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Case Formulation in Dialectical Behavior Therapy for Borderline Personality Disorder

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Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b) is a cognitive-behavioral treatment for clients diagnosed with borderline personality disorder (BPD). Case formulation is essential to efficient, effective DBT. Skillful DBT intervention is guided by a stage theory of treatment, biosocial theory of the etiology and maintenance of BPD, behavioral principles, and ideas about common patterns that interfere with treatment. This chapter introduces the concepts and method of case formulation in DBT.

HISTORICAL BACKGROUND OF THE APPROACH

We begin with a brief description of DBT to orient readers unfamiliar with this approach. Marsha Linehan and her colleagues at the Suicidal Behaviors Research Clinic at University of Washington developed DBT as a treatment for women with a history of parasuicide who met criteria for BPD. (Parasuicide is any intentional self-injurious behavior including but not limited to suicide attempts.) By watching videotapes of Linehan's therapy sessions, she and her research team identified aspects of her style and her modifications of cognitive-behavioral techniques that seemed effective. The treatment was then standardized in treatment manuals (Linehan, 1993a, 1993b), demonstrated in empirical trials to be more effective than treatment as usually offered in the community

(Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994), and now has been adapted for use in various settings in the United States and abroad (e.g., Barley et al., 1993; Miller, Eisner, & Allport, 1994; Swenson, Sanderson, & Linehan, 1996).

DBT is a complex treatment that blends cognitive-behavioral interventions with Eastern meditation practices and shares elements in common with psychodynamic, client-centered, Gestalt, paradoxical, and strategic approaches (cf. Heard & Linehan, 1994). Dialectical philosophy influences every aspect of DBT from the rapid juxtaposition of change and acceptance techniques to the therapist's use of both irreverent and warmly responsive communication styles. Nevertheless, its guiding principle is simple. DBT is based on the theory that most "borderline" behavior regulates dysregulated emotions or is a consequence of failed emotion regulation. This emotion dysregulation both interferes with problem solving and creates problems in its own right. Maladaptive behaviors, including extreme behaviors such as parasuicide, function to solve problems. In particular, amelioration of unendurable emotional pain is always suspected as a consequence that reinforces dysfunctional behavior. Although such extreme responses are understandable given the chronic chaos and suffering experienced by many individuals with BPD, the consistent 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. DBT decreases maladaptive problem solving while working to enhance the capabilities and motivation needed to improve the client's quality of life.

Comprehensive treatment (1) enhances capabilities, (2) improves motivation to change, (3) ensures that new capabilities generalize to the natural environment, (4) enhances therapist capabilities and motivation to treat clients effectively, and (5) structures the environment in the ways essential to support client and therapist capabilities (Linehan, 1996). In the standard form of DBT, these functions are divided among modes of service delivery. For example, clients enhance capabilities by learning skills to regulate emotions, to tolerate emotional distress when change is slow or unlikely, to be more effective in interpersonal conflicts, and to control attention in order to skillfully participate in the moment. They may also enhance capabilities through pharmacotherapy. The client and therapist collaborate in individual therapy to motivate change by identifying patterns associated with problematic behavior and by addressing inhibitions, cognition, and reinforcement contingencies that interfere with solving problems in a more effective manner. To generalize new behaviors across situations in daily life, the individual therapist uses phone consultation and *in vivo* therapy (i.e., therapy outside the office). A weekly consultation meeting provides therapists with technical help and emotional support to remain able and motivated to treat clients effectively. Structuring the environment for both clients and therapists is done as needed by the clinic director or administration, and for the client through case management. In adapting DBT, the particular distribution of functions to modes of

service delivery depends on the resources of a given setting—what is essential is that each function be in place. Typically, one primary therapist ensures that a given client has each function by providing it or acting as a services broker. Often the individual therapist has primary responsibility for crisis management and treatment planning. Case formulation influences each of these functions but is particularly relevant for the primary therapist conducting individual psychotherapy.

CONCEPTUAL FRAMEWORK

Theory-driven case formulation is the cornerstone of DBT. Individuals with BPD typically have multiple problems. The sheer number of serious (at times life-threatening) problems that therapy must address makes it difficult for therapists to establish and maintain a treatment focus. For example, it is difficult to decide what to treat first when the client has numerous problems (panics, is depressed, drinks too much, returns repeatedly to an abusive relationship, becomes mute during treatment interactions, and is chronically suicidal). 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 not meaningful progress. With clients who have multiple serious problems, crisis management and stopgap reduction of acute problems can dominate the therapy to the extent that efficient, effective treatment becomes unlikely.

Treatment decisions are further complicated because clients with BPD often act in ways that distress their therapists. For example, despite experience or training, it can be a struggle to manage one's emotional reactions when a client is recurrently suicidal and both rejects help that is offered and demands help that one cannot give. Even when therapy is on the right track, progress can be slow and sporadic. All of these factors can induce the therapist to make errors, including premature changes to the treatment plan. In DBT, a partial solution to this problem is to use a theory-driven case formulation to guide treatment decisions.

At an introductory level, five sets of theoretical concepts are important in DBT case formulation: (1) stage theory of treatment; (2) biosocial theory of the etiology and maintenance of BPD; (3) learning principles and ideas from behavior therapy; (4) common behavioral patterns of BPD, and dilemmas created by the dialectical nature of these patterns, which interfere with efforts to change; and (5) dialectical orientation to change. These five sets of concepts can be considered the "lenses" through which any problematic behavior will be viewed. Just as one might inspect the same object through reading glasses, infrared goggles, a jeweler's eyeglass, a high-power microscope, and an orbiting satellite, these five conceptual lenses make apparent different facets of problematic behavior. The DBT therapist looks for opportunity to foster change with each lens. Theory-driven case formulation resolves confusing variability into specific hypotheses that guide assessment and intervention.

Stages of Treatment: Behaviors to Target in DBT

The first conceptual lens is stages of treatment. This is the commonsense notion that the current extent of disordered behavior determines what treatment tasks are relevant and feasible. 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 a reasonable quality of life. The relevance of problem behaviors is determined both by the severity and complexity of the client's disordered behavior at the moment as well as the progress of therapy. 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, the primary behaviors to target are therapist and client agreement as to treatment goals and mutual commitment to treatment. Before beginning formal treatment, DBT requires that all parties agree on the essential goals and the basic format of the treatment being offered and make a verbal commitment to them. 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, he or she is 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 therapy targets behaviors needed to achieve reasonable life expectancy, control of action, and sufficient connection to treatment and behavioral capabilities to achieve these ends. Treatment time is distributed to give priority to targets in the following order of importance: (1) suicidal/homicidal or other imminently life-threatening behavior; (2) therapy-interfering behavior of the therapist or client; (3) behavior that severely compromises the client's quality of life; and (4) deficits in behavioral capabilities needed to make life changes.

Stage 2 targets posttraumatic stress responses and traumatizing emotional experiences. Its goal is to get the client out of unremitting emotional desperation.

Stage 3 synthesizes what has been learned, increases self-respect and an abiding sense of connection, and works toward resolving problems in living.

Stage 4 (Linehan, 1996) focuses on the sense of incompleteness that many individuals experience, even after problems in living are essentially resolved. The goal is to achieve the capacity for sustained joy. The task is to integrate the past with the present and future, the self with others, and to accept reality as it is.

