meschel,

1981). Additionally, therapists may not recognize problematic behavior or the absence of effective behavior, either in their own or clients' behaviors. Thus, more direct means of observing therapist behaviors are needed to conduct an effective assessment, including audio recording, video recording, or live observation of sessions. This type of access to the "raw data" of therapy is often essential for supervisors to identify supervisees' training needs and to effectively assist with case conceptualization and targeting.

Direct observation of therapy sessions can be particularly anxiety-provoking for therapists. Creating a culture in which everyone in the treatment setting, regardless of experience level, is recording and reviewing therapy sessions can increase trainee buy-in for this approach and make it more normative. Additionally, supervisors need to be thoughtful about how they provide feedback in response to direct observation, given that trainees often feel more vulnerable in this method of supervision. Just as in DBT treatment, it is important to be direct, avoid treating the supervisee as fragile, and advocate for change as needed, while also creating a validating and supportive environment to facilitate learning.

All types of direct assessment require informed consent from clients, and language describing these methods can be included in the consent documents that clients sign when they begin treatment. Whenever possible, clients should be given the choice to opt in or out of these methods regardless of whether they choose to seek treatment, to minimize risk of coercion. Some clients may decline, which will limit the information that supervisors can obtain about therapist behaviors; it is important to balance therapists' training needs with clients' preferences and autonomy. Some training settings may require forms of direct assessment/observation of trainees (e.g., when therapists are new to DBT, when therapists are students). When this is the case, clients should be oriented to this requirement early in the intake process so they have an opportunity to ask about other treatment options or providers (if available) if they do not wish to be recorded or observed.

As part of the informed consent process, it is important for therapists to communicate to clients the following:

1. The focus of the observation is on the therapist, not the client; this is a way for the therapist to get feedback.
2. They are free to choose not to have a specific session observed/recorded if discussing information that feels too private (i.e., they may revoke consent for specific sessions/topics).
3. Specific security measures for session recordings are in place to protect their confidentiality and privacy (and provide details about what these are).
4. Session recordings will be deleted after a specific amount of time.

All of this information should be provided to clients in writing (in the treatment consent form) and should also be reviewed verbally to ensure that clients understand these policies and can have their questions or concerns adequately addressed.

In most settings, making audio or video recordings of therapy sessions is likely to be more feasible than live observation (tips for setting up recording equipment can be found in Table 18.4). Recordings allow the supervisor to watch at their convenience and to view and discuss the session with the trainee. This approach can also be less intrusive in session. Equipment can be costly, but we have found that

**TABLE 18.4. Tips for Recording Sessions**

- Video/audio recording device should be positioned in as unobtrusive a location as possible.
- For video, ensure that both the therapist and client are in the frame. If possible, try to frame the entire bodies of both therapist and client to capture all nonverbals.
- For both audio and video, test equipment prior to the session to ensure that both the therapist and client's voices are audible on the recording.
- Try to avoid having either the therapist or client sitting directly in front of bright lights, as this will create a silhouette and nonverbals are more likely to not be seen.
- An external microphone may enhance audio quality.
- Make sure that any files are stored securely using HIPAA-compliant technology and systems.

handheld digital recorders, webcams, and even smartphones can suffice as recording devices. Audio recordings may be more comfortable for clients because their face and other identifying information are not recorded; however, the supervisor may find that the absence of nonverbal information makes assessment more difficult. Recordings should be saved only as long as needed to be used in supervision. A helpful guideline is to have no more than two session recordings saved for any given client at any given time. Limiting the number of session recordings that are stored at any given time is important to limit potential confidentiality breaches and data security problems.

Live observation is another means of direct observation and assessment. Although this method eliminates the data security and storage challenges associated with session recordings, it can be inconvenient in terms of scheduling. This method has the advantage of offering the opportunity to provide the trainee with immediate feedback during the session. The gold-standard version of this approach is to observe the therapy session from an observation room via a one-way mirror. As this necessitates having the space and resources to create such a room, the option may be most applicable for larger institutions (e.g., hospitals, graduate programs, larger clinics). However, less resource-intensive options could also be used in private/group practice or small clinic settings. For instance, supervisors could listen to a therapy session live via a range of means, including placing a baby monitor in the therapy room and the receiver in the supervisor's office, or having the supervisor call an office phone or cell phone in the therapy room that is put on speaker mode, so the supervisor can hear both the therapist and the client (the supervisor's phone should also be placed on mute). To hear and *watch* a session live, a supervisor could use HIPAA-compliant video conferencing programs to call the computer in the therapist's office; the therapist's webcam would point toward the therapist and the client, and the supervisor's camera and microphone would be turned off so that the therapist and the client cannot see or hear the supervisor. As an added note, live observation methods allow opportunities not just for assessment, but also intervention, as the supervisor can feed information and suggestions to the therapist during the session. This feedback can be done by simply knocking on the therapy room door and briefly coaching the therapist, or by providing "bug-in-the-ear" or "bug-in-the-eye" feedback as the session progresses (see the following discussion).

If none of the direct assessment methods described above are feasible, role-plays during the supervision session can provide an alternative means to assess therapist skills. Role-plays allow the supervisor to assess specific therapist behaviors, as they can control the parameters of the role-play and the client behaviors to which the

therapist is responding. However, as previously noted, just because a therapist can produce a behavior in a role-play does not mean that they can produce the behavior in the therapy context.

Once a therapist has been taught new DBT strategies (acquisition) and the supervisor has had the opportunity to assess their skills, training can then move to shaping and strengthening those skills. Fortunately for the DBT supervisor, most of these strategies are the same as those used for the same purpose with DBT clients, modified for the supervision setting. It is important to note that just as in DBT therapy, the process of assessment is ongoing throughout supervision and continually informs interventions that the supervisor uses with the therapist to shape, strengthen, and generalize skills.

### *Adopting a Dialectical Stance in Supervision*

Just as DBT therapists are continually trying to balance the use of acceptance and change strategies with clients, it is critical for DBT supervisors to attend to this dialectic in supervision when trying to shape and strengthen therapists' skills. On the one hand, acceptance is essential, including praising or highlighting effective therapist behaviors from the session, as well as validating the difficulty associated with implementing the treatment or of a particular session. This will help create trust, build a positive relationship between therapist and supervisor, support shaping therapist skills, and minimize therapist burnout. At the same time, acceptance alone will not result in supervisees learning and mastering the skills and behaviors necessary to become adherent DBT therapists. Corrective feedback about what the therapist could have done differently in the session, teaching and/or rehearsing a specific therapeutic skill or strategy, and focusing on behaviors that the supervisor would like to see from the therapist in the next session are also essential to increase supervisees' effective delivery of the treatment.

Supervisors may tend toward one pole or the other; however, this can result in deficits in either morale (when leaning toward change) or skill (when leaning toward acceptance). Dialectically emphasizing *both* is essential in training DBT. Importantly, striving for a balance between acceptance and change in supervision does not mean seeking a 50–50 balance between these approaches. Instead, each supervisee will require a different combination of these strategies to develop optimally as a DBT therapist. One of the challenges faced by DBT supervisors is to identify the specific mix of these strategies that is ideal for each supervisee (similar to the challenge faced by DBT therapists in their work with each individual client). Supervisors may benefit from tracking their own use of these strategies in supervision, particularly in instances in which either the rapport with a supervisee is poor (suggesting a possible lack of sufficient acceptance strategies) or the supervisee does not seem to be improving or changing in expected ways (suggesting a possible lack of sufficient change strategies). Additionally, supervisors can seek feedback from supervisees about the balance of acceptance and change in supervision, either informally during a supervision session (i.e., verbal discussion) or via the use of a formal written feedback form.

### *Setting Goals for Supervision*

Toward the beginning of working with any new supervisee, it is recommended that supervisors and trainees collaboratively develop a list of behaviorally specific goals

for supervision. Goals should be informed by both the trainee's stated needs and requests, as well as assessment data that the supervisor has gathered (and will continue to gather throughout supervision) about the therapist's competencies. Some supervisees will need more help with the stylistic strategies of DBT (e.g., learning to be more irreverent or reciprocal), others will need more help with specific treatment strategies (e.g., chain analysis), and others will need a lot of help with both. Supervision strategies, like DBT treatment strategies, should specifically link to the goals set forth by the therapist and supervisor, and should also target supervision- and therapy-interfering behaviors on the part of the therapist or supervisor (see below).

Just as DBT uses ongoing monitoring (i.e., a diary card) to track clients' target behaviors and use of new skills, tracking of therapist behaviors can be an important supervision tool. This can be done in both a formal way (use of a therapist diary card; see the chapter appendix for a sample therapist diary card) or an informal way (checking in weekly about progress toward goals). Whatever the means of ongoing monitoring, targets and skills should be explicitly linked to the goals of supervision to help increase motivation and buy-in from the supervisee and to provide a direct means for the supervisor and therapist to ensure that supervision is effective. In general, providing more structure and formality with this process (via the use of a diary card) is a good idea for new therapists or early in supervision. Therapist diary cards can be used to track the therapist's emotions that are interfering with effectiveness in session (e.g., fear or disgust with regard to the client), and/or to track the practice of specific behaviors a therapist wants to increase and decrease. For example, one of us (J. H.) used a therapist diary card to increase his use of Level 5 validation (Linehan, 1997) and decrease engaging in problem solving prior to adequate assessment. Transitions can be made to less formal methods of monitoring later in supervision when therapists have met many of their training goals and are more self-sufficient in their work.

### *Skill Rehearsal*

Insight and understanding alone typically do not lead to behavior change; thus, the most important way to ensure that therapists are able to engage in new target behaviors is repeated practice, both inside and outside of the supervision session. Role-plays are a primary tool for such rehearsal. As in DBT therapy, activation of new behavior is essential in all DBT supervision sessions. There are frequently many different behaviors that a supervisor could choose to target for a role-play in supervision. Supervisors should target therapist behaviors that are directly related to the highest-order target of the client. For example, if a therapist is avoiding a thorough behavioral chain analysis on a client's life-threatening behavior, this avoidance would be prioritized over other targets.

