Chapter 3
Humor, Irreverent Communication, and DBT

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Keywords Irreverent communication · Humor in psychotherapy · DBT with suicidal · Multi-problem adolescents

3.1 Introduction to DBT, and the Strategy of Irreverent Communication

Dialectical Behavior Therapy (DBT) was created in 1993 by Marsha Linehan, who sought to address a gap in care for individuals living with chronic suicidality (Linehan, 1993). A trained behaviorist, Dr. Linehan had attempted to provide interventions focusing on behavioral change, only to find her clients protest that she was demanding too much and failing to acknowledge the severity of their difficulties. When Dr. Linehan changed her clinical approach to be more supportive in nature, she again received negative feedback from her clients, who wondered why she was not putting greater effort into helping them change the circumstances that were causing such pronounced suffering. Dr. Linehan sought to resolve this impasse by addressing both needs concurrently, prescribing behavioral interventions that would reduce her clients' suffering while also validating the difficulty of implementing these changes. This dialectical approach of allowing two ostensibly contradictory ideas to coexist permeates throughout DBT and provides the theoretical foundation upon which all DBT treatment plans are built. To help clients move more seamlessly through the treatment, making it an "easier pill to swallow," Linehan developed a balanced set of communication strategies: irreverent and reciprocal communication.

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R. D. Friedberg, E. V. Rozmid (eds.), *Creative CBT with Youth*,
https://doi.org/10.1007/978-3-030-99669-7_3

As will be described throughout this chapter, irreverence and humor are integral to the work we do with DBT clients and especially with teens.

3.1.1 What Is DBT?

DBT treatment focuses on using behavior chain analyses to clarify how the client's emotions, thoughts, urges, and behaviors interact to generate and maintain their difficulties. The clinician incorporates a range of change-oriented strategies, including DBT skills, to help clients more effectively navigate these difficulties and work towards their self-identified "life worth living goals." DBT skills are taught to the adolescent client and their caregivers in a multi-family group format, and fall into five modules:

1. Mindfulness Skills (increasing attentional control as well as non-judgmental awareness of internal experiences, thereby improving the client's ability to recognize maladaptive thoughts, feelings, urges, and implement more adaptive solutions).
2. Distress Tolerance Skills (skills for moments of pronounced distress, in order to allow the client to "survive the crisis without making it worse through impulsive action" (Rathus & Miller, 2015, p. 126)).
3. Emotion Regulation Skills (skills that allow the client to change one's emotional experience, e.g., increase positive emotions, reduce vulnerability to negative emotions).
4. Interpersonal Effectiveness Skills (helping the client establish and maintain healthy relationships, while also communicating their needs and maintaining their self-respect).
5. Walking the Middle Path Skills (using dialectical thought and communication to help clients and their parents/guardians understand and shape each other's perspectives, using validation of self and others to convey greater acceptance and understanding, and applying behavioral principles to effect change in self and others).

DBT is a principle-based treatment, meaning that while some components are necessary to the treatment (e.g., the client completing a weekly diary card monitoring their experiences and use of skills; a session agenda that addresses life-threatening and treatment-interfering behaviors before all other treatment targets), the clinician is encouraged to select interventions based on what is indicated by the guiding principles of dialectics and behaviorism. Clinicians strive to consistently adopt and convey the central dialectic of acceptance of the client's difficulties and efforts while at the same time encouraging positive changes to the client's behaviors, emotions, urges, and cognitions. This is achieved by deliberately striking a dialectical balance between empathically taking the client's agenda seriously (i.e., "reciprocal communication"), and interjecting comments that are intended to knock

the client "off balance" and shift thoughts, emotions, or behaviors (i.e., "irreverent communication").

Both forms of communication can be achieved verbally and nonverbally. In reciprocal communication (e.g., nodding along with the client's story, making statements that affirm their thoughts and feelings), the clinician aims to validate the client's understanding of their experiences. The response is in-line with what the client expects and hopes to hear. On the other hand, irreverent communication (e.g., an exaggerated eye roll, expressing dissent in a way that is satirical and noncombative) challenges the client's understanding of their experiences. This intervention is often unexpected by the client, knocking them off a track that the clinician believes to be problematic.

While the use of humors falls within the category of irreverent communication, irreverent communication need not be humorous. This chapter will provide a set of guiding principles for how this broader category of irreverence can be used effectively, so that the reader will understand ways of making use of humor within this framework. In-line with DBT being a principle-based treatment, emphasis will be placed on "function over form" by describing the rationale for selecting certain irreverent strategies, rather than listing specific statements that qualify as "irreverent." Implementing a list of humorous or irreverent phrases whenever an opening presents itself is not enough. Clinicians must have a firm understanding of the function of each irreverent statement, and whether irreverence will act in service of their therapeutic goal in that moment. The authors' intention here is to provide guidance on how this might be achieved using theory and clinical anecdotes.

