Chapter 2: Navigating to a Case Formulation and Treatment Plan

Chapter 1 overviewed DBT's biosocial theory and core strategies, and described how DBT as a comprehensive package structures the treatment environment. This chapter turns to the concepts used to structure the therapist's clinical decision making, illustrating how DBT uses theory driven case formulation for treatment planning. A case formulation is a set of hypotheses about the causes of a person's difficulties that helps you to translate general treatment protocols into an individualized treatment plan. DBT's if-then guidelines are intended to help you think in a disciplined yet flexible manner.

Before we jump in, however, I want to emphasis how *active* DBT case conceptualization and treatment planning must be. Terms like "formulation" and "treatment plan" tend to imply static documents, like maps. Good maps can help you navigate a lot of terrain. For example, you can use Barlow's unified theory (cite) to generate a formulation and treatment plan whether the client fears and avoids spiders, social rejection or his own disturbing thoughts or bodily sensations. Good basic models help you navigate across multiple problems. You still may need a few pointers from a colleague as to how to best tailor assessment and exposure exercises for a particular client. But navigating to a conceptualization and treatment plan in these circumstances is like finding an on ramp on a sunny day with your map and a friendly point in the right direction, you're on your way in no time.

In contrast, finding your way to a formulation and treatment plan becomes exponentially more complicated when a person has multiple, chronic serious problems. You're often in uncharted territory where neither the research literature nor local colleagues can offer confident direction. Further, the usual ways you evaluate whether therapy is on the right track don't work because your interventions are experienced as intensely invalidating and evoke extreme emotional dysregulation. Making sense of what is going on and what is needed is much

like traveling in a blizzard with white-out conditions, you may sense forward motion but often cannot get your bearings to be sure that it is meaningful progress.

Therefore in DBT, navigating your way to a formulation and treatment plan is *active*. *Orienteering* is the best metaphor for formulating DBT cases and planning treatment, because it conveys the level of activity required to find your way from point A to point B. You need the ability to read your client to locate where you are as well as use and extrapolate from relevant science and treatments that offer direction. But you also must continually check your bearings to revise your route yet stay the course. We'll use three sets of concepts to help us navigate:

1. target hierarchies to prioritize assessment and treatment based on the severity of clients' problems.
2. biosocial theory to understand the core problem of pervasive emotion dysregulation. We'll assume that: a) biological vulnerability and social invalidation are contributing factors to emotion dysregulation; and b) primary and secondary target behaviors are likely consequences of emotion dysregulation (e.g., dissociation) or function as the client's solutions to the problem of emotion dysregulation (provide temporary relief from aversive states).
3. behavioral theories of change to identify controlling variables and strengthen more adaptive alternative responses. We'll identify and treat the specific skills deficits and problematic conditioned emotional responses, contingencies or cognitive factors associated with primary and secondary targets.

We will use these concepts dialectically. In DBT, the purpose of case formulation and treatment planning is not to reach some ultimate 'correct' understanding but instead to constructively face the tension of opposing formulations, so that rather than choose one at the expense of the other, the tension is used to create a third more complete model from what is

valid in each position. For example, say a client struggles with social phobia. Catching a bus to participate in skills training group is very difficult (although she does get to church via bus some Sundays). Should the treatment plan be based on accepting her vulnerability and therefore remove the requirement of group attendance or should it block avoidance by insisting on attendance to help her make needed change? In formulating this dilemma in DBT, you would take the position that attending group is overwhelmingly difficult *and* attending group is required. Dialectical assessment and treatment planning would hold both positions simultaneously so that solutions incorporate what is valid from each. For example, the initial treatment plan might be based on accepting that the client's current capabilities preclude regularly riding the bus to group and simultaneously move for change by offering in vivo skills coaching each week on the bus to group. Similarly, change is at times so slow and the client's distress so unremitting that you can't be sure if you are persisting with an ineffective treatment plan or whether in fact the therapy is going as well as it could given the circumstances and you should stay the course. In DBT the idea is that rather than prematurely take one position (therapy isn't working; therapy is working) you instead hold both positions in mind at once, searching for what is valid in each with the stance that truth evolves, seemingly contradictory elements can be synthesized and something is bound to be left out of any current understanding.

Practically, it works best if you use these concepts in three steps. First, you assess to determine the appropriate stage of treatment based on the extent to which the client's behavior is disordered. In particular you are looking for instances of pretreatment and stage 1 target behaviors. Second, you look for the variables that control these pre-treatment and stage 1 primary targets; look especially for patterns across targets and over time. Finally use task

analysis to generate mini-treatment plans for changing the key variables that drive primary targets.

Let's now go step-by-step to show how to generate an initial formulation, and then proceed to how to use the formulation to guide each clinical interaction.

STEP 1. ASSESS USING STAGES AND TARGETS

Your first move toward a formulation and treatment plan is to gather sufficient history to determine the appropriate stage of treatment. This crucial step determines whether comprehensive treatment will be needed to adequately help the client. Even upon first contact, let your standard intake assessment questions be guided by the framework described in Chapter 1: you will stage treatment to match the extent to which the client's behavior is disordered. Table 2.1 shows examples of potential intake questions organized according to target hierarchy. When you ask, for example, "What has brought you to therapy now?" you listen with the target hierarchy in the back of your mind. At an appropriate moment, you might ask explicitly for information about each target area (e.g., "Have things gotten so bad you've been thinking a lot about death or even about killing yourself?" "How have things gone for you in past therapy?").

If the client's responses seem to fit one of the stages of treatment (e.g., stage 1, "yes, I tried to kill myself and ended up in intensive care" or "things blew up with my last therapist" or pre-treatment, "I've had a lot of therapy and nothing seems to change, I don't have much hope for therapy but don't know what else to do"), then use the corresponding target hierarchy to guide further assessment of each target area. For example, if the person sounds ambivalent about changing a particular behavior or about therapy itself, use pre-treatment targets to guide questions. If the person has thought a lot about death or they would be better off dead, or if past attempts at therapy have had mixed results, begin to use stage 1 targets to generate

questions about a more comprehensive list of problems. What difficulties (if any) have they had with intentional self-injury and other life-threatening behavior? How have past therapies gone and what's gotten in the way of getting the help they've needed from therapists and others in their lives? When clients have had histories of failed therapies, be sure to assess what functions of comprehensive treatment might have been missing or problematic (e.g., was there enough attention to increasing skills and generalization, sufficient 1-to-1 work on motivation, did the therapist receive adequate support)? What significant quality of life problems does the person struggle with? Assess each. Finally, what skills does the person need but lack? DBT skills training is geared toward common deficits in mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness. Listen for evidence that skills deficits in one or more of these areas play an important role in the client's problems.

Now consider two individuals, Samantha and Jonelle, as if they were new referrals to your practice. Use the information provided to begin to assess the appropriate stage of treatment and the assessment questions you would have during an intake or initial session.

Samantha

Samantha is a 24 year old who was referred to your DBT program from the state psychiatric hospital. She cuts and burns her arms and legs, and has overdosed on pain killers with ambivalent intent to die ("if it happens, it happens; it's like Russian roulette"). She takes opiates for chronic back pain (at 21 she was hit head on by a drunk driver, and suffered severe injuries. Her passenger died in the accident). She has struggled with bulimia and cutting since she was 16. But after the accident, her intent to die and suicidal behavior became worse and eating disorder more medically serious. She binges and purges and most recently purged to the extent that she induced heart problems that prompted admission to her nearby rural medical hospital. When medically stabilized, she transferred to the state hospital. You hear from the

person referring her that Samantha and the state hospital staff moved mountains to arrange for Samantha to live with an aunt in order to be able to work with you.

Think now in terms of stage of treatment to organize what you know so far and generate assessment questions.

Pretreatment: *Can you reach agreement on therapy goals and methods? What barriers (if any) are there to sufficient commitment to treatment?*

The effort by the client, her family and the state hospital staff to arrange the first appointment indicates some degree of commitment already. Now the highest priority for initial sessions will be to assess the client's goals, including: her desire to stop suicidal behavior and other intentional self-injury; to stop disordered eating and her willingness to learn alternative methods to manage intense emotions. (The final example in this chapter illustrates this type of pre-treatment conversation about therapy goals.)