Depending on the needs of the individual supervisee, role-plays can either begin with the supervisor modeling the desired therapist behavior (in cases where the therapist has not fully acquired the skill being targeted or has indicated that they would like to see the skill modeled first), or can begin with the supervisee demonstrating the specific skill or therapeutic strategy. Supervisors' modeling of a desired behavior has been found to increase the speed with which a supervisee will begin to implement this new behavior (Bearman et al., 2013), so this can be an effective strategy when needed. Role-plays are generally more effective when they target very specific behaviors or problems (as opposed to being general or not well defined). The supervisor should

provide enough orienting and discussion prior to starting the role-play so that the therapist understands what they are being asked to demonstrate. Role-plays are often an iterative process, with supervisors looking for ways to reinforce effective behavior and provide corrective feedback to shape therapist behaviors toward the desired goal. It would not be uncommon for the supervisor and therapist to role-play the same scenario several times during a supervision session to accomplish this. Although role-plays are largely a change-focused strategy, it is essential that the supervisor include statements of validation throughout the process as needed, particularly if the supervisee is struggling with producing the behavior and/or feelings of anxiety or shame. Suggestions for how a supervisor could work with a supervisee's hesitation during a role-play are outlined in Table 18.5.

Role-plays can also extend beyond the supervision session to the DBT consultation team. Although role-plays in a more public setting may be more anxiety-provoking for some supervisees, conducting the role-play with the entire team has the benefit of more opportunities for modeling, feedback, and reinforcement. Additionally, team members may have different ways of demonstrating the same skill, which can provide a range of effective models to the supervisee for the same target behavior. This also has the benefit of extending any learning from the role-play from just the supervisee to the entire team. Group supervision and "hallway consultation" (talking with a colleague as they walk past your office for a 2-minute practice) are additional venues for strengthening specific behaviors and skills.

Specific homework assignments are another form of skill rehearsal and are essential for moving the behavior out of the supervisor's office and into the desired environment (i.e., skills generalization). Whenever a new skill is taught or rehearsed with a supervisee, it is important to assign a behaviorally specific homework assignment related to this skill for the supervisee to complete prior to the next supervision session. For instance, if a supervision session is focused on teaching and role-playing a behavioral chain analysis, a homework assignment could be to conduct two chain analyses with clients in the following week. Noncompliance with homework should be targeted in supervision, just as it would be in therapy, by conducting a chain

**TABLE 18.5. Tips for Dealing with Supervisee Reluctance to Conducting a Role-Play**

- Validate. Typically, emotions, such as fear and shame, interfere. "Of course, you don't want to do this. Most people feel anxious about doing role-plays when they start doing them."
- Link to their goals. "I know you want sessions with this client to go better. Just talking about what to do isn't helpful for changing your or anyone else's behavior. This is the best way I know how to help you get the outcomes you want."
- Use self-disclosure. Just as with clients, it is important to model that the supervisor has also struggled with certain strategies, and improved through repeated practice of the behavior.
- Offer to model the behavior first. Have the trainee play the client and supervisor play the therapist. After running through the role-play, switch roles.
- Plunge in. The supervisor can start the role-play despite the reluctance, remaining in the role of the client until the trainee joins the role-play.
- If the trainee is still unwilling to assess what is interfering, problem-solve and use commitment strategies. Foot in the door can be particularly helpful. For example, offer, "Let's just practice what you will say when the client tells you they didn't bring their diary card again," or provide the therapist with a script to read.
- After completion of the role-play, it is critical to highlight everything that the trainee did well, remembering the principles of shaping. Reinforce them for doing the dreaded task!

analysis or missing links analysis (Linehan, 2015a, 2015b) to assess why the behavior did not occur and to facilitate solution analysis and commitment.

Koerner (2015) discusses *deliberate practice,* a method that can significantly improve trainees' skills. This method involves a clinician choosing a skill to enhance and then consistently practicing the behavior for a sustained period of time (Gawande, 2011). The components of deliberate practice include selecting one particular behavior, identifying what an expert version of this behavior looks like, assigning that version a rating (e.g., 0–5), identifying when to practice the behavior, creating a note as a reminder, mindfully practicing the behavior, and after practicing in session, rating the behavior by comparing it to the ideal and making notes on what to do differently next time (Koerner, 2015). For example, this approach could be used with a trainee learning the commitment strategies. The trainee would pick one commitment strategy to focus on at a time (e.g., freedom to choose and the absence of alternatives) and create a note for themself to keep on their desk or arm of their chair as a reminder to practice. After each session, the trainee would track whether or not they practiced the strategy and rate themself on how well they believe they did. They also would write a quick note of feedback to themself about what went well and what they would like to improve. Therapist diary cards can be adapted easily to incorporate deliberate practice.

### *Skill Strengthening*

Supervisors can use a range of strategies to strengthen skills in their supervisees. Three particularly important strategies are reinforcement, shaping, and coaching. Reinforcement of effective behavior by the supervisor (and the whole DBT team) is essential given that many of the behaviors that supervisors will want therapists to engage in and master will be actively punished by their clients (i.e., applying contingencies, observing limits, removing warmth when appropriate, addressing therapy-interfering behaviors). Reinforcement by the supervisor is necessary to counteract the effects of in-session punishment, or the therapist may not try the behavior again!

Good opportunities for reinforcing skillful therapist behaviors include during role-plays, when reviewing session recordings with supervisees, in weekly team meetings, and in any other setting where the therapist is working on new skills. As with all forms of behavior modification, it is important that supervisors select reinforcers that are salient and meaningful to supervisees to ensure they are effective. As supervisees vary in terms of what they find reinforcing, some trial and error is often needed to find the right reinforcers. Suggestions for potential reinforcers include specific, labeled praise, highlighting the supervisee's effective behaviors during a DBT consultation team meeting, and highlighting the client's progress in treatment. DBT supervisors and teams should feel free to be creative about the ways in which they reinforce therapists' effective behaviors. For instance, one of us (J. H.) was on a team that reserved a "great moments in DBT" trophy that anyone on the team could give to another team member when they observed, or learned of, an effective intervention by that individual. The actual trophy would then be handed out in a clinicwide meeting. The person delivering the trophy explained to the team what they had observed the recipient successfully do. The recipient of the trophy then became responsible for watching for the next "great moment in DBT" by another member of the team and handing off the trophy to that person at a future meeting.

Shaping of therapist behaviors involves both the reinforcement of effective behaviors, as well as providing corrective feedback about behaviors that still need some work, to move the behavior closer to the desired outcome. Shaping can occur in the moment, such as during a live role-play with the supervisee, as well as over time, such as when reviewing a series of session recordings with a supervisee. Reviewing audio/video recordings of therapy sessions is essential for supervisors to be able to help with strengthening and generalizing new skills. Ideally, supervisors and supervisees can watch or listen to recordings of a portion of a session together, targeting a specific skill or behavior. Viewing together also allows therapists to observe their own behavior and participate in the shaping process. The DBT consultation team can also help with the shaping process; for instance, a therapist on the team in which two of us participated (J. S. & T. O.) had considerable difficulty observing limits with regard to coaching phone calls, leading to excessive time spent on the phone on a regular basis. This behavior was ineffective; it did not help the client develop skills to cope independently and it led to the therapist not wanting to work with the client. The therapist targeted this behavior successfully with the help of the consultation team by consistently putting this issue on the meeting agenda. That allowed the therapist to get input from the team about how to shape the amount of time spent on the phone with the client (which involved having to address his own feelings of guilt and change-related behaviors), as well as reinforcement from the team when these goals were incrementally met over time.

### *Skills Coaching*

Coaching in DBT supervision can be viewed as serving a similar function as coaching calls in DBT therapy. The purpose is to help therapists with the generalization of skills they have learned. This can take the form of providing direct instruction about what to do in a particular situation (e.g., during a role-play, while reviewing a session recording, during a crisis with a particularly client) or eliciting such ideas from the therapist. The approach taken will vary depending on the nature of the situation and the training level of the therapist. Coaching can involve both reinforcement and shaping, but at times may simply involve providing information or advice on what to do. This strategy can be particularly helpful with new DBT therapists, new situations encountered by a therapist (regardless of skill level), or during higher-risk situations in which the therapist's own anxiety or distress may interfere with effective problem solving or behavior. This coaching can take place in person (such as during supervision or a team meeting), or via phone or text.

One way of combining reinforcement, shaping, and coaching all at once is for supervisors to use technology-driven tools such as bug in the ear (Gallant & Thyer, 1989) and bug-in-the- eye (Klitzke & Lombardo, 1991), both of which are referred to as BITE, to provide live supervision and real-time feedback to therapists. These methods have the benefit of incorporating acquisition, strengthening, and generalization in one intervention. Bug-in-the-ear involves the supervisor providing live instructions and feedback to the therapist via a microphone used by the supervisor and an earpiece worn by the therapist, whereas bug-in-the-eye allows supervisors to provide such feedback in writing via a computer screen that the therapist can see during the session. This allows shaping and strengthening to take place when the behavior is actually occurring in the desired environment, which arguably could

be the most ideal training context possible. A recent case study (Rizvi, Yu, Geisser, & Finnegan, 2016) and small randomized controlled trial (RCT; Carmel, Villatte, Rosenthal, Chalker, & Comtois, 2016) provide preliminary support for the feasibility and benefits of BITE as a means of providing live supervision to DBT therapists.