3.1.2 Humor as a Reciprocal Communication Strategy

Within this chapter's focus on irreverence, it is important to consider the utility of humor as a reciprocal strategy. While humor can be used to "grease the wheels" of change, it also serves an important affiliative function, strengthening the relationship between the clinician and the client. Empirical support for this function can be found across the lifespan, including in children and adolescents, for whom the use of humor has been shown to result in improved interpersonal relationships (Cameron et al., 2010; Erickson & Feldstein, 2007; Führ, 2002; Geiger et al., 2019). There has been much debate about the primacy of this relationship in the therapeutic process, and there is broad consensus that a strong therapeutic alliance is a predictor of positive treatment outcomes (Horvath et al., 2011; Martin et al., 2000). Although empirical evidence that humor contributes directly to this relationship is hard to come by, anecdotal support might be found by reflecting on the people in your life whom you feel connected to and go to for advice and support. How many of those people do you feel comfortable laughing with, and how many do you feel incapable of connecting with through humor? For the majority of individuals, the former category is more well populated than the latter.

Humor also offers a dialectical balance to the seriousness of the topics discussed in psychotherapy. Clients do not seek out psychotherapy to discuss their favorite TV shows or most recent successes, but instead their fears, doubts, regrets, and difficulties finding a "life worth living." (Linehan, 1993, p. 99). These conversations can feel austere, somber, or frantic, and benefit from being balanced by interactions that introduce a certain amount of levity and play. This emphasis on levity may be why research suggests that not all forms of humor are created equal. Specifically, humor whose focus is "benign" or "benevolent," meaning that it reflects positively on self or others, has been shown to improve mental health, while that which is critical of self or others often has the opposite effect (Kuiper et al., 2004; Martin et al., 2003). More specifically, "affiliative humor," which involves laughing with others in an effort to improve relationships, and "self-enhancing humor," which uses perspective-taking to improve emotion regulation and ability to cope with stressful events, are both associated with cheerfulness, high self-esteem, and psychological well-being, and negatively associated with anxiety and depression.

Although using humor to increase positive interactions and feelings of connectedness may come naturally to many, a more difficult maneuver is to use humor as a dialectical strategy to encourage change. Within DBT, this takes the form of irreverent communication, which are intended to cause the client to "jump the track," or "(1) to get the patient's attention, (2) to shift the patient's affective response, and (3) to get the patient to see a completely different point of view" (Linehan, 1993, p. 393).

This definition succinctly describes the purpose of irreverent communication but offers little instruction on how and when the technique should be implemented. Irreverent statements are not inherently effective and cannot be used in all clinical scenarios. This difficulty is further complicated by the fact that interactions that naturally pull for irreverence can often be characterized by feelings of frustration or irritation within the clinician. This potential pitfall was highlighted by Miller et al. (2007) who stated that "It is essential, however, never to use it in a mean-spirited way; the therapist must be mindful of his or her intentions and attitudes while using irreverence." (Miller et al., 2007, p. 68) For this reason, DBT emphasizes "function over form," focusing on the use of specific forms of irreverence in specific clinical scenarios, rather than on what words or phrases qualify as being "irreverent." As an example, a clinician could collect a list of irreverent statements (e.g., "Sounds like we're both going to need more therapy after this session."; "Well, that would be wildly ineffective."; "What a dreadful plan! Please don't."), but these phrases would be useless if they are not used at the right time, with the right client, for the right purpose. The pertinent question is not "what is irreverence?" but instead "when and how can irreverence be used effectively?" In order to answer this question, one must first understand how DBT conceptualizes mental health difficulties.

3.1.3 DBT Case Conceptualization

When looking to understand clinical complaints and how they can be addressed, DBT clinicians deemphasize diagnostic criteria in favor of problem areas, which correlate with the five aforementioned adolescent DBT skills modules. Specifically, clients are assessed for difficulties in the areas of:

1. Self-Dysregulation (e.g., confusion about self, sense of emptiness, lack of focus, low awareness, or other deficits in mindfulness skills)
2. Behavioral Dysregulation (e.g., impulsive behaviors, including non-suicidal self-injury and substance use, as well as extreme avoidance behaviors, or other deficits in distress tolerance skills)
3. Emotional Dysregulation (e.g., difficulty modulating distress, exacerbated by increased sensitivity to environmental cues, or other deficits in emotion regulation skills)
4. Interpersonal Dysregulation (e.g., interpersonal problems, chaotic relationships, ineffective help-seeking, loneliness, or other deficits in interpersonal effectiveness skills)
5. Cognitive and Familial Dysregulation (e.g., ineffective judgments of self or others, rigid or black-and-white thinking, or other deficits in walking the middle path skills)

Once these areas of dysregulation are identified, the ways that they interact with one another and with the environment are clarified and used to identify alternative, more effective approaches. As an example, when people have difficulty managing their anger (emotion dysregulation), they sometimes say things that they wish they could take back (interpersonal dysregulation), thereby creating discord within their family (familial dysregulation).