Stage 1: *Is there risk from life-threatening behavior?*

Thorough assessment is definitely needed here. A DBT therapist wants details about five types of behavior (in descending order of priority): suicide crisis behaviors; non-suicidal self-injurious behavior; suicidal ideation and communications; suicide-related expectancies and beliefs; and suicide-related affect. Either before treatment or early in treatment, gather details regarding intentional self-injury for the past year, including exactly what was done, the intent of the action, and whether medical attention was required. This history is essential to assess suicide risk accurately, to begin to identify situations that evoke suicide ideation and intentional self-injury, and to manage suicidal crises. In particular, identify the conditions associated with: (a) near-lethal suicide attempts, (b) other acts of self-injury with high intent to die, and (c) other medically serious self-injurious behavior. The information we have about Samantha definitely indicates that further assessment here is needed.

Stage 1: Is there any history of therapy-interfering behavior?

The second target area of stage 1, treatment-interfering behaviors, includes behavior of either the client or the therapist that negatively affects the therapeutic relationship or that compromises the effectiveness of treatment, as described in chapter 1. Information about these targets should be obtained from prior treatment history and prior supervision history. We don't have much information yet about Samantha's history here so we will want to gather that. The consultation team helps the therapist anticipate his or her own therapy-interfering behavior in the new therapy relationship. If Samantha were a new client in your practice, what therapy-interfering behavior might you be likely to bring to the therapy? What are your usual foibles (e.g., running late, having narrow limits) and what might be specifically evoked by Samantha's problems (e.g., not being up-to-date on assessment and treatment of PTSD or pain; biases you have because you are a parent of children about Samantha's age)?

Stage 1: *Are there behaviors that seriously impair the client's quality-of-life*?

The quickest way to assess the third target area, quality of life, would be a diagnostic evaluation and thorough psychosocial history to understand the range of problems Samantha experiences. Assess how problems like mood and anxiety disorders, substance abuse, eating disorders, psychotic and dissociative phenomena, an inability to maintain stable housing, and inattention to medical problems, and so on may impair a client's quality of life, influence intentional self-injury and also interfere with therapy. So far, we know that we want to assess with Samantha disordered eating, chronic pain and use of narcotics, her use of the hospital, and the stability of her living situation.

Because she survived a car accident when others did not and because her problems worsened after the accident, we want to be sure to assess PTSD. Treatment of PTSD is typically deferred until Stage 2, when a client has sufficient emotion regulation and behavioral control to

manage the increased emotion evoked. However, in Samantha's case we want to determine whether there is a functional relationship between the accident and her current difficulties. Might some of her current Stage 1 behaviors function to avoid or regulate emotions or memories to do with the accident? If remembering the accident continues to affect her and is linked to intentional self-injury, these factors might become stage 1 priority targets. However, if exposure based procedures were indicated, assessment and caution are needed to ensure that the client does not use stage 1 behaviors to cope with the increased experience of emotion (Harned & Linehan, 200x). If you found that Samantha's behavior became more unstable or urges to intentionally self-injure became more difficult to control when you talked about the accident, then it would indicate that Stage 1 targets should be addressed before those of stage 2. The infrequency of stage 1 behaviors as well as the speed of re-regulation (rather than the presence of any one instance of behavior) would determine whether Samantha is ready for directly targeting posttraumatic stress responses. Samantha and her therapist should likely test the waters by talking about some aspect of the trauma that is of low distress to see if Samantha can safely tolerate exposure.

Jonelle

Now consider Jonelle who found your name on the internet. She is a 28-year-old legal secretary. When you first speak with her on the phone you learn that her 4-year-old son has been kicked out of his second day care center due to conduct and attention problems. She and her son are living with Jonelle's mother, who endlessly criticizes Jonelle's parenting. Jonelle says she feels paranoid and humiliated by her mother talking with all the neighbors about her 'crazy' daughter. Arguments with her mother and her mother's boyfriend have gotten so loud that neighbors have called the police. In the last argument, Jonelle became intensely angry, locked herself in the bathroom, and punched her legs until she calmed down. At that time, Jonelle said

she seriously considered suicide and even poured her mother's heart medication and sleeping pills into her hand. But the realization of how it would impact her son made her stop. She said the one good thing that came out of it was the clarity that suicide would never again be an option for her.

When you offer her a late afternoon appointment time she balks because she is concerned about taking time off from a new demanding job; the cost of therapy is also hard because she is paying back student loans. Your policy of charging for sessions when there is not 24-hour notice of cancellation also doesn't work for her given how frequently she has to deal with her son's misbehavior. She saw on the internet that DBT has a group therapy component and the idea of going to group therapy turns her off. When you acknowledge how difficult things are for her she says, 'yes, what I really need is to get married. That would get me out of this house, money to pay my loans and somebody who could control my son."

Let's use the target hierarchy again to organize what we know of Jonelle's struggles.

Pretreatment: *Can you reach agreement on therapy goals and methods? What barriers (if any) are there to sufficient commitment to treatment?*

Jonelle is understandably ambivalent about spending time and money on therapy given her finances, new-hire status and responsibilities as a parent. You would definitely want to assess and address the reservations Jonelle has as well as clarify her therapy goals. DBT may be one possible treatment recommendation for Jonelle based on the data we have so far (e.g., her report of one instance of a suicide crisis and intentional self-injury, seemingly precipitated by invalidation and difficulty with emotion regulation, but we don't yet know that this is a pattern for her). Further assessment may show that an equally valid treatment option would be time-limited therapy focused on moving out of her mother's house or focused on parenting training for she and her mother to help negotiate conflicts about her difficult-to-raise son—only further

assessment will show whether the Stage 1 targets are in fact relevant for Jonelle and thereby determine if comprehensive treatment will be needed.

Stage 1: *Is there risk from life-threatening behavior?*

Assess the categories of non-suicidal self-injury and suicidal behavior as described above (suicide crisis behaviors; non-suicidal self-injurious behavior; suicidal ideation and communications; suicide-related expectancies and beliefs; and suicide-related affect). In particularly you would like to understand how determined she feels that she would never attempt suicide again. You would also want to assess the potential for physical aggression toward her mother and perhaps her son. Again, if this was an isolated crisis, you might include elements of DBT in a treatment plan rather than offer the comprehensive model. However, if there are several instances of suicide crises or intentional self-injury comprehensive DBT may be an option for her to consider.

Stage 1: *Is there any history of therapy-interfering behavior?*

There is great likelihood of therapy interfering behavior—Jonelle's circumstances already indicate this will be an important area to discuss with her. As a parent of a young son with behavior problems, she may need the option to cancel at the last minute. As a recent grad repaying student loads, she may need a sliding scale fee. She is lukewarm about group skills training and here again the therapist will need to understand and work out with Jonelle how to solve the barriers if they decide this is a crucial element of the treatment plan. The therapist will need to be clear how Jonelle's needs for flexibility fit his own limits so that they come to mutually agreeable solutions prior to beginning therapy.

Stage 1: *Are there behaviors that seriously impair the client's quality-of-life*?

Gathering a good diagnostic interview and psychosocial history with details about each of the primary target areas will be needed to determine whether Jonelle's difficulties are the

result of a more discrete situational conflict or a pervasive pattern. The mantra is to "Assess, not assume."

As shown with these examples from Jonelle and Samantha, target hierarchies guide you from the first moments of contact, to determine the focus of treatment and how comprehensive treatment may need to be.

STEP 2: LOOK FOR PATTERNS OF CONTROLLING VARIABLES FOR EACH PRIMARY TARGET

When you identify that a particular target area is relevant for a client, select specific instances of that target behavior and use chain analysis to identify the controlling variables. Behavioral assessment (cf. Haynes & O'Brien, 2000) puts a premium on identifying controlling variables (i.e., the conditions that give rise to and maintain problem behaviors and improvements). The assumption is that each individual's problematic behavior is likely to be controlled by a unique pattern of variables, and these variables may differ from one set of circumstances to another. For example, the factors that lead one individual to attempt suicide are different from those of another individual. Even for the same individual, what led to one attempt might be different from a later attempt. Therefore, to understand a specific disordered or problematic behavior, DBT relies on a particularly fine-grained method of functional analysis called chain analysis.

Behavioral Chain Analysis

A behavioral chain analysis is a way to identify controlling variables through an in-depth analysis of events and contextual factors before and after a particular instance (or set of instances) of the targeted behavior. You and the client develop an accurate and reasonable complete account of behavioral and environmental events leading up to and following the problem behavior. The focus is very pragmatic: what would be needed for the sequence of

events to go differently so that the problematic behavior did not occur and instead the client could have a more desired outcome?

