A SHORT-TERM TRAINING CLINIC MODEL FOR DIALECTICAL BEHAVIOR THERAPY (DBT) IN TREATING BORDERLINE PERSONALITY DISORDER (BPD): THE CASE OF "JANE"

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ABSTRACT

Dialectical Behavioral Therapy (DBT) is an evidence-based, long-term psychotherapy initially developed to treat Borderline Personality Disorder (BPD) patients and/or highly suicidal patients. DBT involves four treatment modes: tailored individual therapy, phone coaching from the individual therapist, structured group skills training, and therapist supervision by participation in a "consultation team." While manualized, DBT is a multifaceted and flexibly applied treatment that balances interventions for both acceptance and maintenance (e.g., validating the patient in the present) and change and progression (e.g., encouraging the patient to try on new, more healthy attitudes, emotions, and behaviors). The Dialectical Behavioral Therapy Clinic at Rutgers University (DBT-RU) is a research and training clinic that adapts to DBT Manual to provide short-term (6-months long), comprehensive DBT for community adults presenting with BPD and associated problems. The present project reports an example of the DBT-RU model in action, including the decision-making processes involved, by presenting the case of "Jane," for whom I was the therapist. At the beginning of therapy Jane was a 32-year-old, heterosexual, Caucasian, single mother of a 7-year-old son who worked as a medical technician and who met full DSM criteria for BPD. Her symptoms included: (1) recurrent unstable and intense relationships that alternated between idealization and devaluation; (2) frantic efforts to avoid abandonment; (3) identity disturbance (e.g., fluctuating religious beliefs, changing conception of self in relationships); (4) impulsivity (e.g., potentially damaging sexual behavior, substance use); (5) affective instability due to marked reactivity of mood; (6) chronic feelings of emptiness, as though her "inside is missing"; and (7) inappropriate, intense anger. In addition, she reported past suicidal ideation that was "very strong." In line with Jane's intense, mood-dependent, and challenging presenting problems, the process of therapy was complex. Over the course of

therapy she showed substantial improvement, as reflected by both quantitative measures and qualitative indicators.

Key words: Dialectical Behavioral Therapy (DBT); Cognitive Behavioral Therapy (CBT); Borderline Personality Disorder (BPD); pragmatic case study; case studies; clinical case studies.

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Chapter I: Case Context and Method

Introduction

The following is a pragmatic case study examining the treatment of "Jane," a patient presenting with Borderline Personality Disorder (BPD) and associated problems. Jane received short-term Dialectical Behavior Therapy (DBT) from the author of this project and the team of DBT therapists at the Dialectical Behavior Therapy Clinic at Rutgers University (DBT-RU), a research and training clinic within the Rutgers Center for Psychological Services at the Graduate School of Applied and Professional Psychology (GSAPP).

The focus of this study will be a systematic analysis of a somewhat typical client and treatment seen at DBT-RU. The aim of this pragmatic case study is to provide an account of this short-term DBT treatment in terms of: (a) its procedures and process; (b) its quantitative and qualitative outcomes; and (c) how its procedures and processes are related to outcomes via possible change mechanisms.

Client Selection Rationale

The criteria for determining the case to be studied was based on several primary factors. First, the case would be selected from the author's caseload at DBT-RU. Second, the case was to be representative of a "typical" client presenting with BPD. That is, the selected client met full criteria for BPD and displayed treatment-interfering, mood-dependent behaviors commonly observed in patients with BPD. Third, the treatment would be representative of a "typical" course of treatment at DBT-RU. That is, the client received a 6-month course of comprehensive DBT. Lastly, the decision was additionally based upon the presence of unsatisfactory outcomes throughout treatment that were detected through therapeutic monitoring and systematically

addressed using DBT principals and methods. The hope is that this study will elucidate the dynamic nature of DBT and the decision-making processes involved.

Clinical Setting

Treatment occurred at DBT-RU, which is housed within the Rutgers Center for Psychological Services, the training clinic of the Rutgers GSAPP. At the time treatment took place, I was in my fourth year of the clinical psychology doctoral program at GSAPP and my second year as part of the DBT-RU treatment team.

DBT-RU is a research-oriented psychological treatment clinic for populations struggling with BPD and associated problems. It also trains doctoral-level clinical psychology graduate students to deliver DBT. The overall aims of the research clinic are to determine ways to improve therapist training in existing treatments for complex and difficult-to-treat problems, to develop new and more effective treatments, and to improve the field’s understanding of severe psychopathology.

DBT-RU offers comprehensive DBT with all four modes of the treatment. Each participant receives individual psychotherapy and phone coaching from their individual therapist. Group skills training is provided by a group leader and a co-leader who teach the four DBT skills modules in 6-month cycles. The group leader and co-leader are also individual therapists and may therefore treat some group members in individual therapy. The therapist in the present case was first co-leader and later group leader during the client’s time in treatment. In accordance with comprehensive DBT protocol, each graduate student is part of the DBT-RU consultation team. The team delivers DBT consultation to each clinician to support effective treatment delivery for each of DBT-RU’s patients.

DBT-RU provides 6-month courses of DBT for participants. This contrasts with other DBT clinics that tend to provide treatment for a minimum of one year. Whereas standard DBT typically has clients cycle through a minimum of two 6-month courses of skills group, DBT-RU has participants attend one 6-month cycle. Research produced from DBT-RU indicates this short-term training model effectively and efficiently treats BPD (Rizvi, Hughes, Hittman, & Vieira Oliveria, 2017). The shorter-term nature of this model increases access to care for a population that consumes extensive resources.

Extensive clinical training is provided for graduate student clinicians at DBT-RU. There are typically around 8-10 clinicians on the DBT-RU treatment team at any one time. Each student clinician is in the program for two years. During that time, student clinicians participate in the consultation team and receive training and supervision from the director of the program. The treatment team typically meets together with the training director for two and a half hours weekly. The time during these weekly meetings is divided evenly between didactic training and consultation team. Responsibility for leading consultation team is rotated between each team member, including the clinic director. Clinical supervision is provided by the clinic director for each student clinician and for skills group. Two, sometimes three, student clinicians receive weekly hour-long supervision together. Typically, more advanced clinicians in the program are placed with newer team members in supervision. The newer clinicians are asked to watch video footage of the advanced students' most recent therapy sessions prior to each supervision session. Diary cards and video clips are reviewed during each supervision session. Skills group is facilitated by a group leader and a co-leader. Skills group leaders begin as co-leader for a 6-month rotation before advancing to group leader for an additional 6-month rotation. The skills group leader and coleader meet together with the clinic director for supervision specifically for

skills group. Video clips from the most recent skills group is typically reviewed during supervision and a plan is developed in an effort to maximize patients' skills acquisition.

Methodological Study Strategies

For the present study, video-recordings and therapist notes were used as sources of qualitative data. Therapy sessions were video-recorded and detailed notes were taken after each therapy session and phone coaching call. The notes and video-recordings were used to analyze effective/ineffective elements of treatment during supervision and also used in the post-treatment analysis. Quantitative measures were taken during three assessment sessions and periodically throughout treatment. DBT diary cards, which contained daily ratings of treatment targets, emotions, and skills, were reviewed. These quantitative measures were reviewed for the present study. The measures and results are discussed in the chapters on assessment (IV) and outcome (VIII).

Chapter II: The Client

"Jane" was a 32-year-old heterosexual Caucasian female Army Veteran and medical technician residing in a New Jersey apartment with her 7-year-old son, "Brandon." Jane presented as composed, intelligent, and competent. At intake, Jane was sexually active with multiple male partners. She reported ongoing dissatisfaction with her various relationships. Jane presented to treatment with symptoms of BPD. These symptoms included: (1) recurrent unstable and intense relationships that alternated between idealization and devaluation; (2) frantic efforts to avoid abandonment; (3) identity disturbance (e.g., fluctuating religious beliefs, changing conception of self in relationships); (4) impulsivity (e.g., potentially damaging sexual behavior, substance use); (5) affective instability due to marked reactivity of mood; (6) chronic feelings of emptiness, as though her "inside is missing"; and (7) inappropriate, intense anger. Jane additionally reported "very strong" suicidal ideation in the past. She reported passive suicidal ideation at intake and during treatment.

Jane presented with symptoms of Body Dysmorphic Disorder. These symptoms involved obsessive worry about skin imperfections, such as visible pores and wrinkles. She feared skin damage due to sun exposure. Jane reported engaging in compulsive safety behaviors, including mirror checking and skin picking. She described frequent self-deprecating rumination prompted by her negative judgments about her skin. That rumination frequently led to feelings of hopelessness and passive suicidal ideation. Prior to intake, Jane had received several years of Cognitive-Behavioral Therapy (CBT) to treat her body dysmorphia. She reported significant progress in that area. Jane sought DBT to decrease her symptoms of BPD and to improve her most meaningful relationships. Her treatment comprised twenty-six weeks of individual therapy, phone coaching, and skills group.

Chapter III: Guiding Conception with Research and Clinical Experience

The Nature of Borderline Personality Disorder (BPD)

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines BPD by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts. Diagnostic criteria is met if at least five of the following nine conditions are present: (1) frantic efforts to avoid real or imagined abandonment; (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; (3) identity disturbance characterized by markedly and persistently unstable self-image or sense of self; (4) impulsivity in at least two areas that are potentially self-damaging; (5) recurrent suicidal behaviors, gestures, or threats, or self-mutilating behaviors; (6) affective instability due to a marked reactivity to mood; (7) chronic feelings of emptiness; (8) inappropriate, intense anger or difficulty controlling anger; and (9) transient, stress-related paranoid ideation or severe dissociative symptoms (APA, 2014).

BPD is a severe disorder that represents a significant public health concern. The prevalence of BPD in the United States is estimated at 1.6 percent of the general population and lifetime prevalence at 5.9 percent (Grant, Chou, Goldstein, Huang, Stinson, Saha, Smith, Dawson, Pulay, Pickering, & Ruan, 2008). Those with BPD consume considerable mental health resources (Bender, Dolan, Skodol, Sanislow, Dyck, McGlashan, Shea, Zanarini, Oldham, & Gunderson, 2001). Studies of clinical populations found BPD diagnoses amongst 6.4 percent of urban primary care patients (Gross, Olfson, Gameroff, Shea, Feder, Fuentes, Lantigua, & Weissman, 2002), 9.3 percent of psychiatric outpatients (Zimmerman, Rothschild, & Chelminski, 2005), and as much as 20 percent of psychiatric inpatients (APA, 2013). People with

BPD are at substantially increased risk of suicide, with suicide rates approximated between five to ten percent – many times that of the general population (Oumaya, Friedman, Pham, Abou, Guelfi, & Rouillon, 2008; Pompili, Girardi, Ruberto, & Tatarelli, 2005). Additionally, it is estimated that 70 to 84 percent of people with BPD attempt suicide at least once (Black, Blum, Pfohl, & Hale, 2004). In sum, BPD is associated with significant risk, functional impairment, and consumption of clinical resources (Grant et al., 2008).

Clinical professionals commonly consider BPD to be "difficult to treat" due to the severity of presenting problems, emotion dysregulation, and degree of behavioral dyscontrol often associated with the condition (Linehan, 1993). Indeed, treatment of BPD is associated with highly elevated rates of burnout amongst clinicians and few mental health professionals have the knowledge to effectively treat these problems (Linehan, Cochran, Mar, Levensky, & Comtois, 2000). Luckily, several promising treatments have emerged and have been shown effective in treating BPD (Binks, Dolan, Skodol, Sanislow, Dyck, McGlashan, Shea, Zanarini, Oldham, & Gunderson, 2006; Giesen-Bloo, van Dyck, Spinhoven, van Tilburg, Dirksen, van Asselt, Kremers, Nardort, & Arntz, 2006).

Of the existing evidence-based treatments for BPD, DBT has generated the most empirical support thus far (Binks et al, 2006). However, significant portions of DBT patient populations do not show clinically significant improvement after one year of treatment (Rizvi, 2011). It is therefore important to continue evaluating and improving DBT and other treatments for BPD.

Background of Dialectical Behavior Therapy (DBT)

DBT was originally developed to treat BPD and behaviors associated with suicidality and self-harm (Linehan, 1993). DBT has been shown to significantly reduce the symptoms of BPD,

including suicidal and self-injurious behaviors (Linehan, 1993; Panos, Jackson, Hasan, & Panos, 2014). It has also been shown to reduce rates of mental health hospitalizations and client dropout (Lynch, Trost, Salsman, & Linehan, 2007).

DBT is a form of cognitive-behavioral therapy (CBT). Like other CBT protocols, DBT emphasizes assessment, cognitive-behavioral case conceptualization, operationally defined treatment targets, mutually agreed upon treatment goals, and collaborative therapeutic relationships (Linehan, 1993). DBT applies empirically supported CBT interventions, such as problem-solving, cognitive modification, skills training, exposure and response prevention, and contingency management.

Whereas most CBT protocols focus on facilitating *change* in clients, DBT places an equal emphasis on promoting *acceptance.* That is, in a context where patients come to work towards change, they are also taught to accept themselves and their environments as they exist in the present moment. This balance of *acceptance* and *change* in DBT is derived from Eastern spiritual practices like Zen Buddhism (Linehan, 1993).

DBT is grounded in two overarching theories—the biosocial theory and dialectical theory. The biosocial theory is an etiological model for BPD. It suggests BPD develops in people with biological vulnerabilities for emotional reactivity who endure invalidating environments that punish emotional communication and intermittently reinforce extreme emotional expressions (Crowell, Beauchaine, & Linehan, 2009). The result is an emotionally labile person who lacks the skills for effective emotional regulation and therefore vacillates between emotional inhibition and extreme emotional expression.

Dialectical theory is a worldview that conceptualizes all aspects of reality as being in a perpetual process of change caused by the synthesis of polar opposite forces. The concept of

dialectics produces three primary principles—diametric tension and synthesis, interconnected wholeness, and perpetual change. These principles permeate all aspects of DBT (Linehan, 1993). The role of a DBT therapist is to facilitate the client's embrace of dialectics using specific therapeutic strategies.

Biosocial Model of BPD

DBT conceptualizes the etiology of BPD using a biosocial theory. The theory posits BPD results from the transaction between biologically based emotional vulnerability and pervasive social invalidation. A person is more emotionally vulnerable when variables of their emotional experiences (e.g., sensitivity, intensity, duration) are abnormally heightened. Human emotions can be socially regulated via validation (Hofmann & Doan, 2018). Validation, in this context, refers to the communication of understanding and acceptance of another person's emotional experiences (Linehan, 1997); that those emotions and resultant responses "make sense and are understandable" given the context (Linehan, 1993). Invalidation is the opposite; it is communicating that an emotional experience does not make sense; that it is not understandable and not acceptable. When a person is emotionally vulnerable, they are more likely to receive social messages communicating a given emotional experience and response is "wrong" in some way (e.g., "There is nothing wrong," "You are overreacting," "Stop acting crazy," "What is wrong with you?"). Social invalidation of emotional experiences tends to amplify emotion reactivity and the likelihood of emotion dysregulation (Shenk & Fruzzetti, 2011).

According to the biosocial theory, chronic social invalidation of the emotionally vulnerable can lead to problematic social transactions. The person receiving invalidation is likely to develop extreme behavioral response patterns to regulate substantial emotions. At one extreme, the emotionally vulnerable person might ignore or deny valid emotions and

contributing factors. Such avoidant behavior may result in short-term reduction of unwanted emotions. However, these emotion regulation strategies often fail to address causal factors and the person fails to learn more effective solutions. Not having dealt with causal factors nor learned more effective methods for longer-term emotion regulation, the emotionally vulnerable person is more likely to repeat the experience.

At the other extreme, when self-invalidation does not successfully reduce painful emotion, the person may engage in desperate behaviors to reduce or avoid emotion. Consequently, the person does not learn effective emotion regulation methods.

In such cases, the emotionally vulnerable person may seek help through extreme communication. Help from the environment is commonly sought when short term emotion regulation is not achieved independently. The intensity of the help-seeking behavior increases when social resources invalidate initial attempts to obtain emotional support. The emotionally vulnerable person learns that more extreme communication garners social support that was not obtained through less intense communication. A similar reinforcement paradigm occurs when a person gives a barking dog food from the dinner table when the persistence and volume of the barking increases. As a result, the individual learns to conceptualize emotional experiences in extremes when emotional experiences are chronically invalidated over time. That is, the individual may develop beliefs that negative emotions do not reflect valid concerns or else indicate a catastrophic problem is present.

The Nature of Dialectical Behavior Therapy

Comprehensive DBT involves specific stages, therapy modes, foundational assumptions, evidence-based interventions, and strategies for maintaining and facilitating treatment.

Treatment Progression: There are multiple steps prior to the initiation of DBT. The first requires careful assessment of the client's presenting problems and history. A case formulation is developed to determine the level of disorder and fit for DBT. If deemed appropriate for DBT, clients begin in the pre-treatment stage where the therapist and client establish treatment expectations, set goals, discuss the biosocial theory, complete additional assessment (e.g., risk assessments), and commit to the treatment (Linehan, 1993).

DBT is organized into stages: pre-treatment and Stages 1-4 (Koerner, 2007). The stages exist as a tool for focusing therapy tasks (Koerner, 2007). It is important to note DBT is based on guiding principles rather than stringent rules, and treatment may therefore progress nonlinearly due to this inherent flexibility (Rizvi & Sayrs, 2017). The case formulation delineates the level of disorder and determines the corresponding stage of treatment that the client will enter (Koerner, 2007). The stage has specific goals that define it (Koerner, 2007).

Stage 1 of treatment is designed to control and eliminate behaviors that are life-threatening, therapy-interfering, or detrimental to quality-of-life, such as those that contribute to perilous financial insecurity or homelessness (Rizvi & Sayrs, 2017). Additionally, Stage 1 targets include increasing skillful behaviors, such as core mindfulness, interpersonal effectiveness, emotion regulation, distress tolerance, and self-management (Linehan, 1993). Gaining competence in the application of skills to replace maladaptive behaviors is often an intensive endeavor (Linehan, 1993). The present case, like many short-term cases that begin in Stage 1, did not progress beyond this stage.

Stage 2 aims to reduce and regulate experiences of post-traumatic stress (Linehan, 1993). Many people who exhibit control over maladaptive problem behaviors after Stage 1 are often left experiencing a sense of "quiet desperation" in the face of adverse emotions (Koerner, 2007).

Whereas Stage 1 primarily focuses on present-based behavioral control, Stage 2 addresses past experiences of trauma and invalidation (Linehan, 1993). Stage 1 provides the patient with skills and supports to effectively cope with the emotional upheaval associated with trauma-processing in Stage 2 (Linehan, 1993). The aim of Stage 2 is to increase more effective experiences of emotions through exposure therapies (Hayes, Masuda, Bissett, Luoma, & Guerro, 2004).

Little writing or research exists regarding Stages 3 and 4 of DBT (Koerner, 2007). Stage 3 shifts focus towards developing self-trust in applying skills to solve problems of everyday living, attain goals, increase self-worth, and manage ordinary fluctuations between joy and woe (Linehan, 1993; Rizvi & Sayrs, 2017). This involves transitioning from a reliance on therapy to a reliance on self to cope both independently and with the support of others within a reciprocal interpersonal network (Linehan, 1993). Stage 4 is an optional final step aimed at achieving sustained contentment and resolving the sense of incompleteness for those clients that desire a sense of spirituality or holistic connection (Linehan, Cochran & Kehrer, 2001).

Therapy Modes: DBT is delivered through four modes (Linehan, 1993). Patients receive individual psychotherapy, phone coaching, and group skills training. DBT is also delivered to the therapist via consultation team.

Individual psychotherapy is the primary mode of treatment (Linehan, 1993). It seeks to inhibit maladaptive behaviors and replace them with more effective, skillful ones. The other three treatment modes buttress this overarching goal (Linehan, 1993). Group skills training is provided weekly to teach skillful behaviors in the four skills modules of DBT – Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. The skills modules are taught over the course of six-month rotations. Mindfulness is taught for two weeks at the start of the other three modules, each of which last for six or seven weeks. Phone coaching is provided

by the individual therapist to increase skills generalization in real-life situations. Importantly, DBT consultation team serves to maintain treatment fidelity. The immediacy and intensity of presenting problems faced by patients with BPD can often lead therapists to make ineffective treatment decisions (Linehan, 1993). The DBT consultation team counteracts this phenomenon by "treating the therapist" (Linehan, 1993).

Each mode of treatment serves a variety of functions. Broadly, the functions of DBT include increasing client motivation (individual therapy), increasing client capability (skills group), facilitating skills generalization (phone coaching), structuring the client's environment (sessions including family, significant others, etc.), and increasing therapist skills and motivation (consultation team). The modes of treatment may be used flexibly to serve these functions in whatever ways deemed pertinent to meet the idiosyncratic needs of individual patients.

Assumptions: Foundational assumptions regarding clients, therapists, and DBT itself undergird each intervention, strategy, and mode employed (Koerner, 2012; Linehan, 1993). First, the assumptions about DBT clients state that people in DBT: (1) are doing the best they can; (2) want to improve; (3) need to do better, work harder, and be motivated to change; (4) have lives that are unbearable as they are currently being lived; (5) must learn new behaviors in all areas of their lives; and (6) cannot fail.

Second, assumptions about DBT and its therapists state: (1) the most caring thing a therapist can do is help clients change in ways that bring them closer to their own ultimate goals; (2) clarity, precision, and compassion are of the utmost importance; (3) the therapeutic relationship is a real relationship between equals; (4) principles of behavior are universal, affecting therapists no less than patients; (5) therapists treating patients with BPD need support; (6) DBT therapists can fail; and (7) DBT can fail even when therapists do not (Koerner, 2012).