However, one of the primary barriers to this process is that the client often lacks awareness of these patterns of dysregulation, which have become the status quo and often serve a reinforcing (e.g., negative reinforcement) function (e.g., self-harm may be an effective way of reducing distressing emotions, albeit in the short term). Irreverent communication provides one means through which the clinician can highlight these problematic patterns for the client and redirect the conversation towards more effective ways of being. This is particularly useful when discussing self-harm behaviors with adolescents, who sometimes describe self-injury in a flippant or frivolous manner. Irreverence allows the clinician to block this problematic pattern, diverting the narrative by treating self-harm as a serious treatment target.

3.1.4 Use of Humor as an Effective Therapeutic Change Strategy

In order to understand how to most effectively use irreverent communication and the related concept of humor, let us briefly review what differentiates humor from sarcasm or insult. While attempts to explain the nature of humor date back to Aristotle, the most modern and widely accepted guiding framework is known as "benign violation theory" (McGraw & Warren, 2010). Building off the work of linguist Tom Veatch, benign violation theory suggests that humor requires three conditions be met for a situation to be perceived as humorous; (1) the situation is appraised to be a "violation," or one in which norms and expectations are violated, (2) this violation is not experienced as threatening and hence is interpreted as "benign,", and (3) these two perceptions occur simultaneously.

This framework provides an explanation for why failed attempts at humor are often either too unprovocative (not appraised as a "violation") or too risqué (not interpreted as "benign"). Clearly, "teasing" is more likely to be received positively if it is not targeting traits that are relevant to an individual's self-concept, and if the teasing is exaggerated and able to be interpreted multiple ways (Keltner et al., 2001; McGraw & Warren, 2010). This finding highlights how benign violation theory may offer guidance on how to use irreverent communication effectively, because irreverence, while not "teasing," does consist of statements directed towards the client that also "violate" their expectations. Clinicians should therefore consider whether this violation will be interpreted as "benign" by the client or will instead be perceived as a threat or attack.

The proposed guidelines for effectively using irreverence are as follows:

Implementing Humor Within DBT

Identify whether the client is (or the client and clinician are) stuck in a maladaptive pattern that has gone unrecognized or been accepted as the status quo.

Select a form of irreverent communication that can be used to highlight and break this problematic pattern. The form of irreverence that will most likely be effective will depend on the nature of the problematic pattern. In other words, what strategy is most likely to make the client "jump the track" depends on which "track" the client is stuck on.

Implement this strategy (verbally or nonverbally) in a manner that will be perceived by the client as "benign."

3.2 Clinical Applications

The remainder of this chapter will focus on how to effectively implement this process with six unique strategies of irreverent communication. While these strategies do not constitute all of the ways that irreverence can be used within DBT, they are among the most commonly implemented techniques. Particular focus will be placed on clarifying the conceptual rationale for discerning which irreverent strategy is most likely to be effective, given a particular maladaptive action urge, thought, or emotional response. Focus on this conceptual rationale will provide more specific clinical instruction on how to use irreverent communication effectively and encourage the reader to adopt a clinical approach that emphasizes "function over form."

3.2.1 Reframing in an Unorthodox Manner

Reframing in an unorthodox manner involves restating the client's words such that attention is redirected away from their intended message and towards a new area of focus. In some scenarios, the primary intention is to pull away from a particularly ineffective idea or communication by treating it with little regard or seriousness. Such was my (WB) intention in responding to a client who expressed frustration with her family members and peers, who she suggested held unrealistic expectations about her academic performance. I had good reason to believe that this interpretation was inaccurate, and that her interpersonal difficulties had more to do with her impulsive behaviors, such as when she locked her sister outside in the snow following an argument. I therefore said, "People aren't disappointed because you get bad grades or are unlikely to become president, they're disappointed because you make them act out The Revenant." Here, my intention was to respond in a manner that the client likely did not anticipate, thereby blocking the problematic interpretation held within the initial statement.

This intervention can take the form of not only redirecting an ineffective statement, but also highlighting unintended aspects of what is being communicated. An opportunity later arose with the same client, who stated that only taking two AP courses made her "worthless," and that she might as well kill herself if she could not get into AP Calculus. Not wanting to allow this problematic conclusion to pass by unnoticed, I (WB) responded by saying, "You're ready to accept death, but not Algebra II?" Here, my intention was to place increased emphasis on those aspects of the thought process that were difficult for the client to defend. Although I felt an urge to validate the reasons that academic performance held such weight in the client's mind, I decided to instead highlight how her concerns about her mathematical prowess had grown so immense that they eclipsed even death. The irreverent communication served the purpose of blocking a maladaptive thought process, and also highlighting the specific aspect that made it problematic. Fortunately, the client responded as I had hoped; a wry grin, followed by a somber glance, and a

description of the client's fear and shame. "Fine, Will. We both know I'm not going to kill myself over some numbers…I just can't have more proof that I'm not as smart as everyone else."