Begin the chain analysis by clearly defining the *problem behavior* and picking one instance to analyze. For example, a specific instance of problem behavior might be that a client burst into tears when a supervisor criticized her work yesterday. Next, the therapist and client identify two important types of controlling variables. *Vulnerability factors* are the context in which precipitating events have more influence, e.g., physical illness, sleep deprivation, or other conditions that influence emotional reactivity. *Precipitating events* are the immediate events that began the chain that led to the problem behavior. In our example, the supervisor's criticism might typically be a relative non-event that sets off mild irritation. However, when the same criticism occurs in the context of two vulnerability factors, being sleep deprived and on a tight deadline, criticism becomes a prompting event for bursting into tears. Vulnerability factors set the context for precipitating events to have more power.

Therapist and client then identify each *link* between the precipitating event and the problematic behavior to yield a detailed account of each thought, feeling, and action that moved the client from point A to point B. Close attention is paid to reciprocal interactions between environmental events and the client's emotional, cognitive, and overt responses. Finally, therapist and client identify the *consequences* associated with the problem behavior, those immediate and delayed reactions of the client and others that followed the problem behavior. (See figure 2.1 for a graphical representation of a chain analysis.)

This detailed assessment allows the therapist to identify each juncture where an alternative client response might have led toward a different outcome, away from problem behavior and toward the ultimate change the client wants. When the client's responses are dysfunctional (the responses interfere with achieving the client's long-term goals), the therapist

assesses what alternative behavior would have been more functional and why that more skillful alternative did not happen.

For example, figure 2.2 shows a detailed diagram of the chain analysis of Jonelle's most recent intentional self-injury and suicide crisis behavior. It was mid-morning and Jonelle's son was home sick from daycare causing her to miss work at a new job. Her son was already complaining of being bored and was rummaging around in Jonelle's bedroom closet. As Jonelle turned to ask him to find something else to do, she felt her mother come and pause at the bedroom door behind her to watch the interaction. Jonelle said this put her on 'edge.' She said her actual first reaction had been to say, "5 more minutes and then you need to play somewhere else" but with her mother at the door she instead said in a tense voice, "Come out, I don't need you playing in my closet."

As she waited for him to comply, Jonelle said she imagined hearing her mother say, "You have to be firm with him Jonelle." She had a flood of emotions: irritation and fear as she anticipated her mother's criticism; shame that she 'can't get him to mind'; hurt that her mother, of all people, was not more understanding of how hard it is to parent the boy; and a pit in her stomach of dread and feeling trapped. Her son ignored her request. Without thinking she harshly yelled, "I said GET OUT of there!' Her mother then walked to the closet and said in a gentle voice to the boy, "Come on, honey, let's get you out of your mother's hair." This comment felt extremely critical to Jonelle, her mother's indirect way of saying Jonelle is over-reacting and that she needs to protect the son from Jonelle. It felt as if her mother had said to her son, "your mother's crazy, be quiet and tiptoe around her so you don't set her off."

Jonelle felt furious and viewed her mother as undermining her authority. Jonelle then snapped at her mother, they began arguing, and the son ran from the room crying. Jonelle's mother then said, "Look what you did! You are scaring that boy out of his mind!' Jonelle said at

this point she saw red and had an intense urge to grab her mother by the throat to strangle her. Instead, she screamed in frustration and punched her fist through the flimsy bedroom door.

As she felt herself getting more and more out of control, she stumbled past her mother into the bathroom and locked herself in. She sat on the toilet seat and repeatedly pounded her fists into her thighs "to punish" herself and get herself to "calm down." Jonelle said she was sobbing hysterically at the beginning but had calmed down after about 5 minutes of hitting herself. Then her mother came to the bathroom door and said, "I am going to call child protective services and find out how to get custody and take my grandson away from you." Jonelle said when her mother said this, she suddenly felt very calm. She said it wasn't really words, but just this sense that she could end it and her mother would look after her son. She said through the door, "I know you love my son. You do what you need to do. I just need some time to think now, OK? Just give me some peace." She emptied her mother's heart medication and sleep medication onto the bathroom counter, got a glass of water, and then turned on the shower so her mother would not interrupt her. She said she got scared and also had thoughts about her son and what her suicide might do to his life. Then with great clarity, she realized she could never do that to him. She took a shower until the water ran cold. Afterwards she went to the kitchen and her mother said "either you get help or you get out of here and I am going to take custody of this boy."

Using the Target Hierarchy, Biosocial Theory and Behavioral Theories of Change

Let's again apply the three sets of concepts to this example: target hierarchies, biosocial theory and behavioral theories of change. First, the target hierarchy would guide our thinking. The priority would be to assess and treat the factors leading to suicidal behavior (gathering her mother's medications in preparation for an overdose) and then next to understand the potential for violence toward her mother and self-injurious behavior (punching her legs). Second, social invalidation does seem to have contributed to emotional dysregulation and primary target

behaviors may part of the overwhelming emotional state or may function to end overwhelming emotional states. Jonelle describes both. At times she feels so out of control that she will lash out at anything (out of control behavior is part of extremely dysregulated emotion). At other times, she deliberately hits herself in order to feel calmer when she does that (dysfunctional behavior works to regulate emotion). As will be seen below, understanding the events that led to the incident in more depth, invalidation from her mother was the key precipitant that tipped her over the edge.

Third, behavioral theories of change suggest that dysfunctional responses come from one of four factors: skills deficits, problematic conditioned emotional reactions, contingencies, or cognitive processes. As with primary flavors of sweet, salty, sour, and bitter or with primary colors, the blends are infinite. Again, as you assess the chain that leads to and follows target behaviors you assess whether any of the following factors are controlling variables.

Skills Deficits

First, assess whether the client has the necessary skills in his or her repertoire. Can the client (a) regulate emotions; (b) tolerate distress; (c) respond skillfully to interpersonal conflict; (d) observe, describe, and participate without judging, with awareness, and focusing on effectiveness; and (e) manage their own behavior with strategies other than self-punishment? When clients lack a needed skill, skills training is appropriate. For example, one hypothesis is that Jonelle lacks assertiveness skills—for example, she is not able to ask her mother to stop hovering at the door. The therapist assesses this across situations and across time. It turns out that Jonelle typically avoids conflict with her mother, acquiescing, feeling resentful and then eventually blowing up. The same pattern holds with past lovers. At work, however, while she avoids conflict she has always avoided blow-ups. Across situations, she seldom observes her limits or asks for what she wants—skills deficits may in fact be contributing here. Another

hypothesis is that Jonelle lacks skills to soothe physiology, tolerate distress and down regulate emotion. In the initial interview, Jonelle described being a sensitive child and said that as a teenager she used to get high all the time to be able to tolerate her mother. Now, clean and sober, her mother is constantly on her nerves, and she feels like she's so irritable and jumpy that she can't stand to be in her own skin. Here, too, skills deficits may be a key variable: if Jonelle had reliable and diverse ways to tolerate and manage emotional arousal, it might offer an important way off the chain toward the primary target behaviors.

You can assess whether the person has the relevant skills in several ways. You might ask the client for details about how a problem or interaction has been handled in the past under varying circumstances. You could observe the client's behavior directly. You can ask hypothetically how the client would ideally handle a situation or problem or what advice they would give a friend. Or you can ask the client to try new behaviors during session and in role-plays. In our example, the therapist assessed Jonelle's parenting skills, both through gathering history as well as directly overhearing Jonelle parent her son during coaching calls. The therapist learned that Jonelle and her son experienced very little conflict on weekends when Jonelle's mother was away visiting relatives. Jonelle had effective parenting skills even with a very spirited child~~.~~ ~~I~~ the problem seemed to be accessing the skills in the face of anticipated or actual criticism from her mother. The skill she lacked was the ability to regulate her emotion when criticized. Jonelle also could not effectively assert herself with her domineering mother.

When assessment reveals that the client *can* perform skillfully, then the therapist assesses which of the three other factors interfered with using or choosing more skillful behavior.

Conditioned Emotional Responses

Sometimes conditioned emotional responses block more skillful responding. Effective behaviors may be inhibited or disorganized by shame, guilt, unwarranted fears, or other intense or out-of-control emotions. The person may be "emotion-phobic." She or he may have patterns of avoidance or escape behaviors. If this is the case, then some version of exposure-based treatment is indicated. This is a key hypothesis for Jonelle. As the therapist became more detailed in the chain analysis, it turned out that shame was the primary emotion. When her mother was at the door and then again when her mother said, "let's get you out of your mother's hair", shame flooded Jonelle. Anger was the secondary response. Consequently, principles of exposure therapy will offer an important pathway to change her emotional reactions so they are more regulated, enabling her to access her skillful parenting.