Primary Treatment Targets: DBT targets behaviors in order to move towards goals. DBT delineates hierarchical categories of targets, including life-threatening behaviors (LTBs), treatment-destroying behaviors (TDBs), treatment-interfering behaviors (TIBs), and quality-of-life interfering behaviors (QOLIBs). LTBs refer to those behaviors that may present an imminent threat to the patient's life. These include active suicidal thoughts, suicidal behaviors, and self-harm. Dangerous activities like substance abuse and risky sex are not considered LTBs because those represent longer-term risks to the patient's health and well-being. TDBs are those that pose an imminent threat to the patient receiving treatment. For example, consecutive missed sessions are considered TDBs because participants are removed from the program if they miss four in a row. TIBs are those behaviors that negatively impact effective treatment implementation. These include tardiness, missed groups or therapy sessions, incomplete homework, and detrimental interpersonal behaviors. It is important to note that the DBT therapist may also engage in TIBs. The therapist's TIBs are assessed and addressed just as they are with patients. QOLIBs refer to behaviors that negatively impact the patient's quality of life. These include things like drug use, disordered eating and purging, legal problems, risky sexual behaviors, job loss, financial issues, and relationship problems.

The target hierarchy is arranged in that specific order to prioritize the maintenance of treatment. DBT takes the position that the hard work of improving a client's quality of life is successful only when the client is alive and engaging in treatment. It therefore prioritizes keeping the client alive, in treatment, and engaged in the project of building a life worth living.

Secondary Treatment Targets: Also referred to as "dialectical dilemmas," secondary treatment targets refer to behavioral patterns that commonly hamper or hinder the effectiveness of interventions designed to treat primary targets. The secondary targets are categorized by three

continua: self-invalidation—emotional dysregulation, apparent competence—active passivity, and inhibited grieving—unrelenting crisis.

As the biosocial theory of BPD elucidates, biological predispositions towards heightened emotionality combined with chronic social invalidation produces fluctuations between extreme poles of emotional inhibition versus emotional expression. The poles of each dialectical dilemma are defined by the over-abundance of cold, inhibitory, invalidating rationality at one end of the spectrum and hot, expressive, emotionality at the other.

"Self-invalidation" refers to thoughts and behaviors involved in negatively judging and denigrating one's emotional responses. It is the self-flagellating "off switch" to emotions. Self-invalidation is associated with the unrealistic expectations for oneself that are learned from social invalidation. It blocks problem-solving by blocking the acknowledgement that a problem exists. Conversely, "emotional vulnerability" is the willful behavior associated with emotional overwhelm. It is the ineffective, unskillful behaviors one engages in when surrendering to the action urges of powerful emotions.

"Apparent competence" denotes behaviors that minimize problems and reject the need for help despite desperately requiring it at times. These behaviors convey the impression that one is calm, cool, collected, and competent. Consequently, problems are often inadequately addressed. At the opposite end of the spectrum, "active passivity" refers to the communication of helplessness or hopelessness that indirectly solicits help from others. This behavior interferes with more effective problem-solving methods.

"Inhibited grieving" refers to the tendency to avoid or control strong emotions associated with loss (e.g., grief, sadness, guilt, anxiety, panic). The specific avoidance behaviors are ineffective solutions that maintain suffering and frequently produce new problems. Such

avoidance prevents one from learning how to effectively experience and accept one's emotions. "Unrelenting crisis" refers to the seemingly constant problems that emerge from chronic maladaptive behaviors aimed at avoiding grief. In therapy, unrelenting crises can make therapy disjointed and disorganized as it seeks to rectify problems as they arise without addressing underlying causes.

Interventions: The underlying theory of DBT suggests that presenting problems result from maladaptive thoughts, feelings, and behaviors which are maintained by operant contingencies. DBT interventions treat BPD by replacing maladaptive thoughts and behaviors with more effective ones. The effectiveness of thoughts, behaviors, and interventions is determined by the degree to which they achieve the aims of DBT – movement towards the client's personal "life worth living" goals and values. These goals and values are identified early in treatment and are routinely referenced to assess the effectiveness of interventions and adjust the treatment plan accordingly. As with all aspects in DBT, goals and values can change over time and across situations. They are frequently reviewed to ensure they accurately operationalize a "life worth living" in dialectical balance.

DBT conceptualizes its interventions using four broad sets of interventions: (1) skills building; (2) exposure and response prevention; (3) cognitive modification; and (4) contingency management (Linehan, 1993). Skills building involves learning and employing more effective behaviors in place of treatment targets. DBT seeks to develop clients' competency in specific skills from the four skills modules (i.e., Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness). Exposure and response prevention seeks to extinguish ineffective emotional and behavioral responses to the stimuli that cue them. This intervention involves repeated voluntary actions to elicit adverse emotions while preventing ineffective

responses. Cognitive modification seeks to alter beliefs that inform ineffective actions and thought processes. It promotes cognitive flexibility and cognitive diffusion by challenging patients to defend alternative explanations in addition to their preconceived notions. Contingency management involves targeted changes in cues and consequences. The therapist strategically reinforces effective behavior (i.e., provides a consequence that increases the likelihood of a behavior reoccurring) and punishes ineffective behavior (i.e., provides a consequence that decreases the likelihood of a behavior reoccurring). The therapist provides reinforcers and punishers in treatment and works with the patient to align contingencies the client experiences outside of treatment with the client's ultimate goals.

Skills: The DBT skills represent an amalgamation of evidence-based interventions (Linehan, 2015). The skills are categorized according to their broad functions in DBT. Mindfulness and Distress Tolerance skills are largely considered acceptance-oriented treatment approaches. Emotion Regulation and Interpersonal Effectiveness skills primarily represent change-oriented tactics.

Mindfulness is foundational in DBT. It supports all other skills. Mindfulness in DBT involves the intentional practice of observing, describing, and participating in the present reality (i.e., "What" skills). These skills are done nonjudgmentally, in the moment, and effectively (i.e., "How" skills). Within the DBT perspective of mindfulness, one seeks to find psychological balance and behave skillfully by accessing "Wise Mind" – the synthesis of "Emotion Mind" (i.e., thoughts and behavior primarily ruled by emotion) and "Reasonable Mind" (i.e., thoughts, decisions and behaviors primarily influenced by logic and ignoring emotions) (Linehan, 2015).

Distress Tolerance skills involve accepting reality without trying to change it. They are skills for effectively surviving crises (i.e., STOP skill, Pros and Cons, TIP skills, Distract with

ACCEPTS, Self-Soothing, Improving the Moment) and tolerating strong emotions (i.e., Radical Acceptance, Turning the Mind, Willingness, Half-Smiling and Willing Hands, Mindfulness of Current Thoughts). These skills promote perseverance through stressful situations and painful emotions while preventing ineffective, problematic behaviors that attempt to stop or control such adverse experiences (Linehan, 2015).

The other skills modules focus on change-oriented techniques. Emotion Regulation skills aim to change unwanted emotions. They involve understanding and naming emotions (i.e., Identifying and Labeling Emotions, Understanding the Functions of Emotions, Identifying Obstacles to Changing Emotions), changing unwanted emotions (i.e., Check the Facts, Problem Solving, Opposite Action), reducing vulnerability to emotions (i.e., Accumulate Positives, Build Mastery, Cope Ahead, PLEASE Skills to take care of the body), and managing more extreme emotions (i.e., Mindfulness of Current Emotions, Identifying the Skills Breakdown Point) (Linehan, 2015).

Interpersonal Effectiveness skills are for effectively managing needs in relationships. Core Interpersonal Effectiveness skills seek to effectively obtain interpersonal objectives (i.e., Objectives Effectiveness: DEAR MAN skill) while maintaining relationships (i.e., Relationship Effectiveness: GIVE skill) and self-respect (i.e., Self-Respect Effectiveness: FAST skill). This module also contains skills for building relationship (i.e., Finding Potential Friends, Mindfulness of Others), ending destructive relationships (i.e., How to End Relationships), and balancing acceptance and change within relationships (i.e., Walking the Middle Path, using Dialectics, Validation, and Strategies for Changing Behavior) (Linehan, 2015).

Strategies: DBT employs specific strategies to effectively deliver treatment (Linehan, 1993). As previously discussed, the severity of problems presented by patients with BPD can

often hinder effective treatment implementation. DBT combats this phenomenon with explicit strategies for maintaining treatment. These strategies fall into four categories: (1) Dialectical strategies; (2) Core strategies; (3) Stylistic strategies; and (4) Case management strategies (Linehan, 1993).

Dialectical strategies promote balance in therapy by helping clients and therapists get "unstuck" from extreme positions. Extreme views and polarization in therapy impede progress—they inhibit synthesis formation and foster stagnation or dropout. Dialectical strategies are essentially methods of persuasion that bring clients and therapists away from such stances. Being mindful of dialectical tension within and between members of the therapeutic dyad, the DBT therapist employs different dialectical techniques to facilitate synthesis. Dialectical strategies include teaching (e.g., didactics, use of metaphor), modeling (i.e., exhibiting effective behavior), challenging (e.g., highlighting contradictions), extending (e.g., taking the client more seriously than the client does), reframing (e.g., making lemonade out of lemons), and allowing natural change to occur (Linehan, 1993).

Whereas dialectical strategies promote balance within the therapeutic relationship and its members, core strategies directly target the client's deficits in either *acceptance* or *change* (Linehan, 1993). Acceptance strategies focus on validation—the communication of how logical the client's current state is given the context. The clinician communicates interest and understanding and highlights how the client's thoughts, feelings, and behaviors make sense given the client's biology, learning history, and current situation. The client also learns to self-validate by developing skills in identifying and understanding thoughts, feelings, and behaviors. Clients learn acceptance skills in modules for mindfulness and distress tolerance (Linehan, 2015).

Conversely, change strategies focus on problem-solving. Problem-solving methods involve identifying the problematic causal factors and employing effective means of resolution. Resolution will ultimately involve replacing the client's less effective behaviors with more effective ones. To identify points of intervention, DBT therapists work collaboratively with clients through chain-analyses: detailed systematic assessments of circumstances, internal and external events, and consequences surrounding a maladaptive behavior (Rizvi & Ritschel, 2014). Clients also develop change-oriented capabilities through training in emotion regulation and interpersonal effectiveness skills (Linehan, 2015).

Stylistic strategies entail the manner of communication used to promote dialectical balance. Reciprocal communication strategies are used to convey and encourage acceptance. Such strategies include responsiveness (e.g., displaying interest and concern that aligns with the patient's via eye-contact, smiling, head-nodding, "staying awake," reflecting, verbally expressing interest, active involvement, taking the patient's agenda seriously), self-disclosure (e.g., sharing in-the-moment thoughts and feelings through self-involving self-disclosure, XYZ statements, sharing personal information, modeling self-disclosure), warm engagement (e.g., expressing caring, honest when feeling unwilling, therapeutic touching), genuineness (e.g., displaying natural behavior, helpfulness independent of role, observing natural limits), and acceptance by displaying invulnerability (Linehan, 1993).

On the other end of the spectrum, irreverent communication strategies are used to facilitate change. The intended purpose is to "shake" a client away from a firmly held belief. These strategies typically involve unexpectedly matter-of-fact communication that shocks clients. This technique causes the client to think more dialectically in order to relieve the feeling of being "off-balance." Such strategies include reframing in an unorthodox manner (e.g.,

replying to, "I'm going to kill myself," with "I thought you said you weren't going to drop out of therapy), plunging in where angels fear to tread (i.e., frank discussion of subjects others tend to avoid), using a confrontational tone (e.g., directly challenging an assertion, invalidating through redirection), calling the patient's bluff (e.g., responding to a threat to drop out of treatment by saying, "Would you like some referrals?"), oscillating intensity and using silence (e.g., using a deadpan or highly intense style to contrast the patient's), and expressing omnipotence (e.g., communicating how important you are for the client's progress) or impotence (e.g., communicating that you are "beatable") (Linehan, 1993).

The final category of DBT strategies involves techniques for case management. The strategies for interacting with the community include environmental interventions (i.e., intervening on the patient's behalf when outcomes are important and where the therapist can be effective where the patient cannot be), consultation-to-the-patient (i.e., coaching the patient to effectively self-advocate), and strategies for therapist supervision and consultation (e.g., forming an agenda, holding to consultation agreements, "cheerleading," using dialectical strategies) (Linehan, 1993).

Summary: DBT is a complex, multi-faceted and dynamic treatment modality. The therapy serves to increase acceptance within patients while facilitating behavioral change for more effective pursuit of life-worth-living goals. It fosters progress through skills building, exposure and response prevention, cognitive modification, and contingency management. DBT also dynamically shifts its use of specific strategies to hold patients and their therapists in the treatment, and thereby fosters progress (i.e., dialectical syntheses). The therapy is delivered through several modes to patients (i.e., individual therapy, phone coaching, and skills group) and through the consultation team to the therapist.

Chapter IV: Assessment of Presenting Problems, Goals, Strengths, and History

Presenting Problems

Jane met full criteria for BPD. She endorsed seven of a possible nine BPD symptoms. These symptoms included: (1) recurrent unstable and intense relationships (e.g., parents, son, former spouse, romantic partners) that alternate between idealization and devaluation (e.g., she stated, "When things are good they're amazing, and then it quickly turns to hating them); (2) frantic efforts to avoid abandonment (e.g., frantically text messaging partners, impulsively ending relationships when she fears being left); (3) identity disturbance (e.g., fluctuating religious beliefs, changing conception of self in relationships); (4) impulsivity (e.g., potentially damaging sexual behavior, substance use,); (5) affective instability due to marked reactivity of mood (i.e., intense episodic dysphoria, irritability and anxiety usually lasting hours or several days); (6) chronic feelings of emptiness, as though her "inside is missing"; and (7) inappropriate, intense anger (e.g., angry outburst, yelling, screaming, verbal aggression). Jane denied any suicidal behaviors, self-mutilating behaviors, or stress-related dissociation or paranoid ideation. She reported past suicidal ideation that was "very strong" and led her to research ways to commit suicide. She said her suicidal ideation in recent years has been passive in nature and much less frequent and intense.

Jane met criteria for Body Dysmorphic Disorder (BDD). She reported symptoms beginning shortly after returning from her military deployment. The symptoms increased in intensity over the course of several years until they reached a peak that prompted Jane to seek treatment. At that time, Jane's symptoms included obsessive worry about skin imperfections (e.g., such as pores and wrinkles especially on her face). She reported fears of sun damage and

frequent associated compulsive safety behaviors (e.g., mirror checking, skin picking, avoiding leaving the house, over-applying sunscreen, blocking out sunlight at home, wearing full body coverings outdoors). She received outpatient CBT that significantly decreased the frequency of compulsive behaviors and the impact of BDD symptoms on her daily life. However, she reported continued feelings of "extremely low self-esteem" related to her negative perceptions of her skin.

Jane met criteria for Anorexia Nervosa in partial remission. The last episode that met criteria for anorexia occurred approximately five years prior to intake. The symptoms first appeared when Jane was about 11 years old. The symptoms included food intake restriction, compensatory exercise compulsions, extreme emotional dysregulation if her diet and exercise did not occur as planned, and dysmorphic beliefs that she was fat.

Jane met criteria for Binge Eating Disorder in full remission. The last episode that met criteria occurred approximately eight years prior to intake. The symptoms began when she was approximately 12 years old. She reported times when she was unable to stop eating. Jane stated binge-eating episodes were typically prompted by negative emotions. She recalled feeling "ashamed" and correspondingly took efforts to hide how much she was eating. Jane stated she typically felt "disgusted" with herself afterward binge-eating.

Jane sought DBT to address symptoms that negatively impacted her relationships and her self-esteem. She hoped to build more skillful, effective means of emotion regulation and to increase satisfaction within existing and novel relationships. At intake, Jane described a pattern of managing emotions via emotional suppression. She reported "shutting down" by becoming quiet and withdrawing socially. During those times, Jane's thoughts tended towards hopeless rumination about personal inadequacies (e.g., being ugly, flawed, burdensome, unlovable), dissatisfying aspects of other people (e.g., inadequacies, inability to care for her), and the futility

of relationships. When emotional suppression failed, Jane stated she would "flee" or "explode" in anger.

Jane described a pattern of seeking romantic bonds that she likened to addiction. She reported feeling helplessly preoccupied with and drawn towards romantic relationships despite her best efforts to abstain. Jane reported obsessive rumination about men she was attracted to. Additionally, when Jane perceived close relationships as inaccessible, she reported feeling insufferably "lost," "lonely," and "empty." Jane would seek short-term relief from these feelings through interpersonal connection that she often later regretted (e.g., cheating on partners, engaging in risky sexual behavior, impulsive drug use with men, sleeping at her ex-boyfriend's home). For example, Jane recalled multiple failed attempts to stop intimate interactions with a coworker. She reported feeling "proud" after lasting nine days during one such attempt.

Jane's goals in DBT included improving her relationships (with her son, family members, and romantic partners) and reducing symptoms of body dysmorphia. Jane completed the 26-week course of treatment. During that time, she received comprehensive DBT including individual therapy, phone coaching, and groups skills training.

Relevant Background Information

Jane lived in a New Jersey apartment with her 7-year-old son, "Brandon." Her son was diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD). Jane's biological parents resided nearby and regularly babysat Brandon. Jane maintained a non-romantic relationship with the Brandon's father, with whom she shared childrearing responsibilities without a legally established custody structure. Jane described the relationship as "difficult to manage" because it involved frequent arguments and mutual frustrations.

During treatment, Jane worked as a medical technician and attended online classes towards a master's degree. Prior to her current profession, Jane served in the U.S. Army for three years. She deployed to Afghanistan for one year where she primarily served on base. When she completed her service, Jane returned stateside and maintained consistent while attending college part-time.

Jane grew up in a home with her parents and two siblings – a younger brother, and an older sister. She described a positive relationship with both parents. Jane recalled a "competitive" relationship with her older sister growing up. She stated the relationship became less competitive in adulthood, although she acknowledged she continued to negatively compare herself to her sister. Growing up, the strongest bond Jane reported having was with her brother. Jane's brother died unexpectedly while Jane was deployed in Afghanistan about ten years prior to intake. Jane came home briefly for the funeral and redeployed shortly thereafter. She recalled suppressing her grief in order to function on active duty.

Jane historically experienced difficulty maintaining friendships. She stated that her friendly relationships, which tended not to develop into close bonds, "[fell] apart after a while," and she rarely attempted to maintain or restore them. At intake, Jane said she had three friends at work and felt mostly satisfied with those relationships. One of those friendly relationships included a man with whom Jane was intermittently sexually active. She described the man as a "friend-with-benefits," meaning the relationship was friendly, non-romantic, and included casual sex. Jane reported she often perceived this friend-with-benefits as "unresponsive" to her, which made her feel "angry" and "rejected" in those moments.

Jane was raped on two separate occasions. The first experience was a military sexual assault during her deployment in Afghanistan. During that incident, Jane was drugged and raped

on base. Jane was again drugged and raped by a different perpetrator several years after discharging from military service. She stated she did not recall either sexual assaults because she was unconsciousness during both events. Jane denied any post-traumatic symptoms beyond a "general distrust" towards most men.

Depressive episodes have been a recurrent issue in Jane's life since early adolescence. She experienced several major depressive episodes since then and met criteria for Major Depressive Disorder (MDD), recurrent, in full remission at intake. The most recent major depressive episode occurred more than two years prior to intake and lasted for approximately two months. During these several episodes Jane reported experiencing increased appetite and weight gain, both intermittent hypersomnia and hyposomnia, fatigue nearly every day, excessive feelings of guilt and worthlessness, and recurrent thoughts of death and suicidal ideation. She reported researching a suicide plan and stated she would have likely overdosed on over-the-counter medication had she decided to end her life. Jane stated she did not wish to die and had infrequent, fleeting, passive suicidal thoughts that she found easy to dismiss.

Jane described a history of psychological treatment prior to DBT-RU. Jane was hospitalized in an inpatient psychiatric unit due to restrictive eating when she was 11 years old. Jane had been severely underweight at the time. The treatment was considered successful as Jane regained and maintained body weight within a healthy range. Jane did not receive psychological treatment again until her early 20s when she briefly worked with several different individual psychotherapists. She described these brief stints in therapy as ineffective because she "mostly thought it was stupid" and did not fully engage.

About three years prior to transitioning to DBT-RU, Jane sought psychotherapeutic services at the Rutgers Anxiety Disorder Clinic (ADC) to address severe symptoms of BDD. Her

symptoms of BDD involved obsessive preoccupation and compulsive compensatory behaviors surrounding perceived flaws in her skin that were slight or not observable to others. The symptoms had increased to a point that Jane avoided leaving her house. She stated she was "desperate" at the time she sought treatment at the ADC, where she reported making "mind-blowing progress."

Jane sought treatment at DBT-RU because her individual ADC therapist referred her after suggesting Jane likely met criteria for BPD and would likely benefit from more targeted treatment to address associated symptoms.

Quantitative Assessment

The Borderline Evaluation of Severity Over Time (BEST) is a self-report scale to measure BPD symptom severity. Its psychometric properties were specifically designed for use in clinical trials as they account for changes in BPD severity over time. This scale demonstrates high test, retest reliability, internal consistency, and discriminant validity, and it is sensitive to change (Pfohl et al., 2009; Blum et al., 2002). It has been shown to be of the most robust indicators of illness severity for subjects with BPD (Pfohl et al., 2009).

The scale includes 15 items, each with 5-item likert scales. The items are categorized under three subscales. Subscale A. Thoughts and Feelings (items 1-8) assesses common psychological components of BPD symptomatology, including mood reactivity, identity disturbance, unstable relationships, paranoid, emptiness, and suicidality. Subscale B. Behaviors-Negative (items 9-12) assesses common ineffective coping behaviors exhibited by patients with BPD, including extreme behaviors to prevent abandonment, self-injurious behaviors, suicidal behaviors, impulsive behaviors, and anger outbursts. The items from subscales A and B each refer to specific diagnostic criteria outline in the DSM-IV criteria for BPD. Each item from

subscale A and B are rated according to symptom severity. The symptoms described in each item are rated from 1(None/Slight) to 5 (Extreme). Subscale C. Behaviors-Positive (13-15) assesses more effective behaviors acquired through therapy, including replacing ineffective behaviors with more skillful ones, steps taken to avoid/prevent problematic behaviors, and following through on therapeutic commitments. Items from subscale C are scored according to the frequency with which more skillful behaviors were used. The frequency with which the skillful behaviors described in each item are rated from 5 (Almost Always) to 1 (Never). The BEST is scored by subtracting the subtotal of subscale C from the subtotal of subscales A and B.