This emphasis on "maladaptive functions" also indicates which clinical scenarios are most likely to benefit from reframing in an unorthodox manner: *situations in which a maladaptive pattern is explicitly (verbally) being presented as the status quo.* This might take the form of statements suggesting that the maladaptive decision is actually effective (e.g., "You can say I shouldn't have left her out in the cold, but my sister got the message not to talk to me like that.") or the client's explanation that presents some maladaptive behavior as an acceptable status quo (e.g., "So naturally, I locked her outside in the snow.") Reframing these statements in an unorthodox manner (e.g., "Who told you that banishing your siblings into the wilderness was an effective way of resolving familial disputes? Do you live in some sort of Medieval Fiefdom?") helps to challenge and ultimately change this maladaptive cognition by treating these statements as anomalies that should not pass by unquestioned. This sudden shift in focus draws attention to these patterns and allows the clinician to highlight those aspects that make them ineffective. If the clinician approached this clinical situation with a more traditional therapist response, i.e., validating (reciprocal) communication (e.g., "Wow, sounds like your sister must have been really annoying you for you to decide to leave her out there in the cold."), this client would likely have felt empowered to make such a decision (e.g., "Exactly. That's what you get for being so ridiculous and annoying.")

The clinician must have a clear conceptualization of what makes the behavior, urge, or thought maladaptive, and an ability to describe this rationale if questioned by the client. This is because reframing in an unorthodox manner can be detrimental rather than benign if the strategy is used to target a pattern that is not actually maladaptive. For instance, imagine that the same client shared passive suicidal ideation that she noticed after not getting into AP Calculus, stating "I wish those thoughts weren't there, but they are. I just get so angry at myself, and I guess I start feeling hopeless that I'll never be good enough. I know the bar I set for myself is too high, but it still hurts when I jump and don't catch it." Here, the client's description of their emotions, thoughts, and behaviors is not maladaptive, only painful. The client is noticing suicidal thoughts following a performance that she has historically deemed to be unacceptable, thoughts that she is not engaging with nor suggesting are wise to act on, but instead sharing as indicators of underlying emotions. For this reason, the aforementioned irreverent phrase of "You're ready to accept death, but not Algebra II?" would be clinically contraindicated.

Additionally, we believe it is generally most effective to direct the unorthodox reframe towards the maladaptive urge, thought, or behavior, rather than the individual presenting the maladaptive urge, thought, or behavior as the status quo. For instance, there is a difference between saying, "well, that sounds ridiculous" and "you're ridiculous." While therapists naturally become frustrated with clients from time to time, making the clinician's irritation the primary focus of conversation is seldom helpful. Exceptions might be made when implementing the DBT practice of "radical genuineness" or "self-involving self-disclosure," but even here the

disclosure of the clinician's irritation would be used to highlight the interpersonal impact of the client's behaviors rather than condemn their character. The goal is to allow the client and clinician to direct their attention towards the maladaptive behavior or thought pattern, not elicit shame within the client, who is assumed to be "doing the best he or she can." As such, we recommend the clinician will be more effective focusing on the words rather than on the speaker.

3.2.2 Plunging in Where Angels Fear to Tread

Psychotherapy inherently involves discussions of difficult topics. While the stigmatization of mental illness has decreased in recent years, it is still common for people to feel shame related to their difficulties establishing and maintaining a sense of internal stability and comfort. The difficulty of having these conversations is further complicated by the fact that people unintentionally contribute to their own suffering by responding in ways that serve some protective function but ultimately exacerbate their suffering (e.g., avoiding social scenarios that invoke anxiety, thereby decreasing distress in the short term but exacerbating their functional impairment in the long term). The client and clinician therefore have the difficult task of discussing topics and identifying patterns that the client may prefer to ignore.

Plunging in where angels fear to tread involves pushing past this discomfort and engaging in direct conversation in spite of the anxiety, shame, or anger that may follow. One such opportunity emerged during a conversation with one of my clients who was expressing feeling "rage" towards his coach and boyfriend and was considering quitting his team and ending his relationship. I (WB) had seen this pattern of anger emerge time after time and was concerned about the loneliness and regret that often followed acting on these urges. Pushing aside the anxiety that accompanied what I was about to say, I offered, "Yeah, but you hate everyone, sometimes. You hate me, sometimes. You've fired me a bunch of times." Here, I made the decision to ignore social niceties, and dive directly into the discomforting topic. "Dive" is the operational word, as I was not dipping my toes into the water (e.g., "I wonder if you've ever had these feelings before? If there have been other times where perhaps been this angry at other people? Maybe even me?") but rather I dove in head-first.