Although the stages of therapy are presented linearly, progress is often not linear and the stages overlap. It is not uncommon to hit a snag in stage 1 that requires a momentary return to pretreatment tasks. Indeed, with some clients this occurs repeatedly throughout therapy. The transition from stage 1 to stage 2 is usually fraught with difficulty, and it is not unusual to move back

and forth between the two stages for quite some time. Stage 3 not only overlaps with stage 2 but is, at times, a review of the same issues from a different vantage point. Stage 4 is often a lifelong endeavor that requires acknowledgment and acceptance rather than completion. At termination or before significant breaks from treatment, especially if ill prepared, the client may revert briefly to stage 1 behaviors. The infrequency of stage 1 behaviors as well as the speed of reregulation (rather than the presence of any one instance of behavior) define the differences between stages.

The controlled treatment trials of DBT to date have been with clients entering treatment at stage 1. Across each stage of therapy, case formulation is organized by the extent of disordered behavior that determines the relevance and feasibility of treatment tasks. Although the principles of case formulation are consistent throughout all stages of DBT, the focus of case formulation does vary with the stage of therapy. The remainder of this chapter is about case formulation for stage 1 of DBT.

Biosocial Theory: The Central Role of Emotion Dysregulation

The second perspective guiding DBT case formulation is a biosocial theory of the etiology and maintenance of BPD. Linehan theorizes that the transaction of a biological vulnerability to emotion dysregulation with an invalidating environment, over time, creates and maintains borderline behavioral patterns. On the biological side, individuals with BPD are thought to be predisposed (perhaps due to high genetic loading for emotionality) to have (1) high sensitivity to emotional stimuli (i.e., immediate reactions and a low threshold for onset of emotional reaction); (2) high reactivity (i.e., intense experience and expression of emotion and cognitive dysregulation that goes along with high arousal); and (3) a slow return to baseline arousal (i.e., long-lasting reactions that contribute to high sensitivity to the next emotional stimulus). This biological vulnerability contributes to difficulty regulating emotion. Expanding Gottman and Katz's (1989) definition, emotion regulation requires the ability to (1) decrease (or increase) physiological arousal associated with emotion, (2) reorient attention, (3) inhibit mood-dependent action, (4) experience emotions without escalating or blunting, and (5) organize behavior in the service of external, nonmood-dependent goals.

Transaction with a particular social environment, termed the invalidating environment, can create or exacerbate this biological vulnerability. In an optimally validating environment, a person is treated in a manner that strengthens those responses that are well-grounded or justifiable in terms of the empirical facts, correct inference, or accepted authority, and those that are effective for reaching the individual's ultimate goals. The optimal environment treats the individual as relevant and meaningful, validates the individual's valid responses, and invalidates the invalid.

The invalidating environment, however, fails to confirm, corroborate, or verify the individual's experience and fails to teach the individual what responses

are or are not likely to be effective for reaching the individual's goals. Invalidating environments communicate that the individual's characteristic responses to events (particularly emotional responses) are incorrect, inaccurate, inappropriate, pathological, or not to be taken seriously. By oversimplifying the ease of solving problems, the environment fails to teach the individual to tolerate distress or 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.

Eventually, individuals learn to invalidate their own experiences and search the immediate social environment for cues about how to feel and think. The primary consequence of the invalidating environment is to punish (or fail to adequately strengthen) *self-generated behavior*. Self-generated behaviors are an individual's unique, uncensored responses that are not primarily under the control of immediate aversive social consequences or immediate external or arbitrary reinforcement. That is to say, self-generated behavior is "intrinsically motivated" or "free operant."

Childhood sexual abuse may be the prototypic 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 nor do all victims of childhood sexual abuse develop BPD, it remains unclear as to how to best account for individual differences in etiology. Linehan's theory argues that it is the invalidating aspect of childhood sexual abuse that is most crucial to development of BPD (Wagner & Linehan, 1997).

The transactional nature of this model implies that individuals may reach BPD patterns of behavior via very different routes: despite only moderate vulnerability to emotion dysregulation, a sufficiently invalidating environment may produce BPD patterns. Similarly, even a "normal" level of invalidation may be sufficient to create BPD patterns for those who are highly vulnerable to emotion dysregulation. The transactional result is a disruption of the organizing and communicative functions of emotion.

The stage of treatment and the biosocial theory suggest general hypotheses, that is, determine "what" is to be assessed as one formulates a DBT case. In particular, the running hypothesis for any targeted problematic behavior is that it is a consequence of emotion dysregulation, an attempt to modulate emotion, or both. Behavioral principles translate these general ideas into specific hypotheses about a given individual.

Theory of Change: Learning Principles and Behavior Therapy

The third perspective used in DBT case formulation is a behavioral theory of change. In general, persistent disordered behavior is viewed as a result of deficits in capabilities as well as problems of motivation. Principles of learning and ideas from behavior therapy specify methods to analyze behavior and influ-

ence behavior change. To understand a specific problematic behavior, DBT case formulation relies on functional analysis or behavioral chain analysis. This is where the "rubber meets the road," where general hypotheses regarding problematic behavior guide the analysis of specific antecedents and consequences that maintain (motivate) current problematic behavior. Each individual is likely to have a unique pattern of variables controlling problematic behavior, and these variables may differ from one set of circumstances to another.

Careful analysis of antecedents and consequences is particularly important due to the central role of emotion dysregulation in BPD. The hallmark of emotion dysregulation is instability. Therefore, capabilities disrupted by emotion dysregulation (e.g., an abiding sense of self, resolution of interpersonal conflict, goal-oriented action) are also likely to be unstable across settings and over time. When therapists mistakenly assume that behaviors covary, they may expect consistency beyond what the client produces. Similarly, by assuming that an observed dyssynchrony is traitlike, the therapist may treat the client as overly fragile. It is useful to distinguish between capabilities in a particular context (whether a person can do something under the best possible circumstances), performance difficulty in specific contexts (ease with which a person can perform a certain response), and traits (typical or average behavior across diverse contexts) (see Paulhus & Martin, 1987, for a similar distinction). Keeping these distinctions in mind helps the therapist assess whether the client lacks an ability or has the ability but is inhibited from skilled responding.

A behavioral chain analysis is an in-depth analysis of events and situational factors before and after a particular instance (or set of instances) of the targeted behavior. The goal is to provide an accurate and reasonably complete account of behavioral and environmental events associated with the problem behavior. Close attention is paid to reciprocal interactions between environmental events and the client's emotional, cognitive, and overt responses.

A chain analysis begins with a clear definition of the problem behavior. Next, the therapist and client identify both general vulnerability factors (those factors that are the context in which precipitating events have more influence, e.g., physical illness, sleep deprivation, or other conditions that influence emotional reactivity) and specific precipitating events that began the chain of events that led to the problem behavior. 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*. Finally, therapist and client identify the immediate and delayed reactions of the client and others that followed the problem behavior. This detailed assessment allows the therapist to identify each juncture where an alternative client response might have produced positive change and averted conditions that lead to problem behavior. When dysfunctional links occur (behaviors that interfere with achieving the client's long-term goals), the therapist assesses what alternative behavior would have been more adaptive and skillful and why that more skillful alternative did not happen.