DBT diary cards were also reviewed to assess treatment outcomes on an ongoing basis. A diary card is a weekly tracking form with rows for each day of the week and columns that represent aspects of daily experience relevant to the treatment. Diary cards typically track daily experiences of emotions (e.g., shame, fear, sadness, joy, anger, sadness and misery) and treatment targets (e.g., suicidal ideation, self-harm, substance use, urges to quit therapy, and skills utilization). Additional pertinent information may also be tracked, such as substance use and medication. Urges associated with self-harm, quitting therapy, and sometimes substance use are noted before and after therapy sessions as well. Diary cards may also be customized to include treatment specific targets. For example, Jane’s diary card was augmented to include urges and actions surrounding relationship-coping behaviors and body dysmorphia compulsions (see Figure 2). Importantly, diary cards tend to track the utilization of specific skills each day.

The DBT diary card is not a normed or validated measure. Its purpose is to provide critical information to inform the treatment approach on an ongoing basis. Items include self-report ratings on scales of 0-5 for items denoting treatment targets, relevant emotions, and skills usage. It may include “Yes” or “No” items surrounding actions, as well as fill-in-the-blank areas

about items like substance use. Relevant items from Jane’s diary card are discussed in the depiction of the course of treatment (Chapter VI).

Strengths

Jane was bright and interested in learning and growing, as evidenced by her consistent effort towards academic and vocational progress. She displayed motivation to seek and maintain psychotherapy for several year prior to DBT-RU, and she accepted the recommendations of her therapist to pursue DBT, an intensive treatment requiring significant time and energy. Jane displayed the ability to enact behavioral change to positive effect in treating her BDD symptoms over the course of prior treatments.

Building rapport felt easy with Jane. She noted she often became intimately involved in romantic relationships quickly due to a tendency to divulge intimate personal details and discuss deep topics with new partners. Although these tendencies may contribute to difficulties in romantic relationships, they strongly facilitated the development of a strong therapeutic relationship early in therapy. Jane also had a robust sense of humor that allowed her to continue discussing difficult topics than she might otherwise seek to escape. Jane’s love for her son was a significant strength. The bond served as a significant resiliency factor against suicidal ideation and action.

Chapter V: Case Formulation and Treatment Plan

Formulation

Case formulation in DBT focuses on current functioning, goals, and treatment targets. It is less concerned with etiology than assessment of existing factors that prevent the client from changing her behavior and living a life worth living. DBT formulation involves determining the stage of treatment, identifying the client's goals, establishing a preliminary target hierarchy, and assessing highest-order targets (Rizvi & Sayrs, 2017).

The theoretical underpinnings of DBT informed the conception of Jane's case. It was therefore presumed that preexisting biological emotional sensitivities impacted Jane's behaviors which transacted with her social environment to promote self-invalidation of emotions and associated actions. Jane consequently developed ineffective beliefs and behavioral patterns surrounding her emotions and methods of regulating them.

Jane's stage of treatment was determined based on reported behavioral dyscontrol surrounding her presenting problems. She described problematic behaviors within each of her valued relationships (i.e., her son, son's father, parents, siblings, romantic interests, and friends). Jane stated she tends to suppress discontent and hopelessness regarding herself and her relationships until it "explodes" out of her and she engages in further ineffective behaviors (e.g., yelling, physically hitting, breaking off contact). She said she engaged in obsessive rumination about her romantic interests and compulsively sought affection when she perceived psychological "distance" or unresponsiveness. However, she reported "shutdown" behaviors when experiencing hopeless thoughts about her worth or the sustainability of her relationships. Given her behavioral dyscontrol and inexperience with DBT, it was determined Jane would begin in pre-treatment and receive Stage 1 treatment.

Goals were collaboratively discussed and established during the pre-treatment stage. Jane and I agreed on goals including improved mother-son relationship quality, increased romantic-relationship stability (i.e., relationship status maintenance and reduced frequency of experienced turmoil, break-ups, and infidelity), increased balanced view of self and others, decreased emotional lability, and increased instances of "walking the middle path" of cognitive processing and behavior.

It is also important to note, though Jane and I agreed on some specific goals (e.g., improving Jane's relationship with her son, decreasing symptoms of body dysmorphia), we also acknowledged difficulty satisfactorily defining some goals given the dynamic nature of Jane's mood-dependent aspirations. For example, Jane endorsed the goal of maintaining a fulfilling romantic relationship. However, Jane also expressed her strongly held belief that she would not maintain that goal over time given her past experiences in relationships. As is sometimes the case in DBT, we made "defining goals" one of our ongoing treatment goals.

The target hierarchy was collaboratively assessed based on Jane's behaviors that threatened her life, the treatment, and her quality-of-life. Jane exhibited behaviors classified in each of the primary target categories. Jane's top hierarchy target involved suicidal ideation. She engaged in notable TIBs throughout treatment, including homework non-compliance, lateness, absence from individual and group sessions, and underutilization of phone coaching. Jane also displayed TIBs surrounding commitment to treatment. She stated on several occasions that she was "hopeless" and wanted to quit therapy. In addition, Jane failed to secure childcare on several occasions which resulted in multiple scheduling changes and treatment-impacting accommodations. Jane displayed QOLIBs involving ineffective emotional coping. Chain analyses revealed common patterns of emotional coping methods that Jane and I termed

"relationship-coping." These coping methods were characterized by her approaching relationships (e.g., sacrificing daily functioning for relationships, forming new relationships, having impulsive sex, contacting former intimate partners, and infidelity) or withdrawing from them (e.g., stopping talking, displaying "moody" "shutdown" behaviors that punish others' attempts to communicate, leaving suddenly, and breaking up). We categorized these behaviors as relationship-approach or relationship-withdraw behaviors. Decreasing these QOLIBs were primary targets of treatment.

The increase of skillful behavior is another target category in DBT. It exists in the background of each other primary target. DBT seeks to replace ineffective behaviors involved in higher order targets with more effective, skillful ones. Yet the implementation of skillful behavior is also a target of treatment unto itself. For Jane, targeting her goals meant prioritizing the implementation of new skillful behaviors to disrupt ineffective behavioral patterns and actively work towards her goals. Jane's treatment involved targeting increased skillful implementation of effective behaviors in each of the four skills categories: mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation.

Notable secondary targets were present throughout treatment. Jane displayed secondary targets at the extremes of each of the dialectical dilemmas. Jane exhibited fluctuations between emotional vulnerability and self-invalidation in ways that interfered with treatment. Jane frequently engaged in cold, rational invalidation of her emotional responses. For examples, she rejected my coaching instructions to practice Distress Tolerance skills because she was "just being stupid," or else the situation was "not that big of a deal." Jane told me she did not need to practice Distress Tolerance skills because she did not really get distressed. Later that same session Jane described how she had locked herself in a supply closet at work to cry days prior.

When I pointed out the inconsistency she replied, "Well it wasn't really that big of a deal. I was just being overly emotional." As the above example hints at, Jane displayed strong emotional vulnerability, often to shame, as well as emptiness, loneliness, and hopelessness. For example, Jane was unwilling to discuss aspects of her appearance she felt ashamed about for fear of experiencing an extreme emotional response. Jane's extreme reactivity to shame made her reject effective solutions which led to hopelessness and urges to shutdown, give up, end relationships, and drop out of therapy.

Jane's apparent competence and active passivity also presented significant therapeutic obstacles. Jane typically presented with apparent competence – her demeanor appeared calm, cool, collected, confident and competent. She minimized problems and denied the need for help. A significant portion of our therapy was disrupted by my own TIBs when I attempted implementing skills that, in retrospect, were inappropriate given Jane's actual skill level and emotionality. At other times, Jane's behavior was characterized by active passivity. For example, Jane told me on multiple occasions that her problems with relationships and body dysmorphia were hopeless and would never get better. I would respond with efforts to disabuse her of those beliefs, or else I would try to provide solutions to the problems. The result of such interventions was typically therapeutic polarization and stagnation. Another example of treatment-interfering active passivity surrounded childcare. On multiple occasions Jane said she would be unable to attend sessions due to lack of childcare options. On several of these occasions I told Jane to bring her child to our session which commonly caused disturbances and distractions to the detriment of the therapy.

Jane's behaviors across the inhibited grieving versus unrelenting crisis spectrum represented many of the primary targets in Jane's therapy. Some of the "relationship-coping"

behaviors Jane and I targeted can be thought of as examples of inhibited grieving that often contributed to unrelenting crises. For example, feelings of emptiness can be considered a grief response since it is the emotional fallout of interpersonal loss. Jane avoided and suppressed these emotions with relationship-approach behaviors that involved drug use and sleep deprivation. Jane's performance consequently suffered in school, work, and treatment. These "dialectical dilemmas" are considered secondary insofar as they created recurrent problems that required extensive time and energy to stimulate Jane's active involvement.

Treatment Plan

The treatment plan in DBT is developed based on assessment of the highest order treatment targets. It is important to note DBT treatment planning is fluid, ongoing, assessment-driven, and principal-based. It is understood that the treatment plan is likely to shift with ongoing assessment as interventions are implemented and goals and targets evolve. The treatment plan in the present case illustrates the way DBT principals and ongoing assessment of targets, goals, and interventions are used to flexibly tune the treatment approach in service of the patient building a life worth living.

Assessment in DBT typically involves chain-analysis: the in-depth examination of the context and events surrounding a particular behavior. Common factors emerged within several chain-analyses of Jane's past suicidal ideation. The commonalities involved Jane's shame responses leading to interpretations of threats of abandonment, loneliness, and hopelessness. These imprecise and likely erroneous interpretations were justified in her mind with preexisting negative beliefs about herself (e.g., "I'm ugly," "I'm worthless," "I'm unlovable"). She would then experience significant distress and cope using ineffective methods that provided some short-term relief to her long-term detriment.

Jane and I classified her ineffective coping attempts as relationship-coping QOLIBs. Relationship-coping was defined as an attempt to decrease emotional distress via approach towards and/or withdrawal from relationships. For example, a typical chain might include a situation in which Jane experienced negative self-judgments about her appearance and worth leading to intolerable feelings of "hopelessness" and "despair." In such a chain, Jane would typically cope with such feelings via short-term solutions, like withdrawing from a current relationship that she believed to be hopeless and/or seeking validation via intimacy with another man. The resultant behavior, whether withdrawing (e.g., "shutting down" communication, physically leaving, or terminating a relationship) or approaching (e.g., risky sex, contacting an ex-lover) relationships, provide short-term reductions in aversive emotions. In the long-term, however, these behaviors maintain Jane's suffering by preventing more effective coping patterns from forming and by leading to additional negative consequences (e.g., intense regret, self-loathing, hopelessness, suicidal ideation).

Treating Jane's highest order targets involved tracking the suicidal ideation and replacing the ineffective QOLIBs that prompted it. To decrease ineffective behaviors and increase new skillful ones, it was important to also prioritize TIBs. Over the course of treatment, Jane's TIBs were directly addressed in session and targeted on a case-by-case basis.

Chapter VI: Course of Treatment

Preface

A course of DBT described chronologically can appear chaotic. The treatment is complex and fluid. The presenting problems are often dynamic, unpredictable, and mood-dependent. The resultant interventions can seem scattered and disorganized at times.

Order can be discerned by viewing the treatment through two co-occurring lenses. One lens is primarily concerned with treatment *progression*. It focuses on the goal-oriented pursuit of a life worth living. Through it, we examine behaviors and interventions with regard to their effectiveness in building such a life. One can imagine this lens positioned as if to capture the side view of a tightrope walker as she steps forward and backward on her progressive journey across the rope. The other lens focuses on *maintaining* treatment. Through it, we examine behaviors and interventions with regard to their effectiveness in keeping the patient actively engaged in building a life worth living. We can envision this lens positioned in front of the tightrope walker as she shifts her weight from side to side, struggling to maintain balance and remain on the rope.

There are problems definitively conceptualizing any one movement as the strict purview of one lens or the other. For one, both lenses inherently capture aspects of the other – the front facing perspective sees the tight rope walker growing larger in the frame as she progresses, just as the view from the side observes the struggle to balance. Also, there are not necessarily clear distinctions between progressive movements versus those made for balance. Consider the tightrope walker that regains her balance by placing a foot back down on the rope in front its previous position. Such is the case with many behaviors and interventions in DBT. Take, for example, a Distress Tolerance skill that seeks to replace a suicidal behavior. The intervention progresses therapy by replacing an ineffective behavior with an effective one. It also maintains

the therapy by keeping the patient alive. DBT aims to promote both simultaneously. Preservation and progression. Acceptance and change. Maintaining balance requires movement just as sustaining progression requires balance. Progress is not sustained without balance. Balance is not maintained without progress.

Observing the treatment simultaneously through the lenses of progression and maintenance provides valuable focus and organization to this a complex and dynamic course of treatment. To describe a tight rope walker's actions and decisions, one must account for the movements across both dimensions – the forward-and-backward progress as well as the side-to-side balancing act. Such descriptions in the present case may at times seemingly meander to a degree that the reader can easily lose the forest for the trees. Viewing the treatment through both lenses provides the necessary framework to understand the actions and decisions involved.

The course of Jane's treatment will be described in phases. These phases are not an aspect of DBT but rather a means to organize the following description of the present case. Each phase corresponds to the broad treatment approach taken at the time. It should be noted that the first two phases do not progress chronologically because aspects of each phase overlapped during initial sessions. Within each phase we will examine the various and shifting interventions and decisions made to simultaneously maintain and progress treatment.

Phase 1: Formulating Targets and Goals

The first phase of treatment involved establishing therapeutic alignment and an assessment-driven case formulation and treatment plan. This process encapsulated the first four sessions. The following descriptions in this phase do not occur in chronological order because many of the discussions intertwined and spanned the initial four sessions.

Sessions at DBT-RU begin with client and therapist completing assessment measures. After completing initial measures, Session 1 began with a discussion regarding presenting problems. Jane said her initial concerns had previously centered around body dysmorphia but she had made meaningful strides in addressing those symptoms. She was now more interested in having better outcome in her relationships.

Jane elaborated using a recent example in which an intimate partner's plans to spend time with family prompted erroneous judgments (e.g., "He doesn't care about me"), unjustified feelings of anger, hopelessness and fear, and impulsive behaviors aimed at terminating the relationship. To further explicate her difficulties with intimate connection, Jane provided another recent example involving a co-worker "friend-with-benefits." Jane said the "friend-with-benefits" arrangment was "very stressful in a different way" because it made her feel "more stable" and intermittently "more miserable" than she typically feels in relationships. Jane hypothesized the stability stemmed from her lack of expectations within this relationship, indicating instability often arises when unmet expectations confirm her hopeless beliefs. Jane said this relationship gave her frequent pangs of "misery" and "rejection" when considering the coworker's desire to not form a more meaningful relationship. She explained she would withhold negative emotions and impulses in this relationship to the point that the partner had "no idea" of the emotional turmoil Jane was experiencing.

Jane described feeling "lost" when not in some form of a relationship. She reported discomfort when "feeling alone" and "thinking too much about random things," including negative self-judgments and hopelessness about relationships. She said she "needs to feel wanted" and she feels uncomfortable without that knowledge. Jane recalled failed attempts to stop pursuing intimacy with her coworker on multiple occasions. She described a recurrent

pattern that she likened to an addiction in which she felt helplessly drawn back to the relationship despite her efforts to abstain.

Jane reported a short-term decrease in self-loathing and insecurity during initial phases of relationships. She said she tends to rapidly "open up" and divulge personal information which results in fast feelings of connectivity. That "honeymoon phase" of a relationship, as she put it, typically offers frequent displays of affection that bolster Jane's self-esteem and make her feel secure. However, once the frequency and amplitude of affection decreases, Jane interprets the change as threatening and she begins to question the motives of her partner. "At the first sign" that her partner is not "enamored" with her, Jane said she experiences thoughts such as, "He doesn't care about me," which is buttressed by underlying core-beliefs about herself. For example, "I'm ugly. Why would he even be with me?"

Negative judgments about her skin frequently impacted her relationships as well. She would notice a "flaw" and, before she knew it, she was obsessively ruminating as her mood rapidly plummeted. "I can't do anything [in those moments]," Jane said. "I can't focus. I can't have a conversation because I think you're staring at [my skin imperfections]." She explained further, "Whenever I try to end [the friends-with-benefits relationship], [the rumination] about my skin gets worse." Jane explained she feels worthless and sees all the flaws that make her unlovable. That feeling is intolerable, so she returns to relationships where she gains self-esteem from their attention. But her inability to regulate on her own makes her necessitate perfection from partners. If she perceives her partner's behaviors as evidence that he will not be able to fulfill her needs, she confirms her narrative about the hopelessness of the relationship. Eventually, she seeks need-fulfillment elsewhere or else terminates the relationship. Then, she feels discomfort when alone due to her inability to manage emotions; she fears the consequences

of being unable to regulate. She reaches out for connection which temporarily regulates the adverse feelings. At that point Jane is back to the beginning of her cycle.

With her son, Jane stated she frequently feels angry and yells. Her son was diagnosed with ADHD and engaged in disruptive behavior that often "annoyed" Jane. She reported feeling ashamed of her angry outbursts and she wanted to learn to improve her responses.

Combining information from intake and our initial discussions, we began developing an assessment-driven case formulation and treatment plan. This required us to assess presenting problems, establish treatment stage, determine goals, and develop a preliminary target hierarchy. As described in Formulation (V), Jane's presenting problems involved behavioral dyscontrol appropriate for Stage 1 of DBT treatment. The goal of Stage 1 is to establish behavioral control, even in the presence of high-intensity emotions. As Jane had noted, behavioral control was often mood- and situation-dependent and her ineffective coping behaviors would often lead to significant problems in her life.

Through collaborative discussion, we identified some of Jane's preliminary goals for therapy. They included improving relationships with her son (i.e., increased positive interactions, increased self-efficacy in parenting), and with romantic partners and family (i.e., maintain romantic relationships, decrease distress, shame, anger and hopelessness within relationships, increase comfort in relationships). Additional goals included reducing symptoms of body dysmorphia, reducing emotional lability, and increasing instances of "walking the middle path" of cognitive processing and behavior. Taken together, we said Jane's life-worth-living goals amounted to "feeling fulfilled in relationships" and to "accepting [herself]."

Guided by Jane's stage of treatment, goals, and presenting problems, we began identifying an initial target hierarchy. At the top of the hierarchy, Jane endorsed recurrent

suicidal ideation. She denied any imminent risk of suicide. However, we deemed it important to track and target suicidal ideation since it might increase in intensity as she made behavioral changes over the course of treatment. Jane denied any other life-threatening behaviors or non-suicidal self-injury.

Potential TIBs were assessed for the second rung of the target hierarchy. At the outset, Jane's work schedule presented as a potential barrier to treatment fidelity and was thus treated as a TIB. Jane had rearranged her work schedule so she would be off on Wednesdays to accommodate the DBT skills group that met each Wednesday evening. Her resultant work schedule would alternate every other week from Monday and Tuesday to Thursday and Friday. DBT seeks to increase the likelihood of skills generalization. Having individual therapy and skills group on the same day decreases the likelihood of skills generalization. The patient would not have the opportunity try skills out in the real world and use individual sessions to refine that practice before the next group session. For that reason, DBT-RU's policy is to minimize instances of individual sessions occurring on the same day as group, so long as the policy does not negatively impact treatment. To address this issue, Jane and I arranged treatment sessions to accommodate her alternating work schedule.

Jane described TIBs she had displayed in prior therapies, including lateness, absences, homework non-completion, and premature treatment termination. I inquired about specific circumstances and behaviors that may present obstacles to preventing TIBs. Jane mentioned difficulties obtaining childcare had, at times, resulted in absences in prior therapies. She noted that her wavering commitment was likely to be the biggest obstacle. "I find myself in this predicament a lot," she said. "My commitment is dependent upon mood. In one state of mind, I

feel confident about my goal. But that changes and I can't stick to a goal." By that point, Jane said she tends to disengage with treatment. We conceptualized this as "hopeless behavior."

We characterized her primary QOLIBs as "relationship-coping" behaviors. These behaviors involved excessive "withdrawal" from and "approach" towards relationships. "Relationship-withdraw" behaviors were exhibited to cope with painful emotions within relationships, such as shame, anger, and hopelessness. "Relationship-approach" behaviors referred to using relationships to cope with painful emptiness and loneliness. Below is Jane's preliminary target hierarchy:

- **Life-Threatening Behaviors (LTBs):**
  - Suicidal ideation
- **Therapy-Interfering Behaviors (TIBs):**
  - Missing homework
  - Missing sessions (group and individual)
  - Incomplete diary cards
  - Not utilizing phone coaching, not responding to texts
  - Hopeless behavior (refusal to participate)
  - Therapist reinforcing unskillful behavior
- **Quality-Of-Life Interfering Behaviors (QOLIBs):**
  - "Relationship coping behaviors"
    - Relationship-withdraw
      - "Shutting down"
      - Angry outbursts
      - Terminating relationships
    - Relationship-approach
      - Impulsive sex
      - Sacrificing personal health to spend time with men
      - Infidelity

Therapeutic alignment involved orientation to treatment. An overview of the treatment structure was provided, including descriptions of the therapy modes and treatment expectations. During this process, Jane was introduced to DBT, diary cards, phone coaching, the biosocial theory, and other aspects of the treatment.