My client appeared taken aback, and the intervention served its purpose. He redirected away from arguing that he ought to leave his job and boyfriend and went on to describe how he "hates [me] and hates the Uber driver that brought [him] here," and concluded with his conviction that "he will probably hate three people on [his] way home." Acknowledging the fluctuations in his feelings towards other people allowed my client to see that his urges to end his relationships would likely also change with time. He agreed that it was therefore in his best interest to acknowledge and address his frustrations within his relationship with his coach and boyfriend, but not dissolve these relationships outright.

This technique differs from reframing in an unorthodox manner, which requires that a maladaptive pattern be explicitly (verbally) presented as the status quo. Instead, plunging in where angels fear to tread is best when this *maladaptive pattern is being implicitly (nonverbally) presented as the status quo*. In other words, a maladaptive pattern is presenting itself within the therapy room, and neither the clinician nor the client is highlighting it as problematic. The problem is therefore not so much the words being spoken as what is remaining unsaid.

This framing highlights the interrelated nature of therapy, and the way in which maladaptive patterns of emotions, thoughts, and behavior occur not only within clients, but also within clinicians. While the subject of this intervention may be the client's problematic patterns, the primary barrier to using this intervention is generally the clinician's hesitation to engage in a difficult discussion. With teens, this could include frank discussions about sexual activity, drugs, cheating, etc. This hesitation can be due to any number of factors, including anticipated consequences (e.g., expressed anger from the client, who may leave the room or treatment entirely), and the therapist's vulnerability factors (e.g., a well-intentioned desire to invoke feelings of comfort rather than distress). It is therefore important to assess not only maladaptive patterns that are implicitly being presented as the status quo within the client, but also these same ineffective patterns within the clinician that may be preventing him or her from addressing these difficulties.

This is not to say that reluctance to use this irreverent communication always reflects the clinician's shortcomings or insecurities. Hesitation to discuss topics that will elicit feelings of anger or shame in the client is prudent, as the clinician should be sure that they are acting in the best interest of the client before they deliberately invoke distress. One of the most effective ways of ensuring that this intervention will be perceived as "benign" is to surround it with validation. In the prior example involving my client's "rage" towards his coach and boyfriend, this took the form of my (WB) saying "I understand why you get angry. I know the missteps I've made that have led you to push me away, and I can see how a similar thing is happening here. I also know that you've later regretted some of these decisions. And I would hate for that to happen again." Here, I was not apologizing for or trying to undo my initial statement. Instead, I was acknowledging that I was giving my client difficult feedback, and in the process consciously causing them to feel distress. Highlighting the maladaptive pattern seemed like one of the most caring things that I could do for my client in this scenario. And so too did acknowledging the pain that the client may have felt in response to my intervention and sharing a rationale for why I was willing to make them feel this distress.

The other side of this dialectic is that it is important for clinicians not to fragilize their clients. DBT clinicians agree not to treat their clients as fragile, because trying to save a client from their distress often prevents an opportunity for new learning. Additionally, any pain highlighted by the clinician has already been lived by the client. The clinician is therefore not so much creating pain as drawing attention to its source. While this intervention may be accompanied by initial discomfort, it also reflects a radical genuineness by the clinician that the client may find validating. Put another way by Linehan in her work with adult BPD clients, but equally relevant to

emotionally dysregulated youth, "DBT assumes that borderline patients are both fragile and not fragile; irreverence is directed at patients' nonfragile aspects." (Linehan, 1993, p. 395).

3.2.3 Using a Confrontational Tone

In some ways, using a confrontational tone is an extension of plunging in where angels fear to tread. The clinician uses the same tactic of directing the conversation towards a topic that is discomforting and out of line with social niceties using language that is direct, blunt, and specific. One of my (AM) teen clients gave me a "bullshit" button as a gift when he graduated for me to use with other clients, after he recognized the value of my calling him out many times for his minimizing or denying certain feelings and behaviors. For example, when he said, "my parents don't care if I graduate from HS," or, "my friends don't care if I don't text them back repeatedly," I would simply say "BS. Based on what I know of your parents and your friends they sure as heck care and saying they don't is just a way to reduce your anxiety and guilt!"

The clinician does not try to cushion the impact of their statement through the use of euphemisms or indirect language (e.g., "I wonder if your friends ever see versions of the anger you expressed to your sister, when you locked her out of the house? I know you don't live with them, but your irritation could be coming out other ways.") but instead allows their words to come out unedited, embracing rather than looking to dampen their impact (e.g., "If you treat your friends the way you treat your sister, you won't have any left. And don't say you don't live with them so you can't lock them out. There are many ways to "leave someone in the snow.")