The absence of skilled performance is due to one of the following four factors, linked to behavior therapy change procedures:

First, the client may not have the necessary skills in his or her repertoire; that is, the client has a capability deficit. DBT views specific skills deficits as particularly relevant to BPD, and therefore the therapist assesses whether clients can (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 these skills, skills training is appropriate.

However, if assessment revealed that the client does at times behave more effectively in similar situations, then the therapist assesses which of the three other factors interfered with more skillful behavior. The second possible reason for the lack of skilled performance is that circumstances reinforce dysfunctional behavior or fail to reinforce more functional behavior. Problem behavior may lead to positive or preferred outcomes, or give the opportunity for other preferred behaviors or emotional states. Effective behaviors may be followed by neutral or punishing outcomes, or rewarding outcomes may be delayed. If problematic contingencies are identified, then contingency management interventions are appropriate.

The third possibility is that conditioned emotional responses block more skillful responding. Effective behaviors may be inhibited or disorganized by unwarranted fears, shame, guilt, or 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.

The fourth possibility is that effective behaviors are inhibited by faulty beliefs and assumptions. Faulty beliefs and assumptions may reliably precede ineffective behaviors. The person may be unaware of the contingencies or rules operating in the environment or in therapy. If problems are identified here, then cognitive modification strategies are appropriate.

BPD Behavioral Patterns and Dialectical Dilemmas

Change in primary targets (decreases in behaviors that threaten life, therapy, and quality of life, and increases in behavioral skills) is the main focus of stage 1 DBT. In order to successfully treat primary targets, however, other (secondary) behaviors or behavioral patterns may also need to be targeted. From clinical observation of the problems that prevent (and wreak havoc on) treatment and clinical progress, Linehan (1993a) distilled patterns organized into dialectical poles. Each pattern describes an aspect of the transaction between the experience of emotion dysregulation and a history of social consequences incurred as a consequence of emotion dysregulation. As the word "dialectical" implies, BPD individuals frequently jump from a behavioral pattern that underregulates to another that overregulates emotion, the discomfort of each

extreme triggering oscillation between response patterns. These patterns perpetuate themselves and create new problems. These secondary targets are often common across behavioral chains and common across stages of treatment.

This fourth perspective orients the therapist to behavioral patterns that may destroy treatment if not directly treated. Each pattern highlights the dilemmas faced by both the client and the therapist whenever therapeutic change is initiated. DBT's aim is to help the client arrive at a synthesis or more effective balance of opposing behavioral tendencies.

Emotion Vulnerability and Self-Invalidation

Emotion vulnerability refers to the intense suffering that accompanies the experience of emotion dysregulation. By analogy, individuals with BPD can be considered the emotional equivalent of burn victims where the slightest movement is automatic extreme pain. Because the individual cannot control the onset and offset of internal or external events that influence emotional responses, the experience itself is a nightmare of intense emotional pain and the struggle to reregulate. This unpredictability foils personal and interpersonal expectations because the person can often meet expectations in one emotional state but not another, leading to frequent frustration and disillusionment in both the client and others. Even dysregulation of positive emotions creates pain. For example, a client reported, "I got so happy and excited when I went home for the holidays, I couldn't stand it. I laughed too loud, talked too much, everything I did was too big for them!" These individuals despair that vulnerability to uncontrollable emotion will ever lessen and suicide may seem the only way to prevent further suffering. Suicide can also be a final communication to an unsympathetic public. Emotional vulnerability is an important link to parasuicide and therefore becomes a target in itself.

The suffering associated with inability to regulate emotion creates numerous obstacles in therapy. Nearly any therapeutic movement evokes some emotional pain, much as debriding does in the treatment of serious burns. Sensitivity to criticism makes it painful to receive needed feedback; in-session dysregulation (dissociation, panic, intense anger) interrupts therapeutic tasks; generalization and follow-through on in-session changes and plans goes awry. Therapy itself may be traumatic. An understanding of emotion vulnerability means the therapist must understand and reckon with the intense pain involved in living without "emotional skin." The DBT therapist is empathic, coaches and soothes, and most importantly treats the emotion dysregulation in session. For example, in response to intense emotional reactions during therapeutic tasks (e.g., talking about an event from the week), the therapist validates the uncontrollable, helpless experience of emotional arousal, and teaches the individual to modulate emotion in session.

Self-invalidation occurs when the client responds to his or her own behavior (or the absence of needed self-generated behavior such as emotion control) as invalid, taking on the characteristics of the invalidating environment. Self-invalidation takes at least two forms. On the one hand, clients may judge themselves harshly for their vulnerability ("I should not be this way"), act in self-punitive ways, and feel self-hatred. The experience is of oneself as the agent of one's own demise. In this case parasuicide may function as punishment for transgression. On the other hand, clients may deny and ignore their vulnerability ("I am NOT this way") and hold unrealistically high or perfectionistic expectations. In doing so, the client minimizes the difficulty of solving life problems. By ignoring or blocking emotional experience, the person not only loses information needed to solve problems but disrupts the organizing and communicative functions of emotion. Self-invalidation is often a crucial link in the behavioral chain to parasuicide. Increasing self-validation and decreasing self-invalidation become essential secondary targets. The explicit focus on the necessity of appropriate self-validation is a hallmark of DBT.

The intense discomfort of either extreme results in an oscillation between experiencing vulnerability and invalidation of that experience. The dilemma for "June," a client, becomes who should be blamed for this predicament. She is either able to control behavior (as others believe she can) but won't, and therefore is "manipulative," or she *is* as unable to control emotions as she experiences herself to be, which means she will always be this way and dooms her to a never-ending nightmare of dyscontrol. June can try to fulfill expectations that are out of line with her capabilities and fail, feel ashamed, and decide she deserves to be punished or to be dead. Or she can see her vulnerability and adjust her standards. But if others do not also change their expectations of her, she can become angry that no one offers needed help and become convinced that suicidal behavior is the only means to communicate that she cannot do what is expected.

The dilemma in therapy is that focusing on accepting vulnerability and limitations may lead June to despair that she will always have the problems she has; focusing on change, however, may lead her to panic because she knows there is no way to consistently meet expectations. Further, if she changes her problematic behavior, she may feel ashamed that she could have done what was expected all along but did not because she was "lazy" or "manipulative." To negotiate this dilemma, the DBT therapist flexibly combines, moment to moment, the use of supportive acceptance and confrontive change strategies. The therapist communicates, in word and deed, that June is doing her best yet must do better.

Active-Passivity and Apparent Competence

The second set of opposing behavioral tendencies is active-passivity and apparent competence. Active-passivity is the tendency to respond to problems passively and to regulate oneself, if one tries at all, by regulating the relevant aspects of the environment. Regulating oneself by regulating the environment is not a problem per se—the problem is that the individual with BPD is not skillful *enough* at regulating his or her environment.