We reviewed DBT using a handout titled *What Is DBT?* It provided explanations of dialectical theory, behavioral therapy, and the DBT assumptions about clients, therapists, and therapy. We reviewed the different therapy modes, including individual psychotherapy, skills group, between-session phone coaching, and consultation meetings for the therapist. We additionally went over the stage-wise structure of DBT, the goals of each stage, and the target hierarchy that would guide our work together.

Diary cards were introduced in the first session and reviewed several times over the course of orientation. It was explained that diary cards are an essential aspect of DBT. They provide the necessary information to effectively track and address target behaviors. Diary cards would be collected and reviewed at the start of each session and used to set the agenda so that targets are effectively managed on an ongoing basis. It was also explained that diary card completion can at times serve as a proxy for what we were working towards. Since the goal of DBT is to develop more effective, skillful behaviors, that process begins with completing the diary card. When it is not completed, this serves as a starting place for therapy to effectively target the TIB, replace it with effective behavior, and thereby affect the first of many behavioral changes that will move the client closer to a life worth living. I provided Jane a diary card in Session 1 and asked her to begin filling it out daily.

By the end of Session 4, we had collaboratively used our target hierarchy to identify additional behaviors to track, including perceived urge level to engage in safety behaviors related to body dysmorphia (e.g., mirror checking, picking, covering-up, avoiding sun) and "relationship coping" behaviors (i.e., relationship-approach behaviors and relationship-withdraw behaviors) to avoid uncomfortable feelings (e.g., shame, emptiness, loneliness, fear). See Jane's diary card in Figure 2.

We collaboratively reviewed a phone coaching handout to establish the goals and expectations for this mode of treatment. It was explained that the purpose of phone coaching would be to help Jane skillfully get through crises and identify DBT skills that may be useful in real world situations. We addressed expectations for phone coaching. Calls are brief (typically 5-15 minutes) and involve concise description of the situation, expression of emotions and corresponding urges, identification of goals, review of skills already tried, evaluation of other potentially helpful skills, determination of a plan, and commitment to enact the plan to be reviewed at a later time. What *not* to expect from phone coaching was also discussed. That is, a coaching call would not be a therapy session and it would not involve in-depth analysis of situations. It was also conveyed that Jane would be expected to enact skills and that phone coaching would not facilitate unskillful, ineffective or willful behavior.

Jane was taught the biosocial theory that undergirds DBT's approach to treatment. Using a handout titled *The Biosocial Theory of BPD*, Jane and I reviewed the biological and social transaction that DBT conceptualizes as the root cause for her presenting problems. Reviewing this model together provided me my first glimpse into Jane's self-invalidation. She initially rejected the notion that she had been invalidated growing up. Jane said that most invalidation tends to come from herself and her own expectations. "I usually just go crazy and overreact," she said. Here, I introduced Jane to DBT's focus on noticing judgments and rephrasing such language to be more precise. I demonstrated rephrasing her statement nonjudgmentally: "For example," I modeled, "I might rephrase that as, 'I experience a heightened emotional response.' The difference is that a 'heightened emotional response' is something that can be targeted without judgment. If you 'just go crazy' what do we target? 'Crazy' isn't specific and it minimizes the difficulty of what you are dealing with."

Jane was informed that she would be expected to attend all therapy sessions and skills groups, utilize phone coaching, complete weekly diary cards, listen back to audio recordings of each session, and complete all assigned homework. I explained the four-miss rule: four consecutive absences from individual therapy or from skills group would result in immediate treatment termination, and *only* four consecutive absences would produce early treatment termination. That is, once she committed to treatment, Jane would not be considered out of the program until four consecutive sessions were missed. Should Jane decide to "quit" therapy, the whole DBT treatment team would continue striving for her re-engagement with treatment until the fourth consecutive session was missed.

Orientation also involved discussing the therapeutic relationship. I informed Jane about myself, my training, and the importance of a positive and collaborative working relationship. I also asked about Jane's feelings about working with a male therapist. Jane denied having any issues. However, this discussion opened the door to discussing such issues in the future, as would later prove relevant.

DBT seeks to obtain a firm commitment to treatment. The expectations in comprehensive DBT are considerable and intensive. We anticipate urges to quit are likely to arise. Devil's Advocate strategies are implemented to elicit change-talk from participants with the goal of cultivating commitment at the outset. Through it, we aim to have clients argue against the cons of making behavioral changes by endorsing the pros. I challenged Jane, "You said that you are down for this [treatment] and that you will be committed, but this is really hard. Why in the world would you want to do this?" Jane responded, "Well [my mental health] is not working out. It will suck to continue going through life like this. I need an external source of accountability, like a personal trainer to do what I need to do [to improve my mental health]." I reflected and

validated her response. Then I continued to challenge her. "Are you sure, though? This is a lot. I'm going to be pushing you. DBT is really tough. Like there is a reason you haven't changed these behaviors. Its really hard." Jane replied, "Well yeah, but I need this. I'm not going to do what I need to do without it."

We discussed specific behaviors that would need to change. I told her, "To get what you want, you'll need to stop using relationships to cope with your problems. You'll need to face them head on. But you will also have to stop running away from relationships. Do you really want to stop doing that?" Jane said, "Well, I mean, yeah I obviously do want to stop that. I just don't really know how." I told her, "I don't know how we are going to [replace your ineffective behaviors] just yet but I know it is going to suck. Wouldn't it be a lot easier to just continue [coping how you have been coping]?" Jane disagreed. "I mean I know that it will be hard but I know it's what I need. I can't keep living the way I have been." With that, I asked Jane if she was ready to commit and she confirmed that she was. I told her I would take her seriously – that I expected her commitment to waver *and* I expected the ineffective behaviors to stop.

After the first session, I presented the case to consultation team. As the whole team is responsible for each client, it is essential that the team be informed and updated about each case. I additionally requested consultation with team after the fourth session. These initial consultations helped me formulate my understanding of how we, the treatment team, would formulate the case and plan treatment. I began completing a *DBT Stage 1 Case Formulation and Treatment Planning Worksheet* after the first session and my team helped me differentiate goals, targets, and solutions. For example, Jane had endorsed a goal of increasing her use of skills. Was that a goal, target, or solution? Consultation team reminded me that goals were what made life worth living. She did not need to live in order to be skillful, she needed to be skillful in order to

live. Effective solutions are the ascending steppingstones that require an effortful climb toward a life worth living. Targets are the old, descending steps that lead to continued suffering. They are the short-term solution that are easier to travel at first and yet make life more difficult by moving the voyager further from a life worth living. In this case, unskillful behavior was a target, and increasing skills a solution.

Phase 2: Targeting Relationship-Coping Behaviors with Emotion Regulation Skills

By Session 2, top tier targets were already being addressed using the diary card. For example, Jane did not have her diary card at Session 2. She said she lost the diary card shortly after receiving it. Arriving to session without a diary card is considered a TIB and is therefore prioritized as a target behavior to decrease in treatment.

Interventions used to target TIBs may vary. Often times, the DBT therapist performs a chain-analysis on a target behavior and collaboratively identifies links to replace with more skillful behaviors. For this first instance of a missing diary card, I opted to target the TIB by holding Jane accountable (i.e., requesting another diary card), setting the expectation that she will continue to be held accountable (i.e., restating that diary cards would be collected at the start of each session), and establishing the expectation that she will be held accountable for problem-solving if similar situations should arise (i.e., informing Jane it is her responsibility to problem-solve in the future and she can always reach out to me for help). I then had Jane complete the diary card in session. This provided a contingency attached to the TIB of showing up without a diary card.

Session 4

In Session 4, we utilized Jane's diary card to inform our agenda. I directed her attention to the target hierarchy we had developed. We added updates about TIBs to the agenda. No top targets were elevated on her diary card. We opted to target increased skills she had practiced over the week.

We started with the TIBs. Prior to Session 4, Jane had texted in advance of the session requesting to bring her son to therapy due to difficulty finding childcare. I called Jane and provided coaching to brainstorm solutions. During the call, Jane and I agreed on a potential solution of asking her mother using a DEAR MAN (i.e., *Describe* the situation, *Express* emotions about the situation, *Assert* needs to resolve unwanted emotions, and *Reinforce* how it is in the person's interest to acquiesce). Several hours later, Jane texted, "I have to bring [my son]." Her son, Brandon, joined the session. Though the session was largely productive, Brandon did disrupt the session on several brief occasions. These disruptions were conceptualized as TIBs. I told Jane we would need to target these TIBs. A solution to the problem might be securing additional childcare, so I asked her to describe her current options. Jane said the father of her child and her parents were her only childcare options at present. We discussed the reliability of these options. Jane said her son's father was unreliable and unpredictable. She said her parents were reliable and highly likely to be available. I asked Jane if she would be willing to investigate additional childcare resources as a backup plan. Jane committed to doing so and we moved on.

During our discussion, Jane off-handedly mentioned she had "broken things off" with her friend-with-benefits coworker and deleted everything associated with him (i.e., phone number, text history, pictures). She stated that it was necessary to prevent rumination that she feared would lead to her losing resolve and reaching out to him again. However, she stated that she looked up his phone number from an employee list and texted him a question several days after

the breakup. She considered this lapse a relationship-approach behavior. However, she declined my suggestion to perform a chain-analysis on the behavior because she said it "wouldn't happen again" (*apparent competence*).

We shifted gears to target skills acquisition by reviewing a phone coaching call. Jane had called for help coping with a work situation. She requested scheduling a time to review the scenario and develop a plan for dealing with it effectively in future. During the scheduled coaching call, Jane described a distressing situation and I helped her identify her emotions, associated urges, and skills she had already tried. I offered some Distress Tolerance skills and Jane committed to trying Paced Breathing if a similar situation arises in the future. She committed to practicing Paced Breathing in the meantime so she would be better prepared to enact the skill in a moment of distress. Jane also committed to calling me to briefly review how the skills implementation went. Jane called later in the week and reported she had effectively implemented the Paced Breathing skill at work. She reported it had effectively reduced distress and improved her overall effectiveness thereafter. She said implementing Paced Breathing cued thoughts about DBT and helped her resolve her problem.

When we reviewed our phone coaching call in Session 4, Jane said she had not expected to use phone coaching often and that she was surprised she had done so early in treatment. I told her I was glad she had used it (*reinforcing contingency*) and I asked if she anticipated any issues that might prevent her from seeking phone coaching in future. Jane posited that her negative perceptions of men in certain moods may sometimes influence her decision to contact me. I replied with overt sincerity, "Thank you so much for sharing that. That is so incredibly important and helpful to me. I really appreciate you telling me that." (*reciprocal communication, warm engagement, radical genuineness, self-involving self-disclosure*). I asked if she was referring to

anything specific. Jane recalled telling me her "friend-with-benefits" relationship was easier to cope with than a committed relationship and I had replied, "Yeah, I can understand that." Jane said she experienced the statement as validating at the time. However, she later thought back to the interaction and had negative judgments about me—her male therapist—because she thought, "@#$%ing men. Of course [my male therapist] thinks [a friends-with-benefits arrangement] is easier." Jane's mood-dependent negative judgments about men led to negative judgments towards me and thereby presented a barrier to Jane contacting me for in-the-moment phone coaching. I validated and normalized her response and, once again, thanked her for her candor. When I asked if there was anything that could be done to increase her comfort (i.e., target TIB of missed phone coaching), Jane said the fact that we were discussing it already made her more comfortable.

After Session 4, Jane texted me around 8 pm saying she was feeling "numb," "empty," "sad," and "hopeless" and experiencing passive suicidal ideation. She asked for ideas of what she could do to cope. I decided to call Jane back. It is pertinent to note the process behind the decision to call. The job of the phone coach is to train the client to perform and generalize effective behaviors in place of maladaptive ones. Phone coaching is, in part, a means for practicing skillful help-seeking behavior. Often times, if a client texts when a call would be a more effective, the DBT clinician may ask the client to call and directly request coaching. This may indeed have been an appropriate intervention to shape Jane's behavior in this case. However, based on Jane's shame response surrounding help-seeking for emotional difficulties, I felt that a text response encouraging her to call and directly request help may have been an unnecessary obstacle for her. Doing so would have prioritized "help-seeking behavior" over the higher priority "suicidal ideation" target. I chose to call Jane both to reinforce the successive

approximation towards effective help-seeking behavior in hopes of shaping it overtime, and to help Jane skillfully get past the difficult emotional state she was experiencing.

I called and praised Jane for reaching out (*reinforcing contingency*) and informed her of my rationale for calling instead of requesting that she call (*micro-orienting*). Jane and I then worked through the steps of phone coaching together. I had her describe the situation and express what she was feeling again. Jane denied having tried any skills. I pointed out that she just used Interpersonal Effectiveness skills by describing the situation, expressing how she was feeling and requesting help. Basic solutions utilizing Opposite Action from the Emotion Regulation module were offered and Jane committed to trying them.

Session 5

The next session, Session 5, Jane informed me she did not perform the solutions we had agreed upon during our call. Instead, she went to watch a movie with her son and his father. I reinforced Jane's effective solution implementation. I described how her behavior had replaced less effective behavior (*micro-orienting*). Then, I praised her effective use of Distress Tolerance skills (i.e., Distract with ACCEPTS) and thanked her for sharing those behaviors with me (*reinforcing contingency*). I reminded her that we are a team and that filling me in on effective interventions may help us in future situations (*micro-orienting*). Additionally, I pointed out that we had agreed on a different intervention that Jane had not performed (*plunging in where angels fear to tread*). I encouraged her to follow through on our plans whenever possible in future.

Session 5 then shifted focus to targeting ineffective relationship-coping behaviors. We did not perform a chain-analysis because Jane did not report any instances of relationship-coping over the week prior. Instead, we collaboratively discussed what might be helpful based on previous assessment. We concluded that Jane's mood frequently impedes effective behavior and

is therefore a salient vulnerability factor to begin targeting. Jane said that routine healthful behaviors like sleep and exercise had been important for self-regulation in the past. Jane and I then reviewed ABC PLEASE skills (i.e., Accumulate Positives, Sleep, Exercise) from the Emotion Regulation module and Jane committed to engaging in regulating behaviors (e.g., intentionally perform behaviors that generate positive emotions, exercise, sleep) to reduce vulnerability to Emotion Mind.

We discussed potential obstacles to performing these skills. Jane mentioned willful lethargy. I asked Jane to connect the planned Emotion Regulation skills homework to her life-worth-living goals. Initially, Jane effectively outlined ways in which skillfully targeting vulnerability factors would bring her closer to improving her relationships. I had intended the conversation to lead to teaching Jane the Cope Ahead skill. However, during her explanation, Jane referenced a previous conversation about accepting the reality that relationships are often painful for her. She admitted she has difficulty accepting that reality. In processing her struggles to accept reality, Jane began speaking from a perspective of non-acceptance about the futility she feels working on something she cannot fix.

Jane's shift into non-acceptance prompted me to help her regain balance by shifting away from hopeless rumination and return back to the therapy. To promote acceptance and reduce potential polarization, I validated the pain and difficulty of her struggles. I then used the dialectical strategy of metaphor to facilitate learning and commitment. My first attempt flopped. I related her circumstance to the film *The Shawshank Redemption* in which the protagonist's radical acceptance of his life sentence in prison leads to him living a fulfilled life. Jane replied, "Yeah, but I just don't know how to accept [that relationships are painful]." I tried a different metaphor. "Alright," I said, "Imagine that you lose an arm. You have one arm and you look

around at all of the two-armed people and think, 'Why is it so easy for them to do things? What is wrong with me? It shouldn't be this hard for me.' So, there you are, trying to multitask opening a door while carrying your groceries wondering why it's so hard for you compared to other people. You have one arm! Of course it is more difficult to do a two-armed task! This is your life in relationships. You keep trying to proceed as though you have two arms. Accepting that you are missing an arm is the necessary first step to improve your ability to function. Once we accept that, we can begin working towards making you more skilled. That is how we will reduce your suffering and build a life worth living."

Jane said that made sense to her and she would be willing to put in the work to learn how to cope with relationships more effectively. We returned to planning Emotion Regulation skills (e.g., ABC PLEASE skills including Accumulating Positives, prioritizing Sleep and maintaining regular exercise) to practice over the next week.

While collaboratively planning specific skills to implement for homework, Jane and I became polarized. She had identified a number of behaviors to perform on her days off from work and I wanted her to do so for workdays as well. Jane's demeanor changed when I proposed that she practice skills on workdays as well. Her forward-leaning body position shifted away from me and she replied with reasons she could not practice these skills on workdays. I attempted changing her mind by providing ideas for skills to implement. She responded with reasons my ideas would not work – either she did not have time, or it would not be appropriate in a particular setting, or she simply did not like my suggestions. Jane was no longer problem-solving, and her arms had crossed in a seemingly defensive pose. Yet I persisted, determined to force the issue. Jane providing reasons why she would not perform the behaviors I suggested. Though the conversation was light and amicable, Jane and I were polarized. Upon noticing we

had entered a verbal tug-of-war, I metaphorically dropped the rope. I expressed my approval of the homework we had collaboratively determined and shifted our focus to other targets.

Jane and I reviewed phone coaching experiences thus far and discussed ways we could make it more effective in the future. Jane expressed her dislike of Distress Tolerance skills. She said she felt like they are not accomplishing anything and that she would prefer to implement Emotion Regulation skills because they involve solving problems. I described the purpose of Distress Tolerance as a way in which we prevent making situations worse. Jane stated she understood the concept and did not feel like those skills apply to her. She requested that we shift away from Distress Tolerance skills for more Emotion Regulation and problem-solving. I committed to acquiescing to her request.

Here, Jane's apparent competence interfered with therapy. Jane wanted to solve-problems in moments of high distress. Her calm demeanor and tendency to suppress emotions convinced us both that she would be able to effectively implement skills involving higher-level information processing. In truth, Jane's tendency to minimize the degree of her dysfunction under emotional duress meant she inaccurately judged her capacity to implement skills in such instances. This pattern – Jane conveying competence and me interfering with therapy by repeatedly attempting to implement overly intensive skills – would prove to be a recurring treatment barrier.

Session 6

In Session 6, we continued specifying goals and targets. Jane reported starting a new exclusive romantic relationship with one of the men she had been recently sexually involved with. I had a family vacation planned for the ensuing two weeks. We sought to limit the degree to which my own behavior would interfere with treatment. Missing consecutive weeks of treatment was deemed a TIB. I also sought to balance the dialectic of providing care while

observing my own personal limits. A plan was developed to provide therapy via video-conference for one of the weeks. We planned video-conferencing sessions based around Jane's availability and my vacation schedule. We also set up phone coaching with another clinician on the treatment team for one of the weeks I would be away. The remainder of the session revolved around homework review. Jane had successfully implemented the Emotion Regulation skills targeting vulnerability factors. The idea had been to establish new behavioral patterns that reduced vulnerability to Emotion Mind to facilitate practice of skills requiring higher levels of cognitive processing. Her homework was to maintain that progress and continue increasing her skills through skills group.

Phase 3: Targeting Relationship-Coping Behaviors with Interpersonal Effectiveness Skills

Session 7

The next session was performed virtually. Jane's diary card showed increased suicidal ideation. The suicidal ideation was related to Jane breaking up and reforming her relationship with her new boyfriend twice over the week prior. "Breaking up" was determined a relationship-withdraw behavior based on the criteria we had previously outlined (i.e., coping with aversive emotions caused by the relationship by withdrawing from the relationship). It served as a prompting event for Jane's suicidal ideation. The session was used to perform a chain-analysis on both target behaviors.

The following is the chain-analysis we collaboratively produced: Vulnerability factors (lack of sleep, poor eating, easier to justify breaking up when partner's behaviors are not in line with own) > Prompting event (shared sexual fantasy) > Emotion (fear of being hurt, either through rejection or being taken advantage of) > Thoughts (each return text is viewed with a bias

towards interpreting malice) > Emotion (anger) > Thought ("he's taking advantage of me," and "@#$% him!") > Thought ("I'm going to break up with him") > Behavior (stop responding to texts, "withdraw") > Behavior (go for a jog) > Behavior (read return texts while jogging but not responding) > Emotion (increased anger) > Behavior (return home) > Target behavior (send break up text along with intentionally hurtful accusations) > Short-term consequences ("felt better," comfortable, powerful, confident that we would discuss the issue, confident the relationship was not over but that it could be if I need it to be) > Long-term consequence (anxiety about being left because her angry breakup may have caused his change in behavior rather than genuine care for her; hopelessness about the relationship; suicidal ideation; reinforced ineffective breakup behaviors).

It was determined that the "break up" behavior functioned to indirectly communicate Jane's needs. During solution analysis, I suggested using Interpersonal Effectiveness skills in place of ineffective breakup behavior to obtain the behaviors she desired from her partner. I hypothesized that doing so would have the downstream effect of reducing suicidal ideation. Jane said she was uncomfortable expressing her needs and feelings—a key component of DBT Interpersonal Effectiveness skills—and that she would prefer not to. I considered the pros and cons of shifting to a different solution. A different solution might be simpler and easier to practice and implement. Shifting might reinforce avoidance of direct communication of needs. Interpersonal Effectiveness skills is an important skill, and likely an effective solution to directly replace the ineffective relationship-withdraw behavior. I opted to move forward with teaching Interpersonal Effectiveness for this chain.

In retrospect, I believe my decision here – to continue prioritizing Interpersonal Effectiveness skills – proved to be a TIB. I believed these skills would directly replace the

relationship-coping behaviors that prompted suicidal ideation (LTB) and would be critical to addressing Jane's core problem – shame-driven responses to her own needs and emotions. Though my reasoning may have been accurate, my judgment of Jane's capabilities was not. Effectively expressing needs and emotions within relationships would indeed prove to be an important aspect of the treatment. However, the act of independently expressing her needs and emotions required Opposite Action to substantial shame and deep-rooted avoidance behaviors that Jane was not prepared or willing to perform at that time. Not recognizing this, I pushed Jane to perform skills that were outside her range of capability and tolerance.