Problematic Contingencies

Skilled performance may be absent because circumstances reinforce dysfunctional behavior or fail to reinforce more functional behavior. Effective behaviors may be followed by neutral or punishing outcomes, or rewarding outcomes may be delayed. For example, Jonelle's effective parenting is often immediately followed by her mother's comment, "See that wasn't so hard! Why can't you do it that way all the time?" Over time, this aversive consequence has decreased the probability of Jonelle's effective parenting when her mother is around. Problem behavior may lead to positive or preferred outcomes, or give the opportunity for preferred behaviors or emotional states. For example, intentional self-injury often generates desirable consequences (e.g., sleep, release of endorphins, a sense of control) (CITE Nockxxxx). When self-harm functions to communicate distress and then is followed by increased responsiveness of others in the environment, the likelihood of future self-injury may increase. Said differently, non-suicidal self-injury may be maintained by positive reinforcement. However, intentional self-injury often also is maintained by negative reinforcement. It ends aversive states, such as

negative emotions or the tension as one struggles against urges to cut. Jonelle experienced great calm and relief after she punched herself and also when she fantasized about taking an overdose. The same individual may have both types of contingencies controlling intentional self-injury. When Jonelle first began to hit herself as a child, her teachers were solicitous (positive reinforcement) and her mother would stop her verbal attacks (negative reinforcement). If problematic contingencies maintain the target behavior, then use contingency management interventions.

Problematic Cognitive Processes or Content

The fourth possibility is that effective behaviors are inhibited by patterns of problematic thinking, or specific faulty beliefs and assumptions. If problems are identified here, then cognitive modification strategies are appropriate. It's tempting to assume that Jonelle is over-reacting because she misinterprets or distorts her mother's comment ("she's calling me crazy in front of my son") and to consider cognitive modification to decrease anger (e.g., to find alternative interpretations such as that her mother's intent was helpful, even if unwelcome). Rather than assume, the therapist assessed this further and in fact found that Jonelle's mother is extremely verbally abusive~~.~~ ~~I~~f anything Jonelle minimized rather than exaggerated the invalidation. Instead of cognitive restructuring to modify misinterpretations and help Jonelle be less angry, the hypothesis instead here is that Jonelle needs help believing she has the right to appropriately assert her needs even when others are displeased and critical.

Such detailed chain analysis shows the client and therapist junctures where an alternative client response might have led toward a different outcome, toward the ultimate change the client wants and away from problem behavior. When the client's responses are dysfunctional (the responses interfere with achieving the client's long-term goals), the therapist assesses what alternative behavior would have been more functional and why that more skillful

alternative did not happen. In figure 2.3, the "Xs" mark dysfunctional response links that Jonelle and her therapist identified as most important. The three top areas where they will work to find replacement behaviors are: 1) no matter how extreme her mother's invalidation, Jonelle will not resort to suicidal behavior or intentional self-injury. 2) Jonelle wanted to handle the conflict with her mother in a way that did not upset her son. 3) Although almost beyond Jonelle's ability to imagine, Jonelle would like to be able to effectively stand up to her mother, especially regarding her parenting.

As you gather history and preliminary behavioral chain analyses, look for patterns especially by grouping behavior into classes that function in the same way. For example, try using these concepts as we look for patterns across three chain analyses of primary targets for Samantha that were gathered in the first two sessions of therapy. You'll notice that there's much less detail than in the example with Jonelle—that's because Samantha had a crisis between session one and two. Managing the crisis left little time for gathering history. Many clients like Samantha begin therapy amidst chaos and crisis management that disrupts thorough assessment. Nonetheless, by looking for patterns across chain analyses of primary targets you can generate preliminary hypotheses about key controlling variables that keeps therapy focused even amidst crises and sketchy information. Look now at analyses of three target behaviors for Samantha: the most recent suicide crisis behavior that prompted her last psychiatric hospital admission; a sequence of therapy-interfering behaviors by client and therapist during and after the first session; an argument Samantha had with her aunt (that threatens housing and therefore threatens therapy if she moves away). We'll apply the concepts discussed thus far to look for patterns across target behaviors.

Guided by the target hierarchy, Samantha's therapist prioritized getting history of suicide attempts and other life-threatening behaviors in the first session. Figure 2.4 shows the chain

analysis of the last psychiatric hospitalization precipitated by medically serious purging and an overdose on pain medications with ambivalent intent to die. The client was living with her parents when she was contacted by a friend, a Marine about to come home on leave from Iraq. Her purging and restricting became more frequent as she wanted "to look good for him." They talked for hours when he got home. He understood completely how bad it feels to have a friend die and be responsible. His dark humor expressed empathy without ever having to "talk about it", like a soothing drug. When he left to return to active duty, she was bereft and obsessed that he would be killed. She continued restricting, purging and stopped taking pain medication because "it makes me gain weight." She stayed in her room, crying and sleeping and listening to trance music. Her parents were used to her holing up in her room to work on art projects and thought nothing of this. A few days later, in the middle of the night, "things got weird, like they do sometimes." She carved his name in her thigh, fell asleep, then woke, disgusted with herself and with exacerbated back pain from the hunched position she held for hours while cutting. She took pain medication, then took more, and then more, while thinking, "F- - - it. Nothing matters." She doesn't remember much after that but said she was found by her parents, and then was taken to a nearby hospital where she ended up in the Intensive Care Unit before she was medically stabilized enough for the psychiatric floor.

In the first session, the therapist asked Samantha a little about the car accident. Samantha spoke in a poised, strong yet vulnerable, insightful manner that conveyed to the therapist that Samantha was coping remarkably well. The therapist and Samantha made a good plan about how Samantha would manage the predictable increase in feelings that might be evoked by talking with the therapist about the accident. Unbeknownst to the therapist, Samantha was extremely dysregulated by the conversation. She left the session so cognitively

disorganized that she was almost hit by a car in the parking lot. That night, she went out with friends drinking to the point that she blacked out.

She then slept in all day Saturday and Sunday. Finally her aunt became so concerned that she rousted her and insisted she "get out of the house and get some fresh air or call your cousin and run out to the community college to see what classes are available." The aunt continued with many problem-solving ideas; Samantha remained pleasant and non-committal, finally leaving the house acting cheered up for her aunt's benefit. She went to the corner bar and started calling old friends, planning to move. She left the therapist an apologetic message explaining things weren't working out living with her aunt so she'd be moving away and must cancel the next session. (The therapist luckily retrieved her message and reached Samantha before she'd burned any bridges, convincing her to keep their scheduled session the next day.)

What commonalities stand out to you across these different chain analyses? Again, let's begin with the running hypothesis from the biosocial theory (1) that disordered behavior may be a consequence of emotion dysregulation or an effort to re-regulate emotion and (2) that invalidation may play a role in maintenance of current difficulties regulating emotion. Do you see secondary targets (i.e., emotion vulnerability and self-invalidation; active passivity and apparent competence; inhibited grieving and unrelenting crisis (described in depth pp. Chap. 1)? Finally, what skills deficits, conditioned emotional reactions, contingencies, and cognitive processes or content contribute to Samantha's target behaviors? Figure 2.4 shows the therapist's first pass at identifying each of these common links across target behaviors.

Samantha has many secondary targets. She seldom looks distressed and has a persona of incredible strength. For example, her friends and family were completely taken off guard by her suicide attempt, and find it inexplicable that she can't get it together to finish her degree. The therapist will want to explicitly orient Samantha to the pattern of apparent competence

because it may result in the therapist underestimating distress and suicide risk. Further, Samantha is caught in a Bermuda triangle of inhibited grieving, unrelenting crises and emotional vulnerability. Everything reminds her of the car accident, shame and grief become overwhelming, and she impulsively engages in problem behaviors to avoid strong feelings. Even the brief rendition of the car accident that she gave her therapist at intake felt so overwhelming that it precipitated a crisis. Samantha's secondary targets appear to play a large role in primary targets of suicide crisis and therapy-interfering behavior.

In our example with Samantha, the most urgent skills deficits appear to be difficulty tolerating distress without doing something impulsive that actually makes the situation worse. It's not clear yet what contingencies are maintaining Samantha's highest risk behaviors, but her intentional self-injury appears to be maintained by negative reinforcement. It temporarily ends aversive states, such as negative emotions. It does not appear to be maintained by positive reinforcement (i.e., Samantha hides evidence of self-harm and it does not function to communicate distress to others). Samantha definitely experiences problematic conditioned emotional reactions and emotional dysregulation. The skillful, effective behaviors she does have are often inhibited and disorganized by shame, guilt, unwarranted fears, or other intense or out-of-control emotions. It's not clear yet what cognitive processes or content pose the most problem, but "It doesn't matter," seems to be a recurrent hopeless thought that for Samantha precedes a complete passive stance toward living or dying. Samantha's response after discussing the trauma with the therapist provides evidence that Stage 2 exposure work should be postponed until she's stabilized intentional self-injury, disordered eating and acquired strong emotion regulation skills.