For example, "Paula," a client, returns from a psychiatric hospitalization and her roommate asks her to move out. Instead of searching for a new place to live, Paula spends the day in bed and is silent during therapy despite all efforts by the therapist to encourage active problem solving. Paula experiences herself as, and actually is, unable to do what is necessary without more help. If she had just been discharged with a broken leg, help might be forthcoming. However, without observable deficits, she may get feedback that it is socially unacceptable to need "too much" help or reassurance or to be "too" dependent. Thus, she either avoids getting necessary help or attempts to get it in a way that is experienced as demanding by others. That is, regulation of her environment to solve her problem is deficient or unskillful and ineffective. As the situation worsens, the therapist becomes frustrated that Paula creates a crisis that could easily be solved if she would cope actively (get the newspaper, find another place). Her experience, however, is that the situation is hopeless no matter what she does. This style of problem solving—acting extremely inadequate and passive in the face of insufficient help and at times magnifying problems if they are not taken seriously—is often overlearned from repeated failure despite one's best efforts in an environment where difficulties are minimized. Remaining passive in a manner that activates others confirms that, in fact, the problems could not have been solved without help, that in effect things are as bad as claimed. While regulating in this way can be effective, overreliance on this behavioral pattern often means problems are not solved and life gets worse. This pattern can contribute to parasuicide in many ways, including increasing life stress as problems go unsolved, alienating helpers, and making suicide one of the few means of communicating that more help is needed.

Therapeutic changes stay under the control of the therapy relationship rather than adequately generalizing to the client's natural environment unless this pattern is addressed directly. Consequently, in DBT it is as important to teach the client to solve problems as it is to get the problems solved. As one DBT therapist said to a client with activity-passivity (in spades), "I can see you are working hard in therapy, but you're not working smart. You've got to be learning to create your own therapy, not just following orders." The secondary targets here are to decrease active-passivity behaviors and increase active problem solving, especially skills to more effectively manage oneself and one's environment.

Apparent competence is the sum total of behavioral responses that influence observers to overestimate and overgeneralize response capabilities. Apparent competence takes one of two forms. First, observers are likely to overgeneralize when verbal and nonverbal expressions of emotion are incongruous. Often clients verbalize extreme negative emotions but convey little, if any, distress nonverbally. Observers are likely in these instances to believe nonverbal over verbal expression when, in fact, it is the verbal channel that is the more accurate expression. Second, observers overgeneralize when they ignore the critical context needed for skilled behavior. For example, in the context of either a positive mood or positive relationship, many behaviors are more easily performed. To the extent that Paula is a relational person and has little control of her emotional state (to be expected when the core problem is emotion dysregulation), then she has little control over her behavioral capabilities. Variable and conditional competence across settings and over time may be due to behavioral capabilities that are overly mood or context dependent. Nevertheless, the absence of expected competence is interpreted as manipulation and decreases others' willingness to help. The further implication here is that others have difficulty knowing when the person needs help, thereby creating the invalidating environment. Here the goal is to increase accurate expression of emotion and competencies and to decrease behavior that is overly dependent on mood and context.

The dilemma in therapy is that active-passivity and apparent competence make it difficult for the therapist to determine the level of help that should be offered with what Paula can do for herself. At times and for a variety of reasons, she may need more help than those in her environment are willing or able to provide. Apparent competence leads others (including the therapist) to expect more than can be delivered. The appearance of competence also desensitizes the therapist and others to low level communication of distress. "Doing for" the client when the client is passive but does have the capability to help herself reinforces the problematic learned helplessness and blocks her from learning active problem solving. But abandoning Paula to her own means without sufficient help prevents appropriate skill training, increases panic, and increases the probability of further dysfunctional behavior. The DBT therapist negotiates this dilemma by responding to low-level communication of distress with active help and coaching of more effective behavior while insisting that the client actively solve her own problems.

Unrelenting Crisis and Inhibited Grieving

Unrelenting crisis refers to a self-perpetuating behavioral pattern in which the person with BPD both creates and is controlled by incessant aversive events. Emotional vulnerability and impulsivity combine to make an initial precipitant quickly snowball into worse problems, as when a person impulsively acts to decrease distress and inadvertently increases problems. For example, yelling in anger at a case worker and impulsively ending an interview needed to complete a housing application can result in being unable to reschedule with another worker before being evicted and homeless. Incomprehensible over reactions make more sense when viewed against a backdrop of repeated experiences of helplessness. The inability to recover fully from any one crisis before the next one hits leads to a "weakening of spirit" (Berent, 1981) associated with parasuicide and other emergency behaviors. This crisis-of-the-week pattern interferes with follow-through on any behavioral treatment plan and has led DBT to separate crisis management (psychotherapy) from skills training (psychoeducation). The secondary targets are to decrease crisis-generating behavior and to increase realistic decision making and good judgment

Inhibited grieving is an involuntary, automatic avoidance response of painful emotional experiences, an inhibition of the natural unfolding of emotional responding. The individual does not fully experience, integrate, or resolve reactions to painful events but, instead, inadvertently increases sensitization to emotion cues and reactions by avoidance and escape. Borderline individuals are constantly exposed to the experience of loss, start the mourning process, automatically inhibit the process by avoiding or distracting from relevant cues, reenter the process, and so on. The grief inhibited may be associated with childhood trauma or revictimization as an adult, or it may be evoked by the many losses that are the current consequence of maladaptive coping. Inhibited grieving is the primary target of stage 2 of DBT, but it is targeted in stage 1 when it is linked to the primary targets. The goal is to decrease inhibited grieving and increase emotional experiencing.

The dilemma in therapy is that unrelenting crisis and inhibited grieving interfere with crucial therapy tasks. Systematic behavioral interventions, particularly exposure-based therapy dealing with trauma, are not feasible when these patterns are prevalent. It is difficult to engage in "uncovering" work and, simultaneously, to inhibit grief reactions and to avoid exposure to cues that evoke memory of past loss and trauma, particularly when one is in perpetual crisis. Avoidance and escape from painful feelings with maladaptive behaviors that generate a crisis inadvertently increases exposure to crisis-induced losses, which in turn increases avoidance of cues through further maladaptive behavior, and so on. In part, this pattern differentiates a stage 1 client from one in stage 2. The DBT therapist expects oscillating expressions of extreme distress and complete inhibition of affect and teaches the client skills needed to tolerate emotional experience without engaging in behavior that worsens the situation while decreasing the behaviors that lead to further loss of relationships and other things she or he values.

Dialectics of Change: Philosophical Guiding Principles

Dialectics has been referred to as the logic of process and as a coherent system of exploring and understanding the world (Basseches, 1984; Kaminstein, 1987; Levins & Lewontin, 1985; Riegel, 1975; Wells, 1972). Within DBT (cf. Linehan & Schmidt, 1995), dialectics provides an overriding context for case conceptualization. In contrast to the four lenses reviewed so far, dialectics shifts attention from the client alone to the *context* within which the client interacts. The "case" that is formulated, from a dialectical perspective, is not the individual per se but rather the relationships among the client, the client's community, the therapist, and the therapist's community. Factors impinging on the therapist become as important as those impinging on the client.

As a worldview, there are several essential tenets of dialectics. First, it is assumed that a "whole" is a relation of heterogeneous "parts" in polarity ("thesis" and "antithesis") out of whose "synthesis" evolves a new set of "parts" and, thereby, a new "whole." The parts, which hold no intrinsic or previous

significance in and of themselves, are important only in relation to one another and in relation to the whole that they define. Considering phenomena to be heterogeneously composed has important implications for case formulation. The fact that parts are not merely diverse but also are in contradiction or opposition to one another focuses the observer not on a taxonomic identification of the parts but rather on the relationship or interaction of the parts as they move toward resolution.