I addressed Jane's hesitancy by balancing acceptance-based reciprocal communication stylistic strategies with change-oriented dialectic teaching strategies to promote new learning and change. I began by validating her position; I stated why it made sense to feel uncomfortable and unwilling to express emotions given her learning history.

Metaphor was used to teach and promote buy-in. Because Jane is a medical technician, I asked her to teach me the steps involved in extracting a blood sample from a patient. We discussed the difficulty of drawing blood as a beginner and the early blunders she experienced before the skill became easy and automatic. We then collaboratively related the experience to learning the Interpersonal Effectiveness skillset. I completed the analogy by stating, "[Expressing your emotion] will be difficult, and you are likely to make mistakes, *and* with practice, it will become as automatic as drawing blood." We collaboratively identified a behavior Jane could request of her boyfriend and I modeled what using Interpersonal Effectiveness skills might look like. Jane was assigned the homework of writing out the request using the DEAR MAN format.

Session 8

Jane arrived late to Session 8. Late arrival interferes with therapy and must therefore be addressed. Overemphasis on tardiness can also interfere with therapy. Doing so may use valuable time during an already shortened session and damage therapeutic alignment in such a way that it decreases the patient's willingness in other areas. Taking this into account, I merely mentioned that Jane was late. The statement, "You're late," in a non-judgmental, matter-of-fact tone communicated to Jane that the lateness is noted and she is accountable.

Responses on Jane's diary card that corresponded with treatment targets were noted and I asked perfunctory questions about those items in a form of triage, identifying pertinent treatment targets and tentatively noting them in the agenda according to the target hierarchy.

Instances of suicidal ideation were assessed via chain analysis. Of note, Jane reported suicidal ideation (*LTB*) arising in the context of urges to withdraw from her current committed relationship (*relationship-withdraw QOLIB*). She expressed difficulty identifying emotion links in the chain. I offered some potential possibilities, such as "fear of being hurt," and "anger" connected to her interpretation that her partner was readying himself to abandon her, or "shame" at her perceived worthlessness contributing to potentially losing a valued relationship. Jane restated that she could not recall experiencing an emotion. To explain the lack of emotion, Jane described a similar unemotional recollection of being drugged and raped during deployment in Afghanistan. She said she feels no particular emotion towards that event; that it simply happened, makes sense, and she bears no anger towards the perpetrator. Jane explained she believes that being raped or abandoned are both logical occurrences for someone with low self-worth such as herself. Jane said she does not experience overt emotions while cognitively processing these scenarios because they conform neatly with her accepted beliefs and expectations about herself and others.

Though Jane had asserted she felt no emotions about being drugged and raped, I nevertheless felt strong emotion as she described her experiences of sexual assault. It might have been invalidating to validate emotions when Jane had denied experiencing any. Yet I also felt it might be invalidating to simply validate the lack of emotions and move on. Instead, I opted to validate her experience using self-involving self-disclosure. I conveyed understanding of how she might feel numb given her life experiences and I shared that I felt "sad" as she told her story and "angry" towards the perpetrators (*warm engagement, genuineness, self-involving self-disclosure*). She smiled when I shared my emotion and nodded once, signaling to me that she appreciated my compassionate stance.

We moved on to homework review rather than perform solution-analysis. Greater priority was placed on reviewing homework and learning Interpersonal Effectiveness skills than on solution analysis for the same target— "shame" prompting "hopelessness" involving suicidal ideation and urges to withdraw from the relationship. Though we might have increased her skill in identifying solutions, I judged it more effective to prioritize mastering the difficult Interpersonal Effectiveness skills we had started rather than moving on to new ones.

Jane stated she had not performed the homework (*TIB*). She said she had not written the DEAR MAN because she believed Interpersonal Effective skills to be inappropriate for the situation. I acknowledged that her intuitions may be correct (*validation*) and asked that she develop a DEAR MAN anyway for the sake of gaining practice (*invalidating through redirection*). With my guidance, Jane wrote out a DEAR MAN in session. Notably, Jane paused on several occasions to restate negative judgments about using direct communication for the situation. She negatively judged her actions and emotions in the situation to be her "fault" and "so stupid in the first place" that it would be inappropriate to inform her partner of how she felt

and request that he change his behavior to decrease her negative emotions. Initially, I pointed out her judgments and asked her to rephrase them non-judgmentally. Yet I noticed Jane becoming frustrated. I wanted to keep her engaged so she would practice the Interpersonal Effectiveness skill. It was my belief that she would find the skill useful once she gave it a chance. I shifted tact so that when I noticed judgments, I pointed them out, validated her concerns, and refocused her attention back to the goal: increasing competence in the skill. Jane wrote a full DEAR MAN and role-played delivering it several times. Homework was assigned to write out another DEAR MAN that could replace an ineffective relationship-coping behavior.

Additionally, Jane had not called for phone coaching in two consecutive weeks. I highlighted this as a TIB and we performed a brief "missing links analysis"—a stepwise checklist for determining what elements contributed to the absence of a desired behavior. Jane said she had not thought to call in times when it may have been effective. She also mentioned a desire to avoid "bothering" me. "Thinking to call" and "comfort calling while feeling like a bother" were determined to be missing links. Jane and I collaboratively problem-solved and Jane committed calling two times over the next week (*increase "thinking to call"*) during dinner time (*Opposite Action to "calling while feeling like a bother"*).

Phone Coaching

In addition to calling twice for homework, Jane called in genuine distress several days prior to Session 9. She reported strong urges to break up with her boyfriend (*relationship-withdraw QOLIB*). At the time of the call, Jane was experiencing intense emotions—so much so that she later said she almost did not call for coaching because she believed she would be unable to talk due to the intensity of her emotions. Indeed, her initial attempts to explain the situation were incoherent. Approximately ten minutes of dialogue elapsed before I gained a sufficient

understanding of the situation to provide coaching. As per the session prior and the homework Jane had been working on, I suggested she deliver a DEAR MAN. Jane said she did not believe it would be effective. An hour-long conversation ensued. The call was mired by polarization as I tried to convince Jane to implement the Interpersonal Effectiveness skill. By the end of the call, Jane agreed to deliver a DEAR MAN we had collaboratively formulated. I neglected to request that Jane call back to review what ended up happening.

It bears repeating that phone coaching calls are not intended to last for an hour. Nor are they intended to involve polarized discussions or attempts to convince patients to perform skills. Coaching calls tend to last between 10-15 minutes and involve the therapist offering solutions that the client may choose to accept or decline. I cared about Jane and felt strongly that direct communication of her emotions would prove effective. I was overly focused on resolving the crisis. Resolution is not always the most effective course of action in the midst of a crisis. Asking Jane to engage in Interpersonal Effectiveness skills was akin to asking her to confront a tornado head-on instead of preparing her home to survive it. Sometimes, one must do what is necessary to tolerate distress in order to weather the storm.

Session 9

At Session 9, Jane and I discussed the phone coaching call and its aftermath. Jane had not delivered the DEAR MAN. She said she had accidentally locked herself out of the house when she called for phone coaching and was therefore unable to practice the skillful behavior. Instead, Jane had traveled to a local store to pass the time while she waited for her boyfriend to wake up and let her back into the house. Jane said “everything was fine” by the time she returned home and she no longer felt it was necessary to deliver the DEAR MAN.

In session, I asked Jane to practice delivering the DEAR MAN in a role-play. Once again, Jane paused several times to state that she did not see the purpose of expressing her feelings. She said, "What's the point? What's he supposed to do about it? That's just how it goes." Strong urges arose in me to challenge Jane's assertions. However, I was wary of allowing the session to become polarized. I refrained from attempting to change Jane's perspective. Instead, I repeated my response from the session prior and pointed out that building proficiency in a difficult skill was the goal, not necessarily solving this particular situation (*invalidation through redirection*). After several role-plays, Jane said she felt more comfortable and confident expressing her emotion. She also said she could now see how the skill might be helpful in this situation. We discussed the concept of using emotional expression of "insecurity" and "shame" as an Opposite Action skill for reversing her shame. She committed to delivering the DEAR MAN to her boyfriend over the next week.

The session moved on to address vulnerability factors. Jane reported significant changes in her typical behaviors as a result of spending time with her boyfriend. Such changes included significant decreases in sleep, irregular sleep schedule, decreased exercise, dietary changes including increased junk food, and changes in recreational drug use. These recent changes were connected to her desire to spend time with her boyfriend. She reported that this pattern of assuming the behaviors of boyfriends is a common pattern for her in past relationships. We identified these as relationship-approach behaviors. Jane committed to homework of prioritizing sleep and exercising at least two times over the next week.

Phase 4: Targeting Relationship-Coping Behaviors with Distress Tolerance Skills

Supervision

Review of session footage and phone coaching calls in supervision uncovered areas of ineffective intervention. My supervisor pointed out that I had been pushing to enact Interpersonal Effectiveness skills during phone coaching while the client was in Emotion Mind. Additionally, my instructions to practice Interpersonal Effectiveness skills over the past two sessions had been met by Jane with substantial opposition. My supervisor specifically recommended that treatment prioritize Distress Tolerance skills in times of distress in place of skills that require more cognitive processing. She also highlighted that the therapy was becoming polarized and advised that I shift to acceptance-based strategies to maintain therapy and promote progress.

Skills Group

Skills group was held the evening prior to Session 10. I was co-leader at the time and I reached out to group members via text message regarding an update about Group. Jane did not respond to the text. She also did not show up on time for group. As co-leader, I was responsible for group members' attendance. I called Jane when she had not arrived after several minutes and I received an automated message saying Jane's voicemail box was full. I texted to inquire about her status. Jane responded via text to say that she would be so late to group that it would not be "worth it" to come at all. I called again and spoke to Jane briefly and attempted to problem-solve. Jane said she would "see what she could do" but she ultimately did not attend group. When I texted her the skills group homework, Jane texted back her thanks and stated she would be present for the individually therapy the following day.

Session 10

Jane's diary card at Session 10 revealed high urges to quit therapy (*TIB*) on the night of group. Jane said her son's father had opined that she should not quit because he thought Jane was "doing a lot better." Jane said her boyfriend similarly advised her not to quit and instead said,

"Maybe wait a few days before doing anything." Jane had agreed to stick with DBT for the time being.

Urges to quit therapy are considered TIBs. I assessed for factors that may have contributed to her recent thoughts about quitting. Jane described a litany of vulnerability factors that led her to depict her life as "falling apart" at the moment. She described recent behaviors that were over-prioritizing her relationship (*relationship-approach behaviors*). It had resulted in significant sleep dysregulation, instances of intentionally staying awake all night, diminished quality of diet, decreased exercise, increased recreational drug use, increased self-medication, and increased frequency and intensity of emotion dysregulation and suicidal ideation. Further, Jane described changes outside the relationship, including missed work, missed DBT skills group, an angry outburst at work, increased negative feelings towards her son, and decreased time spent with her son.

After assessing these factors, I sought to address Jane's urges to quit therapy, along with other TIBs (i.e., missed Group, missed homework, no phone coaching calls). In an effort to avoid polarization, I began by validating Jane's emotions. I validated how tough her current situation feels. I highlighted the many vulnerability factors she was experiencing and how it feels like her life is falling apart. I also noted the challenging behavioral changes I had been demanding and how working on Interpersonal Effectiveness skills had thus far not led to increases in effective behavior. I stated that it may be more effective to make a strategic shift in treatment to target the vulnerability factors that were causing distress at that time. Doing so would simultaneously target TIBs (i.e., absences, non-homework compliance) and QOLIBs (i.e., relationship-approach behaviors). Additionally, I stated my belief that Distress Tolerance skills would likely be an effective category of skills to prioritize.

Polarization ensued. Jane reported ambivalence about targeting vulnerability factors because she "knew" it would "require spending less time with [her boyfriend]" and she was not prepared to do that. I contradicted her assertion and insisted that targeting vulnerability factors, and including Distress Tolerance skills in the process, was the path towards spending time with her boyfriend more effectively, rather than the ineffective behaviors leading to feelings of hopelessness about the relationship later on (*directly challenging*). I pressed the issue using additional change-based tactics, including humor and irreverence. For example, when Jane rebutted my recommendation to use Distress Tolerance skills saying, "It's not like I was going to do anything crazy," I playfully responded, "Right! You weren't going to do anything crazy. You were just going to break up with him" (*irreverence, humor, plunging in where angels fear to tread*). This stylistic strategy facilitated Jane finding synthesis. She laughed and briefly conceded. I seized the opening to explain the importance of the Emotion Regulation and Distress Tolerance skills given her current problems. I then taught Jane the skill she had missed from group, the Emotion Regulation skill of Mindfulness of Current Emotions (MoCE) – mindful experiencing of emotions without acting upon them.

By the end of the session, Jane acquiesced to my requests. She agreed to target vulnerability factors and practice MoCE, ABC PLEASE skills, and Crisis Survival Distress Tolerance skills. It is important to note that I persisted in my use of change-oriented strategies in the face of polarization. My behavior opposed the acceptance-based approach I had intended to take. Jane was acting actively passive. Her communication of hopelessness increased my desire to facilitate change. And, though she had verbally committed to making changes, Jane's opposing stance had not fully dissipated.

Phone Coaching

Jane called over the ensuing week to inform me she had cheated on her partner and was experiencing passive suicidal ideation and hopeless rumination. We performed a brief chain and identified the cheating as a relationship-coping behavior that decreased immediate adverse feelings of "emptiness" and "loneliness" while her partner was away and inaccessible by phone. Afterwards, she began experiencing grief because she believed an indelible loss had occurred within her relationship with her boyfriend. The grief led to hopelessness and passive suicidal ideation (*LTB*).

Given the degree of emotion dysregulation Jane was experiencing, I provided coaching with the aim of avoiding making a bad situation worse (*Distress Tolerance skills*). I provided concrete directions. First, I told Jane wait for our next appointment before choosing whether to break up with her boyfriend. In the meantime, I instructed Jane to notice thoughts about breaking up without acting on them (*Mindfulness of Current Thoughts*). Next, I instructed her to engage in Intense Exercise (*TIP skill*) and to distract herself by calling a friend (*Distract with ACCEPTS*). The idea was to wait out the intense emotions without making a bad situation worse.

Session 11

At the next appointment, the top targets were suicidal ideation (*LTB*), consecutive missed Group sessions (*TIB*) and relationship-coping behaviors (*QOLIB*). We discussed suicidal ideation and Jane denied any intent or plan. We reviewed and added to the chain-analysis we had performed over the phone. Relationship-coping behaviors were identified as the prompting event for the suicidal ideation. Stemming from her physical separation from her boyfriend, thoughts and feelings associated with loneliness prompted relationship-approach behaviors. The target would therefore be to reduce relationship-approach and increase more effective coping with loneliness. Jane and I collaboratively developed a Cope Ahead plan – vividly imagining a

problem situation and coping with it effectively – to replace urges to perform relationship-approach behaviors.

I mentioned the missed Group sessions and reminded Jane that participants are released from the program if four consecutive sessions are missed. Missing consecutive groups could therefore destroy treatment. For that reason, I informed Jane that we would treat it as treatment-destroying behavior (TDB). If that were to happen it would become our top priority because it presented the greatest imminent risk. I requested we work on finding solutions to the obstacles that prevent Jane from attending Group. In a discussion about obstacles to obtaining childcare, Jane revealed she had never had a babysitter before and said she was uncomfortable having a stranger watch her child. She also stated she does not know anyone she would trust to babysit. However, she conceded that she would be comfortable with someone watching her son if she knew the person and felt they were trustworthy.

Through collaborative problem-solving, Jane identified several people she would be comfortable asking for help in locating childcare options. She committed to finding one additional childcare option for homework. In addition, we developed a plan to ensure she did not miss the next group. Jane committed to checking with her parents in advance of group about their availability. She also said she would identify a backup option should her parents be unexpectantly unavailable. We also practiced the Cope Ahead skill for the potential problem of feeling willful about attending group. Jane imagined not wanting to attend and feeling urges to quit and acting opposite to willfulness by getting into her car and traveling to group. Jane also imagined calling me for phone coaching in such an instance.

Phase 5: Targeting Urges to Quit Therapy with Acceptance-Based Strategies

Session 12

TIBs noted the week prior persisted into Session 12. Jane had attended one skills group and then missed the next one – her third missed Group out of the last four. Though she was not in immediate danger of release from the program, the miss of any group session is considered therapy-interfering and the miss of three sessions in one month is both magnified and potentially indicative of a pattern that could contribute to therapy dissolution. Indeed, Jane's diary card indicated high urges to quit therapy, as well as elevated suicidal ideation.

Jane's demeanor was noticeably different compared to prior sessions. She appeared to move slow. Her speech was slowed and lower volume than usual. Her tone of voice seemed lethargic. Jane said she did not attend group because she simply "did not want to go."

I was facing a dilemma. The target hierarchy clearly indicated that LTBs and TIBs had to be addressed. Yet I felt that addressing these issues would entail change-oriented interventions that would push Jane further towards quitting. Supervision had yielded the same message as the week prior: *shift towards acceptance-based interventions*. My intuition in session was the same: a push to directly address suicidal ideation and missed groups would be received by Jane as a push to change and would drive her away from therapy.

Jane described a sense of hopelessness because her self-worth is so closely tied to her appearance. She believed her skin to be deformed and only getting worse with age. I reflected and validated Jane's thoughts and feelings, careful not to validate invalid assertions. By leaning on validation, I was effectively employing acceptance-based strategies.

Yet, as the conversation progressed, I felt pulled to facilitate change. Here again, Jane's hopelessness transacted with my urges to help (*active passivity*). I used metaphor to promote a psychological conceptualization of her problem. I said her physical appearance was a crutch to

keep her self-worth standing. And as her crutch recurrently broke, Jane persistently attempted to maintain and fix it. All the while, her fixation on the crutch prevented her from learning to walk without it.

Our discussion led to the consensus that Jane's chief difficulties stem from her shame and the self-judgment and ineffective coping methods driven by it. Her primary coping tactics have been to escape the shame via two primary methods. One method involved identifying and thwarting threats to her body image. That meant obsessively checking her body for flaws and her environment for threats and comparisons, while simultaneously searching for opportunities to improve her appearance. The other method involved relationships. She would seek out relationships to feel accepted by others (*relationship-approach behaviors*) (e.g., reassurance seeking, forming sexual relationships). However, reliance on appearance and relationships only served as short-term solutions to her feelings of shame, worthlessness, and emptiness. Inevitably, Jane would become fixated on a "flaw" and would once again "realize" that she is "worthless" and "unworthy of love," and that her relationships are hopeless. It is at that point that Jane tends to exit relationships to escape overwhelming shame associated with addressing her problems (*relationship-withdraw behaviors*). Yet being alone just as assuredly exposes Jane to the intolerable stimuli of shame, self-judgment, and emptiness. Thus, the cycle would continue.

We collaboratively decided that this negative cycle is perpetuated because the core problem in the cycle never gets resolved. Jane would not accept her shame. Accepting shame and acting opposite to it would be necessary to tolerate the distress and obtain her needs. Her cycle of suppression and escape could only be reversed by facing her shame head on. Having determined that Interpersonal Effectiveness was an ineffective approach thus far, we decided on a different tact to promote acceptance. We resolved to begin targeting shame and emptiness by accepting

them, without seeking to change them. Jane stated that she often experiences emptiness when she is alone at night. So, we collaboratively designed an exposure to “emptiness” and “shame” for one night of the week. Jane committed to practicing mindfulness while performing the exposure to “loneliness” and “emptiness” one night over the next week.

Phone Coaching

Jane called in distress several days before her next appointment. She said the father of her child was refusing to give her son to her. She said she felt “angry” and “hopeless” because she would “have to deal with this forever.” Given the degree of Jane’s dysregulation, I directed Jane to employ Distress Tolerance crisis survival skills. She initially rejected my suggestion. I reframed it by instructing Jane to distract herself with exercise in order to reduce emotional intensity to get through the crisis without making it worse. Jane stated she would “give it a try.” She did not call back to discuss the results of implementing the Crisis Survival skill.

Session 13

Jane cancelled the originally scheduled session via text and requested rescheduling. I replied stating that I was willing to reschedule and would do so with her when we met at skills group that week. Jane responded the next day stating she would be late to skills group. I replied thanking her for the update and offering to problem-solve with her about tardiness should she like help. I also said we could discuss rescheduling during the break that occurs in the middle of group. Jane did not respond. Nor did she show up to group. As group leader at the time, I asked the co-leader to reach out to Jane and attempt to get her to group. Jane did not respond to the co-leader’s calls or texts. Nor did she reply to mine the following day. The session was never rescheduled. However, when I texted to confirm our next regularly scheduled Monday appointment, Jane replied confirming she would be there.

Session 14

At the next session, considered Session 14, Jane reported high urge to quit therapy. She reported "hopelessness" regarding the potential effectiveness of therapy and stated she did not "see" how DBT would address her presenting problems effectively. Once again, I engaged in a polarizing discussion during which I attempted to convince Jane of the utility of DBT. I used metaphors to teach her DBT. I also used self-involving self-disclosure, sharing my frustrations that talking about DBT often resulted in us not enacting DBT methods. As had occurred in similar polarizing discussion in past sessions, it ended with Jane half-heartedly agreeing with my logic and committing to re-engage with treatment. Specifically, Jane committed to practicing mindfulness for homework as a means of "re-starting" treatment. Notably, I neglected to check-in about the exposures Jane had agreed to perform two weeks prior. This represents TIB on my part.