The detailed assessment of chain analysis shows junctures where an alternative client response might have led toward a different outcome, toward the ultimate change the client

wants and away from problem behavior. When the client's responses are dysfunctional (the responses interfere with achieving the client's long-term goals), the therapist assesses what alternative behavior would have been more functional and why that more skillful alternative did not happen. In figure 2.5, you see the simplified pattern the therapist showed to Samantha in their third session to check whether this accurately captured the key elements of what happens. Although the therapist, at times, takes the lead to highlight, observe and describe recurrent patterns and comment on implications of behavior, the spirit is one of intentionally fostering that same stance in the client.

As you move through these steps with different target areas and specific problematic behaviors, it is easy to get lost in detail, so focus (and refocus) on what helps you navigate. Go, again and again, for the essence of the problem—a one-liner, a label, a metaphor—a phrase that captures the heart of the problem formulation.

Try to hold a theme or pattern lightly so that you are adequately open to influence by new evidence yet hold it tightly enough that it can guide you. Strive for "a constantly questioning attitude, a thinking process that incessantly reviews the original hypothesis as it bumps up against the real world. That's what keeps the hypothesis from turning in to a bias that distorts the evidence. It's what leads to original insights and guides the search through a bewildering array of possibly related facts to find what truly matters (Jack Hart (cite) p.21)"

Use the concepts in DBT case formulation like orienteering tools. If one doesn't work, pick up another until the picture of controlling variables resolves into clarity (or at least enough clarity to take the next step).

STEP 3: USE TASK ANALYSIS TO GENERATE MINI-TREATMENT PLANS FOR KEY COMMON LINKS

Finally, find your way out of the specific problems the client faces and toward the client's goals through task analysis. A task-analysis describes the step-by-step behavioral sequence required to get from the client's current capability and circumstance to the desired behavior or outcome[1]. You and the client may conduct a spontaneous task analysis in the flow of conversation or may do it in a more deliberate way. The question you ask is "what would be a more effective response in this circumstance?" Identify replacement behaviors for each target behavior and the most usual dysfunctional links and figure out *exactly* what the client must do to engage in the replacement behavior. Then pull together treatment strategies to create "mini" treatment plans to help the client move from old behaviors to new ones at key junctures and to replace common links.

Draw ideas from three pools. First, consider replacing dysfunctional links with DBT skills. Second, look to the research literature on treatment and normal psychology for replacement behaviors. Finally, consider personal experience. In similar situations, how exactly did you or others you know solve a similar problem? The key with task analysis is to be sure that the replacement behavior you select actually works for the client's circumstance. For example, when highly dysregulated, it is nearly impossible to do skills that require complicated thinking. The step-by-step task analysis should in that circumstance begin with emotion regulation before a skill that requires you to already be regulated such as an interpersonal effectiveness skill. Finding situation specific solutions can be an incredible challenge. For example, how do *you*, in the midst of extreme emotional arousal but inadequate interpersonal support, inhibit ineffective action urges and instead do what is effective for that moment? This aspect of task analysis is a spatial task, almost as if someone called you on the phone to ask for directions but unsure where he is or how his location relates to where he wants to go. If you know an area

[1] My thinking has been deeply influenced by Les Greenberg's work. See Task Analysis and Greenberg & Pinsof (1986).

well, you'd describe the landmarks to get his confirmation that he's where you think he is, and then describe exactly how to proceed. Step-by-step, what exactly how does when get from here to there? At times a client cannot or will not articulate what is happening, which requires the therapist to have a highly refined ability to locate the client. For example, Samantha's therapist rapidly learned to read highly subtle cues that indicated Samantha was more dysregulated than was apparent and then routinely moved to activities such as a balance board and holding ice to help Samantha reregulate emotionally before she left the session.

The therapist and Jonelle did a task analysis of exactly how Jonelle would prefer to handle moments where her mother hovers, ready to criticize Jonelle's parenting. They began by imagining an outcome and set of interactions that Jonelle would feel proud of. She wished she could say to her mother: "Please leave; I don't want your help parenting right now. He minds just fine when we have the space to do it our way." Then Jonelle and the therapist went step-by-step to determine how Jonelle could get from where she is to the responses she'd prefer. Jonelle would need the ability to recognize when she needs to assert herself (their assessment showed Jonelle did not have this ability, so self-monitoring was used). She needed to have the interpersonal skills to obtain her objective, while maintaining the relationship and her self-respect. (Jonelle knew how to act to avoid conflict, but not how to get her objective and keep self-respect.) As the therapist and Jonelle role-played various ways Jonelle might observe her limit with her mother, it became apparent that Jonelle believed she had forfeited any rights to speak up and felt great shame about her failings as a mother. Even in the role-play with the therapist, when shame fired, she become completely dysregulated and capitulated to the therapist as she played the role of her mother making an unreasonable request. Therefore another important step of the task is to help Jonelle regulate shame and to do whatever cognitive restructuring is needed to actually believe she has the right to assert herself. She'll also

need the ability regulate anger as her mother verbally attacks and criticizes her. Jonelle had skills at work, but did not use these skills in intimate relationships. As she and her therapist further assessed Jonelle's skills, it became clear that hurt fired followed quickly by anger and judgmental thoughts: Jonelle thinks, "She shouldn't be like that! Of all people, she should understand and support me!" Therefore, another piece of the task is to help Jonelle radically accept that, for many reasons, her mother often is critical and unsupportive. The therapist's mini treatment plan based on the task analysis of how Jonelle will get from where she is to where she wants to be must include skills training, imaginal exposure, and cognitive modification.

Acting skillfully is no simple proposition. For example, many of us have the ability to patiently redirect a child until he stops misbehaving. However, having one's own critical parents or in-laws observe our child disobeying our instructions is an entirely more difficult situation. We may have the component abilities needed such as knowing what to say to our child, being able to regulate our frustration and embarrassment, being able to accurately read whether the other adult is judging us, etc. But the skillful response is putting it all together under pressure: in front of someone we think is judging us, we either assertively block the other adult from undermining us or let in help because we are too frustrated to be effective with the child. By analogy, in the privacy of weekday morning at a nearby basketball court, I can shoot a net-swishing free throw. But that is different from being able to execute it in a game and different still from being able to do it in the last seconds of a championship game. DBT treatment plans therefore emphasize not only skills training but skills strengthening and generalization to progressively more difficult situations like those faced in daily life. Not just practice, but practice in all relevant contexts. Behavioral rehearsal is essential and emphasized in all DBT treatment plans.

From these situation-specific solutions of task analysis, you come to see the recurring obstacles that interfere with replacing dysfunctional behavior. In other words, across situations, clients experience recurring problems when they try to adopt more functional behavior. Here, again, return to the four sets of assessment questions from behavior therapy. (1) What are the skills deficits? (2) what emotional reactions interfere with more skillful responses? (3) which contingencies are problematic? (4) what cognitions or cognitive processes interfere with more skillful responses? For example, with Samantha the task analysis across problems highlighted how often apparent competence interfered with getting the help she needed. The immediate therapy task was to help Samantha tolerate distress without making things worse. But Samantha became so dysregulated that in fact her brain simply wouldn't function—she needed more help. Yet she was ashamed to ask for help; afraid of devastating disappointment if the therapist was unavailable when she needed her; and extremely scared to open up and then be left alone with overwhelming feelings. But you'd never know this from looking at her. Outwardly, even while expressing distress her poise and apparent competence constantly led others to the assumption no help was needed. Consequently, the therapist and she began to implement contingency management strategies along with behavioral rehearsal: Samantha was to call every day at a pre-specified time for two weeks to practice, whether she needed help or not. Her task was to accurately express (as best she could) what her current emotions were. The therapist, alerted to the helpfulness of Samantha's Marine friend's banter, kept the calls light but deeply empathic as she coached use of distress tolerance skills.

These mini-plans to treat specific problems and mechanisms add up to make the full treatment plan. You use the navigation tools of chain analysis and task analysis to see what paths lead to important target behaviors, what needs to change and what might get in the way of change. And perhaps most importantly, you learn what is common across time and across

problem areas, which allows you to focus on changing those processes that will affect multiple targets.