The methods previously described for conducting live supervision can be adapted to use for BITE. Many DBT supervisors will likely need to use "low-tech" versions of these systems that are affordable and workable across different types of settings. There are a variety of ways that a supervisor could provide written instructions to a therapist during the session. In all cases, the monitor or device through which the therapist is viewing the instructions from the supervisor should be out of the client's line of sight if possible. One option would be for the therapist and the supervisor to each have a monitor attached to the same computer, such that the therapist can read whatever the supervisor types; another option is to have both view a Web-based shared document (such as a Google doc) that can be viewed by multiple individuals at once. The supervisor could then type instructions in the document and the therapist would see these prompts on the screen in real time. Additionally, screen-sharing software can be used between computers in the supervisor's location and the therapy room. Similar to the Google docs suggestion, screen capture allows the supervisor to type instructions into a Word document that can be viewed in real time on the trainee's computer (Rizvi et al., 2016). Finally, written prompts could be provided via a text message between the supervisor and therapist's cell phones. The downside of this approach is that the therapist would need to have the cell phone close enough to them to see the prompts, which could become distracting to the client.

Regardless of the format of BITE used (verbal prompts or written prompts), supervisors should provide very specific and short instructions ("Validate more, try V5") or reinforcement ("Fantastic!"); lengthy statements or suggestions will be too distracting for the therapist to process while also attending to the client. Providing specific feedback and coaching in real time (i.e., "Look shocked and say, 'WHAT?!' ") can get a therapist to emit a behavior that would have taken a long time to drag out otherwise (just as phone coaching in DBT is a primary means of eliciting new behavior quickly). Any form of live supervision and coaching can be extremely rewarding and enjoyable, particularly when the therapist sees new strategies having a positive impact on the session and the client. A downside of this approach is that, just as with live observation, it requires the supervisor to be available during the time of the therapy session.

### *Commitment and Troubleshooting*

Once a trainee has learned the required behavior, rehearsed it, and received coaching, it will be helpful for the supervisor to obtain a clear commitment to try the new behavior in session, and to troubleshoot what could go wrong. Asking the therapist, "What could throw our plan completely off track?" can elicit answers such as "I'll be fine unless the client is mad at me, then I don't know what I'll do!" or "I'm still feeling super nervous about this plan. I'm not sure I can do it." Just as in DBT treatment, troubleshooting can highlight where further commitment, training, or other interventions may still be needed.

### *Supervision-Interfering Behaviors*

Supervisors can face many obstacles when trying to help supervisees strengthen and generalize new behaviors. Common challenges include willfulness on the part of the supervisee, emotions that interfere with effective behavior, avoidance, supervisor nonmindfulness, and other obstacles. Each of these problems can occur in the context of any of the strategies described above.

Just as with therapy-interfering behaviors in DBT, supervision-interfering behaviors (SIBs) are behaviors that impede the supervision process and can be engaged in by either the supervisee or the supervisor. Behaviors that interfere with supervision can run the gamut from minor to extreme. When addressing SIBs, it is important that the supervisor maintain a non-judgmental stance and a matter-of-fact tone of voice. Depending on the SIB, it may be easy for the supervisor to become frustrated and use a tone of voice and phrasing that the supervisee finds punishing. This will likely result in either shame and/or anger in the therapist, which will impede assessment and solution analysis. A more common occurrence in our experience is for the supervisor to be hesitant and use an overly cautious or sweet tone of voice in conjunction with alluding to the problem instead of diving right into it (both of these styles of communication are examples of SIBs on the part of the supervisor). Approaching SIBs this way tends to inadvertently communicate that the supervisor perceives the trainee as fragile and to increase the anxiety of the therapist. It is important that the supervisor communicate to the trainee that whatever is happening is just a problem to solve. Using a matter-of-fact non-judgmental tone, behaviorally specific language, and a lot of validation is critical for accomplishing this.

Addressing SIBs is a similar process to addressing TIBs in DBT. Highlighting the behavior when it appears is the first step. For example, "I notice that every time I give you feedback on behaviors to change in session, your body tenses and you tell me that these aren't behaviors you need to change, or you list all the reasons the suggestions I am making will not work. Do you notice that, too?" After addressing the behavior, it is important to assess what caused the behavior; if supervisors just assume they know what the problem is, they are at risk of solving the wrong problem. Continuing on with the above example, this may sound something like the following: "I have to say, I can't think of one person I know who totally relishes getting critical feedback, learning can be so freaking painful! What happens for you in those moments where I give you feedback and make suggestions for behaviors to change?"

Once the problem has been identified, the supervisor and supervisee can engage in collaborative problem solving. It is important that once solutions have been generated, the supervisor reintroduce the cue so the trainee can practice the new behavior. "All right, this is great, I am so excited we got this nailed! Let's do this, let's go back to reviewing your tape and I am going to give you the same feedback about increasing your use of V5 instead of jumping straight to problem solving. What are you going to do when I do that? OK, great!" After rehearsal, it is important for the supervisor to get a commitment from the supervisee to practice these new behaviors and to troubleshoot what will interfere with practicing them.

Just as therapists can be the ones engaging in TIBs in DBT, supervisors can be the ones engaging in SIBs in supervision. Sometimes the supervisee will be the one to address the SIB with the supervisor. Other times the supervisee might not say anything to the supervisor for several reasons, including that the supervisee is early in training

and does not believe the behavior by the supervisor is interfering, or the supervisee is reluctant to address the behavior due to the imbalance of power. Whatever the case, it is beneficial for the supervisor not to rely solely on the supervisee to bring SIBs to the supervisor's awareness. A good strategy is for the supervisor to routinely check in with the supervisee about how supervision is going and how the supervisee experiences the supervisor's style and behavior. Once the SIB has been identified, it is important that the supervisor implement the same strategies used above for assessing the cause of the behavior and creating a solution analysis. If necessary, the supervisor can use their team and/or their own supervisor to aid in this process.

## Other Training Strategies

### *Training Director*

A key component of having an effective in-house training program is institutional support for training and supervision (Beidas & Kendall, 2010). Some settings may benefit from assigning a person to the role of training director. This director can address all of the training needs, including didactics, supervision, peer supervision, team, and other components, to ensure that each trainee, and each member of the team more broadly, receive the ongoing training needed. This director does not need to provide all of these elements, but manages and coordinates them and confirms each therapist's training needs are being met. In other settings, it may not be feasible to have a training director due to the size of the clinic, financial means, or time restrictions. In this case, the DBT team leader may be the natural choice to organize the components of therapists' training.

### *DBT Team*

Attending DBT team is a formal part of providing adherent DBT and yet another source of ongoing education and skill enhancement. We will not discuss DBT team in general here (more can be found in Linehan, 1993, and Sayrs & Linehan, 2019a); we will only discuss its relevance to training. A DBT team's primary aim is to address any obstacles to providing adherent DBT, with a particular focus on therapists' motivation and capability. While it is expressly not a place to focus on didactics, if a therapist needs to acquire certain skills to provide adherent DBT (e.g., learn how to use irreverence in a particularly challenging clinical situation, learn how to treat hair pulling for a particular client), the team can be an important resource. The team may briefly model, rehearse, shape, and reinforce the new behavior (e.g., learning to say, "That's bulls*&t!" to a client), or help the therapist locate the right resources. Additionally, participating in team and discussing and supporting effective treatment for a wide variety of cases can be wonderfully enriching and educational.

## Summary

Training and supervision are critical components of the continued dissemination and implementation of DBT. Indeed, as more clinicians provide this treatment, ensuring

fidelity to the treatment model is of the utmost importance to provide clients state-of-the-art care. Training clinicians in DBT can be a labor- and resource-intensive process, particularly for those in smaller practice settings or settings with limited funding. The aim of this chapter is to provide examples of gold-standard supervision and training in DBT, as well as adaptations for a range of clinical settings. Fortunately, clinicians who are well versed in DBT already know many of the strategies that are used in DBT supervision, as much of the process mirrors that of DBT treatment.

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**APPENDIX 18.1.** A sample therapist diary card—both the blank and filled-in versions of it—appears below. It can be adapted for daily use by changing "week of" to "Date." The behavior rating scale used aligns with Fruzzetti's DBT Therapist Rating and Feedback Form (2012).

| Name: | | | | Week of: | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Session Date/Time | Fear | Anger | Shame | Guilt | Disgust | Joy | Bx Inc (Action/Rating) | Bx Dec(Action/Rating) | Notes |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Number of Sessions Taped This Week: | | | | | | | | | |
| Emotion rating scale: 0: None 1: Minimal 2: Mild 3: Moderate 4: Strong 5: Extremely Strong | | | | | | | | | |
| Bx Rating: 1: Very Effective 2: Effective 3: Mixed 4: Ineffective 5: Very ineffective | | | | | | | | | |
| Homework: | | | | | | | | | |

| Name: J. Doe | | | | Week of: 1/22/18 | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Session Date/Time | Fear | Anger | Shame | Guilt | Disgust | Joy | Inc Matter of Fact Tone | Dec "Therapist Voice" | Notes |
| 1/22/18 2:00pm | 3 | 0 | 3 | 3 | 0 | 2 | N 5 | N 5 | Lower tone of voice, ask clearly without hesitating |
| 1/22/18 4:00pm | 2 | 0 | 0 | 1 | 0 | 4 | Y 3 | Y 2 | Don't raise tone of voice at end of sentences |
| 1/23/18 10:00am | 3 | 2 | 2 | 1 | 2 | 5 | Y 2 | Y 2 | Asked about LTB matter of factly! |
| 1/24/18 1:00pm | 0 | 2 | 0 | 0 | 0 | 4 | Y 3 | Y 2 | Hesitatent tone of voice assigning HW |
| 1/25/18 11:00am | 4 | 2 | 4 | 4 | 2 | 2 | N 5 | N 5 | "T" Tone came out once C began yelling at me |
| Number of Sessions Taped This Week: | | | | | | | | | |
| Emotion rating scale: 0: None 1: Minimal 2: Mild 3: Moderate 4: Strong 5: Extremely Strong | | | | | | | | | |
| Bx Rating: 1: Very Effective 2: Effective 3: Mixed 4: Ineffective 5: Very ineffective | | | | | | | | | |
| Homework: Practice telling people they have something in their teeth, use matter of fact direct tone without hesitating before speaking<br>Practice 5 minutes a day asking "Did you cut yourself?" in same tone as asking "Do you like wheat toast?" Do this in team, ask for feedback. | | | | | | | | | |

CHAPTER 19

# Pharmacotherapy Guidelines for Treating Stage 1 DBT Patients

ELISABETH P. BELLOWS, W. MAXWELL BURNS, and CHELSEY R. WILKS

Dialectical behavior therapy (DBT) is a coordinated care treatment model, wherein multiple providers deliver specific treatment interventions to the patient. When pharmacotherapy is part of the overall DBT plan, it can significantly impact the patient's well-being. Stage 1 DBT patients are often clinically complex, presenting with multiple diagnoses and significant risk for suicide and self-injurious behaviors. Many patients start DBT treatment already taking medications and may have an established relationship with a prescriber. However, not all prescribers are familiar with DBT principles, may not have prior experience with DBT teams, and may not have specialized knowledge for the treatment of people with borderline personality disorder (BPD). Additionally, DBT therapists vary considerably in their knowledge and interest in the particulars of pharmacotherapy. Therefore, it is important for medical prescribers and DBT therapists to collaborate effectively, sharing their respective areas of expertise for the benefit of the patient and the overall treatment plan.