This strategy can apply to any of the clinical scenarios highlighted thus far, where the maladaptive pattern is being endorsed as the status quo either explicitly (verbally) or implicitly (nonverbally). Regardless of the manner in which the client is endorsing this pattern, the clinician can still draw attention to it using language that is forceful and impactful. However, these adjectives draw attention to the primary factor that needs to be considered when considering the use of this strategy: is the pattern severe enough that it warrants a "forceful and impactful" response? For instance, the prior confrontational statement will likely be more effective if the client has lost multiple friendships due to ineffective expressions of anger, rather than if they make an uncharacteristically untoward comment in a moment of distress. Webster's dictionary defines "confrontational" as "feeling or displaying eagerness to fight." It is reasonable to expect the client to experience this kind of tone as somewhat unsettling, if not threatening. Whether or not this response is a warranted and effective way of knocking the client "off their track," or a heavy-handed response to a light problem will be determined by assessing the severity of this maladaptive pattern.

The significant impact of this intervention also draws attention to the difficulty in ensuring that the clinician's words are perceived as "benign." Indeed, this strategy

requires the clinician to be confrontational, which by definition involves expressing an openness to conflict. However, the impact of the clinician's message will also be lost if the client perceives the confrontational tone as an unwarranted attack, with no purpose other than causing the client harm. It is therefore necessary to try to set the stage for the intervention to land on benign ground, while also allowing the impact of the confrontational tone to be felt.

One of the most effective strategies is again to surround the confrontational statement with validation. For instance, in the prior scenario, I (WB) could have followed up my prior statement by saying, "I'm giving you this feedback because I like you, and I want others to as well. You're too much fun, too charismatic to be losing relationships left and right. You've got a silver tongue, it's just a little too sharp at times." It is important to note that I am not backing away or apologizing for the prior statement but instead acknowledging its sting and reinforcing my care for and commitment to the client. Dialectically, the message and impact of the confrontational statement need to be allowed, and so too does the fact that this alternative perspective is painful to adopt.

Some might suggest it is helpful for the clinician to establish a strong rapport with the client prior to making use of this intervention to help mitigate the likelihood of the clinician's words being perceived as an attack rather than well-intentioned feedback. The other side of the dialectic, however, is that some teens respond positively to irreverence and "calling their bluff" or "calling bullshit" even in an intake, paradoxically to help build rapport. Thus, we encourage clinicians to remain flexible and not feel rule-bound and necessarily need to wait a certain amount of time before applying this sort of intervention.

3.2.4 Calling the Patient's Bluff

As detailed earlier in this chapter, DBT seeks to strike a balance between acceptance and change, demonstrating support and understanding for clients while also pushing them towards engaging in behaviors that are more in-line with their long-term goals. This act of pushing (as highlighted in the irreverent strategies detailed throughout this chapter) often generates distress within the client, as their current behaviors and beliefs are challenged as being ineffective. It is natural for clients to respond to this distress by pushing back, making statements that function to stop the clinician from pursuing painful topics.

For instance, a client who was weeks away from starting her DBT skills group once told me that although I (WB) "seemed like an ok guy," she would "never participate in that ridiculous group." I had spent weeks trying to build her willingness and motivation for joining (unsuccessfully, it would seem), and I knew it would not be therapeutic to see her without this treatment component. Taking "ok" as a ringing endorsement of our budding rapport, I decided to gamble and leverage our relationship against her willingness to participate in the skills training: "It's a shame because I think you're also 'ok'. And you're right, you'll probably hate the group. I don't

know, I guess you just won't come, use up the allowed absences, and then we can say goodbye." The client and I sat in silence until she finally spoke: "I mean, are you at least going to show me where it meets?" She attended the following week, initially begrudgingly.

Calling the patient's bluff differs from previous forms of irreverence, as the setting of the problematic pattern is the therapy room rather than the patient's daily life. Specifically, this intervention is best applied to *problematic patterns of verbal behavior, in which there is an incongruence between the client's words (*i.e.*, behaviors) and underlying intentions (*i.e.*, cognitions).* This incongruence causes the client's words to act as red herrings, obfuscating their genuine cognitions and emotions and making it difficult for others to respond appropriately. Calling the patient's bluff seeks to rectify this incongruence, taking what is being stated at face value, thereby blocking the maladaptive function of the behavior.