A second tenet of dialectics states that parts acquire properties only as components of a particular whole. The same part may have different qualities when viewed as an aspect of different wholes. Parts of different wholes will embody different contradictions and dialectical syntheses. The importance of this point for case conceptualization is that no clinical phenomenon can be understood in isolation from the context in which it occurs. Because the system itself is dynamic, the ever-changing relationship between clinical phenomena and their contexts must also be a focus of assessment, conceptualization, and change.

A third tenet is that parts and wholes are interrelations, not a mere collision of objects with fixed properties and immutable boundaries. As such, the parts cannot participate in creating the whole without simultaneously being affected themselves by the whole. An important implication of this view is that it is impossible for clients not to alter the therapy system within which they interact (and which would not exist without them), even as they are simultaneously affected by the system. Attention to the "parts" other than the client, therefore, is as important as attention to the client.

Fourth, as already mentioned, dialectics recognizes change to be an aspect of all systems, and to be present at all levels of a system. Stability is the rare occurrence, not the idealized goal. Dialectics is neither the careful balance of opposing forces nor the melding of two open currents, but instead is the complex interplay of opposing forces. Equilibrium among forces, when found, is discovered at a higher level of observation, namely, by looking at the overall process of affirming, negating, and forming a new, more inclusive synthesis (Basseches, 1984, pp. 57–59).

Examination of the root metaphors of dialectics (dialectical materialism vs. dialectical idealism) suggests how dialectics relates to DBT case conceptualization. In dialectical materialism, the "energy" or force that ultimately drives the creation and synthesis of opposites is the efforts of humans to compel change in their world. In contrast, in dialectical idealism this process is energized by the Universal Truth (i.e., the universe itself drives the process). DBT case formulation moves back and forth between the two views, employing human activity as the motivator in some instances (e.g., pointing out the contradiction between the ideals created and upheld in a culture and actual body types of individuals) and larger, natural contradictions in others (e.g., the interplay of chance and skill in the outcome of human interventions). While the philosophy of dialectical materialism relevant to DBT (corresponding to behavioral theory as a foundation of DBT) views humans as imposing an order

on an uncaring world, dialectical idealism (corresponding to the roots of DBT in Zen psychology) believes that we can recognize and experience a unity and pattern inherent in the organization of the universe. Dialectical materialism focuses the therapy and the therapist on the application of change procedures, and the case formulation identifies both what needs to change as well as what procedures would be most effective. Dialectical idealism focuses the therapy and the therapist on radical acceptance of the whole—beginning, middle, and end.

To summarize the conceptual framework of DBT case formulation, the stage of treatment influences what problem behaviors are targeted in therapy as well as the goals one is working toward. The biosocial theory frames the key hypothesis about what variables are central to development and maintenance of the problem behaviors. Learning principles suggest both methods of behavioral analyses and change. BPD behavioral patterns and dialectical dilemmas suggest secondary behavioral patterns functionally linked to both problem behavior per se and to difficulties changing these patterns. The dialectic between change and acceptance, between dialectical materialism and dialectical idealism, is the central dialectic of DBT and informs case conceptualization at every level of treatment.

INCLUSION/EXCLUSION CRITERIA

Although DBT is currently being adapted for non-BPD client populations, there is empirical evidence only for its effectiveness with chronically parasuicidal female clients with BPD. Consequently, we focus on the issues encountered when working with clients who have severely disordered behavior. It is important to note that the diagnostic criteria for BPD are considered as samples of behavior and appropriate targets of intervention in themselves, rather than as signs of an underlying phenomenon that is "manifested" or "indicated" by behavior.

STEPS IN CASE FORMULATION CONSTRUCTION

There are three steps to formulating a DBT case: (1) gathering information about treatment targets; (2) organizing information into a useful format; and (3) revising the formulation as needed.

Step 1: Gather Information about Treatment Targets

Problem Definition and History

This is the essential task of DBT case formulation: in the initial sessions one must assess the range of client problems to determine the appropriate stage of treatment. A client is in stage 1 if he or she is at least minimally committed to

treatment and has life-threatening and/or parasuicidal behavior, behavior that interferes with therapy, and/or behaviors that severely compromise the client's quality of life. When the client enters therapy at stage 1, collaboratively identify and obtain a history of these primary target areas.

The first target area includes five types of behavior (in descending order of priority): suicide crisis behaviors; parasuicidal acts; suicidal ideation and communications; suicide-related expectancies and beliefs; and suicide-related affect. Either before treatment or early in treatment, the therapist should obtain a thorough parasuicide history. In the University of Washington research protocol, the Parasuicide History Interview is used to get this history (PHI-2; Linehan, Heard, & Wagner, 1995). The PHI asks for all details regarding parasuicide 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 parasuicide and suicide ideation, and to manage suicidal crises. In particular, one must identify the conditions associated with near-lethal suicide attempts, parasuicide acts with high intent to die, and other medically serious parasuicidal behavior.

The second target area, treatment-interfering behaviors, includes behavior of either the client or the therapist that negatively affects the therapeutic relationship or compromises the effectiveness of treatment. For clients this may include missing sessions, excessive psychiatric hospitalization, inability or refusal to work in therapy, and excessive demands on the therapist. For therapists this may include forgetting appointments or being late to them, failing to return phone calls, being inattentive, arbitrarily changing policies, and feeling unmotivated or demoralized about therapy. Information about these targets should be obtained from prior treatment history and prior supervision history.

The third target area, behaviors that severely compromise the client's quality of life, includes behaviors that disrupt stability or functioning and thereby curtail treatment effects. A diagnostic evaluation may help to assess the range of problems a client experiences. Structured diagnostic interviews such as the Personality Disorder Examination (Loranger, 1988) and the Structured Clinical Interview for DSM-III-R—patient version (SCID-P; Spitzer, Williams, Gibbon, & First, 1988; American Psychiatric Association, 1987) are useful. Mood and anxiety disorders, substance abuse, eating disorders, psychotic and dissociative phenomena, as well as inability to maintain stable housing and inattention to medical problems, impair the client's quality of life and may also influence parasuicidal behavior and interfere with therapy.

This history will allow an operational definition of the specific target behaviors. Frequency, duration, and past and present severity of the problem should be noted—for example, "Client cuts arms with a razor, 2–3 times per month, in the past requiring up to 20 stitches, but in the last year requiring no medical attention"; or "Client misses one out of every four sessions and then calls in a crisis, demanding help on the phone."

Chain Analysis

The next step is to specify the controlling variables for each targeted behavior. Returning to the metaphor of viewing behavior through the lenses of stage theory of treatment, biosocial theory, behavioral principles, behavioral patterns/dialectical dilemmas, and dialectics, it is as if the therapist were a quality-control inspector examining lengths of chain for problems with individual links. Clients monitor target behaviors using a diary card that is reviewed at the beginning of each DBT session. As the therapist reviews the card, asks about the week, and observes both him- or herself and the client in-session, he or she picks up those lengths of the behavior chain that end with parasuicide, therapy-interfering behavior, or behavior interfering with the client's quality of life.