This chapter will provide guidelines for both DBT therapists and prescribers regarding the pharmacotherapy of Stage 1 DBT clients. When is medication indicated? What evidence supports pharmacotherapy for BPD behavioral targets? How do the prescriber and the DBT therapist define their roles? What are effective strategies for communicating between patient, prescriber, and DBT therapist? How does the DBT therapist contribute to the pharmacotherapy plan? Finally, for prescribers, how is pharmacotherapy conducted in a manner that aligns with DBT principles?

## When to Use Pharmacotherapy

From a DBT standpoint, the purpose of pharmacotherapy is to enhance patient capabilities so that the patient can achieve their long-term goals. When a behavioral target

(or a co-occurring diagnosis) is known to respond to pharmacotherapy, the prescriber offers medication with the expectation that the behavioral target will improve, and the patient's capabilities will thereby increase. Offering pharmacotherapy includes a risk-benefit analysis; medication is recommended when the behavioral target is expected to respond to the medication (benefit), and the adverse effects of the medication are likely to be tolerable (risk).

Thousands of scientific studies over the course of decades have demonstrated that pharmacotherapy, provided alone or in conjunction with psychotherapy, is effective for a wide range of problems, including affective disorders, psychotic disorders, anxiety disorders, attention-deficit/hyperactive disorder (ADHD), obsessive–compulsive disorder (OCD), alcohol use disorders (AUD), and opiate use disorders (OUD), among others. In addition to knowing when pharmacotherapy is indicated, it is also important to recognize when pharmacotherapy is relatively contra-indicated or shown to be ineffective. Some behavioral conditions have been extensively studied and appear to be resistant to pharmacological agents (for instance, restrictive eating disorders; Aigner, 2011). In other cases, the risk associated with an effective medication is too high to be used without special precautions (e.g., Lithium treatment for highly suicidal bipolar patients; Baldessarini et al., 2006). Finally, when an effective psychosocial treatment is available, medication may not add significant clinical value to the treatment plan (e.g., outcomes for BPD following DBT are not improved by concurrent use of selective serotonin reuptake inhibitor [SSRI] antidepressants; Simpson, 2004).

### *Research Supporting the Use of Pharmacotherapy for BPD*

We conducted a literature review of placebo-controlled randomized clinical trials (RCTs) investigating pharmacotherapy effects in subjects who met the criteria for BPD. Most RCTs report their outcome measures using standardized rating scales that correspond to diagnostic criteria for BPD listed in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). Therefore, we used DSM-5 diagnostic criteria for BPD to summarize the efficacy of pharmacotherapy on BPD behavioral targets (Table 19.1). One can remember the nine BPD diagnostic criteria using the acronym IMPULSIVE (**I**mpulsivity, **M**ad anger/hostility, **P**sychotic symptoms, **U**nstable relationships, **L**abile affectivity, **S**uicidal behaviors, **I**dentity disturbance, **V**ulnerability to abandonment, and **E**mptiness).

As summarized in Table 19.1, specific medications may benefit specific diagnostic criteria of BPD without necessarily improving the overall severity of the condition. The first five diagnostic criterion behaviors appear to respond to several medication options. The sixth diagnostic criterion, suicidal behaviors, has very limited data supporting pharmacological benefit. The last three criterion behaviors have been shown to be unresponsive to pharmacological treatment studied thus far.

Moreover, some atypical antipsychotic drugs (Stoffers et al., 2010) and some anticonvulsant mood stabilizers (Stoffers et al., 2010) appear to be effective in treating multiple criterion behaviors of BPD. Antidepressants are noticeably ineffective (Stoffers et al., 2010). Other medications have been studied and reported to be ineffective, including carbamazepine, fluoxetine, mianserin, phenelzine, risperidone, thiothixene, and ziprasidone (Stoffers et al., 2010). The most treatable diagnostic criterion of BPD appears to be anger; this behavior responded to all medications listed in Table

19.1, except antidepressants (Stoffers et al., 2010; Black et al., 2014). Suicidal ideation (SI) was improved in one RCT using omega-3 fatty acids (Stoffers et al., 2010), which is a very safe treatment option. Olanzapine has been reported to have mixed effects on suicidal behaviors; one study reported improved outcomes (Zanarini et al., 2011) while others reported increased SI (Stoffers et al., 2010). Only two medications have been shown to improve the overall severity of BPD: quetiapine and olanzapine (Black et al., 2014; Zanarini et al., 2011). Both of these studies reported that benefits from quetiapine and olanzapine were reduced after 10–12 weeks of pharmacotherapy. A non-pharmacological form of brain stimulation, repetitive transcranial magnetic stimulation (rTMS) of the dorsolateral prefrontal cortex, was shown to be effective in ameliorating two BPD targets: labile affect and anger/hostility (Cailhol et al., 2014). The positive effects of rTMS for BPD targets was confirmed by another randomized RCT that did not include a placebo (sham coil) control (Reyes Lopez et al., 2017).

In clinical practice, lamotrigine is often recommended as a treatment for affective instability in patients meeting criteria for BPD. Two small RCTs reported that lamotrigine (50–225 mg/day) improved affective lability, anger/hostility, and impulsivity in BPD patients (Reich, Zanarini, & Bieri, 2009; Stoffers et al., 2010). However, a larger and more recent 12-month RCT showed no significant differences between placebo versus a higher dose of lamotrigine (400 mg/day) (Crawford et al., 2018). The same study reported a very low adherence rate (less than 45%) with assigned drug or placebo medications (Crawford et al., 2018). Taken together, the three lamotrigine studies serve as a cautionary example regarding pharmacotherapy research in BPD. Although early studies with lamotrigine looked promising, the more definitive study (using a higher medication dose, a larger number of patients, and a longer treatment duration) failed to show significant benefit. Additionally, patient adherence to medication may impact treatment efficacy during long-term pharmacotherapy.

### *Medication Summary*

Evidence-based recommendations for pharmacotherapy of Stage 1 DBT patients are currently based on short-term RCTs with small patient populations. In lieu of robust research findings, we offer the following treatment recommendations:

1. Select the behavioral target that will most improve the patient's function and use Table 19.1 to choose between efficacious medication options.
2. Aripiprazole, quetiapine, and olanzapine have been shown to improve multiple criterion behaviors for BPD within the first 2–10 weeks of treatment. The ongoing efficacy of these atypical antipsychotic drugs should be reevaluated after 12 weeks of pharmacotherapy.
3. Topiramate and valproate effectively treat some BPD targets, while lamotrigine appears to be ineffective.
4. Antidepressants are not effective in treating BPD and should be used only if there is a strong indication for this class of medications (i.e., major depression disorder, panic disorder).
5. Avoid using benzodiazepine and potentially addictive medications.
6. rTMS appears to be a promising non-pharmacological treatment for BPD.
7. Omega-3 fatty acids may improve SI among patients with BPD.

**TABLE 19.1. Efficacy of Pharmacotherapy on Behavioral Targets for BPD**

| Drug Efficacy Expressed as Number Needed to Treat (NNT) | | Low-Risk Treatments | | Atypical Antipsychotics | | | Mood Stabilizers | | Antidepressants | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Transcranial Magnetic Stimulation | Omega-3 Fatty Acids | Aripiprazole (Abilify) | Quetiapine (Seroquel) | Olanzapine (Zyprexa) | Topiramate (Topamax) | Valproate (Depakote) | Paroxetine (Paxil) | Amitriptyline (Elavil) |
| 1. Daily Dose Range Studied in Randomized Double-Blind Placebo-Controlled Trials (RCTs) and Used to Calculate NNT | | 10 sess. 10 HZ RDLPC | 1.2 g EPA 0.9 g DHA | 15 mg | 150–300 mg | 2.5–20 mg | 200–250 mg | 500–3000 mg | 40 mg | 100–175 mg |
| Medication Possibly Effective Based on RCTs (NNT) | 2. BPD Overall Severity | | | | **3** | **6** | | | | |
| | 3. **I**mpulsivity | | | **2** | | | **8** | | | |
| | 4. **M**ad: Anger and Hostility | **2** | **5** | **4** | **2** | **9** | **8** | **39** | | |
| | 5. **P**sychotic Symptoms | | | **3** | **5** | **13** | | | | |
| | 6. **U**nstable Relationships | | | **7** | **4** | | **4** | **3** | | |
| | 7. **L**abile Affectivity | | | | | | | | | |
| | a. Affective Instability | **2** | | | **4** | **8** | | | | |
| | b. Anxiety | | | **4** | **2** | | **6** | | | |
| | c. Depression | | **2** | **5** | **3** | | **68** | **5** | | **5** |
| Efficacy Uncertain | 8. **S**uicidality | | | | | | | | | |
| | a. Suicidal Ideation | | **3** | | | **↓14**[a] **↑9** | | | | |
| | b. Nonsuicidal Self-Injury | | | **6**[b] | | | | | | |
| | c. Suicidal Behavior | | | | | | | | **9**[c] | |
| Medication Ineffective | 9. **I**dentity Disturbance | | | | | | | | | |
| | 10. **V**ulnerable to Abandonment | | | | | | | | | |
| | 11. **E**mptiness | | | | | | | | | |
| 12. Number of RCTs Reviewed to Calculate NNT | | **1** | **1** | **1** | **1** | **4** | **3** | **2** | **1** | **1** |

*Note.* Row 1 presents the dose range of each medication studied in RCTs on pharmacotherapy of BPD. Rows 2–11: Efficacy data for specific BPD behavioral targets are expressed as Number Needed to Treat (NNT), defined as the number of patients needed to receive the medication so that one patient experiences significant improvement in the specified target compared to placebo (Andrade, 2017). RCT published data were transformed from standardized mean difference (SMD) to NNT using the method of Hasselblad and Hedges (1995). Row 12 presents the number of placebo controlled RCTs contributing to the NNT data.