For instance, we often hear clients state that they want to drop out of treatment during the moments when they seem to need it most. There are an infinite number of reasons why this occurs. The client may be uncertain about their therapists' ability to alleviate their suffering, or their own ability to make use of their therapist's suggestions. They may also fear that the discomfort involved in the process will be unbearable or unrewarding, or feel ambivalent about whether they want to let go of a way of being that has served an important function for them up to this point. However, instead of communicating these thoughts and feelings, they are expressing a tangentially related desire to drop out of treatment. Following this line of thought would bring the clinician farther away from a discussion of these underlying feelings, towards problem solving a scenario that may not occur. Provided that the client is not actually at imminent risk of dropping out of treatment, time spent troubleshooting this topic will only pull the clinician and client away from the painful emotions that preceded this statement.

Of course, this formulation assumes that the client does not actually intend to drop out of treatment. If the assessment of my client's willingness to attend skills group had been inaccurate, or she really did deem me to be not much better than "ok," then my ultimatum may have been met with an early discharge from treatment. In order to effectively call a bluff, one must be sure that the statement is actually a bluff, or at least something that can be reconsidered. This highlights the first component of allowing this intervention to be perceived as "benign," which is that the clinician must have good reason to believe that the client's statements do not reflect their actual intentions. Anecdotal evidence suggests that errors in this area sometimes occur when clinicians are feeling frustrated with their clients and fail to recognize that urges to make an irreverent statement are coming from their own irritation, rather than an accurate assessment of their client. For instance, a particularly frustrated therapist might make the mistake of responding to a client who genuinely does not feel any attachment to therapy by saying "Ok, go ahead, drop out." Here, the urge for irreverence is not originating from the client's problematic pattern of behavior, but instead from the clinician's own distressing emotions or hopeless thoughts.

However, even if the therapist does accurately assess the client's "bluff," they still need to leave the client a way out after the bluff is called. It is provocative to call a client's bluff, as this often involves making an offer that you do not expect them to accept (e.g., "So would you like referrals for a provider who won't make you attend a silly group?"). While an ideal outcome would be for the client to acknowledge the bluff and readjust their focus, this is not always the case due to the potential embarrassment and vulnerability that this can require. A more effective approach is for the clinician to provide the client with a way out, for instance, by saying "Or maybe you could give this a shot? Sometimes I say smart things by accident. Besides, you can always fire me later." It is also important for the clinician to leave a bit of space between calling the patient's bluff and providing them with a way out, so as to allow the impact of this irreverent statement to be felt by the client. In other words, "The secret here is in the timing of calling the bluff and providing the safety net. The meek therapist provides both at once (bluff and net); the cruel, insensitive, or angry therapist forgets the net." (Linehan, 1993, p. 396).

3.2.5 Oscillating Intensity and Using Silence

Conversations are a bit like melodies in that they take on different tones, and with these tones come different expectations of what, when, and how things are said. A conversation about the birth of a child has a different tone than a discussion of the loss of a grandparent, and a joke directed towards a coworker may be appropriate when discussing their impending promotion, but not their impending termination. The ability to assess and respond with the expected tone is one of the ways that people put each other at ease and communicate in ways that feel expected and comfortable.

However, there are also times when what is expected and comfortable is not in the client's best interest. Oscillating intensity and using silence are most effective in these scenarios, where *the emotional tone of the conversation is acting as an obstacle to treatment progress.* For instance, we often find that conversations with clients who are struggling to find the motivation to combat symptoms of depression naturally take on a melancholic tone, with words that are spoken softly and slowly, reflecting the fatigue and hopelessness being discussed. While this parallel between the content and tone of the conversation is understandable, it may not be productive. Although a DBT therapist's words may contain encouragement for fighting against the amotivation that characterizes depression, our tone invites the client to continue engaging with the malaise. We find it beneficial for therapists to oscillate their intensity, altering the delivery to reflect energy, lightness, or playfulness. This could be achieved nonverbally (e.g., changing tone and cadence, or beginning to play catch with the client; we use a foam strawberry or soft mini football that we occasionally toss at clients who are being particularly dour) or verbally, such as by stating, "Geez it's getting dark and damp in here. Downright morose. You ever see that movie, Titanic? This is like the end of Titanic."

The clinician can also change a problematic tone or pattern of interaction through the use of silence. Social norms rarely endorse silence as an appropriate response to a statement or question, which makes it a highly effective way of pulling back from a pattern of interaction that has become unhelpful. The silence puts a sudden stop to the conversation, and invites the client to try a different approach, as their current style of interaction is generating interpersonal discomfort. While this response may not be the final perspective the clinician is hoping the client will adopt, it can help dislodge the conversation from a problematic pattern.