In subsequent sessions, you use a similar process of clinical reasoning to locate where you and the client are at any given moment. For example, once you can see recurrent patterns, then you more quickly locate yourself on the chain of events and more quickly see where to work. It is as if you, the therapist, were a quality-control inspector examining lengths of chain for problems with individual links. As you hear about your client's life and observe what happens in-session, you pick up those lengths of the behavior chain that end with intentional self-injury, therapy-interfering behavior, or behavior interfering with the client's quality of life.

Usually there is no shortage of problematic behavior and the struggle is to choose where to intervene and how to sustain intervention in the face of slow change and extreme distress. Choosing well means to "pick up the correct length of chain" that leads to primary treatment targets (intentional self-injury, therapy-interfering behavior, and behavior interfering with the client's quality of life) and to work on change wherever the client happens to be on that chain. In the metaphor of inspecting lengths of chain for problematic links, our quality-control inspector faces an urgent task. He or she is to inspect chain that will be used as a rescue rope...in fact the chain is already in use! For example, when a client is at imminent risk for suicide, the links that most need inspection and correction are those associated with immediate danger. In essence the inspector goes over the edge, tool kit in hand, and fixes each link within reach during the therapy hour, preferably in a manner that teaches the client to fix links for the rest of the week between sessions. When the client is further from the edge, then the therapist can "inspect and repair" those links that occur earlier in the chain. Visually diagramming these pathways can be very helpful for both clients and therapists (see figure 2.6). Together client and therapist identify how to move away from problematic responses and toward adaptive

responses, prioritizing (1) how to avoid at all costs engaging in life-threatening behavior, (2) catching the patterns early when the client is still more regulated and capable, and (3) common links that cut across problems.

Throughout the process of formulating and treatment planning, continually summarize, paraphrase, and check things out with the client. Be transparent, collaborative, and psychoeducational (as much as is useful to the particular client) as you refine, verify, or discard hypotheses. Repeat this process to look for the controlling variables for each important problem behavior.

DIALECTICS AND DIALECTICAL ASSESSMENT

Finally, use a dialectical stance as you formulate problems and plan treatment. The key idea here is: truth evolves. The individual therapist does not find his way by reasoning from an immutable set of facts. But neither is clinical reasoning a relativistic process where anything goes. Instead, taking a dialectical stance means that you enter a series of dialogues, with the client and others important to your work together, including the scientific evidence base and each of your life experience. These dialogues lead to syntheses. As you formulate the client's problems, you can only hold a part of the "truth"[2](footnote to pragmatic truth criterion definition). Perspectives of others (the client's parent or psychiatrist) or direct observations of the client at different points in time (e.g. in a good mood versus in a crisis state) are all parts of a greater whole. What is known from science about 'the average client' may or may not apply to this specific person; what is 'known' changes over time. Any understanding is likely partial and likely to leave something important out yet through dialogues we experience the contradictions inherent in our own position, through dialogues we reach more whole and coherent truths that help us change.

[2] See xxx for clinically useful discussion of epistemology and the pragmatic truth criterion.

From a dialectical stance, therefore, feeling stuck or polarized becomes a useful cue, a reminder that you've temporarily forgotten the nature of reality and taken the bit you happen to hold in your hand as the whole, absolute truth. Tension, confusion, and polarity between the client and therapist and amongst team members about how to best understand and treat problems are expected even welcomed, and used as cues to open up to look for what is valid in opposing views.

For example, the therapist may assess contradictions within the client's responses with a pointed focus as a way to reach a new understanding. The conversational or thinking style of dialectical assessment can feel a lot like pushing one of those old-fashioned red and white balls used as fishing bobbers under the water with the tip of your finger. The pointed tension in a conversation or line of thought creates a counter tension in the same way that holding a bobber under the water does. The pressure from the point of contact makes the bobber roll to pop up a different place. To illustrate, say a client felt immediate emotional relief when she burnt her arms with cigarettes, and was reluctant to give it up. As the therapist assessed the factors that led to a recent incident, the client nonchalantly said, 'the burn really wasn't that bad this time.' The therapist responded to accentuate the inherent contradictions in the client's responses:

T: 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.

C: No I wouldn't.

T: Why not?

C: I just wouldn't.

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

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

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

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

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

The client simultaneously believes that one should not burn someone under any circumstances and that burning herself to get relief is no big deal. This style of dialectically assessing "how do these go together for you" yielded important information about the client's values (similar to building discrepancy in motivational interviewing). A dialectical stance prioritizes exploring such inconsistencies among the client's own actions, beliefs and values as well as the therapist's inconsistencies. Such exploration in itself may prompt change as the dialectically-informed dialogue focuses on helping clients and therapists reach a viewpoint that is more whole and internally consistent.

Similar conversations happen between the therapist and consultation team. For example, a therapist asks for consultation on his work with a client. The team immediately remembers her – she's the one who habitually expresses distress with her husband and her health in an overly dramatic, helpless style that has burnt out all her supportive people. The therapist hasn't talked about this client in weeks. What the team hadn't realized is that, for the last 6 weeks, the client has only sporadically attended individual therapy sessions. The therapist is seeking help now because the client left a message that morning casually informing the therapist that she attempted suicide. The client took a minor overdose of Advil, went to the emergency department, and somehow finagled placement to the city's most plush, supportive day treatment program. The individual therapist flips out in exasperation. While his team mates commiserate and help plan the therapist's next move, somebody on a dialectically

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

Dialectical assessment is a thinking style, a stance that keeps your mind agile and flexible. At each point in time, the assumption is that any understanding is partial and likely to leave out something important. Polarization is an expected phenomenon, something to be explored rather than avoided. When confused, polarized or stuck, you assess what's left out and what's valid in each position so that case formulation and treatment planning are a series of dialogues that lead to synthesis rather than rigid reasoning from immutable facts. All assessment should promote contact with and dialogue about what interferes with the client having the life that they want. Any solution or intervention must take into account the multiple valid points of the dialogue in order to be effective. Attention is not on the client alone but rather the relationships among the client, the client's community, the therapist, and the therapist's community.

EXAMPLE: PRE-TREATMENT CONVERSATION

An extended example of dialogue from a pre-treatment session illustrates how the therapist brings these ideas together and provides an early look at the treatment strategies that will be described in chapter 3, 4, and 5. Many times clients feel reluctant to make needed changes. They may hesitate, feel ambivalent, or downright refuse to agree to components or elements of therapy that you believe are needed. This is particularly true at pre-treatment but may occur in

big and small ways throughout the course of therapy. At these moments, you formulate the problem and plan treatment by balancing opposing positions and working to find genuine syntheses. You balance the client's needs, goals and preferences with your own professional and personal limits to reach a true workable agreement for therapy. You use the target hierarchy to guide chain analyses and weave DBT's core strategies (change, validation and dialectical strategies) to assess and treat the highest priority target.

In this example, the client is reluctant to give up non-suicidal self-injury as a way to get relief from intense painful emotions and also initially refuses to give up the option of killing herself if the pain gets too bad. (As an aside, the therapist would use very similar blends of interventions any time the client had difficulty finding and sustaining motivation to make needed changes in any targeted behavior, not only self-injurious behavior.)

The therapist went to a local inpatient unit to meet with the client as a condition of her discharge. The client, Manny, has had very serious non-suicidal self-injury as well as multiple high risk suicide attempts. She's had multiple therapies, none of which she viewed as helpful in the end, and is hopeless. In her lifetime she's been given diagnoses of chronic PTSD, bipolar NOS, atypical psychotic, borderline personality disorder, and intermittent explosive disorder. Manny's current hospitalization occurred after an overdose precipitated by a falling out with her prior therapist who is refusing to resume Manny's care. (For sake of space, detailed history gathering has been omitted from this excerpt.) After a few preliminaries, the therapist says,

T: You mentioned on the phone that you felt mixed about whether to try therapy again. If you were going to get into therapy again, what would you want my help with?

C: I don't really know. Everybody's been telling me that DBT, whatever that is, is the thing for me, so that's why I agreed to meet with you. (T: umhmm) But therapy in general has not worked for me.

T: Mmhmm. So people have a lot of opinions about you needing to get into therapy, but you're not sure what help therapy can offer. I'm happy to tell you more about how we would work if we decide to work together and use DBT (*warm, responsive style and emphasis on acceptance oriented validation of the client's perspective*), but I guess, I'd like to hear more about what you mean that therapy has not worked for you.

C: I'm surprised you are even considering being my therapist. I didn't think anyone would take me, given Dr. Jones kicked me out." (*T follows the conversational flow and takes the opportunity to assess therapy interfering behavior of C and her former therapist*.)