Consultation Team

That week I requested help from consultation team. I was feeling increasingly frustrated that our treatment seemed not to be progressing and that sessions were consistently becoming polarized. At team, we make specific requests for what we feel we need help with. I requested assistance problem-solving. Yet, when I presented, a team member pointed out that it sounded like I could use some validation. Laughing, I agreed. My consultation team validated the difficulty of the problems I was bumping up against and the frustration I was feeling. They also validated my approach. They convinced me I did not need problem-solving. The approach was sound. The issue was my delivery. Though I would enter sessions intending to prioritize acceptance, by the end I was leaning on change tactics. The approach to Jane's problems did not

need to change. Rather, a change needed to occur within me. I resolved to focus my efforts on maintaining an acceptance-based approach.

Session 15

In Session 15, Jane recounted an argument she had with her boyfriend that resulted in her breaking up with him over the week prior. She said she felt convinced he no longer liked her and she submitted to her urges to exit the relationship. Though this QOLIB was a high treatment priority, Jane’s strong urges to quit therapy presented as a higher-order TIB that needed to be addressed. I inquired about her urges to quit therapy and she confirmed they were still high. Since I had resolved to take an acceptance-based approach, I inquired about her thoughts and feeling surrounding therapy up to this point. She said she conceptually understood how DBT skills are broadly helpful she just could not see it helping her. It was making Jane feel “hopeless” which prompted her urges to quit therapy.

I validated the hopeless feeling. “It must be really hard when you feel like you are drowning and just can’t find a life-raft to grab on to,” I said. Jane agreed. She said she felt unable to radically accept herself and her reality, and that she could not repeatedly turn her mind towards acceptance no matter how hard she tried. For several minutes, I continued to reflect and validate Jane’s valid thoughts and feelings, while being careful not to validate the invalid.

Yet my resolve to maintain acceptance-based approaches and validation started to waver. Jane asserted she can “never” maintain effective behavior because she is frequently at the whim of her mood. I found it difficult to keep validating her emotions and problems while I felt like the solutions to her problems were within arm’s reach. I could not understand how she could think her problems were unsolvable. Consequently, I lacked the empathy I needed to provide radically genuine validation.

I changed tact and used a metaphor. This time, I employed this change-oriented tactic to facilitate a change in myself rather than in Jane. I wanted to foster my own acceptance to facilitate synthesis. "Ok," I said, "I'm having trouble. I need your help understanding and accepting the problem." I posed a hypothetical question: "If you suddenly learned all of DBT, like it was uploaded into your brain like in *The Matrix,*" – a film about living in a simulated reality where knowledge and skills can be programed into the mind like a computer – "how would you act differently when you feel willful?" Jane said she did not know if she *would* act differently because she already knew what behaviors would be more effective, but her emotions carry her to act ineffectively. I reflected her sentiment, "So, even when you have the knowledge you can't act effectively in those moments." Jane agreed and I validated how hard that must be.

With that, we commiserated about how difficult it is to be helplessly carried by emotions, unable to act effectively. Jane recounted how that had happened recently when she broke up with her boyfriend. She admitted she did not actually want to break up but she did not know how she could continue while feeling so hopeless. Once again, I validated her feelings, telling her how that makes sense to me once I accepted how difficult it is to act effectively in Emotion Mind. With that, I tried balancing my communication with a change-oriented strategy. I posed a leading question: "Is it possible that DBT is less about knowing the skills and more about putting the knowledge into *action*. That you lack practice acting effectively while in Emotion Mind?" Jane agreed.

Yet when she considered recommitting to DBT she continued to take a hopeless stance. "I feel so behind," she lamented. I validated the feeling and normalized it. I informed Jane that many other DBT participants had expressed similar feelings towards the middle and end of treatment. I then asked Jane what re-engaging with treatment might accomplish (*eliciting*

commitment). She ultimately said she would be better equipped to act effectively and improve her closest relationships. After saying that, Jane re-committed to engage with treatment to work towards her goal: improving her closest relationships. We spent the remainder of session reviewing what Jane had missed in skills group. Jane committed to performing the homework and to attend all group and individual sessions moving forward.

Phase 6: Targeting Relationship-Withdraw Behaviors with Distress Tolerance Skills

Session 16

Jane had gotten back together with her boyfriend by Session 16. In reviewing her diary card, we noted substantial urges to break up again. She described "annoyance" with her boyfriend and judgmental thoughts about his irresponsible behaviors. These thoughts led to hopeless rumination about the sustainability of the relationship and urges to withdraw from it. Further, Jane stated she had mentally committed to breaking up. She had even started making plans to meet with another man. We performed a chain-analysis which revealed Jane had acted skillfully. Though she had reached out to another man, she did not meet up with him. Instead, Jane had implemented the Distract with ACCEPTS skill from the Distress Tolerance module.

Jane additionally mentioned that her prediction that her relationship was unsustainable "upset" her because she would prefer not to break up. On the contrary, she said she would prefer to effectively change her boyfriend's behavior so she could feel more comfortable and confident about the relationship's future. At that moment, I was sorely tempted to return to Interpersonal Effectiveness skills. To me, it would likely be the most effective way to change her boyfriend's behavior. However, as previously noted, our past attempts to increase Interpersonal Effectiveness

proved premature. Although Interpersonal Effectiveness may indeed be an effective skill for the situation, focusing on that one skill was unlikely to be any more effective this time.

It is pertinent to note here how DBT functions based on principals rather than rules. No rule dictates that therapy prioritize less intensive skills in this situation. DBT seeks to balance the objectives of moving towards goals, while maintaining treatment and learning skillful behaviors. With that in mind, I might have prioritized Interpersonal Effectiveness skills and increased the likelihood that the skill is performed effectively by taking a more active role. Doing so might detract from Jane's skill acquisition and generalization in the short-term while ultimately progressing the treatment. An intervention is assessed based on its effectiveness and is not considered "wrong" if the approach adheres to the principals of DBT. There are infinite DBT-consistent interventions to implement. The art of the science is found in the balance.

Here, though, I took a different approach that was equally consistent with DBT principals. I opted to approach the goal of increasing skillfulness by shaping the behaviors Jane had already successfully implemented. Jane had effectively employed a Distress Tolerance skill to replace an ineffective relationship-coping behavior. Thus, there was an opportunity to reinforce the more skillful behavior. Jane reported having had urges to engage in ineffective relationship-approach behaviors (i.e., to reduce loneliness and emptiness by connecting with another man). Yet she had successfully implemented a more effective DBT skill instead. Though she initially reached out to the other man, she did not meet up with him. She said she recognized doing so would make the situation worse so she stayed home and implemented the Distract skill to replace what would have been an ineffective relationship-coping behavior. Thoughts about breaking up were defined as ineffective relationship-coping behaviors. They were assessed via

chain-analysis. I had Jane complete the chain independently to promote learning and goal-directed action.

The chain provided rich detail of the broad chain surrounding relationship-coping behaviors. Jane recounted a sequence of events that began when she introduced her partner to her parents. The encounter led to judgmental thoughts about her partner, fears about requesting behavior change, certainty that making requests of her partner would "not go well," hopelessness about the viability of the relationship, "discomfort" and "emptiness" at the prospect of being alone, thoughts about contacting another man, anticipation of comfort being with another man, and reaching out to that man. Ultimately, however, Jane had used the Distract skill to replace additional ineffective behaviors that might have otherwise resulted in increased problems and emotional distress in future. Jane completed most of the chain in session and was assigned the homework of providing more detail with regards to thoughts and feelings involved in her ultimately effective actions. She additionally committed to calling at least two times to increase phone coaching behaviors.

Session 17

When we met for Session 17 Jane reported significant increases in skillful behaviors. She indicated substantial relationship-coping urges but few associated actions. Jane missed group the week prior due to difficulties obtaining childcare and we agreed to collaboratively develop a plan for obtaining childcare when obstacles inevitably arise in the future.

The TIB of missed group was targeted first. Jane had not followed through on the initial plan of locating a babysitter to care for her child during group. We engaged in a missing-links analysis and determined that the thought of contacting a babysitter did not occur to Jane. Further, Jane said she would have been uncomfortable doing so in that situation. She stated she was

willing to have a babysitter watch her child but reminded me she had never done so before. Therefore, "comfort" and "availability of the thought to contact a babysitter" were identified as missing links. Additionally, I noted that I had engaged in a TIB by not requesting updates about our previous plans to address this issue. I had failed to adequately prioritize Jane's childcare issues and I did not hold Jane accountable. We collaboratively problem-solved and each made commitments to address these issues. Jane committed to returning next session with at least three viable childcare options she would be willing to pursue. I committed to writing a note on each upcoming agenda until the Jane successfully establishes a childcare plan.

I then taught her the Mindfulness of Current Thought skill that was taught during the group she missed. We identified situations in which Jane might utilize the skill. We then practiced the skill in-session via role-play. Jane committed to practicing again for homework.

Session 18

Jane arrived to Session 18 without her diary card. She said she thought to do it but initially experienced willfulness bringing herself to print the diary card and later forgot to do so. Jane said the same thing happened with calling for phone coaching; she experienced initial willfulness and then forgot. I had Jane complete a diary card for the first ten minutes of the session. Apropos of Jane's professed willfulness in printing the diary card, my supervisor had asked me to begin providing Jane with a new diary card each session instead of having her print it. Having Jane print her own diary card was determined to be an unnecessary and potentially ineffective barrier to treatment. I informed Jane of the new procedure and gave her a diary card for the following week. We worked together to set an agenda based on the data provided in her diary card. We agreed to review homework and address other primary targets, including TIBs of

homework non-compliance (i.e., no phone coaching, no diary card), QOLIBs related to relationship-coping, and, as always, increasing skills.

While setting the agenda, Jane said she no longer felt it useful to perform chains on relationship-coping behaviors involving infidelity because she believed infidelity unlikely to reoccur. I validated Jane's perspective. "What I am hearing you say is you are doing better at this. You didn't hook up with another man and instead exercised some skills. So, now you are feeling like this is not so much of thing that we need to go over." (*reciprocal communication acceptance-based strategy*). Jane agreed. "Nice," I said in a deadpan tone, "Sounds like relationships aren't really an issue anymore" (*irreverent extending*). Jane shook her head, looking confused. "No, I just meant I don't think I'm going to cheat. I learned my lesson." "Look," I replied, "Our goal is not to reduce cheating. [Our goal] is to have better relationships. If you are having urges to cheat, we need to address that. What we are trying to do is to get to a place where you don't feel an urge to do something that might be ineffective and instead more naturally act skillfully." Jane agreed to work towards making skillful behavior occur more naturally.

We started at the top of our agenda: homework review. Jane had identified a potential option for childcare. She committed to reaching out to the potential babysitter. We then addressed willfulness that resulted in Jane not completing her other homework. I asked Jane to explain how calling for planned phone coaching – especially when she does not have anything specific to discuss – will help her move closer to her goals. Jane stated she did not know. It was determined that Jane's lack of understanding contributed to her willfulness. I engaged Jane in a discussion about the reasons for practicing calling. I reminded her she had said her problem was not lacking the knowledge of how to act effectively but rather lacking the practice of acting

effectively when in emotion mind. I explained that calling more often makes it more likely that she will think to call in times of need. Thinking to call increases mindful awareness and makes DBT concepts more available during emotional circumstances. Calling in emotional circumstances is the first step towards practicing acting effectively while in Emotion Mind. If a call is made in such times, that means the situation was likely handled with greater skill because making a call requires mindfulness, the STOP skill, and Effectiveness. Also, it has the added benefit of providing separation from the emotional situation to access Wise Mind and proceed more skillfully. We agreed that having practice calling would likely increase Jane's use of skills that will benefit her overall quality of life. Jane recommitted to calling twice over the next week.

We moved on to homework review of the Mindfulness of Current Thoughts skill. Jane reported practicing MoCT everyday over the past week. She stated the practice made her more aware of her thoughts during an argument with her boyfriend which she believed prevented her from acting on her emotional urges. Jane said she did not perform any relationship-coping behaviors. We hypothesized the skill disrupted the chain that often leads to relationship-coping.

Once again noting the goal of acting effectively while feeling emotional, I praised Jane for implementing the skill during a heated situation. I had expected Jane's response to the praise to be positive and possibly prideful. Instead, Jane gave little reaction to her accomplishment and responded in a matter-of-fact tone that notably contrasted with my enthusiasm. I shared with Jane I had interpreted her response as communicating she was disinterested with the MoCT skill and unconvinced of its utility (*self-involving self-disclosure*). On the contrary, Jane explained she was experiencing judgmental thoughts towards herself, not the skill. My praise cued "embarrassment" because Jane believed she "shouldn't need to use a skill like this." I rephrased her judgmental word choice: "You *would like* to not have to need a skill like this," I reminded

her. "We have been working towards using skills when you're in emotional situations. You did that. If that is not a cause for celebration, I don't know what is." I smiled and Jane half rolled her eyes and returned my smile. Recognizing my praise had elicited a shame response, I committed to altering my approach to reinforcement. With collaborative discussion it was determined I could more effectively reinforce skillful behavior by decreasing the intensity of my praise and by more explicitly stating how the behavior connected with her goals. I committed to doing so in future. Homework was assigned to practice MoCT at least five minutes per day and to call at least twice as practice. I also reminded Jane to reach out to the babysitter she had found.

Phase 7: Targeting Shame with Emotion Regulation Skills (i.e., Opposite Action)

Session 19

In Session 19, Jane stated she has not "been herself" over the last week. She said she had been late to work nearly every day, late handing in assignments, and not been taking care of herself. Together, we reviewed one of the days on the diary card with particularly high ratings of negative emotions. Jane reported drinking, smoking, and taking acid that night. She reported experiencing significant negative emotions while intoxicated; she said she couldn't decide whether *she* was "not real" or if *everything around her* was "not real." Jane recalled feeling "super tense," as if something was about to go wrong. Her description sounded like an experience of derealization.

During group the night prior, I had perceived Jane's behavior and body language as withdrawn and emotional, as if something was wrong. I conveyed these interpretations and expressed my concern, as well as my "apprehension" to share my concern with her (*self-involving self-disclosure*). Jane affirmed my interpretations and told me she disliked that I felt

apprehensive about sharing my concern. The conversation facilitated acceptance of her issues and willingness to openly express how she had been feeling.

The ensuing discussion illuminated Jane's difficulty asserting her needs with her partner. Jane described urges to do what her partner wants to do because of the positive feelings of connection she experiences with him. Yet doing what her partner wanted had reached a point of excess (*relationship-approach behaviors*). Jane conveyed significant discomfort at the thought of expressing her thoughts, feelings, and needs with her partner. With radical genuineness, I validated Jane's experience based on her current circumstances and learning history (*acceptance-based intervention*). Given Jane's aversion to expressing emotions and needs, I judged that doing such high-level Opposite Action would likely require substantial support and shaping to perform effectively. Jane had frequently described her boyfriend as compassionate, validating, supportive, and psychologically minded. I therefore felt confident that expressing emotions and needs with him would prove effective. Jane just needed help doing so effectively. I suggested we have him join one of our session so I could support her acting opposite to shame by expressing her needs and emotions to him. Jane agreed.

Phone Call

Jane did not attend the next group. We had started the Interpersonal Effectiveness module that evening. Since I strongly believed Jane needed intensive training in this skill, I contacted her after group and scheduled a phone call for the following morning so we could review what she had missed.

When I called the next day, Jane answered sounding tired and disoriented, as if she had just woken up. Jane confirmed she had indeed awoken to her phone ringing. I suggested she take some time to wake up and get organized. She called back several minutes later to review the

group work. During the call, Jane displayed significant difficulty processing information. I suggested we do the review at another time. We agreed to discuss further at our next scheduled appointment.

Jane sent a follow-up text message several minutes after the phone call ended. In the text, Jane apologized for "being incapable of a productive conversation" and explained she had been depressed for several days and took LSD with her boyfriend against her better judgment the night of group. Jane described the acid trip as "very upsetting" and "soul-crushing. Jane reported taking several klonopin early in the morning as a sleep aid intended to escape the "miserable" experience. She was consequently unable to effectively process information during our call.

In a text reply, I thanked Jane for sharing and I expressed appreciation for her candor. I also expressed appreciation for her attempts at learning the group material despite it proving unproductive. I conveyed my belief the current situation may offer an opportunity to practice skills and I encouraged Jane to reach out for coaching. Jane did not call or reply to the text.

Phone Coaching

Jane called for coaching the following day. I reinforced the effective behavior and asked what had prompted her to call. Jane said she did not have a concrete coaching request but she was feeling depressed and felt compelled to call due to my persistent encouragement to do so, and because she had committed to call for coaching as homework. Before assessing for solutions, I had Jane directly ask for help relieving her depressive symptoms. We had determined that expressing feelings and requesting help is difficult for Jane so this provided an opportunity to practice more effective behavior. Jane said she was feeling "depressed," "low," and lethargic and she directly asked for help coping. When she denied having tried any skills, I asked what skills she could use. Jane said she was unsure. I suggested using Opposite Action to her lethargic urges

associated with her depressed mood. We collaboratively brainstormed and Jane ultimately committed to engaging in a fun activity with her son.

Consultation Team

With Jane's increasingly ineffective behaviors I felt our therapy had taken a downward turn. My supervisor agreed and highlighted the fact that Jane's increased ineffectiveness had led to intense suicidal ideation. The increased ineffective behaviors and strong suicidal ideation made it important that I present the case at consultation team.

Each consultation team meeting begins with a mindfulness exercise followed by agenda setting. The team leader of the day has team members request time to discuss matters that fall into several categories, including administrative matters, group updates, clients at increased risk for suicide, clients displaying significantly more dysfunctional behaviors, and other requests.

I requested 20 minutes for problem-solving my client's increased risk of suicide. My request was submitted under the LTB category because of her increased suicidal ideation. Her increasingly dysfunctional behaviors would be addressed by targeting the LTB. When I described the current state of treatment, I expressed my feelings of frustration, inadequacy as a therapist, disappointment that we had "not accomplished anything," and stress about the limited time left in treatment (~six sessions remaining). I became noticeably emotional. Members of the team reflected and validated my feelings of overwhelm. Their compassion and warmth helped regulate my affect. "I don't know what to do now, though," I said. I felt like there was too much to do and not enough time to do it. I rejected initial suggestions from team members by explaining why their proposed interventions would not be effective. Team members pointed out I had taken on my client's stance. I was overwhelmed, hopeless, and ruminating instead of

actively problem-solving. Convinced, I assumed a more open and willing mindset and once again asked for their help problem-solving.

Through collaborative discussion, we used the target hierarchy to dictate how treatment would be prioritized. It was decided a chain-analysis ought to be done on the suicidal ideation to illuminate problematic links. I complained that doing so would lead to the same things we have been working on to no effect. I explained that she had been engaging in ineffective relationship-approach behaviors that over-prioritize her relationship to the detriment of other important areas of her life. And we still had so many other things to address: missed group, childcare homework, non-homework completion, phone coaching, preparation for treatment termination, and preparation for our upcoming partner session. And that was everything *except* for targeting relationship-coping behaviors – the QOLIBs I believed to be a primary contributing factor to her suffering. My consultation team recommended I highlight how much there is to do and to start from the top. As a strategy to shake Jane away from hopeless rumination, it was advised I "enter the paradox" by explicitly stating there is a lot to do so we should take it slow. Though I still felt over-whelmed, I felt more regulated, organized, and prepared.

Session 20

Session 20 began as usual. We collaboratively formed the agenda using Jane's diary card. I told her I would like to talk about "what happens during crisis." Jane said she felt like it was "unlucky" so many things seem to be overwhelming her at once. I told her, since we have about six sessions remaining, there are particular areas we would like to address before terminating treatment. I said I would like to do a chain-analysis on suicidal ideation; she said, "This is stuff that has come up before and there is nothing I can do about it." I felt pulled to challenge her thoughts. I shared I was feeling pulled to do so (*self-involving self-disclosure*) and told her I

would nevertheless move on to the next agenda item since it would more effectively move her towards her goals (*micro-orienting, invalidating through redirection*). I added, "And since we have such limited time, I want us to go slow" (*enter the paradox*). Jane laughed and we moved on.

I said I would like to go over how phone coaching went. I also noted substantial increases in BDD thoughts and behaviors on her diary card. Jane said BDD thoughts tend to be the prompting events that lead to suicidal ideation; she described it as "the thing that affects [her] the most," and she expressed hopelessness about it ever improving. I replied with a joking tone and exaggerated gesticulations, "It's hopeless!" I threw up my arms, "Things will never get better! We will never get there!" (*irreverence and extending*). She replied, "Well, basically." Knowing about Jane's prior treatment targeting BDD symptoms, I asked if she had ever made improvements in the past. She smiled, knowing full well I was aware of the significant progress she had made in the past, and said, "Well, yes... But fleeting!" I smiled, laughed, and jokingly said, "That's all I needed! Let's move on to the next."

I mentioned Jane had not made a second phone coaching call as she had agreed. Jane provided understandable excuses for why she did not call that nevertheless resulted in her not practicing asking for help. I validated her reasons and politely asked that she follow through on her commitment next week. Next, we discussed planning the partner session. I asked Jane to practice requesting help by asking her boyfriend, Ian, to join us on a specified date. Jane agreed to ask.

We collaboratively wrote out a chain on Jane's suicidal ideation. The prompting event involved Jane judging and picking her skin. "You have thoughts about your skin which lead to negative emotions," I reflected. "And then you engage in behaviors – in this case 'picking'

behavior – that reinforces the initial thoughts and increase the negative emotions. These behaviors are where we can intervene." Writing out the chain, Jane displayed she understood how her behaviors reinforced her negative view of her skin. However, Jane firmly stated that working towards decoupling her emotional response from her skin was doomed to fail because problems with her skin are such a big problem in her life. I acknowledged her concern (*validation*) and again reminded her of the progress she had made in past treatment (*directly challenging*). I encouraged her to resume the interventions she had engaged in with her previous clinicians at the ADC to cease her anxious response behaviors.