Repeated chain analyses identify the precipitants, vulnerability factors, links, and consequences associated with each primary target. Each link (in-session or out) is considered in light of whether the client's response is functional or dysfunctional, that is, whether it moves the client toward or away from long-term goals. This sorting process is guided by hypotheses about controlling variables suggested by biosocial theory, behavioral principles, and the behavioral patterns/dialectical dilemmas. The biosocial theory suggests that the core problem is one of emotion dysregulation; it suggests further that the conditions that have created emotion dysregulation have led to other predictable skills deficits. Common dysfunctional links might include dysregulation of specific emotions, distress intolerance, punishment and perfectionistic self-regulation strategies, nondialectical thinking, crisis-generating behaviors, active–passivity, apparent competence, self-invalidation, and inhibited grieving. The behavioral principles and ideas from behavior therapy suggest searching for controlling variables in the current environment and examining ways that skills deficits, emotional responses, cognition, and contingencies interfere with more skillful responding. For example, Don, a client, may experience immediate relief from intense anxiety when he cuts his wrists and have no other reliable means for reducing anxiety. In addition, sporadically, his estranged parents take care of him after particularly serious parasuicide incidents. It is important to note that although increased care and attention follow parasuicide, this may or may not have been an intended consequence and may or may not increase the probability of suicide or parasuicide. Particularly when assessing the contingencies maintaining parasuicide, the therapist should assess (rather than assume) the functional relationship between consequences and parasuicide.

The behavioral patterns/dialectical dilemmas also suggest problematic patterns that may occur across chains and prevent therapeutic change. Maintaining a dialectical perspective reminds one to ask, "What is being left out?," thereby expanding analyses to include the effect the client has on the therapist and the influence of the therapist's own community and context on the process of therapy. As one gains information about the chain of events that leads to problematic behaviors and difficulties with change from each of these perspectives, patterns emerge.

At times a minimal intervention may replace a weak link (e.g., suggesting a solution that the client hadn't considered). More frequently, a problematic link will need a fair amount of work before it is replaced by more functional behavior. Then, the assessment task becomes to determine what specific functional behavior should replace dysfunctional links and what change procedure will best replace the target behavior.

Task Analysis

Identifying replacement behaviors for each target behavior and most usual dysfunctional links requires a task analysis. This means a step-by-step behavioral sequence for the particular set of circumstances needed to bypass the dysfunctional links and get to the desired behavior. The necessity of situation-specific solutions can be an incredible challenge—for example, how does one, in the midst of extreme emotional arousal, inhibit the associated action urge and do what is effective for that moment? Step by step, what is needed? There are three pools to draw ideas from. First, one should consider replacing dysfunctional links with DBT skills. Staying mindful of the balance between acceptance and change, one should consider interpersonal skills to change or leave the environment, emotion regulation (emotion observing, emotion describing, emotion experiencing, attention control, self-soothing, etc.), distress tolerance (including radical acceptance), mindfulness, self-management skills, active problem-solving behaviors, congruent emotional-expressive behaviors, self-validating behaviors (acting so as to increase self-respect instead of active–passivity and apparent competence patterns). Second, one should look to psychological literature on treatment and normal psychology for replacement behaviors. And, finally, one should consider personal experience. In similar situations, how exactly did one solve the problem?

From the situation-specific solutions of task analysis comes an understanding of the more general obstacles that interfere with replacing dysfunctional behavior. In other words, across situations, clients experience recurring problems when trying to adopt more functional behavior. Here, again, ideas from behavior therapy suggest one of four classes of problems. The client may lack the needed skills (behavioral deficits that preclude engaging in the desired behaviors), may have emotional reactions that interfere with skillful behavior or beliefs that are incompatible with being effective, or something about the situation may derail him or her (inappropriate stimulus control that elicits interfering behaviors or inhibits goal-directed behavior).

These standard steps of behavioral assessment are used to determine controlling variables and appropriate behavioral change strategies. One further step is needed, however, with many BPD clients. The question is what interferes with a straightforward use of change strategies? Here, secondary targets should be considered, and in particular the dialectical dilemmas of emotion

vulnerability/self-invalidation, apparent competence/active passivity, and unrelenting crisis/inhibited grieving. Also, attention should be paid to the transactional relationship of the individuals with the entire system—intra-organismic, within therapy, and among the individual's therapist(s) and the environment.

Step 2: Organize Information in a Useful Manner

Within the first 2 months of treatment, one should organize information on each target area into a written format. The purpose here is to create a format that helps identify areas that need further assessment, prioritize the areas that need change, and systematically consider the appropriate avenues of intervention. The content of the formulation will represent a synthesis of the five perspectives (stage of treatment, biosocial theory, behavioral theory of change, dialectical dilemmas that interfere with change, and dialectics per se) into a single statement of the problem, its controlling variables, and the behaviors required to get from problematic behavior to preferred behavior.

The written formulation should be in a format that is useful to those who will use it. A written format is particularly important with suicidal clients. The pressures and complexity of work with chronically suicidal, multiproblem clients increase the odds that a therapist will overlook, forget, or in some way miss important connections that a written format will bring to focus. For some a narrative would be most useful, whereas for others a flowchart would be best. The essential feature is that information on each target behavior be organized to guide further assessment and to keep a clear priority of targets to be treated. A flowchart is used in the "Case Example" section below.

Step 3: Revise the Formulation

DBT formulations are under constant revision as more is learned about the factors influencing problematic behavior or interfering with preferred behavior. These revisions tend to be refinements of original hypotheses, but at times significant revisions may be needed. It is difficult to decide, however, whether one is working from a mistaken formulation or whether one is in the midst of slow, sporadic progress expectable with this client population. A more fundamental reassessment of the formulation, the treatment plan, or both, is warranted when there is stagnation or impasse in the therapy. In DBT the emphasis is on changing the formulation or the treatment plan based on evidence from further assessment rather than based on the therapist's emotional responses to this often difficult work. The DBT therapist's first assumption is that lack of collaboration or progress is a failure in dialectical assessment—that is, something was missed in conceptualizing the case and the treatment. The therapist's job is to figure out a reformulation that will get the client moving toward agreed-upon goals.

The therapist looks for any information about the client that might be left out, and in a matter-of-fact manner raises questions regarding the formulation with the client. The therapist reviews case notes, particularly written chain analyses, and consults with other members of the treatment team to search for relevant patterns that were not noticed.

Impasses in DBT can also be caused by failure to balance technique (e.g., by too much emphasis on change or on acceptance); the therapist uses the consultation team and supervision to decide on the best means of regaining balance (Fruzzetti, Waltz, & Linehan, in press). Where other approaches might view lack of change as resistance or lack of motivation, DBT views patterns in light of environmental determinants. In particular, the DBT therapist considers how he or she may be contributing to therapeutic impasse. Transactions between the client and therapist must be examined as well as the larger context within which the therapist is working. The transaction between a client with BPD and a therapist can lead to therapeutic impasse or actually be iatrogenic even with therapists who are very effective with other clients. Clients with BPD frequently have interpersonal behaviors that interfere with the therapist's abilities to deliver treatment. Deficient abilities to self regulate emotions and emotion-related actions are a common source of difficulty. This is not specific to clients with BPD. Across types of treatment, "client difficulty" rather than symptom severity may be a more important influence on therapist's ability to competently deliver therapy (e.g., O'Malley, Foley, Rounsaville, & Watkins, 1988). Hostility and help rejection can be extremely difficult for therapists to respond to, and clients with BPD have more than their fair share of difficult interpersonal behaviors. As Linehan has noted, such clients often seem to reinforce iatrogenic therapist behaviors and punish effective behaviors. In addition, quite independent of the client per se, factors unique to the particular therapist, such as therapy skills deficits, stressful work or home conditions, or difficult interactions with other therapists treating the client, may make conducting effective treatment extremely difficult. Limited skills, narrow personal limits, and conflicts with other staff members affecting the therapist–client interaction must all be assessed and their role in the treatment considered in the case conceptualization.