T: so what happened with your former therapist that she "kicked you out"? (*Assessing therapy interfering behavior, dialectical stance means assuming both likely contributed*).

C: well, I had been doing better, in some ways, and then I went downhill and she couldn't take it anymore.

T: what pushed her over the edge? (*warm, matter-of-fact tone, communicating that T has no judgment or preconception that C was problem, it could've been T being too fragile*)

C: I started hurting myself again and then I took an overdose after I told her that I had gotten rid of the pills.

T: (*hearing opportunity to assess highest priority target, suicide attempt, T refines focus of assessment*) so you were doing better, then somehow you went back to old behavior of hurting yourself, then somewhere in there you started hoarding pills but not telling your therapist…?

C: yeah, I was going back to school and I got a work study job in the library but this guy in one of my classes started stalking me, he started to hang out in the parking lot, and be there at closing and then I ended up just quitting everything.

T: you must've been so disappointed! And scared…

C: yeah, I talked to the police but they said they couldn't do anything (*total blasé voice*) so I ended up trying to get my mom to help with money so I could quit at the library but she wouldn't help and…

T: (*gently interrupts*) you know, as you're talking you sound very matter-of-fact, almost casual, but I get the sense that this was a tremendous setback for you…(*notes discrepancy between content and emotional expression and moves to assessing for apparent competence, difficulties accurately expressing or experiencing emotion, hypothesis that this may be a factor that interfered with prior therapy making it hard for therapist to read how distressed client was, self-invalidation*)

C: yeah, I was actually doing good that quarter.

T: so that must have made it even more painful, disappointing?

C: yes

T: yes, you know your voice tone about all this, the way you are saying it, it sounds like you had a problem finding a parking space. (*T exactly replicates client's breezy voice tone and says*,) "yeah, you know, I was having the best quarter ever, really getting my life together and then this guy stalked me, and the police couldn't help, my mom wouldn't help, so I lost it all." (*T uses an irreverent communication style to prompt change while validating difficulty*)

C: (laughs)

T: I could see mistaking your tone of voice to mean this is not important to you…but it was a huge setback, wasn't it? C: yes. (*C's eye contact conveys T has understood exactly and feels relieved*) [*T files away apparent competence as hypothesis that might be relevant but due to time wants to get more detail on higher order targets*] there's this huge setback with school, and when did you start harming yourself again? (*using target hierarchy to keep priority on identifying what leads to intentional self-injury, beginning high level chain analysis*)

C: when my mom said she wouldn't help, I knew I had to drop out, and we were on the phone (T: you and your mom?) no, me and my therapist, I was really crazy inside and she called me back and then she talked me into making a cup of tea and then I just got so mad I poured the water over my hand.

T: while she was still on the phone with you?

C: no. I hung up on her. Then I just did it. Then I saw her the next day and I had had to go to the emergency room because I had burned myself so bad and had all these bandages on my hand and she's like, "What happened?" and I'm like, "Well, the tea didn't really help."

T: hmm. That sounds like you were really mad at her…(*difficulty regulating anger? Problems with assertiveness? T failure to recognize extent of client's difficulties or C's deficit in communicating? Stimulus control problem where if means to self-harm are available C can't inhibit behavior?)*

C: I was mad at everybody. I broke my hand when I hit a wall earlier that week, I almost got into a fight waiting for my bus, I was totally out-of-control.

T: yeah, I see what you're saying. Is that something that happens a lot (*OK, difficulty regulating anger?*)

C: what, getting that mad and out-of-control? (T: yeah) C: I,I just screwed it all up. (*C shows big shift in affect. T files away need to come back and assess anger further, but noticing that C seems to feel either shame or perhaps sadness about loss of last therapy, sensitive to the possibility that perhaps now in-session dysregulation may be occurring, that maybe asking about frequency felt invalidating…stays on chain that led to overdose but thinks increasing validation might be useful*).

T: (*gentle but matter-of-fact tone*) yeah, that kind of thing can really strain a relationship. You really wish things had gone differently, and feel a lot of regret, it looks like…(*validating emotion and reading C's adaptive, positive intent*)

C: (silent, nods)

T: (*T has choice of either assessing for emotional dysregulation further and perhaps treating it a bit or continuing with assessment of past suicide attempt. T attempts to use matter-of-fact non-judgmental voice tone to assist client in regulating emotion and continuing with conversation without further heightening emotional experience*) I am glad you are telling me about how hard this was. So you lost school and then that week you were really angry, kind of out-of-control, then you burn your hand, and then you're talking about it with your therapist and then what happened?

C: she said she wasn't going to work with me if I keep doing that, she could transfer me, but she'd had it.

T: you sound like this came as a surprise.

C: I could tell she was kind of freaked out over the summer when I came in with my arms all cut up, but…she understands I get to the point where I can't take it and then I hurt myself. (*C's manner of phrasing this raises hypothesis that having cuts visible to the therapist may have been communication about how much misery she was experiencing and T notes need to come back and further assess whether self-injury is maintained by communicating to others. Client also highlights potential deficit in distress tolerance skills ("get to the point where I can't take it". However now T prioritizes understanding suicide attempt*). But she said that she wasn't willing to work with me if I was going to act out at her in that way.

T: so it was really past her limit to have you hurt yourself right after she tried to help.

C: Yeah but it wasn't about her, I was getting so out-of-control I needed to calm down…I was just so…I just couldn't stand it, so I just did it, it was stupid, but I did it.

T: so you were desperate for relief, she tried to help, even though it wasn't about her something about the call or getting off the call…something in there seems to have actually made things worse, and then you scalded your hand? (C: yeah) and then, what, you just kind of showed up with the bandages and…?

C: yeah, I almost didn't go, I knew she'd take it bad. It was a crappy, stupid thing to do.

T: yeah, not a shining moment to say, "the tea didn't work", yeah. Sounds like a really difficult conversation. This might be a place we work together, you know, how to help you have these really painful emotions somehow without ending up doing things that you later so regret. Would that feel right to you? (*T gently begins change-oriented work of building commitment*)

C: yeah, I just get so out-of-control, and screw everything up, it's been that way my whole life

T: yeah, I can feel how much you don't want that to happen. You asked about DBT earlier, and one part of it is exactly for what we're talking about here. A lot of people who have very intense emotions never get to learn how to handle overwhelming emotions. One of the skill modules is exactly for this kind of moment you're describing, you learn how to tolerate distress so you don't do things you regret later. Right now all you can do is white knuckle it, you don't have enough options to help when emotions get so overwhelming. (C: yeah) But so she said, look I can't work with you if you do this and then what'd you say? (*Again T is attempting to minimally treat shame by increasing tolerance for it even amidst higher priority task of assessing chain leading to suicide attempt. T's voice tone is matter-of-fact conveying complete acceptance without judgment, yet not shying away from fact that C views her own behavior as unacceptable*.)

C: (*very solemn, as if saying a final good bye*) I said I really appreciated everything she'd done for me, she'd been a great therapist, and I was really sorry I screwed up therapy just like everything else.

T: hmm, that doesn't sound good. (*T reads the finality and guesses increase suicide ideation*.)

C: and then I went home and took an overdose.

T: so in the conversation, somewhere in there, you decided to kill yourself?

C: you know, sometimes, you have to face that it's your own fault, no one's doing it to you, and you should stop making everyone else suffer, you know? Just end it.

T: so somewhere in the conversation you started thinking like that, condemning yourself? (C: yeah.)…shame at how you'd handled things, blaming yourself for all your problems, almost sounds like really strong self-hatred, yes? (C nods)…yes, that' a dark, dark place. So you need some help with that place, maybe in therapy. And then you took an overdose? C: yes. T: what exactly did you take (*detailed suicide risk assessment history is redacted here*).

T: let me say back to you what I understand so far to see if I get it, ok? the root of things that led up to you trying to kill yourself started when you lost everything then couldn't get help and then you started to get out-of-control, angry, doing things you regret, and the emotions got so intense you started going back to old behaviors to cope…yes? C: yes. T: and then somehow when things get that hard, and you aren't getting help you need, somehow you start hating yourself for being a burden, for having all these problems, and try to kill yourself, kind of to take yourself out of misery and spare other people the misery too…? C: yes. T: then you end up here against your will, and people are wanting you to start DBT…am I getting it? C: yeah, that's it. You got it.