[a]In one RCT (Zanarini et al., 2011) olanzapine decreased suicidal ideation (NNT = 14). In a meta-analysis combining two RCTs (Stoffers et al., 2010) olanzapine increased suicidal ideation (NNH = 9).

[b]Nonsignificant effect size ($p$ = 0.2096) according to meta-analysis (Stoffers et al., 2010); however, an 18-month unblinded continuation study appears significant (Nickel, Lowe, & Gil, 2007).

[c]Data from Cluster B personality disorder subjects (Verkes et al., 1998).

**TABLE 19.2. Risk of Pharmacotherapy for BPD: Overdose Risk and Adverse Side Effects Risk**

| Overdose Risk Expressed as Morbidity Index and Unsafe Supply: Adverse Side Effects Risk Expressed as Number Needed to Harm (NNH) | | Low-Risk Treatments | | Atypical Antipsychotics | | | Mood Stabilizers | | Anti-depressants | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Transcranial Magnetic Stimulation | Omega-3 Fatty Acids | Aripiprazole (Abilify) | Quetiapine (Seroquel) | Olanzapine (Zyprexa) | Topiramate (Topamax) | Valproate (Depakote) | Paroxetine (Paxil) | Amitriptyline (Elavil) |
| Overdose Risk | 1. Morbidity Index: Serious Medical Consequences per 100 Overdose (OD) Exposures | **n/a** | **n/a** | **9** | **24** | **24** | **13** | **13** | **7** | **35** |
| | 2. Unsafe Supply: Number of Days of Medication Supply Associated with Serious Consequences Following OD | **n/a** | **n/a** | **15** | **5** | **5** | **9** | **9** | **19** | **4** |
| | 3. Daily Dose Range Studied in RCTs and Used to Calculate Unsafe Supply | 10 sess. 10 HZ RDLPC | 1.2 g EPA 0.9 g DHA | 15 mg | 150–300 mg | 2.5–20 mg | 200–250 mg | 500–3000 mg | 40 mg | 100–175 mg |
| Adverse Side Effects Risk (NNH) | 4. Adverse Side Effects Most Likely to Cause Treatment Discontinuation Expressed as Number Needed to Harm (NNH)[a] | **18** Headache | **16** Mild Gastric Disturbance | **22** Weight Gain > 7% Total Body Weight | **14** Weight Gain > 7% Total Body Weight | **5** Weight Gain > 7% Total Body Weight | **13** Cognitive Problems | **17** Weight Gain > 7% Total Body Weight | **11** Sexual Dysfunction | **6** Sedation or Dry Mouth |

*Note.* Row 1 shows the Morbidity Index expressed as the risk of serious medical consequences (including death) per 100 single-drug OD exposures. (Nelson & Spyker, 2017; Wills, 2014). Row 2 estimates the Unsafe Supply, e.g. the number of days of medication supply that could lead to serious medical consequences if used for a single-drug overdose. The estimate is calculated using the maximum daily dose shown in Row 3 and published lethal dose information (Henry, 1997; Nelson & Spyker, 2017; Wills, 2014). Row 3 presents the dose range of each medication studied in RCTs on pharmacotherapy for BPD and used to calculate Unsafe Supply. Row 4 presents the Number Needed to Harm (NNH)[a] for the adverse side effect most likely to cause discontinuation of that medication. NNH is defined as the number of patients needed to receive the medication so that one patient experiences the specified adverse side effect compared to placebo.

[a]NNH data were used from published calculations of large meta-analysis to get more accurate medication risk: rTMS (George et al., 2010); omega-3 FA (Stoffers et al., 2010); aripiprazole, quetiapine and olanzapine (Musil, Obermeier, Russ & Hamerle, 2015); topiramate (Kramer et al., 2011); valproate (Bowden, et al., 2006); paroxetine (Jakobsen et al., 2017); and amitriptyline (Saarto & Wiffen, 2007).

## Information for DBT Therapists

### *Primary Therapist and Prescriber: Definition of Roles in DBT*

In her DBT treatment manual (1993), Marsha M. Linehan advocated assigning individual psychotherapy and pharmacotherapy to different providers instead of using a DBT-trained prescriber to conduct both aspects of the treatment. Because DBT is a complex treatment designed to treat complex patients, reviewing medication issues *and* behavioral targets during individual therapy sessions may overcomplicate sessions and/or shortchange necessary treatment components. Therefore, the goal of enhancing patient capabilities is best served with a split-care model that includes both a DBT therapist and a separate medication prescriber.

The job of the DBT primary therapist is to be in charge of the overall DBT treatment plan, and the job of the prescriber is to be in charge of the medication plan, in collaboration with the patient. DBT therapists design behavioral interventions to target problematic behaviors that interfere with a life worth living. On the

other hand, prescribers target dysfunctional behavior using pharmacotherapy. In this relationship, tensions may emerge from these competing theoretical beliefs as to how problematic behavior is developed and is maintained, and in the strictest sense, the individual DBT therapist prioritizes behavior therapy over pharmacotherapy. Therefore, the patient's individual DBT therapist is assigned responsibility for the overall treatment plan. Pharmacotherapy is viewed as an ancillary treatment (Linehan, 1993) provided by an expert adjunct provider. Nonetheless, Linehan (1993) insists that medical decisions be made by individuals with a medical degree, rather than the individual therapist. These two roles can work in conjunction in effective treatment; for instance, while the primary DBT therapist is orchestrating the overall treatment plan, the prescriber can manage potential treatment-interfering behaviors (TIBs) involving medication that may develop during the course of DBT (e.g., medication noncompliance). In addition, individual therapists and prescribers may have distinct, but nonoverlapping knowledge sets, and when patients require coaching about their medications, these calls should be fielded by their prescriber. Taken together, we highly recommend that prescribers attend the consultation meetings of the DBT treatment team to collaboratively advance care.

While these job descriptions seem fairly straightforward, tensions do arise. For example, providers occasionally step outside their assigned role with the patient. In the following example, a prescriber feels the urge to step outside her role of prescriber to "fix" a behavioral problem. A prescriber is seeing a patient in DBT who endorses depressed mood and insomnia with both targets leading to elevated SI. The prescriber reviews the patient's diary card and learns that the patient is drinking caffeine in the evenings and cannot remember his sleep hygiene routine. The prescriber may feel a strong urge to fix the problem by assigning another sleep hygiene plan. While educating the patient about the general benefits of using a sleep hygiene plan and teaching them about sleep hygiene falls within the task assigned to the prescriber, in this context, she would be stepping out of her role as medical expert and into the role of DBT therapist. Indeed, when the prescriber designs a behavioral intervention, it can cause confusion for the patient and is considered a TIB by the prescriber. Patients may be left with competing instructions and behavioral tasks, which may inhibit treatment goals. While the prescriber may be tempted to intervene, to assess what is interfering and solve the problem, her focus should remain on highlighting its importance and assessing whether the patient has discussed this with his therapist, then working with the patient to figure out his game plan to bring up the issue with his therapist so it can be addressed. The next time the prescriber sees the patient, she should follow up with him to make sure he raised the issue with his therapist and his poor sleep is getting addressed. In the event that the prescriber assigned a competing sleep hygiene plan, the individual therapist could communicate directly to the prescriber with the patient present or coach the patient to communicate to his prescriber. True to DBT, when provider TIBs occur, solutions are generated collaboratively with the team and patient in a non-judgmental manner.

## Consultation to the Patient and Provider Collaboration during DBT

As we alluded toward the end of the aforementioned example, patients are active participants in treatment decisions and communication between professionals.

In the ideal scenario, a DBT therapist coaches their patient to discuss medication issues directly with their prescriber, rather than the therapist fielding the call on the patient's behalf. This principle functions to empower patients to direct their own care and become advocates for themselves (Linehan, 1993). That being said, at the beginning of treatment, the patient may not possess the requisite skills to transmit accurate information to another provider. In this instance, the DBT therapist would role-play and shape the patient's behavior to enhance the patient's communication skills, while also ensuring that essential information is accurately reported to the prescriber. Initially, the DBT therapist may reach out directly to the prescriber while the patient is in the room, which would simultaneously model skillful communication as well as keep the patient in the therapy loop. Subsequently, the patient will take on more responsibility for communicating with the prescriber using interpersonal effectiveness skills such as DEAR MAN GIVE FAST. For example, the patient might role-play telephoning the prescriber, using the DBT therapist for feedback and encouragement. Eventually, the DBT therapist simply asks the patient to compose the message, specify a communication plan, and later confirm completion of the task. Although, if the information is medically important or urgent, the DBT therapist requests a brief summary of the information shared with the prescriber or uses one of the shaping strategies listed above.