APPLICATION TO PSYCHOTHERAPY TECHNIQUE

The case formulation guides each intervention. Usually there is no shortage of problematic behavior among chronically suicidal borderline clients, 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 in stage 1 of DBT means to "pick up the correct length of chain" that leads to primary treatment targets (parasuicide, therapy-interfering behavior, and behavior inter

fering 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. An important point in DBT is that the therapist always moves for in-session change whenever the opportunity presents itself. The following case example illustrates how DBT case formulation guides intervention.

CASE EXAMPLE

Step 1

Our composite client, "Mary," is a 27-year-old white female who has a history of parasuicide including two near-lethal suicide attempts. From the PHI, the therapist learned that Mary has injured herself by head banging and ingesting harmful substances since age 10. Currently she uses a razor to cut her arms and legs, and overdoses using prescribed medications. Due to physical abuse and neglect she was removed from the custody of her biological parents by Child Protective Services at age 10. Through various foster care placements, she hoped that she could return to live with her family, where she hoped to receive the care and assistance she felt she needed to get her life on track. At 16 she attempted suicide after a phone call in which her mother said that she never wanted Mary to return home and would prefer that Mary stop calling. Mary cut both wrists and only by chance was found by a friend before she died. This led to the first of many subsequent psychiatric hospitalizations.

Mary was referred to the DBT program after her second near-lethal attempt. After a 6-month period of high functioning (job, romantic relationship, successful outpatient treatment for alcohol dependence), she was laid off from work. For financial reasons she moved in with her romantic partner. Mary became depressed, failed to find work, and as her unemployment compensation dwindled, argued violently with her partner until in a state of intense anger she stormed out. She then had a panic attack, drove to a secluded spot, and overdosed on prescribed medications (which she always carried in her purse) with the intent to die.

Mary had past diagnoses of eating disorder (not otherwise specified), major depression with psychotic features, and alcohol dependence. When she started DBT, she met criteria for BPD and dysthymia, had panic attacks but

did not meet criteria for panic disorder, and was socially avoidant but met criteria for neither avoidant personality disorder nor social phobia.

By Session 3, Mary and her therapist had reached agreement that their top priorities for a year would be to stop her cutting behavior and suicide attempts (parasuicide, primary target stage 1), reduce the use of psychiatric hospitalizations (both therapy-interfering and quality-of-life–interfering behavior), and reduce the frequency of panic attacks (quality-of-life–interfering behavior and also on the chain to parasuicide), and to replace these with more skillful coping. After 4 months in the DBT program of individual therapy and group skills training, Mary and her individual therapist had identified the most typical sequence of events that led to both cutting and increased suicidal ideation. A chain analysis of suicidal crisis behavior gathered about 2 months into therapy is representative. In the late evening, Mary called her therapist (who had just arrived back from vacation that night), sobbing, "It's over," and stating she wanted to die and it was all she could do not to slash her throat. As the therapist began to assess imminent suicide risk, Mary had a call on the other line. She returned to the therapist to say it had been her partner, crying, saying she was sorry they fought. Mary said she would be able to make it through the night and agreed to a session early the next morning.

In the behavioral chain analysis during the next session, they identified the vulnerability factors (difficulties at work) and immediate precipitating event (an argument with her partner about whether Mary should or should not quit her new part-time job). At work Mary was asked to take on a project that had been clearly stated in her job description but which she had no idea how to do. Rather than ask for help or ask that the task be modified, she set unrealistic standards for her performance (self-invalidation). As the week of orientation continued, she began to fail at the task but never communicated effectively that she was having difficulty (apparent competence). She left work early Thursday with a migraine and called in sick on Friday. Over the weekend, she lay on the couch fighting a migraine, ruminating about work. During a conversation with her partner about her work problems, Mary said she was thinking about quitting and her partner said, "I hope you're not thinking I'm going to support you. I can't take you quitting anymore." Panic at the thought of being on her own to handle a problem she experienced as overwhelming and out of her control ensued but within seconds changed to fury at her partner for withdrawing help and pressuring her not to quit. As the argument and anger escalated, Mary began to have vivid images of cutting her wrists and of blood pouring out. In-session she was unable to label the emotion other than to say she felt "incredibly tense, wound up," desperately wanted someone to help her, and thought, "You don't understand. I can't stand this." The argument ended with her partner's parting comment, "This is not going to work out." Mary then sat alone in their dark apartment. She began invalidating her disappointment in her partner and her legitimate work difficulties, planning to kill herself by cutting her wrists, imagined the process of dying, of being

met by her nurturing grandmother who had died 2 years ago, and kept repeating to herself that she had failed again, things would never get better, and being dead would stop the pain. As this continued, the anger decreased and tearfulness, sadness, emptiness, and apathy increased. As she got out the razors, she thought of her therapist and called the answering service.

Step 2

A more general summary of the events leading to Mary's parasuicidal behavior is shown in the flowchart (Figure 13.1).

First, her vulnerability to emotion dysregulation was heightened by recurrent migraines. Second, she had a variety of problems that resulted from not keeping a job. Most work problems originated from not being appropriately assertive and from an appearance of competence, both of which kept her from obtaining needed help. Third, unstructured time alone regularly resulted in ruminative thoughts about past failures and a downward mood spiral that culminated in overwhelming shame, anxiety and limited-symptom panic attacks. Finally, when the situation was further complicated by conflict with a partner, she had panic, anger, and intense urges to cut herself and to escape. The best predictor of a chain ending with increased suicidal ideation or a suicide attempt was her interpretation of the likelihood of reconciliation with her partner versus being alone forever.

Even a brief task analysis suggests many possibilities of what could change to reduce Mary's suicide crisis behavior. Adequate pain management of migraines would lower her vulnerability to emotion dysregulation. The skills deficits that contribute to problems at work (a lack of appropriate assertiveness and apparent competence) would be remedied by skills group attendance and systematic work in individual therapy to apply these new skills to the work setting. Further, the individual therapist could watch for Mary's tendency to minimize problems and discrepancy between emotional experience and expression in-session and encourage change whenever these behaviors occurred. Another dysfunctional link to parasuicide is the pattern of rumination about past failures. The therapist could use a variety of strategies, from activity scheduling during the weekends to exposure and cognitive restructuring to modify the overwhelming shame evoked by thoughts of past failures. In addition to the emotion regulation and distress tolerance skills taught in the group sessions, the therapist also might teach basic panic management techniques. Practical measures such as removing razors and not keeping a lethal dose of any medications in the house would decrease her risk of impulsive parasuicide (self-management skills and contingency management). A final area for further assessment highlighted by this behavioral analysis is to identify exactly what it is about the loss of a love relationship that leads to suicide attempts. For example, Mary had the belief that if she makes someone who loved her reject her, she deserved to be dead; a belief that if she were dead the other person would regret leaving her; an unwillingness to exist unless she was loved in-