I assigned her homework to do a chain-analysis where the problem behavior is "breaking up with a boyfriend" and the prompting event was a "skin-related judgment" (e.g., notice skin > self-judgmental rumination > "I am unworthy" > shame > withdrawal > hopelessness). My rationale was that this chain would provide an overarching view of the interaction between Jane's shame-response and ineffective attempts to escape it.

Session 21

Jane texted hours in advance of our session to ask if her son could join us. I replied to tell her that would be fine with me. By that point in treatment, I judged it ineffective and treatment-interfering to problem-solve finding another childcare option.

Jane's diary card revealed significant reductions in BDD "checking behaviors" related to skin imperfections. She reported a corresponding decrease in urges to check. She attributed the decrease in urges to a general improvement in her mood rather than reductions in "checking" behaviors. We collaboratively formed the agenda: plan for a partner session, increasing phone coaching, and review chain-analysis homework to develop treatment targets.

I chose to target increased phone coaching first; not because it was the top priority but because I chose a short intervention: with a smile and a joking, light-hearted, pleading look I said, "Can we *please* increase phone coaching?" We laughed together and she said, "I know, I know, ok I will call for coaching." I asked her to set an alarm as a reminder. She complied, I said, "Great," and we moved on.

Next, we spoke about planning the partner session. I told her the purpose of bringing in her partner would be to assist her in achieving her therapeutic goals. We collaboratively discussed ways in which a partner session might help facilitate movement towards her goals (e.g., reducing/replacing relationship-withdraw and -approach behaviors, increasing skills).

Jane's stance shifted. She said she was not sure what could be accomplished by having her partner join. I responded by explaining ways in which partner sessions can be helpful. She responded with reasons my suggestions would not apply to her situation. So, I asked her how she thought it might be helpful. She said, "I don't know. He asked me that yesterday and I said, 'I don't know' then too." I inquired about the context and she described a moment in which her boyfriend asked how he could be helpful to her because he noticed Jane was "off". Jane had indeed been feeling "off" at that moment because she was ruminating on negative self-judgments related to her skin. At that time, as with this moment in the therapy, Jane did not know how a supportive other could be helpful in such a situation. I drew a connection to her stated reasons for infrequently utilizing phone coaching. Jane had repeatedly told me some version of, "I am not really sure what I am calling for, so I don't call," or "I don't think there is a solution to my problem, so I don't call." I reflected back the paradox: "It's like, 'I don't know what I need so I cannot ask for it,' or 'I have already tried everything, and I know there is no solution, so I don't ask for help.' You believe there is no solution and yet you believe you need a solution." We sat

in silence. Then Jane said, "Yeah. So that's it." I replied, "Yeah. That's it. I guess we have to accept it."

With an eye on "acceptance," we turned our attention to the chain Jane had completed for homework. Her chain read as follows: "Behavior (notice new skin flaw) > Emotion (frustration) > Thought (" I am not in control of my skin") > Behavior (inspect skin in different mirrors at different angles in different lighting) > Emotion (sadness, loss of self-worth) > Thoughts (self-deprecating rumination; come up with a list of a million things of everything I hate about me) > Thoughts ("I'm ugly"; engage in social comparisons; "why do other people get all the good stuff?" and "it's not fair") > Emotion (hopelessness) > Thoughts about seeking out a specialist to fix skin > Thought ("well, it is only going to keep getting worse" > Emotion (hopelessness, frustration and anger) > Behavior (look up surgery options just to keep an open mind about the possibility of changing my flaws because it gives me a sense of control, but not really) > Thought (hopeless thoughts about the relationship; "he can't handle this"; I might as well end things now).

After reviewing the chain, I asked Jane, "What kind of skin 'flaws' are you referring to?" Jane said she was not comfortable telling me what skin flaws she has. I asked if she talks about this with anyone, other than herself. She said, "No." So I asked, "If you were to discuss or even show me a feature about yourself that you feel ashamed about, what are you afraid might happen?" She considered briefly, laughed and then said, "I mean... I guess it's just about [experiencing] the emotion [of shame] because I don't think you would judge me or anything. But I am still not going to show you or anything!"

Here we began becoming polarized: she on the side of "hiding" and me on the side of "exposing" herself. I pointed out her chain had skipped from considering surgery options to

hopeless thoughts about her relationship. I told her an important aspect was missing from her chain. She experiences "shame" and corresponding action urges to "hide" her perceived flaws, which means her issues can never be resolved with her partner which leads to hopelessness about the relationship. I noted the fact that hiding thoughts and feelings instead of sharing means she misses the opportunity to learn what actually happens if she does share. Jane repeatedly conveyed she would not be comfortable sharing with anyone the aspects of herself that she is ashamed about.

Noticing we were polarized, I highlighted it: "I'm noticing us getting into a bit of a tug-of-war here. Let's drop the rope for now and return to the chain." I instructed her to add "shame" to the chain and asked her what the action urges are associated with it. Jane said, "My action urge is to hide. And also to break up [with my boyfriend] before he... You know what I mean?" I filled in the blank: "Before you lose the relationship because of you flaws, which would be more painful than breaking up with him preemptively?" She laughed and agreed. We completed the chain and looked back at it together. We had identified several problematic behaviors leading up to the target "breakup behavior."

We switched gears and engaged in solution-analysis. I guided Jane in identifying skills that could potentially replace links in the chain that led to the problematic "breakup behavior." Jane identified Opposite Action as a skill to replace several problematic links. I reminded Jane she had reached this same conclusion several sessions prior (when we originally planned to have her partner join a session so we could practice Opposite Action to shame). The session was running out of time, so I gave her homework to complete the rest of the solution-analysis, and to call for coaching while doing so.

Before wrapping up, I checked-in and asked, "So how are you feeling about this?" Jane expressed some feelings of hopelessness, like she would be "living with this forever" and there was "nothing she can really do about it." I reflected her feelings back to her and voiced how hard it is to be open with people when she so often feels "shame" and associated urges to hide (*validation*). She agreed and briefly described the surprise she felt thinking about how emotionally open a colleague was with friends. I reflected that back too and self-disclosed: I said, "I've always felt [like I am kept] at arms distance from you. It's like I am not getting to know 'all of you' because you are holding back" (*self-involving self-disclosure*). She agreed and said she does that, in part, because she already felt attached to me and knew our relationship would end so she felt she needed to "avoid opening up too much" to protect herself from the intensity of grief when the therapy inevitably came to an end. I validated her feelings and connected it to her chain by noting that "hiding" prevented her from feeling "shame" and from feeling "overly attached" and vulnerable to grief (*inhibited grieving*). With that being said, we agreed we were working on the correct treatment targets because shame appeared to continually get in the way.

Group

Jane texted in advance of group to inform she was sick and would be unable to attend. She later cancelled our next appointment due to illness. She also missed the following group due to the same illness. I felt frustrated since Jane had now missed three of four Interpersonal Effectiveness groups.

Session 22

Jane presented to Session 22 without her diary card. As ever, the missing diary card represented treatment-interfering behavior. As we strive to replace ineffective behaviors with

more ineffective ones, it is important to keep in mind that interventions can potentially interfere with treatment. However well intentioned, an intervention can be ineffective, inefficient, or even damaging. In this case, I judged that problem-solving would likely be less effective and concise than alternative options. I chose not to have Jane compete a diary card in session because it was overly time-consuming, and we needed to use our valuable time preparing for our partner session. This took priority because I believed the partner session would most effectively address her LTBs prompted by shame. I opted to express my disappointment (*contingency management*) and have Jane commit to bringing that week's diary card along with the following week's to our next session.

We collaboratively formulated our agenda. I also asked about instances of relationship-coping behaviors. She denied experiencing any significant urges to cope with emotions via relationship-coping. It was important to assess the status of treatment targets, especially since I had opted to forgo diary card review for that one session. I briefly checked-in about other pertinent events over the last week to inform session structure. I pointed out we had four sessions remaining and we plotted out our upcoming schedule.

I presented end-of-therapy letters – written letters the patient and therapist write to one another that facilitates a reflection on the treatment and a meaningful goodbye. These are not required components of DBT but they are encouraged at DBT-RU. I provided Jane a handout with guidelines to inform the end-of-therapy letters we would write to one another. We reviewed the guidelines and agreed to read our letters aloud to each other during our last session.

We then shifted to planning the upcoming partner session. I reminded Jane the goal we had identified was to practice Opposite Action to shame with her partner. We also agreed on another goal of providing concrete behaviors her partner can do for Jane to facilitate treatment

goals. Jane reiterated her difficulty identifying helpful behaviors for her partner to engage in. I offered several suggestions. Jane declined each suggestion and provided reasons why she believed they would be not helpful. For example, Jane said she did not want her boyfriend to validate her feelings because she disliked being validated. I disagreed and briefly challenged her assertion to no avail. I soon became aware we were becoming polarized. Rather than continue to "tug the rope," I decided to drop it. Instead, I described the frustration I was experiencing attempting to identify effective actions for her boyfriend (*self-involving self-disclosure, modeling self-disclosure*). At my prompting, Jane confirmed she experiences similar frustration, even hopelessness, about getting what she needs from her relationships. We discussed what it might be like to share *that* with her partner: that she feels frustrated and hopeless, and possibly request her boyfriend be patient while she continues to work on her effectiveness in obtaining needs within the relationship.

Through that conversation, Jane conveyed how difficult it is for her to express thoughts and feelings associated with shame and self-judgment. Having identified urges to "withdraw," "hide," and "shutdown" as problematic links in her chain, we recommitted to practicing Opposite Action for shame during the upcoming partner session. We planned to first have Jane inform her partner she is actively working on increasing instances in which she uses Opposite Action to shame by expressing it, instead of "shutting down" and "hiding". The plan would then be to practice Opposite Action in session by stating "I feel ashamed telling you about how I feel right now and I feel ashamed at how difficult it is for me to tell you that."

Planning the rest of the partner session went smoothly after concretely committing to the goal of practicing Opposite Action to shame. We also planned to use the partner session to request support from Jane's partner in counteracting relationship-approach behaviors by

implementing ABC PLEASE skills to maintain a more robust resource pool to regulate her emotions. Jane noted her partner's sleep-wake pattern negatively impacted her sleep. We planned to specifically ask for his support in encouraging pro-sleep behaviors.

Session 23

We began Session 23 reviewing Jane's two diary cards. We started with top priority QOLIBs: ineffective coping with shame. I asked for updates about the partner session we had been planning. Jane said, "I'm not sure it is going to happen anymore." My heart sank. Jane confirmed she had requested he join a session and he was willing. However, a variety of logistical issues were making it difficult for him to attend.

After briefly attempting to problem-solve, it became clear Jane had not directly engaged in planning with her boyfriend. I noticed Jane appeared uncomfortable conveying to her boyfriend how important it was to her that he join. Consequently, she did not develop a plan for him to get to the session. I asked what it would be like to tell him how important the partner session was to her and to ask if they could collaboratively problem-solve. Jane responded, "I don't think he has any ideas." I told Jane that conveying this specific need to her boyfriend presented an opportunity to practice Opposite Action. Jane appeared conflicted and did not immediately respond. I asked her, "What is going on for you right now? What emotion are you experiencing?" She expressed worry that her boyfriend would respond "impatiently" or in some way that would "hurt" because she was being "unreasonable" and burdensome. I validated her concerns. I told her I understand why she worries about that given her learning history (*validation*). I then challenged her inclination that expressing these emotions and needs would be inappropriate or excessive (*using a confrontational tone, directly challenging an assertion*). I provided psychoeducation about the role of emotions in relationships and the potentially

detrimental effects of withholding such information from partners. Jane disagreed with my assessment of the situation. I replied, "Okay, maybe you're right. Here's how I might handle this situation. Tell me what you think."

I modeled an abbreviated DEAR MAN using GIVE skills. The GIVE skills prioritize maintaining the relationship while still being assertive. I demonstrated how I might assert myself while emphasizing being gentle, validating, and conveying easy manner. In a light-hearted, playful tone, I asked, "Is there any way we can figure out a way to get you to one of my DBT sessions? I know it's a hassle (*Validate*) but when I think about you not coming in (*Describe*), I get really disappointed (*Express*). It actually means more to me than I was thinking before (*Reinforce*). Can we try to brainstorm again (*Assert*)?" Jane conceded she liked my approach and "might" try to ask him again in a more expressive way. "Might?" I prodded playfully. "Okay, okay, I'll do it!" She laughed with light-hearted exasperation. I had Jane practice her own, impromptu DEAR MAN several times until it was expressed smoothly (*skills building*). She committed to delivering it to her boyfriend. She told me she would let me know later in the day. I told her I would call if I did not hear from her (*contingency management*).

The session shifted to homework review of Jane's solution-analysis. Jane had provided several possible replacement behaviors for problematic links. We went over what she had come up with and collaboratively identified of additional options. Jane committed to adding more skillful solutions to her solution-analysis for us to review next session. The stated goal was to create a written plan for her to have after therapy as a guide for how to more effectively handle similar situations in the future. Jane texted later that day to confirm her boyfriend would indeed be joining our next session.

Session 24 – Partner Session

Session 24 began in the waiting room where I met Jane's boyfriend and, after initial introductions, asked him to remain in the waiting room for 10-15 minutes while Jane and I met individually. We collaboratively reviewed notable items on her diary card and developed our agenda. We agreed to use our individual time to review our plans and goals for the partner session. The goal of the partner session was to express her emotions and needs to her partner by practicing Opposite Action to shame. Namely, Jane would describe the shame she often feels about herself and her worry that her emotions and needs will be judged negatively and be burdensome. Fully anticipating a shame response, we restated our intention to approach this skillfully using "all the way" Opposite Action. I assured Jane I would guide the session and help when needed. LTBs, TIBs and QOLIBs were all being targeted so the most important objective was conveying the message to her boyfriend. Building skills in Interpersonal Effectiveness and Opposite Action was secondary. For that reason, my priority was exposing Jane to a corrective learning experience by acting opposite to shame with her partner. We were also hoping to target TIBs by getting her partner on the same page as us. We sought to enlist his help to decrease the excessive relationship-approach behaviors that had negatively impacted so many other areas of Jane's life.

We committed to our plan and Jane brought her boyfriend back from the waiting room. I began by informing Ian of the goals of our session. I explained we had him join to help facilitate Jane's goals of improving her life and relationships. Specifically, we hoped to have Jane practice Opposite Action to shame by expressing her emotions and requesting help. I also encouraged Ian to ask questions of both of us. With that, I prompted Jane to enact what we had practiced.

Jane, with my guidance, described the frequency and types of scenarios in which she becomes emotionally dysregulated. She quickly became visibly ashamed. Her eyes were

downcast, infrequently flicking up toward her partner as she spoke to the floor. Yet her boyfriend leaned forward and appeared to angle himself as if to catch her eye and convey reassurance (*responsiveness, validation*). Jane's boyfriend responded by thanking her and requesting, with sincerity (*warm engagement, genuineness, responsiveness*), for her to communicate her emotions with him in those moments going forward (*modeling direct communication*).

Jane's demeanor shifted. Her eye contact with Ian increased and she sat up in her chair. Jane expressed worries that she will be "annoying" or "a burden" if she expresses herself in those moments and that she fears he will want to leave her if she does. Jane's boyfriend replied, "It's honestly more of a burden to me when you don't tell me what's going on," and "I give you full permission to be annoying. Please be annoying. It's way more annoying when you shutdown." Jane laughed and committed to doing her best in future. I reminded her that doing so is difficult and that we had planned to ask for Ian's patience as she works to increase her expressiveness. Jane said, "Oh yeah, that too," and we all laughed together.

Next, we transitioned to providing context. Jane explained a typical chain that might lead to feelings of disconnection. She explained how BDD thoughts often spiral into hopeless rumination about her life and relationships causing her to shutdown and withdraw. With my guidance, we inserted Ian's thoughts, feelings, and behaviors into the chain-analysis. Ian expressed feeling "confused," "frustrated," "worried," and "scared" when Jane would shutdown. He explained he could sense her withdrawing from him and he would try his best to connect with her but he often felt "shutout" and helpless. Jane said she did not realize what his experience was like in those moments. He replied, "Yeah, it's not great."

Jane and Ian then collaboratively discussed ways of handling such situations in the future. With some prompting and guidance from me, they concluded that, while Jane would do her best

to be more open and expressive, Ian would also check-in when Jane appeared shutdown and, when appropriate, convey affection, acceptance, and validation as well as encouragement for her to proceed skillfully (e.g., STOP skill, Distress Tolerance skills, and Opposite Action).

With that, we turned our discussion to ways of promoting skills implementation. I prompted Jane to explain Opposite Action more fully and how she had just used it to express her feelings only minutes ago in session. Ian actively engaged in the discussion and helped develop plans to implement the skill in future. We transitioned to discussing the other skills Jane had planned to ask for Ian's help implementing. Jane explained she is more vulnerable to emotion dysregulation with less sleep, exercise, and various other activities that promote daily functioning. We reviewed ABC PLEASE skills and I prompted Jane to ask Ian for his help prioritizing these skills. Jane rolled her eyes at me and, smiling, directly asked Ian for his help. Ian laughed good-naturedly and agreed to help Jane address vulnerability factors in the future.

Session 25 – Final Session

The final session began, as ever, with form completion, diary card review and agenda setting. We planned to discuss two items from Jane's diary card, review the partner session, and read our end-of-therapy letters.

Jane expressed that the partner session had been "a lot more helpful" than she had expected. She said she now finds it easier to talk to her partner about the issues we had addressed (e.g., shame, BDD, prioritizing sleep). Discussing those topics prior to the session induced shame and fears of being burdensome or judged. Afterwards, she said it felt "almost normal" to discuss those needs with her partner.

Jane also expressed how impactful it was to hear her partner's perspective during the partner session. Although Ian has asked her to be more "open" with him several times in the past,

she doubted he understood what he was asking for. She believed her emotions and needs would be "too much" for him and ultimately lead to her being rejected and abandoned. In session, however, Jane had described her emotions and problems and fears about being annoying or burdensome and Ian had been undeterred. On the contrary, he had replied with acceptance and understanding, and he had requested, with sincerity, that Jane share her emotions with him in those moments. In that moment, Jane experienced her partner as a true teammate for the first time. She felt he understood her issues and, indeed, *actually* accepted and wanted her to openly share her thoughts and emotions. That meant everything to Jane.

We discussed another valuable aspect of the partner session: the inclusion of her partner in the chain-analysis process. Typically, when performing a chain-analysis, the information is provided by one source: the patient. Yet many of Jane's most problematic chains involved her partner. By including him in the chain-analysis process, we added important thoughts, emotions, and behaviors from him that substantially influenced the clarity of information Jane had at her disposal. For example, she now recognized the "shutdown" behavior is likely to annoy Ian than sharing her feelings. More importantly, Ian was likely to nonjudgmentally accept Jane's emotions if she expresses them. Jane said it had been "helpful to see through his eyes."

A related aspect of the partner session that Jane found helpful was the opportunity to see her partner displaying comprehension. Jane described watching her boyfriend discuss the skills and learn about their treatment targets and feeling like he "got it" which made her feel "understood" and accepted. Jane expressed increased "hope" for the future of her relationship, and we concluded in agreement that we believed the interventions employed during the partner session were effective.

Believing her partner would accept her required her to believe he understood her issues. Yet understanding her issues required Jane to act opposite to shame and express her problems and emotions. That had been the key. From early in therapy, we had worked toward Jane expressing her emotions and needs. Yet she was not prepared to do so at the time. It required substantial work to get to a point in which she was willing to expose herself to shame by expressing her emotions. It also required substantial assistance from me in the moment to effectively enact the skill.

We moved on to reading our end-of-therapy letters to one another. Jane expressed gratitude to me and the program. She described ways her worldview had changed over the course of therapy. She said she found the DBT assumptions validating and helpful. For example, she identified with the assumption that she was trying the best she could to improve *and* needed to try harder and do better. She additionally referenced the idea that all behaviors are caused. It helped her accept that her struggles are not her fault but merely facts that needed to be accepted and addressed. Jane also noted areas in which she would like to continue growing. Chiefly, she acknowledged how difficult she continued to find expressing emotions. She said treatment helped her recognize the purpose and utility of emotions and emotional expression and she was determined, with Ian’s help, to continue working on it. Jane demonstrated a strong understanding of the skills throughout her letter. When I later read it to consultation team, I expressed how surprised I was by the amount Jane appeared to have taken away from the therapy and how much she seemed to have benefitted. It was clear the demanding and seemingly chaotic nature of the treatment had blinded me to the remarkable progress that was occurring.

Treatment Follow-Up

An unstructured interview was conducted with Jane during a follow-up appointment one and a half years post-treatment. The interview involved discussion about Jane's present life circumstances, experiences in DBT, and perceptions of the ways in which treatment impacted her life and relationships. We reviewed Jane's treatment goals, examined effective and ineffective aspects of our treatment, assessed post-treatment progress, and identified areas Jane would like to continue to grow. The BEST was administered as a measure of symptom severity.

Jane affirmed she considered our therapy a success. She said it "made a huge difference" in her life and relationships and it continued to have a positive impact. Beyond the skills, Jane claimed DBT changed her worldview. It made her more aware of judgments and of alternate interpretations to most situations. She said mindfulness had a particularly strong impact on her life because she found herself more present-centered and aware of context, thoughts, feelings, and behaviors.

We reviewed each of her treatment goals (i.e., improve relationships with romantic partners, son, and family, reduce symptoms of body dysmorphia, reduce negative emotions and associated dysregulation) and collaboratively assessed her present status with each. Jane reported marked improvement in the quality of her romantic relationship. She described meaningful reductions in the ineffective relationship-coping behaviors we had targeted throughout treatment. As a testament to changes in Jane's relationship-withdraw behaviors, Jane reported she had not broken up with her boyfriend since our treatment. She said she continued to experience urges to shutdown and withdraw within the relationship, especially in midst of shame. However, Jane reported "very few" urges to break up. In fact, when I asked if she was still dating Ian, Jane appeared surprised by the question and replied incredulously, "Yeah, of course. He's not going

anywhere." Jane reported decreased relationship-approach behaviors as well. She said she had been better balancing her own needs with those of the relationship. Consequently, she reported a return to her pre-relationship levels of functioning in terms of sleep, substance use, school, work, and overall daily functioning. Jane said she continues to struggle with feelings of emptiness and tends to cope using relationship-approach behaviors. For example, when choosing whether to go home or visit her boyfriend after work she often decides based on how quickly she thinks she will fall asleep because she fears being unable to cope with emptiness on her own. Nevertheless, Jane said she no longer relies on the relationship in ways that negatively impact her other values and needs.