Occasionally, when the patient is unavailable or unable, it is necessary for the therapist to implement an environmental intervention by speaking directly with the prescriber. Environmental interventions can be very powerful if implemented effectively but should only be conducted in certain instances such as high-stakes outcomes (e.g., acute withdrawal symptoms) and/or interactions with powerful or bureaucratic agencies (e.g., obtaining Medicaid approval for hospitalization or getting a patient out of the hospital) (Linehan, 1993). In our experience, providers are more likely to request private consultation with the DBT therapist when they perceive that the client is at risk.

The following case vignette illustrates some of the challenges that can occur when balancing consultation-to-the-patient strategies with environmental interventions. A DBT therapist is working with a patient with chronic SI, but with no plan or intent. The patient consults a new non-DBT prescriber for medication monitoring. The prescriber learns that the patient has SI and calls the DBT therapist, leaving a message with an urgent request for the DBT therapist to conduct a risk assessment and to send the results to the prescriber within 24 hours. The prescriber, believing that the therapist is more equipped to conduct the risk assessment, plans to use it to make a decision about arranging hospitalization. Rather than immediately calling the prescriber to perform an environmental intervention, the DBT therapist calls the patient and learns that the frequency and intensity of her SI have not changed. The therapist and the patient agree that hospitalization would likely cause significant environmental and financial disruption. Furthermore, the patient does not feel confident in her ability to reassure the prescriber, so patient and therapist agree to have the therapist call the prescriber directly. Together, the DBT patient and therapist plan what information to communicate to the prescriber. Additionally, the DBT therapist suggests coping ahead for future interactions with the prescriber by coaching the patient how to orient the prescriber to the principle of consultation to the patient, the methods used in the patient's therapy to monitor and assess suicide risk, the patient's safety plan, the access to phone coaching, and the skills the patient is using

to decrease her risk of self-harm. Preparing the patient to orient the prescriber at the first medication visit can usually prevent this type of crisis scenario. Although private communication may eventually occur between the two providers, the DBT therapist first makes an effort to assess (rather than assume) and to engage the patient in planning the conversation with the prescriber. In this case, the prescriber agreed that adequate information had been provided and emergency services were not required.

### *Coaching Effective Medical Consumer Behaviors*

Because sessions with the prescriber are often short, it is particularly important for DBT patients to behave skillfully as medical consumers. An effective medical consumer is capable of asking specific questions, expressing concerns, and contacting the prescriber in appropriate ways. If the patient does not already possess these skills, the DBT therapist teaches "medical consumer behaviors" prior to the medication visit, using modeling, rehearsal, and role-play.

For example, before starting pharmacotherapy, the DBT therapist might help the patient to identify what benefits they want from medication and to express their wishes to the prescriber. When considering a medication change, patients should ask the prescriber to discuss the relevant benefits and risks of the proposed change. Additionally, patients should be encouraged to evaluate their response to medication by completing the 4-way pros and cons exercise (Linehan, 2015). Figure 19.1 provides a

1. What are the possible benefits of taking this medication?
2. What are the possible risks of taking this medication?
3. What is the likelihood of experiencing a benefit or an adverse side effect?
4. How long will it take for the benefit to become apparent?
5. How long should I take the medication before concluding it is not helpful?
6. What can I do to make it more likely this medication will work?
7. What factors might interfere with a good medication result?
8. What other alternatives exist to this medication plan?
9. What should I do if I miss my medication doses?
10. What would be the possible consequences of taking medication irregularly?
11. What would be the possible effects of stopping the medication abruptly?
12. Are there any side effects that are potentially dangerous?
13. What are the effects of taking too much of this medication?
14. How does the prescriber evaluate the medication response?
15. Why is a dose reduction/termination of this medication recommended?
16. What are the possible benefits of reducing/stopping this medication?
17. What changes might occur when I reduce the medication dose? When will those effects begin, and how long will those effects last?
18. How can I get in touch with the prescriber? After hours? In a crisis?
19. How does this medication plan contribute to my long-term goals?

**FIGURE 19.1.** Questions for patients to ask their prescribers. DBT therapists can also use these questions to assess the patient's understanding of the pharmacotherapy plan when changes in medication occur.

list of questions that DBT therapists can review and rehearse with the patient prior to their next appointment with the prescriber.

### *DBT Therapist Enhancement of Pharmacotherapy*

In addition to shaping the patient's medical consumer behaviors, the DBT therapist supports and extends the pharmacotherapy by monitoring medication adherence during weekly therapy sessions. These extending functions can make a big difference when DBT clients are interacting ineffectively with their prescriber or engaging in nonadherent behaviors that affect medication treatment response. The DBT therapist and the patient start by identifying how the prescriber typically monitors medication adherence, side effects, and clinical response. The DBT therapist may extend or supplement these routines by tracking medication adherence, side effects, and/or responses on the patient's diary card. The goal here is to have the DBT therapist and the prescriber collaborate on data gathering that will be used to assess the efficacy of the pharmacotherapy. The DBT therapist supplements patient education and data collection activities, thereby enhancing treatment decisions made by the prescriber during pharmacotherapy. Figure 19.2 offers a list of medication-monitoring routines that can be considered by the DBT therapist, the prescriber, and the patient.

#### *Discussing Medication Nonadherence*

Like patients with less severe problems, patients with severe emotion dysregulation are likely to engage in medication nonadherence, which can include taking more or less medication than prescribed, sharing medications with other people, and engaging in recreational substance use. Studies show that among patients with BPD, 70% are nonadherent with medication (Crawford et al., 2018), 87% misuse their medication, and 47% engage in substance abuse (Dimeff, McDavid, & Linehan, 1999). Patients frequently report adjusting their daily medication dose according to their mood; for

1. Obtain history of prior medication overdoses or prior noncompliance.
2. Ask for a commitment to take medication as prescribed.
3. Ask for a commitment to refrain from overdosing on medication.
4. Ask about stockpiling medications or accessing locked medications.
5. Be aware of a prescriber restricting patient access to medications.
6. Monitor daily medication compliance on the diary card.
7. Conduct behavioral analysis on instances of noncompliance or misuse.
8. Design interventions to target medication noncompliance or misuse.
9. Monitor response to medication using a diary card or rating scales.
10. Review response to medication with client; elicit client's point of view.
11. Monitor for adverse side effects; encourage client to report to prescriber.
12. Cheerlead and validate during medication tapers.
13. Perform pill counts to confirm medication record.
14. Perform urine drug screening for patients with substance use disorders.

**FIGURE 19.2.** DBT therapist activities to extend medication-monitoring services.

example, a patient may skip her medication if she "feels good," while doubling her dose on a "bad day." Other patients acknowledge their daily routines are not well established and the timing of medication doses will vary, depending on when they wake up, go to bed, or visit a friend. Additional reasons for medication nonadherence can include patient myths about medications: objections to ingesting "chemicals," worries about being stigmatized, fears of being controlled, or experiencing a change in their personality. The consequences of medication nonadherence range from trivial to potentially life-threatening (Jimmy & Jose, 2011).

When patients have trouble remembering to take their medications, it may be useful to tie the dose-taking behavior to another well-established routine, such as eating a meal or brushing one's teeth. Patients who have highly variable routines will need to plan a time of day for taking medications and then set an alarm as a reminder. Detailed planning about when and how to take medication is akin to rehearsing new behaviors and allows the DBT therapist to troubleshoot the patient's plan for establishing routines.

Lack of information about the medication plan may also contribute to patient nonadherence. Although informed consent discussions with patients are time-consuming, orientation is an important step in engaging the patient in their DBT treatment, including the pharmacotherapy. Patients who know *why* a medication is being prescribed, *when* to expect the onset of benefits, and *how* to respond to adverse side effects will make wiser choices with regard to medication adherence (Jimmy & Jose, 2011). DBT therapists can enhance this orientation process by asking "beginner's mind" questions that invite the patient to "teach" their medication knowledge to the therapist (see Figure 19.1). The overarching purpose of these discussions is to promote an accurate understanding of the medication plan that may, in turn, improve the patient's adherence.

Strategies to track medication adherence, misuse, and illicit substance abuse are easily incorporated into the DBT session. While medication adherence is already integrated into the DBT diary card, attending to and monitoring medications within DBT should not be overlooked. At the beginning of treatment, the DBT therapist should question the patient about every dose of medication (prescribed or not) that is ingested or omitted, as well as any changes that occur during treatment. In addition, the therapist should check the medication record every week, as part of the diary card review, looking for skipped doses or overuse of medications. Given the complexity of patients who enter DBT, it may be tempting to overlook medication adherence within sessions to focus on other targets; however, if the therapist ignores or overlooks medication adherence, this communicates to the patient that medication adherence is not important.

In some circumstances, it may be important for the DBT therapist to inquire about the use of birth control in women of child-bearing age. One study examining the efficacy of lamotrigine in the treatment of BPD reported that 5 out of 276 subjects became pregnant during the 12-month study, despite giving assurances that subjects were taking adequate precautions and did not intend to become pregnant (Crawford et al., 2018). The same authors note that valproate, another anticonvulsant mood stabilizer known to cause birth defects, is used off-label in 10% of patients diagnosed with BPD in the United Kingdom (Crawford et al., 2018). These data indicate that nonadherence to medical instruction extends beyond drug dosing and may include other important aspects of patient self-care. Both the prescriber and DBT therapist

need to directly and repeatedly inquire about birth control use during pharmacotherapy.

When an instance of medication misuse or substance abuse occurs, the DBT therapist targets the behavior using standard DBT protocols and coaches the patient to inform the prescriber of the nonadherence. Additionally, a record of daily medication adherence is not something that prescribers usually request from patients. There can be added benefit in having the prescriber also review the detailed medication record; sometimes prescribers can change the medication plan to improve patient adherence. Keeping a daily medication record and, if necessary, performing urine drug screens require ongoing effort from the DBT therapist. However, we believe that the potential benefits of the additional data are worth the time and energy required.