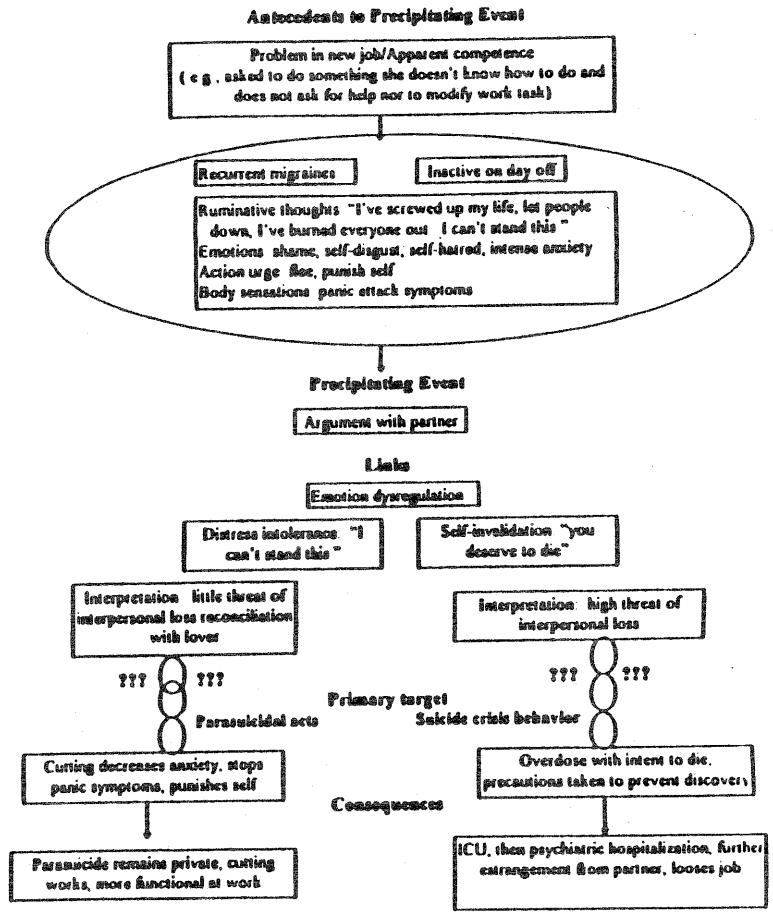

FIGURE 13.1. Example of flowchart describing determinants of parasuicidal behavior

tensely; and a belief that she was incapable of making it on her own. Again, there are many potential strategies to break the link between the threat of interpersonal loss and suicidal behavior, including cognitive modification of beliefs that maintain suicide as an effective solution, strengthening distress tolerance and reality acceptance skills, strengthening the therapeutic relationship to provide another source of love and regard, increasing other sources of social support, and increasing skills (and recognition of those skills) for coping with everyday problems in living.

The written formulation helps the therapist select, from all of these potential areas of change, those most likely to reduce parasuicide. Because Mary's

suicide attempts had been so nearly lethal, the therapist's foremost goal was to break the link between threat of interpersonal loss and suicidal behavior. This included increasing Mary's skills at maintaining good relationships, couples work, practical agreements about not keeping lethal means available, and active use of distress tolerance skills during relationship conflicts. The other target selected as central was to stop rumination about past failures and to increase Mary's ability to self-validate and regulate shame reactions. While the therapist watched for opportunities for change in each of the areas in the task analysis, these two areas of change became the primary focus of the first stage of therapy.

Step 3

As therapy proceeded, it became clear that part of Mary's social avoidance was due to worries that if she increased her interactions with others, she would lose her temper and become physically violent. She reduced that possibility by limiting social interactions, placing few demands on the environment to avoid frustration and anger, and limiting her emotional expressiveness in general. Given her history of physical aggression toward others, these worries were realistic. Consequently, anger management techniques were added as a central intervention. The consultation team also helped the therapist see that she was responding to Mary's hostile statements and suicide threats by decreasing demands on the client, inadvertently reinforcing these behaviors and increasing their frequency over time. Analyses indicated that the therapist was experiencing a hostile work environment as well, which decreased her tolerance for client hostility and stress. The therapist was also unskilled in how to assess for and treat credible suicide threats. By problem solving with the therapist about her own work environment and its effects on the treatment, as well as by providing support, encouragement, and skills training (regarding response to suicidal behaviors), the team helped the therapist to decrease the rate of therapist reinforcement of hostile and suicidal behavior and to tolerate the resulting "behavioral burst" that occurred before the behavior decreased.

TRAINING AND RESEARCH

Training in DBT case conceptualization can be a complex task, depending on the previous training and experience of the therapist to be trained. Because DBT integrates behavior therapy with an Eastern psychological approach drawn from Zen, the therapist must think like a behaviorist and experience like a Zen student. In addition, the empirical-minded, hypotheses-generating and -verifying frame that DBT case conceptualization sits within requires a flexible mind and skill at logical and scientific testing of hypotheses. The necessity of using one's reactions to the client but not letting one's own emotional reactions control the case formulation requires therapists who are able to think clearly under stress and regulate emotions in situations where almost anyone would have a reasonable level of emotional arousal. The emphasis in the treatment on use of basic psychological principles as well as behavior therapy procedures suggests that DBT training should begin after an individual is already reasonably well trained in behavior therapy. To date, our primary method of training research therapists has been to combine the following into an ongoing training/supervision program: an intensive formal didactic seminar (approximately 100 hours), individual case supervision (1 hour weekly), ongoing didactic training in principles of DBT case conceptualization, observing and discussing videos of expert treatment, group outlining of case conceptualization of various training cases (1 hour weekly), DBT peer team consultation (1 hour weekly), and various readings via e-mail communications and journal articles. As yet, we have done no research on whether the adequacy of case conceptualization actually affects treatment outcomes. Obviously, this is an important area for future research.

SUMMARY AND CONCLUSIONS

In this chapter we have introduced the basic concepts and method of case formulation used in DBT individual therapy for stage 1. DBT is guided by the etiological theory that "borderline" behavior is a function of emotion dysregulation. In attempts to regain emotional equilibrium, clients oscillate between extreme behavioral patterns that are self-perpetuating and present significant obstacles to change. Stage 1 of DBT seeks to decrease parasuicide and behaviors that interfere with therapy and the client's quality of life. Repeated and detailed review of particular instances of problematic behavior identifies the unique antecedents and consequences that maintain the chain of environmental and experiential events leading to the problematic behavior. Through this process, the therapist identifies skills deficits, cognition, emotional responses, and contingencies that interfere with more functional behavior. The therapist uses this information to select the appropriate change strategies (skill training, cognitive modification, exposure therapy, and contingency management). Noncollaboration and therapeutic impasse are to be expected and should occasion further review of how both parties contribute to problems in therapy. The formulation is a "work in progress," under constant revision, yet maintaining coherence with respect to targeted behaviors and the conceptual framework within which they are analyzed.

Case formulation is a crucial element of effective, efficient DBT. Despite the time it takes, case formulation should be a standard of care with multiproblem interpersonally difficult clients. With these clients, therapist skill and motivation are often under siege. Case formulation helps direct focused activity, even when the therapist is under duress, and serves as a reference point for thoughtful changes in the treatment plan.

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