T: well, maybe let me tell you what I think I might offer. But let me say, first, is that I only do voluntary treatment, ok, I only work with people when we both think it's a good idea and have agreed to how exactly we're going to work together. That's what I see us doing now is you telling me how things go for you, me telling you if I think working together we could help them go different and more like you want. I'd want to talk more about what you want, but if after that, we both feel like we're a good team together and we can do the work you want to do, then we'll make a formal commitment about how long we're agreeing to work together, how we'll handle any problems that come up between us, things like that. I can already tell I like you, which is a big thing for me, how are you feeling? Comfortable talking or…? C: yeah, I am kind of surprised I'm

talking so much, I don't usually do that..T: ok, I feel that, that's neat and a good start for us. Let me tell you the ideas I have so far to see if they fit for you and seem worth trying.

I work mostly with people who have very intense emotions who through no fault of their own never learned ways to work with emotions. They get trapped and can't get life problems solved and then emotion gets out-of-control and people find that harming themselves gives relief, it makes the emotion stop, like you said earlier that cutting makes you feel calm. (C: right) So the therapy I offer is for people who have intense emotions and helps them learn other ways to help themselves other than self-injury. But for a lot of people giving up self-injury is hard. Have you ever tried to stop before?

C: yes, I try not to do it, but sometimes it's the only thing that helps.

T: yeah. (pauses)

C: I mean I know it's messed up, but sometimes it's cut or kill myself, you know?

T: yeah. A lot of people feel like that when they start our program...where they feel like if they can't relieve the tension, they get more suicidal.

C: exactly.

T: right. So what's the longest you've ever gone?

C: I guess I went almost a year one time, and just before all this stuff happened this summer and fall.I guess it'd been 4 months I was doing better.

T: wow. It almost makes me cry to think of how hard that time was for you. Wow. OK so you know next time we meet, if you decide you want to meet again, we might want to talk about what you already know about how to stop but I guess, right now the more important question for us is, all things being equal would you rather have a different way of helping yourself with these intense emotions and life problems? I mean are you attached to being a cutter or anything?

C: what do you mean?

T: I mean like for some people, it's part of their identity, who they are.

C: no, it's not like that, it's just I can't stand it.

T: right. I guess based on what you've told me, my question to you is, it seems like what you really need is a solution where when your life is falling apart, you know, truly bad things are happening, one thing you need is more help with the actual problem like money for school, getting safe, you know those were real problems and more help would've been good. And then the second thing you need is there are times when the emotional pain gets where you can't stand it and I'm wondering if we worked together could we work on how when there is this overwhelming emotional pain, for you to have ways to help yourself other than cutting? How would it fit for you to work on that?

C: that's just not going to happen, you know, I've tried a lot of therapy, it just never goes well.

T: yeah, I need to understand that more...because I know for me, I wouldn't want you to try something you know and get disappointed again...you've tried a lot of therapy (*T accepts the client's legitimate worry while continuing to strengthen commitment to change)*

C: yeah

T: yeah. (long pause.) I'd really want us to talk more about that so we're both sure our therapy would get you where you want to go. One place I would propose we start is using your urges to harm yourself, especially thoughts of killing yourself, as our indicator light of where things are most difficult—we would really work to help you with the real life problems that make you want to be dead and help you have more options with overwhelming emotions Do you know much about learning theory? (C: no) ok, so let me just draw this on the white board, ok. Here's emotion intensity and here's time. When something happens to make an emotion fire, it goes up like this. OK for some people it's slow to set off, and only goes up some and then pretty

quickly comes down. But for some people it's more like this it fires and then up here it is completely unbearable and a person will do anything to escape. This is where I think you say, "I can't take it." (C: yeah, I can't.)

T: But the problem is that if you escape here at the most intense point, what does your brain learn? C: what? T: think about your brain like a kid that really wants something and is escalating 'give me escape!!' like a kid would scream, "I want candy!" Say you then give it escape, what happens the next time your brain is in the candy store, so to speak?

C: It has an even worse tantrum, this is just like my niece, who is 3.

T: right, and then you give in eventually because she is screaming so loudly. You escape the discomfort of her screaming. So how about the next time, how high does the emotion go if you try to hold off escaping...?

C: As high as it needs to to get me to give in.

T: right. *That's* the problem with self-injury as a solution. If you want emotions to come down...it works in the moment, but it makes it worse and worse in future situations. That make sense?

C: so I get relief when I cut, but then if I hold out trying not to cut then my emotions keep going up and up and eventually I give in...

T: right. So if you were going to help your niece having an out of control emotion, would you give in or what would be your treatment...

C: no. I would never give in...I mean eventually she'd learn not to have tantrums if you don't give in

T: yeah. That's in essence what I would propose we do. If we decide to work together, we would look at all the circumstance and life problems that set off these unbearable emotions and then we'd do several things at once to help. First is that you don't have enough options in these moments where things are hardest and most overwhelming. So I mentioned the skills training earlier, and if we start soon, then I would love for you to join the group of Gary and Kristen, because they are hilarious, great teachers, and really genuine as people, and I think you might like them (*T continues change-oriented commitment work*). You'd learn a lot of skills so you had a lot more help in these hardest moments. Another thing I'd suggest is that you and I work very, very hard and closely together and I would be available to you on the phone to help in real time to offer ideas and help you through. Because it is unbelievably hard to change intentional self-injury because it works, it ends the emotional pain. But just like you said with your niece, when your brain screams it can't take it, what we'd do is stay close and ride these through so that under no circumstances would you give in when your brain screams it has to escape. ...it'll be some white knuckling at first and then over time you'll have more skills and it'll get easier. (*T pauses*.) So it'll look like this over time...

C: what do you mean no escape?

T: when I say no escape, I mean that I think we should agree to take these escape strategies like cutting and attempting suicide completely off the table for a period of time while you learn new ways to work with emotional pain. I mean, you've tried other therapies where you got support and kept using your escape strategies and you were just describing how that's not worked...(*T continues to accept C's legitimate worries to strengthen commitment to change*).

C: yeah (both silent, looking at the whiteboard together) so you're saying I would have to not do any of these escapes...

T: actually, I'm not saying you 'have to' do anything. Like I said I only work with people where we both really agree about what we're doing (*freedom to choose*)...I think more what I'm saying is look, here's my understanding of how brains work. If you want things to go differently, you have to find some way other than escape. Support plus occasional escape, you've tried. You are of

course free to try that some more…(*said with a light tone and smile that the client shares*), no seriously, this way of not escaping is really, really hard, and I bet the social workers could help find some other options besides me, so I really mean it about you choosing if you want to go this path. But if we work together then I think, especially seeing now some of the strengths you have and this initial feel of how easy it is for us to talk, I think if we took this escape stuff off the table and really worked our rear ends off, I think in 4-6 months you'd have learned to manage these intense moments in a way you feel good about, and in a year we could really make more of a life you want…it'd be really hard, you know, maybe harder than anything you've ever done in your life…(long pause. *T internally shifts fully away from change and deeply into appreciating the magnitude of pain in the client's life, following her breathing*).

C: ok. (both silent)…let me think about it…it's a big commitment…

T: yeah. For the kind of payoff you want, I'm thinking that's what's needed…yeah…and I think it's good to really think about it, because it is really hard to give up escape and find a different way…we're right at the end of our meeting time…I guess let me say, I've learned enough to feel interested in continuing the conversation, I have a good feeling about working together, and really it's up to you at this point of whether we should meet again…

C: let me, let me think a bit,

T: sure (*warm, easy manner*), if I were you, I'd need time to think, too, that's totally fine. The social worker said you're here for 2 more days, that right? (C: yes) OK, well, I'm back on this side of town late afternoon tomorrow so if you have questions or whatever, that would be a good time for me to meet, just call and let me know if you want to meet again. Here's my cell phone, that's by far the best way to reach me (*hands C card with handwritten note*). Ok, (*standing, reaching to shake hands, very warm*) I'll wait to hear, and of course now knowing that I like you I'm hoping you want to continue the conversation but of course it's a big decision…do you want to walk me out?

C: yeah.

This example shows how the concepts discussed in this chapter are used to guide initial interactions. By using the target hierarchy, biosocial theory and secondary targets, and then adding behavioral theories of change, the therapist assessed the problems prompting Manny's referral. Figure 2.7 and Table 2.2 begin to organize the information gleaned so far and direct the next round of assessment questions. You may have found that the hypotheses you generated while reading the transcript are different. That's to be expected and even hoped for in DBT because at least somewhat divergent views may more rapidly lead to useful understanding of the client's problems and the best way to approach them. This excerpt also illustrates a common pre-treatment interaction giving a first glimpse of how the therapist blends DBT's core strategies to assess, orient, and build commitment to change. We turn now to show in detail the change-oriented (Chapter 3), acceptance-oriented (Chapter 4) and dialectical strategies (Chapter 5).