### *Cheerlead during Medication Tapers*

When a medication appears to be ineffective, it is appropriate to discontinue the medication altogether. Although patients may express appreciation after the fact, it can be alarming to contemplate giving up one or more medications of uncertain benefit that have been prescribed for years. A team approach is recommended that focuses on collaborative decision making between the patient, the DBT therapist, and the prescriber. This is particularly important when the function of a medication taper is to assess the drug's continued efficacy after long-term prescribing. Under these circumstances, there is a very real chance that reducing the medication will cause the patient to feel worse temporarily. However, the alternative is taking the medication indefinitely while not knowing if there is any ongoing benefit to doing so (e.g., "Are you thinking of taking this medication forever? What if it's not doing you any good?").

Ideally, the prescriber begins the taper by prescribing a small dose decrease for a single medication. The DBT therapist facilitates informed consent by having the patient ask orienting questions before the dose reduction begins (see Figure 19.1). The DBT therapist encourages the patient to keep daily records and to inform the prescriber of changes that the patient observes during the medication taper. As the taper progresses through several dose reductions, the DBT therapist provides soothing and validation, similar to the support provided during a behavioral extinction protocol. Research subjects who participated in the initial DBT trials took *no* medication during the 12-month study duration (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Using metaphors that emphasize the primary importance of mastering skills while temporarily leveraging the benefits of pharmacotherapy can loosen patient attachment to pills (e.g., "We only use a splint to support a sprained finger temporarily; the real healing occurs as a result of the physical therapy exercises that you do").

Even when following evidence-based recommendations, medication is rarely curative and may only partially alleviate the behavioral target (National Collaborating Centre for Mental Health [NCCMH], 2009). Patients are understandably disappointed when there is a partial response and often ask for a higher dose of the same medication, a change to a different medication, or the addition of a second medication. Over time, this process results in patients taking multiple medications at higher doses. We routinely see patients diagnosed with chronic mental health disorders that are taking 10 different psychotropic medications apparently without a satisfactory result. DBT therapists can help minimize this overprescribing by educating their DBT patients to have realistic expectations of pharmacotherapy and to understand

the limitations of evidence-based research. For example, the therapist can say to the patient, "Medication alone cannot give you a life worth living. Even the most successful medication protocols often leave residual complaints. Therefore, it is important to work on skills as well as taking medications as directed."

### *Medication Risk Management*

Not all overdose behaviors are intentional and not all are suicidal. Therefore, it is important for DBT therapists to ask patients (even nonsuicidal patients) about previous instances of medication misuse and overdose. Even if the patient has no intention of suicide or self-harm, medication overdoses may occur by accident, as an effort to communicate, or as a result of urges to escape or to feel better. When taking an overdose history, the DBT therapist should inquire about what outcome the patient wanted in an effort to identify the function of prior overdose behaviors.

Patients who are planning an overdose may stockpile medications, saving enough pills over time to acquire a potentially lethal dose. We recommend directly asking patients about medication stockpiling as well as including the question on their diary card. The daily medication record will also reveal stockpiling behavior, assuming the patient is truthful in their record keeping. Because the prescriber sees the patient less frequently, it is important for the DBT therapist to check the medication record every week. The accuracy of the medication record can be double-checked by performing pill counts. Note, however, that pill counts are more helpful in discovering overuse of medication and will not reveal stockpiling. When patients acknowledge stockpiling medications, they should be asked to properly dispose of the stockpile and provide confirmation to the DBT therapist that the disposal has been completed. We recommend that patients confirm proper disposal of medications by videotaping the disposal, bringing in a reliable witness to observe the disposal, or handing over the medication stash to the DBT therapist or prescriber for disposal.

When patient access to medication must be limited to a 1- or 2-day supply or when medication adherence needs to be directly observed, a third party (such as a partner or parent) steps in to help. Third parties can confirm that a medication has been taken each day and can store medication in a hidden or locked location. Alternatively, automatic dispensing devices can be purchased to keep the pill bottles locked up and to dispense only the daily dose. In our experience, determined patients may find a way to get around safe-keeping arrangements or lockboxes. Therefore, behavioral components of the medication plan need to include a strong commitment to taking medication as prescribed and positive contingencies for adhering to the plan. The DBT therapist should be aware of any restrictions that the prescriber has placed on the patient's medication supply and understand the reasons for that decision. Additionally, DBT therapists should routinely ask if the patient has discovered how to gain access to sequestered medications.

## Information for Prescribers

### *Use DBT Principles to Guide Pharmacotherapy*

Prescribing medication to Stage 1 DBT patients requires a solid foundation in psychopharmacology and familiarity with evidence-based medication treatment of BPD and

co-occurring mental health conditions. DBT treatment principles can then be adapted to guide medical decision making for prescribers who work with this complex and challenging patient population. Figure 19.3 presents a list of "DBT-friendly" pharmacotherapy guidelines adapted from the Moncton Group, New Brunswick, Canada (see Dimeff et al., 1999) for prescribers to consider when choosing between treatment options for Stage 1 DBT patients.

DBT has clear recommendations for prioritizing and structuring the medication visit (Witterholt & Manning, 2010). At every medication visit, the highest-priority task of the prescriber is to address any treatment-destroying behaviors that are present. Examples of treatment-destroying behaviors include imminent suicidal behaviors, florid psychosis, explosive anger, or forging prescriptions. The second-priority task is to treat behaviors that contribute to a mental health diagnosis using evidence-based pharmacotherapy. Medications are chosen, doses are adjusted, and side effects are managed with the goal of optimizing the patient's response to pharmacotherapy. When the first two priorities have been adequately addressed, the prescriber moves on to the third priority: enhancing the patient's ability to manage their own health care. Patient education and information about referrals or health resources are examples of third-priority tasks. The fourth-priority task is to target medication nonadherence. However, when a nonadherent behavior appears to be "on the path" to destroying therapy, the nonadherence is addressed as a first-priority rather than a fourth-priority task. For example, a patient who previously dropped out of DBT due to binge drinking now discloses that they stopped taking disulfiram. The nonadherence with disulfiram could result in treatment dropout, so the prescriber targets the medication nonadherence as a first-priority task.

### *Safe Supply*

It is essential to ensure patient safety by not giving suicidal patients access to a potentially lethal supply of medication. Reports estimate that 60–80% of patients with BPD have engaged in parasuicidal behaviors (Oldham, 2006). Nonsuicidal patients

**S**afe Supply: Do not give a lethal supply of medications to suicidal patients.
**A**dverse side effects: Reduce treatment failures by targeting adverse side effects.
**F**rugality: Avoid overprescribing in response to intense misery, crisis, or chronicity.
**E**fficacy: Use medications that have been shown to be effective for the chosen target.

**S**pectrum: Narrow-spectrum drugs are very specific in their actions, wide-spectrum drugs may allow the targeting of multiple behaviors.
**C**ritical target: Treat high-priority targets first.
**R**elief: Use one nonaddictive medication for insomnia or agitation during a crisis.
**I**nduction: Consider how long it will take to reach the onset of therapeutic action.
**P**atient preference: When medications appear to have equivalent efficacy, consider patient preference.
**T**endency to misuse or abuse: Prescribe medications that are less likely to be abused.

**FIGURE 19.3.** Prescribing guidelines according to DBT principles. These guidelines can be remembered using the mnemonic SAFE SCRIPT.

may also take more medication than prescribed, sometimes with serious medical consequences. When two or more medications are known to be effective for a behavioral target, choose the least lethal medication to prescribe. One must also pay attention to medications that may not be lethal when taken alone, but become potentially lethal when combined with other medications or recreational substances. For example, the risk of serious medical consequences following overdose on olanzapine nearly doubles when fluoxetine is combined with olanzapine (Nelson & Spyker, 2017).

When patients are actively suicidal or when the medication is potentially lethal, the prescriber limits the number of pills dispensed with each prescription. The prescriber also informs the DBT therapist of any restrictions placed on the patient's access to medication. To determine how many pills to dispense to a patient at any one time, the prescriber needs to know the minimum lethal dose for each medication being prescribed. The prescriber then makes a *conservative* estimate of how many pills should be dispensed and stipulates the dates for future refills.

Toxicity data for medications with demonstrated efficacy in treating BPD are presented in Table 19.2. The Morbidity Index presented in Row 1 indicates the number of serious medical consequences (including death) that occurred per 100 single-drug overdoses (Nelson & Spyker, 2017; Wills et al., 2014). The Unsafe Supply data presented in Row 2 shows the maximum days supply of medication that should be given to an at-risk patient, assuming the daily dose range specified in Row 3. This estimate was calculated by the authors using toxicology reports of the consequences of overdose with known amounts of medication (Henry, 1997; Nelson & Spyker, 2017; Wills et al., 2014). We caution all readers to use these data as an informal indicator of comparative medication overdose risk, rather than an authoritative assurance of safety.

When patients are at high risk for engaging in lethal behaviors, it can be tempting for the prescriber to increase the medications. Treating high-risk patients with multiple medications or frequently changing medication doses can give the illusion that the prescriber is "doing all they can" for the patient. For patients who meet criteria for BPD with or without co-occurring mental health disorders, we are hopeful that the standard of care among prescribers is moving toward a more targeted pharmacotherapy approach where "less is more." DBT therapists can contribute to this effort by informing the prescriber how DBT treatment actively targets self-harm thoughts and behaviors. Sharing the safety plan, the diary card targets, the phone coaching agreements, the therapist's willingness to "stick close to the patient," and any notable patient progress demonstrates that the DBT therapist actively engages in risk management and can provide functional validation to prescribers.

### *Adverse Side Effects*

Another important source of medication failure is adverse side effects. In our experience, DBT patients are likely to notice medication side effects and often react with alarm or distress. Adverse side effects that patients do not tolerate for any significant length of time include weight gain, sexual dysfunction, nausea, and agitation. When choosing a medication, discuss potential side effects with the patient to learn which adverse effects the patient is less likely to tolerate and prescribe accordingly. Aggressive treatment of side effects can make the difference between continuing with the medication plan and bailing out abruptly (which can precipitate a discontinuation syndrome).