For instance, I (WB) once found myself at an impasse with one of my teen clients, who had not completed her diary card, refused to identify topics she wanted to discuss in therapy, and insisted that she would no longer be using DBT skills outside of session. I do not enjoy feeling stuck in the mud and had urges to once again review the rationale for the diary card that she found so burdensome, suggest difficulties that would be important to discuss in therapy, and convince her that I knew ways of navigating these obstacles. While this intervention was once effective, it had since run its course, having recently been met with counter arguments detailing why DBT was silly, and I was silly for suggesting otherwise. So instead, I fell silent and watched the client with a slight smile. After a few minutes, the client decided she'd had enough of my silence and relented: "What do you want??…Me to do the things?" ("things" being the diary card, agenda, and in-session engagement). "Yes!! Do the things!" I responded. After some hemming and hawing, and a bit more of my aforementioned motivational strategies, my client went on to do the things.

Ensuring that this intervention is experienced as "benign" requires that the tone of the conversation is actually problematic. To oscillate intensity by suddenly becoming flippant and jovial when a client is expressing valid concerns about a loved one's health, or silent if the client shares genuine sadness if this loved one were to pass, is not just ineffective but also deeply invalidating. A less harmful but equally ineffective example of using this strategy might include oscillating intensity or using silence for no discernible reason aside from being irreverent. To return to the prior point about function over form, the irreverent clinician does not make use of these strategies simply because they see the opportunity to do so. Oscillating intensity or using silence without a well-defined purpose is likely invalidating at worst, and unimpactful at best.

3.2.6 Expressing Omnipotence and Impotence

Therapy inherently involves a power differential. Regardless of whether a clinician uses the term "client," "patient," or "consumer," there remains a difference in the assumed expertise in terms of understanding and engendering mental health. This tends to work in favor of the treatment process, with the client acting as the expert on their experiences, and the clinician as the expert on how mental health principles might decrease the frequency and severity of the client's suffering.

This aspect of the status quo is generally favorable, creating a relationship that recognizes the clinician's expertise while remaining collaborative. However, it is also a variable that can be irreverently adjusted if a maladaptive pattern is emerging within treatment. This strategy is often implemented when the patient is stating that the suggested interventions won't work, or that they do not have the mental or physical resources required to carry them out. This could be seen as a *problematic cognitive pattern, in which the client is engaging with beliefs that are not in the interest of their long-term goals.* Both omnipotence and impotence serve the function of jarring this problematic cognitive pattern, the former by suddenly suggesting that the clinician's wisdom is beyond reproach, and the latter by throwing all responsibility for change on to the patient, thereby inviting them to "pick up the rope" as the therapist presents as ineffective and incapable.

For instance, during moments when my (WB) suggested interventions are repeatedly being met with skepticism and hopelessness, I will at times respond with omnipotence ("Look, I'm a smart guy with smart ideas. If you do the things I'm suggesting, things will get better. The skills work. It's the decision of whether or not to use them that gets tricky.") and other times with impotence ("Look, I'm a glorified advice-giver. All I can do is talk at you, and that doesn't seem to be working so I'm out of ideas."). Here, the intention is to change the balance of power within the relationship, throwing all of the weight onto the therapist's back in the first example, and on the client's back in the second.

Ensuring that this strategy is perceived as "benign" is less important than other scenarios, as the intervention is directed at the clinician rather than the client. There is always the risk that this intervention will validate a different problematic cognitive pattern, being the client's belief that the clinician is either insufferably arrogant or incompetent. A strong rapport helps to protect against this interpretation, as it assumes that the client has already established more positive judgments of their provider. That being said, these irreverent strategies can be quite powerful even at intake since they often get the clients' attention in a positive way. In turn, the DBT clinician is seen as different from prior "traditional sounding" therapists they may have seen who, without irreverence being utilized, appear less real or compelling.

3.3 Conclusion

Therapy is an intricate process, in which clinician and client work together to try to understand and address the suffering that brings the client into treatment. It is also a complex and sensitive process, in which the clinician must try to assess and influence an infinite and constantly shifting number of interrelated variables, thereby disrupting patterns that have often taken years to develop. The age of these patterns, and the way that they often serve an important function to the client (i.e., "maladaptive behaviors are often the solutions to problems" (Linehan, 1993, p.99)), can make these well-worn channels difficult to rework. Working with emotionally dysregulated teens, in particular, requires an extra special clinical skill set to engage and

retain them in treatment. Irreverence provides a tool to assist in this process and allows a way of causing the client to "jump the tracks" of their unhelpful patterns and begin to approach their distress with new eyes, even as early as the first session. In this chapter, we have sought to outline the process through which this can be achieved: (1) identifying a maladaptive pattern of thoughts, emotions, urges, and behaviors occurring within the client, or between the client and clinician, (2) make use of whichever of the aforementioned strategies most effectively targets the problematic pattern, and (3) do so in a manner that will be perceived as "benign."

Ultimately, these guidelines are intended to provide initial direction on a process that will require significant practice and experimentation. With time, these strategies can become a natural part of the clinical process and help clinicians maneuver around the impasses that obstruct the path between the client and the life they want to live.

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