I highlighted the contrast between Jane's ambivalence about long-term relationships at the start of treatment compared to her newfound confidence and commitment. Jane pointed to our partner session as a turning point. She described the partner session as a "huge deal" because it upended her previously held fears about sharing her emotions and needs with her partner. She said it "completely changed" her ability to be "open and honest" and obtain much needed validation and assistance from her partner. It was clear speaking with Jane that her relationship had deepened, and her ineffective relationship-coping behaviors had meaningfully decreased.

Jane reported one significant rupture in her romantic relationship since treatment ended. Jane had kept her infidelity early in the relationship a secret. She said she believed telling Ian would have been "pointless," and she feared hurting him and harming the relationship. However, Jane was honest when Ian later asked if she had ever cheated on him. In the aftermath, Jane said Ian had been unsurprised and largely unperturbed by the infidelity. Instead, Ian had been far more affronted and hurt by Jane withholding the information for so long. Jane said she and Ian were both continuing to build trust in the relationship by fostering Jane's openness and honesty.

Jane said Ian carried lessons from the partner session forward and would frequently prompt her to be forthcoming with her emotions. For example, on more than one occasion after Jane had privately engaged in BDD compulsion in the bathroom, Ian had pointed out that Jane seemed emotionally withdrawn and asked what she had been doing. In such circumstances Jane said she would typically lie: "Going to the bathroom. What do you think?" However, more recently, Jane had begun recanting such falsities and admitting to her BDD behavior more often and readily.

Jane's relationship with her son had also improved. She described a brief "backslide" for the first couple of months after Brandon resumed online schooling in the fall of 2021 during the Covid-19 pandemic. At the time, Brandon had been exhibiting substantial emotion dysregulation that Jane found difficult to manage and cope with. Jane said her mother, who tended to struggle less with Brandon, had experienced similar difficulty and overwhelm during that time. Jane said she had practiced DBT skills to regulate herself but felt unable to act effectively. However, since Brandon's behavior settled down, Jane said her relationship with him had greatly improved. Compared to the start of treatment, Jane reported increased positive interactions and substantially reduced negative interactions. She said she practices DBT skills and believes they help her regulate ineffective emotions and improve her interactions with Brandon.

Jane portrayed her relationships with her parents and siblings to be largely unchanged. She provided one update regarding her relationship with her mother. Jane said she had sought emotional support from her mother for the first time since she was a teenager. Jane had reached out to her mother in severe distress due to a situation involving Brandon and his father. Jane said her mother was supportive. However, Jane is was still unsure about sharing her feelings with her mother for fear of being judged or overly burdensome.

Jane said she continued to struggle with symptoms of BDD and the associated shame and compulsions. She said the symptoms were largely unchanged since her treatment at the ADC prior to starting DBT. However, she noted one significant improvement in this area. Jane said she no longer felt fear and hopelessness about her romantic relationship in connection with BDD-related self-deprecating rumination. During treatment, Jane had noted BDD-related rumination as recurrent prompt for hopelessness, fear, relationship-withdraw behaviors, and suicidal ideation. Jane said she could not recall that occurring since our partner session. This represented a meaningful improvement in her life.

In the final part of our post-treatment interview, Jane and I turned our attention to specific treatment take-aways. First, I summarized Jane's case formulation. We agreed Jane's core problem was her shame-response to her self-image and her emotions. Feeling ashamed of herself caused Jane to hide, reject, and invalidate her emotions. She did not address her emotional needs directly and relied on relationships and BDD-driven compulsions to feel better about herself. This prevented her from building more effective emotion management skills. DBT had helped Jane begin to accept herself and her needs, manage emotions more effectively on her own, and express and assert herself in her relationship. We discussed how Jane could continue growing in these areas. For example, Jane said she would continue to practice Radical Acceptance of her emotional sensitivity. She could exercise Opposite Action to shame via emotional expression and Interpersonal Effectiveness. She could Cope Ahead and perform planned exposure and response prevention to practice accepting loneliness and emptiness, instead of escaping through sleep. Jane also said she would like to be more emotionally available for her boyfriend's emotional needs. She said she would like to begin practicing Interpersonal Effectiveness skills for validating her partner.

Chapter VII: Therapy Monitoring and Use of Feedback

Ongoing therapeutic monitoring used as feedback for treatment planning and decision-making is fundamental to DBT. Tracking of primary targets and skills is achieved with the mandatory use of diary cards. This is consistent with the aims of the pragmatic case study design. diary cards provide ongoing therapeutic monitoring that directly contributes to treatment formulation and planning each session. The diary card provides an organized menu of primary targets and the efforts made to skillfully replace them. The agenda is set each session based on the targets reported in the diary card. The treatment status is therefore consistently reassessed, and each session is specifically tailored based on that information.

Chain-analyses performed on primary treatment targets are of equal importance. The systematic analysis of thoughts, emotions, behaviors, and circumstances surrounding target behaviors provides essential assessment information. Much like a pragmatic case study, the chain-analysis offers rich contextual details as data to examine the effectiveness of behaviors and interventions. Thus, the DBT therapist and patient engaging in diary card review and chain-analyses are essentially engaging in consistent, pragmatic, rich evaluations of problems and solutions. In this way, DBT utilizes consistent therapeutic monitoring as feedback along with systematic analysis to inform case formulation and treatment.

Feedback from supervision and the consultation team is also utilized in this training clinic model. One member of consultation team shared a supervision block with me. The team member would watch my video sessions in advance of supervision. At supervision, we would all look over Jane’s diary card and discuss the case. Video clips of the prior session were usually viewed during each supervision session. Together, my team member and I worked with our supervisor to

assess treatment and plan ways to flexibly adjust to meet Jane’s needs. Thus, this model for DBT training provides consistent feedback to promote treatment fidelity and effectiveness.

Chapter VIII: Concluding Evaluation of the Therapy Process and Outcome

Quantitative Results

As seen in Figure 1, Jane's symptom severity generally displayed a downward trajectory over the course of therapy. Importantly, the treatment effects appear to have sustained at follow-up one and a half years later. In fact, Jane's severity scores at follow-up were the lowest to date.

We cannot draw definitive conclusions based on this quantitative data. A sample size of one is insufficient to draw such conclusions. Nor can we assuredly attribute severity reduction to the treatment. This is perhaps especially true at follow-up, given the myriad of influences Jane experienced in the months following treatment. However, these quantitative data points can be examined in conjunction with other qualitative data to paint a fuller, more nuanced picture of the treatment and its outcomes.

Table 1 shows the raw BEST scores, including the scores of the individual subscales. The scores illuminate a reduction in symptoms and an increase in positive behaviors over time. These are encouraging results as DBT aims to reduce dysfunctional thoughts, feelings, and behaviors by replacing problematic thoughts and behaviors with more effective ones. These scores are consistent with qualitative results of the study. I believe this is a testament to Jane's progress since beginning treatment.

Qualitative Results

The qualitative results of this study were based on video, notes, observations and Jane's self-report during and after treatment. Outcomes were judged based on observed goal attainment and changes across target behaviors. Jane's treatment goals primary revolved around improving her relationships. She wanted to improve relationships with her romantic partners, son, and family members. She also wanted to change her relationship with herself. That is, she hoped to

accept herself and thereby reduce her self-deprecating rumination and hopeless feelings about her life and relationships.

Based on my own observations in conjunction with Jane's self-report during and after treatment, significant progress was made across Jane's goals. She reported significant improvements in her relationship with her boyfriend and her son. She described significant reductions in instances of emotion dysregulation and corresponding ineffective coping via relationship-approach or -withdraw behaviors. She did not report substantial changes in the relationship with her family members. However, she reported reduced instances of behavioral dyscontrol within those relationships. Importantly, Jane also reported reduced shame and self-deprecating rumination. She acknowledged significant progress as well as room for growth in each of these areas.

Discussion

The outcome of Jane's treatment was largely successful. Jane's metaphorical tightrope walk was facilitated by DBT's methods for promoting both progress and maintenance, change and acceptance. To continue the metaphor, the therapist is on the tightrope helping guide the patient forward and regain balance as needed. All the while, the consultation team is on a platform controlling ropes and pulleys to help the therapist maintain balance. While my treatment delivery often led to stagnation and imbalance, my consultation team helped maintain and progress the treatment. The relentless process of developing skills and replacing maladaptive behaviors with more effective ones resulted in significant improvements in Jane symptoms and her ability to continue maintaining and making gains.

The repeated, systematic process of assessing therapy targets and interventions proved efficacious in identifying effective approaches to address Jane's core problems and associated

ineffective behaviors. With initial discussions, diary cards, and chain-analyses, Jane and I hypothesized relationship-coping behaviors were our top-tier QOLIBs. Jane's self-report and initial chain-analyses led us to conclude that Jane's mood and self-regulatory capacities would significantly impact our interventions. We decided to establish a consistent baseline of behaviors using the ABC PLEASE skills from the Emotion Regulation module to reduce vulnerability factors. We also had initial successes implementing Distress Tolerance skills. However, Jane displayed apparent competence and requested we stop using Distress Tolerance skills and I acquiesced, likely to the detriment of treatment.

Jane's first break-up with her boyfriend early in treatment represented an overt relationship-withdraw behavior to be analyzed and targeted. The function of the behavior was to reduce fear and to indirectly communication Jane's needs. Overestimating Jane's competency, I opted to prioritize Interpersonal Effectiveness skills, despite Jane's reluctance to openly express her emotions and needs with her partner. The following several sessions were marred by polarization as I pushed Jane to perform skills that were beyond her capability or willingness. Jane exhibited TIBs when she did not perform homework. I exhibited TIBs when I did not adequately assess the TIBs and continued to push my own agenda. Supervision ultimately gave me the perspective I needed to see how my insistence on a particular intervention was causing polarized stagnation in the treatment.

I resolved to prioritize promoting synthesis to progress treatment. By the time we next met, Jane had successfully decreased relationship-withdraw behaviors by suppressing her emotions and needs. Chain-analyses revealed how Jane was self-regulating via relationship-approach behaviors (i.e., spending excessive time with boyfriend, reduced sleep with boyfriend, excessive drug use with boyfriend) to such a degree that other areas of her life were "falling

apart," as she put it. My acceptance-based interventions proved insufficient to balance the changes in relationship-approach QOLIBs that I was advocating for. Each chain-analysis revealed more and more problematic links I wanted to change. Yet pushing to change resulted in more polarization. I recommitted to prioritizing acceptance-based interventions on multiple occasions. Still, by the end of each session I found myself unsuccessfully prioritizing change.

Consultation team provided me the coaching I needed to adjust. They helped me realize a change *in me* was necessary to effectively facilitate synthesis in treatment. Jane and I collaboratively made sense of the hopelessness she was feeling by using a metaphor as a change-tactic to increase my own empathy and acceptance. It proved effective. I spent more time validating Jane, our perspectives aligned, and a synthesis was found. For several weeks Jane was engaged in treatment and her relationship-approach behaviors were no longer prompting TIBs. Her urges to quit therapy had seemingly dissipated and she was completing homework and attending sessions (although she missed one group due to lack of childcare). Jane practiced Distress Tolerance skills and her relationship-withdraw behaviors correspondingly reduced. However, Jane was not reporting elevated relationship-approach behaviors during that time and I was not adequately assessing for them since they had not produced TIBs. With about six weeks left in treatment, Jane's over-prioritization of relationship-approach behaviors had created substantial problems in her day-to-day life that came to the fore and resulted in a resurgence in TIBs.

Supervision and consultation team helped reduce my overwhelm and hopelessness during that time. I approached treatment with greater skill. Having learned from previous successes, I emphasized acceptance and thereby reduced polarization and facilitated syntheses to produce progress. We homed in on Jane's core-problems surrounding her shame response and planned to

directly target it through Opposite Action. Ultimately, it was Jane's interpersonal effectiveness during the partner session that constituted the Opposite Action to shame that was necessary for her to decrease the shame and associated relationship-coping behaviors that maintained it.

As the individual therapist working with Jane, the treatment felt largely ineffective much of the time. Her behavior appeared to increasingly ineffective over time. Jane frequently missed sessions, including important groups. Many of our discussions became polarized. Jane underutilized phone coaching and often did not complete homework or attend group. Yet, in the end, Jane appeared to profit enormously from the treatment. The juxtaposition between my perceptions during and after treatment was likely due to multiple factors.

Reducing target behaviors often resulted in a corresponding increase in effective behaviors. For example, as we replaced relationship-withdraw behaviors with Distress Tolerance skills, Jane engaged in more relationship-approach behaviors. Jane's time and activities with her boyfriend diminished her functioning in work, school, treatment, and daily tasks. At the time, it felt to me like taking one step forward meant taking five steps back. Each time therapy-interfering behaviors occurred we spent more time addressing those concerns. And Jane did not find discussions about diary card completion or childcare stimulating or motivating. Jane's engagement reduced and it felt to me like we were moving further from her goals.

The chaotic nature of the treatment progression was in part due to my own ineffective treatment delivery. For example, the approach I took to targeting Jane's increasing TIBs decreased her engagement in treatment. Another example was in my interaction with Jane's apparent competence and active passivity. Jane's competent demeanor combined with my own beneficent desires led me to emphasize overly onerous interventions for parts of the treatment.

Yet my response to her hopelessness led me to work harder for her which only increased treatment stagnation.

In retrospect, it seems I could have more directly targeted Jane's core-problem – her shame response – earlier in the treatment. While reducing Jane's relationship-withdraw behaviors was pertinent, it more directly targeted her experience of hopelessness. While it is true Jane's hopelessness stemmed from her shame-response, reducing the resultant relationship-withdraw behaviors without addressing the underlying shame only led Jane to lean more heavily on relationship-approach behaviors to cope. Instead, we might have focused on exposure and response prevention for shame. Indeed, my insistence on developing Jane's Interpersonal Effectiveness skills was an attempt to have her Act Opposite (i.e., exposure herself) to shame within a relationship. Yet, as previously mentioned, my efforts were ineffective because I was advocating an approach that Jane was neither capable nor willing to take. In the end, as Jane and I both observed, it was the direct targeting of shame via Opposite Action during the partner session that led to the most meaningful improvements. However, it cannot be discounted that Jane ultimately stayed in the treatment, increased skillful behaviors, reduced ineffective behaviors, and moved closer to her goals and values.

Taking a pragmatic approach to this case study taught me a valuable lesson about the nature of DBT's approach. Just as the pragmatic case study assesses treatment for effectiveness to elucidate and improve treatment as a whole, DBT repeatedly uses that very same approach to elucidate and improve the treatment of an individual. It is important to recognize that problems will arise within any treatment approach. This is perhaps especially true when treating severe, mood-dependent dysfunctions commonly seen in BPD. As such, DBT acknowledges that any singular approach or intervention is likely to encounter problems. It accounts for this by utilizing

diary cards and chain-analyses to produce pragmatic, in-depth analyses of interventions and outcomes to continually improve the individual’s treatment. In addition, DBT accepts the difficulty of maintaining a treatment that consistently encounters problems. DBT therefore employs specific tactics for maintaining the treatment, both by the therapist for the patient, and by the consultation team for the therapist. Taken together, the frequent therapeutic monitoring and fluid adjustments made based on the principal-based methods for maintaining and progressing treatment proved successful in treating this difficult and complex case.

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Table 1

Borderline Evaluation of Severity Over Time (BEST) Scores Through Treatment and Follow-Up

Date	Time Point	Total Score	A. Thoughts and Feelings Subscale	B. Behaviors-Neg Subscale	C. Behaviors-Pos Subscale
04/09/2019	Pre	24	24	10	10
05/20/2019	Session 4	28	27	11	10
06/27/2019	Session 8	23	23	9	9
07/25/2019	Session 12	26	26	10	10
08/26/2019	Session 16	24	21	11	8
09/11/2019	Mid	19	20	8	9
10/03/2019	Session 20	18	21	7	10
11/04/2019	Session 24	23	23	9	9
11/26/2019	Post	17	20	9	12
03/19/2021	Follow Up	13	16	8	11

Note. BEST was administered every fourth session and at follow-up at the start of session by the treating clinician. BEST was administered by a different assessor at Pre-, Mid-, and Post-treatment assessment sessions.

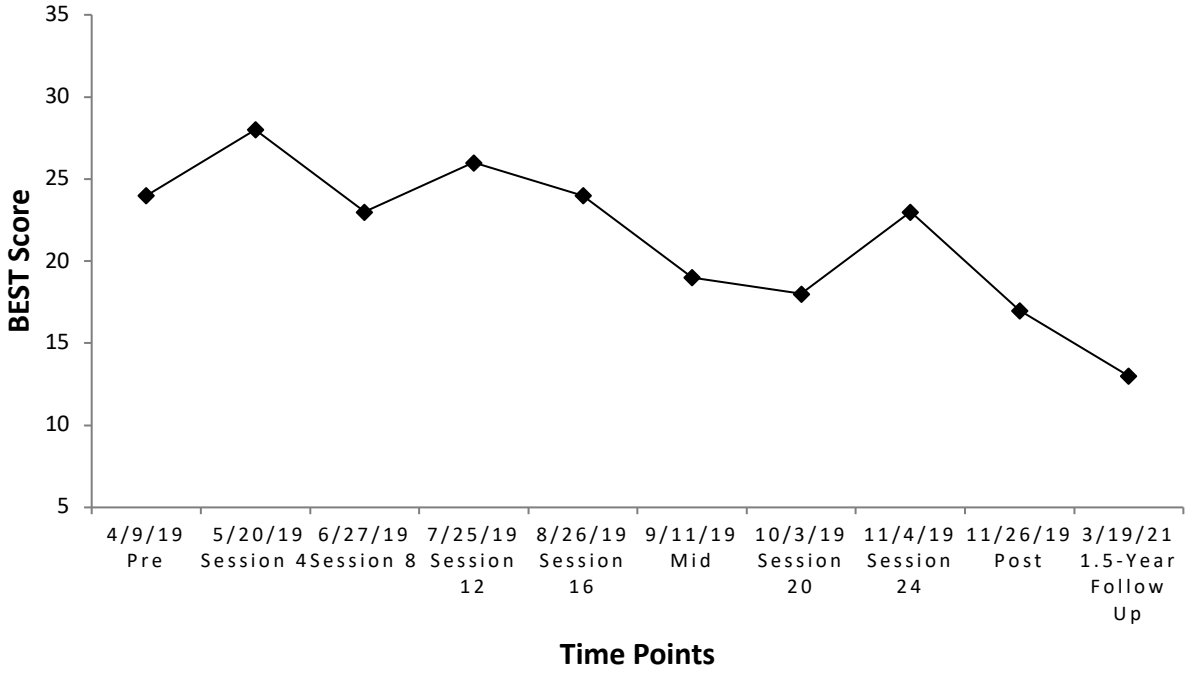

Figure 1. Changes in Borderline Evaluation of Severity Over Time (BEST) Scores Across Treatment and Follow-up

Note. BEST was administered every fourth session and at follow-up at the start of session by the treating clinician. BEST was administered by a different assessor at Pre-, Mid-, and Post-treatment assessment sessions.

DBT-RU Diary Card						ID #		Filled out in session? Y N		How often did you fill this out? _ Daily __4-6x __ 2-3x __ 1x						Date started _____			
Day and Date	Urge to Use 0-5	shame 0-5	fear 0-5	joy 0-5	anger 0-5	sad 0-5	Prescription Medications #	Specify	Alcohol and Drugs #	Specify	SI 0-5	Misery 0-5	Self-Harm Urges 0-5	Self-Harm Action Y/N	Used Skills Y/N	Skills Rating* 0-5	RC Urges 0-5	RC Action Y/N	BDD Urges 0-5	BDD Action Y/N
Mon																				
Tue																				
Wed																				
Thu																				
Fri																				
Sat																				
Sun																				

* SKILLS RATING

0 = N/A, did not use skills
1 = Felt *very ineffective* in my use of skills
2 = Felt *mostly ineffective* in my use of skills
3 = Felt *neither effective or ineffective*
4 = Felt *mostly effective* in my use of skills
5 = Felt *very effective* in my use of skills

Urge to harm (0-5): Before therapy session: ___ After therapy session: ___ Recorded Session: _____

Urge to quit therapy (0-5): Before therapy session: ___ After therapy session: ___ Listened to Session: _____

Dialectical Behavior Therapy SKILLS DIARY CARD	Instructions: Circle the days you worked on each skill.		Filled out in session? Y N		How often did you fill out this side? _ Daily __4-6x __ 2-3x __ 1x		
1. Wise mind	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
2. Observe: just notice	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
3. Describe: put words on	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
4. Participate: enter the experience	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
5. Nonjudgmental stance	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
6. One-mindfully: in-the-moment	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
7. Effectiveness: what works	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8. Obj. effectiveness: DEAR MAN	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
9. Relationship effectiveness: GIVE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
10. Self-respect effectiveness: FAST	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
11. Check the facts	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
12. Opposite action	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
13. Problem solving	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
14. Accumulate positives	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
15. Reduce vulnerability: PLEASE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
16. Build MASTERy	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
17. Cope ahead	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
18. Mindfulness of Current Emotion	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
19. TIP	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
20. Distract	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
21. Self-soothe	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
22. Improve the moment	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
23. Pros and cons	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
24. Radical Acceptance	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Figure 2. Jane's diary card