### *Frugality (Few Drugs, Few Doses)*

Overprescribing is more likely to occur when patients suffer from refractory conditions that do not respond to standard medication interventions. Using multiple drugs, sometimes for the same indication, increases the patients' risk of impaired cognition, drug-to-drug interactions, and serious consequences of overdose (Kukreja, Kalra, Shah, & Shrivastava, 2013). Unintentional errors in taking medications are more likely to occur when the medication regimen is complex and multiple daily doses are required (Jimmy & Jose, 2011). It is therefore preferable to keep the dosing schedule simple, using once-daily or twice-daily dosing schedules. Choosing medications with longer metabolic half-lives and using extended-release formulations can also simplify the dosing schedule.

Another source of overprescribing is the partial medication response. If a medication is only partially effective, the prescriber may offer the following options to the patient: Stay at the same dose for a longer duration, increase the dose, add a second medication in combination with the first, or substitute a new medication for the partially effective first medication. Choosing between adding a second medication (combined pharmacotherapy) versus switching to a different medication (substitution pharmacotherapy) will depend on the behavioral target, the body of evidence for treatment of that target, and the urgency of the overall clinical picture. Other things being equal, it is preferable to substitute medications rather than combine medications in an effort to minimize the total number of medications prescribed to the patient.

### *Efficacy*

Once patient safety is addressed, the most important prescribing guideline is to choose medications that are likely to be effective in treating the behavioral target. Table 19.1 indicates those medications that have been shown to improve specific behavioral targets in patients with BPD (Rows 3–9).

There is currently no research that evaluates the pharmacotherapy of mental health conditions *co-occurring* with BPD. This is important because Stage 1 DBT patients often present with co-occurring mental health disorders that have their own evidence-based pharmacotherapy algorithms. For example, Zanarini and her colleagues (2004) reported that over 85% of patients meeting diagnostic criteria for BPD also met criteria for an affective disorder or anxiety disorder. The same study reported that remission of BPD was positively correlated with improvement in co-occurring disorders.

Diagnostic criteria for BPD overlap with other mental health conditions, making it difficult to determine if the presenting targets represent a manifestation of BPD or an independent co-occurring condition. In clinical practice, distinguishing a BPD diagnosis from other co-occurring conditions relies on close observation over time, as well as a detailed history of medication response. Despite such diagnostic complexities, the NCCMH guideline (2009) for pharmacotherapy of BPD recommends using evidence-based pharmacotherapy to treat co-occurring conditions, while focusing on psychosocial interventions to treat BPD. However, pharmacotherapy of conditions co-occurring with personality disorders may result in suboptimal responses (Levenson, Wallace, Fournier, Rucci, & Frank, 2012). Due to the refractory nature of mental

health conditions that co-occur with BPD, the prescriber needs to be thoroughly patient, and persistent in their efforts. Modest improvements in clinical targets may not seem like an optimal outcome, but they could be meaningful to the patient.

### Spectrum of Action

Choosing a medication with a narrow therapeutic spectrum allows the prescriber to treat the behavioral target with a minimum of unintended side effects. Other medications have beneficial effects at multiple targets and the prescriber can use such medications, when appropriate, to simplify the medication regimen. For example, omega-3 fatty acid appears to be an effective narrow-spectrum treatment for anger in BPD. However, if a patient diagnosed with BPD presents with anger, anxiety, insomnia, and psychotic symptoms, it would be preferable to prescribe quetiapine because the wider spectrum of action could treat multiple behavioral targets.

### Critical Target

If a patient presents with multiple behavioral targets, the prescriber will want to consider which target is critical to improving the patient's functioning. Certain behaviors may severely impair the patient's ability to participate in DBT, thereby hampering the treatment of the BPD. For example, a patient diagnosed with an opiate use disorder may have difficulty attending skills class or completing homework exercises. Prescribing buprenorphine would therefore be a high-priority intervention to enhance this patient's capacity to benefit from DBT.

### Relief of Suffering

Patients often ask for medications to relieve their insomnia or emotional distress. When clients need medication to help them sleep, we choose one medication from the following options: sedating antihistamines; sedating muscle relaxants (but not carisoprodol); sedating antidepressants, clonidine, gabapentin, or quetiapine. We avoid prescribing benzodiazepines. To ensure that patients do not stop using skills when medication is prescribed, patients are instructed to take the relief medication only after completing their list of appropriate skills.

Considerable pressure to prescribe more medication(s) may arise during crisis periods. Nevertheless, medication changes in response to a crisis should be minimized to avoid reinforcing crisis-generating behaviors. The NCCMH guideline (2009) recommends prescribing a single drug, temporarily during the crisis, when additional medication is needed for agitation or insomnia. Ideally, a non-addictive sedating antihistamine is prescribed for less than 1 week at the minimum effective dose. Further recommendations for crisis medication protocols include identifying a primary prescriber, obtaining consensus between all providers, and conducting a team assessment of the impact of medication changes on the long-term treatment plan. DBT therapists will appreciate the additional recommendation that medications not be used in place of appropriate psychosocial interventions (NCCMH, 2009).

Benzodiazepines and the related benzodiazepine agonists (BZBZA) such as zolpidem (Ambien) and eszoplicone (Lunesta) pose a special challenge in treating Stage 1 DBT patients. Patients often report immediate yet temporary relief from

emotional misery using these sedatives. However, there are compelling reasons to avoid prescribing BZBZAs to Stage 1 DBT patients. Benzodiazepines are known to be disinhibiting and can cause paradoxical reactions with increased emotional and behavioral dysregulation (Griffin, Kaye, Bueno, & Kaye, 2013). BZBZAs are preferentially used in overdoses, can be fatal when combined with other substances, and cause drug dependence with rebound anxiety during withdrawal (Griffin et al., 2013). Perhaps most importantly, BZBZAs impair short-term memory and reduce the brain's ability to learn from new experiences (Longo & Johnson, 2000). Therefore, a patient taking a therapeutic benzodiazepine dose is practicing skills or exposure treatments with an impaired capacity for new learning. For all of these reasons, we recommend that Stage 1 DBT clients do not receive BZBZAs as part of their outpatient medication plan.

### *Induction and Onset of Benefit*

Some medications exert their beneficial effects immediately, while other medications require weeks of daily administration to develop a maximal beneficial response. Some medications must be started at a low dose and gradually increased to reach the therapeutic threshold. For example, lamotrigine requires a slow induction to minimize the risk of potentially life-threatening skin rash. The prescriber needs to consider both the urgency of the clinical situation and the need for a lengthy induction period when choosing between medication options.

### *Patient Preference*

Patient preferences may be honored when the patient's choice does not steer them away from a more clinically sound option. For example, evidence suggests that all antidepressants are equally effective in the treatment of major depressive disorder (Cleare, Pariante, & Young, 2015). Therefore, patient preference can be considered a valid reason to choose one antidepressant medication over another. Patients may have a more positive response to treatment when assigned to their preferred treatment option (Winter & Barber, 2013).

### *Tendency for Misuse or Abuse*

Certain medications are more likely to be misused by patients. In our experience, patients tend to overuse medications that exert their effects immediately, hoping for either a stimulating or a sedating effect. We therefore avoid prescribing benzodiazepines or stimulants to Stage I DBT patients. Patients are more likely to skip doses of medications that have side effects they don't like (e.g., sexual dysfunction) or do not have a daily observable benefit (e.g., mood stabilizers).

## Summary and Conclusions

The following biological treatments offer evidence of improving specific BPD behavioral targets: aripiprazole, olanzapine, quetiapine, topiramate, valproate, omega-3 fatty acids, and rTMS. Antidepressants and lamotrigine appear to be largely

ineffective. Certain BPD behavioral targets such as anger, psychotic symptoms, and labile affectivity are most responsive to medication. There are still unanswered questions about the role of pharmacotherapy in the treatment of individuals diagnosed with BPD. In particular, the efficacy of combining pharmacotherapy and behavior therapy for the treatment of emotional and behavioral dyscontrol in Stage 1 DBT patients needs to be elucidated. At the present time, pharmacotherapy should be implemented on a case-by-case basis, with careful and repeated evaluations of each medication's efficacy on specific behavioral targets.

It is important to understand that ongoing clinical care of the Stage 1 DBT patient is just as important to the pharmacotherapy outcome as the choice of medication. Prescribers need to collaborate with the DBT therapist, understand the overall DBT treatment plan, remain vigilant to self-harm and nonadherence issues, and assess medication efficacy using subjective and objective data. When a medication seems to be ineffective after an adequate clinical trial, it is best to discontinue that medication to avoid overprescribing. If the prescriber is considering changing medication in response to a clinical crisis, the decision should be discussed with the entire team of providers. Finally, providers should expect diminished medication responses when treating mental health conditions that co-occur with BPD. That being said, the persistent efforts of the prescriber may contribute to incremental improvements in the overall functioning of the Stage 1 DBT patient.

In contrast to other psychotherapy treatments, DBT calls for the primary therapist to actively engage with both patient and prescriber around medication issues. The DBT therapist provides coaching to improve the patient's interpersonal skillfulness with the prescriber. Additionally, the DBT therapist offers to perform medication-monitoring activities in more depth and detail than the prescriber usually provides alone. The prescriber may not have the time or expertise to design behavioral interventions to target patient nonadherence or treatment-interfering behaviors with medication. It therefore falls to the DBT therapist to identify, analyze, problem-solve, and monitor problematic behaviors that involve pharmacotherapy. Finally, when the DBT therapist actively collaborates with the prescriber, each provider receives the benefit of sharing their expertise as well as the emotional burden of working with difficult-to-treat patients.

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*Note.* *f* or *t* following a page number indicates a figure or a table.

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