Chapter 4
DBT and Treatment Engagement in the Context of Highly Suicidal Complex Clients

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Dialectical Behavior Therapy (DBT) (Linehan, 2014a, 2014b; Linehan, 1993) was developed by Linehan in the 1980s to treat individuals who were chronically at high risk for suicide and who met criteria for multiple mental disorder diagnoses. Many such clients with high risk for suicide met criteria for Borderline Personality Disorder (BPD) (Leichsenring, Leibing, Kruse, New, & Leweke, 2011). Linehan saw emotion dysregulation as a core problem for these clients that led to many dysfunctional or destructive behaviors that significantly interfered with their lives.

Linehan's goal was to treat this clinical population to help suicidal individuals build a life worth living, not to develop a new treatment. The intense suffering in the lives of suicidal individuals made change a mandate of treatment. Linehan reverted to classic behavior therapy (Goldfried & Davison, 1976; Skinner, 1974), the technology of change, as the means to achieve that change. However, an unwavering focus on change was not a good fit for individuals with emotion dysregulation and high sensitivity to invalidation. Clients responded negatively to this approach. They experienced suggestions for change as invalidating leading to intense shame, anger, and urge to suicide. Basically, clients experienced suggestions that they need to

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change their behavior as messages that they were "bad," or that they were to be blamed for their problems. A focus on standard cognitive techniques that challenged clients' maladaptive beliefs was also nonproductive. Clients perceived cognitive restructuring as equally invalidating of their experience and communicating that once again they were "bad" and their suffering was their fault. These reactions were consistent with insights from the social psychological literature on consistency theory. Research by Swann and colleagues explains how information that does not confirm individuals' self perception leads to increased arousal, cognitive dysregulation, and discarding of new information (Swann, Stein-Seroussi, & Giesler, 1992). A demand for change was extraordinarily painful for highly suicidal, diagnostically complex clients, and led to disengagement from therapy manifested by a variety of responses such as dissociation, lack of collaboration, abrupt termination of sessions, or ultimately abandoning therapy altogether.

Close empirical observations during therapy lead to the conclusion that a change-focused treatment approach was not effective for complex clients with high risk for suicide. As a result, Linehan changed her approach completely, moving to an acceptance-based Rogerian stance, based on the assumption that clients have the inner wisdom and capacity to solve their own problems and alleviate their own suffering. Such an acceptance-based approach was also perceived as invalidating by clients, who communicated to Linehan "If you really understood how much I am suffering, how could you suggest I don't change anything?".

Both unwavering change and unwavering acceptance were perceived as invalidating of clients' suffering and were not successful in effecting clinical change. The solution that evolved and became the foundation of DBT was seeking a balance between accepting the clients as they are in the moment (and helping them accept themselves), while helping them change to build a life worth living. Dialectics emerged as the glue that helped contain these apparently mutually exclusive perspectives into a coherent philosophical stance (Linehan & Schmidt, 1995). It is this attempt that led to embracing an overarching dialectical philosophy to treatment.

Given the complexity of this clinical population, treatment engagement was a fundamental aspect to be addressed. Indeed, DBT includes an array of strategies for increasing treatment engagement. The importance of identifying and solving behaviors that got in the way of therapy led to defining a new concept—"therapy-interfering behaviors" (TIBs). Essentially, TIB represents any behavior from the client, therapist, or the greater environment that gets in the way of the client receiving therapy. The complexity and abundance of problems that needed to be solved to build a life worth living for highly suicidal individuals led to the creation of a hierarchy of primary targets to guide efficient allocation of therapy resources to the most critical problems (Linehan, 1993). At the top of the target hierarchy in DBT are decreasing life-interfering behaviors, followed by decreasing TIBs, then decreasing quality of life-interfering behaviors, and finally, increasing behavioral skills.

Although specific strategies targeting an increase in client engagement with treatment were initially developed in the context of diagnostically complex suicidal clients, such techniques have broad applicability and evidence for efficacy across a wide array of clinical populations and problems. In this chapter, we begin with a brief overview of research on DBT's efficacy and treatment retention across a broad range of clinical populations and problems and review engagement strategies that are part of DBT, with a particular focus on TIBs.

Overview of Research on DBT's Efficacy and Treatment Retention

Currently, DBT is an internationally recognized evidence-based treatment (EBT) for individuals meeting criteria for BPD (Kliem, Kroger, & Kosfelder, 2010; Stoffers et al., 2012) and other diagnoses. Multiple randomized clinical trials (RCTs) have evaluated DBT and found it efficacious for individuals specifically selected for high risk for suicide (Linehan et al., 2006; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; McMain et al., 2009; Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012). For example, participants in DBT made half the number of suicide attempts, were less likely to visit the emergency departments for suicidality, and were 73 % less likely to be hospitalized for suicidality compared to treatment-as-usual (TAU) (Linehan et al., 2006). DBT was also found superior in decreasing suicide attempts when compared to a psychodynamic treatment supervised by experts (Pistorello et al., 2012), but not when compared to general psychiatric management plus emotion-focused psychotherapy (McMain et al., 2009).

Findings are mixed when evaluating DBT's efficacy compared to control treatments for decreasing suicide ideation, with some studies finding DBT to have superior outcomes (Koons et al., 2001) while others not finding such an effect (Linehan et al., 1991, 2006). In evaluating DBT's efficacy on reducing non-suicidal self-injury (NSSI) most RCTs found DBT to be superior to the control condition (Bohus et al., 2004; Koons et al., 2001; Linehan et al., 1991); however, some studies found no differences in reduction of NSSI between DBT and the control condition (Carter, Willcox, Lewin, Conrad, & Bendit, 2010; Linehan et al., 2006).

Use of crisis services is another outcome of interest particularly with individuals at high risk for suicide and who have a complex diagnostic picture. Some studies found DBT to be more effective at reducing visits to the emergency department, admissions to hospitals for psychiatric reasons, and duration of stay in psychiatric hospitals (Koons et al., 2001; Linehan et al., 1991, 2006), while others did not (Carter et al., 2010; McMain et al., 2009).

In studies evaluating its efficacy in the treatment of BPD or suicidal behavior, DBT has also been found to be effective in treating co-occurring disorders. Compared to control conditions, DBT was found more effective for individuals

meeting criteria for BPD and comorbid substance dependence (Linehan et al., 1999, 2002) as well as in reducing high-prevalence co-occurring conditions such as depression and anxiety (Bohus et al., 2004; Koons et al., 2001; Pistorello et al., 2012; Soler et al., 2005).

Skills-only DBT groups represent a cost-effective treatment delivery option. Skills training was identified as a mechanism of change in DBT mediating outcomes as decrease in suicide attempts, NSSI, and depression, as well as increase in anger control over time (Neacsiu, Rizvi, & Linehan, 2010). In light of these findings, significant research has evaluated DBT skills-only as a treatment option for a wide variety of conditions. At least 12 published RCTs evaluating DBT skills-only treatment found it efficacious with clients with BPD (Soler et al., 2009), binge eating (Hill, Craighead, & Safer, 2011; Safer, Robinson, & Jo, 2010; Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001), treatment-resistant depression (Harley, Sprich, Safren, Jacobo, & Fava, 2008), depressed older adults (Lynch, Morse, Mendelson, & Robins, 2003), incarcerated women with childhood abuse (Bradley & Follingstad, 2003), ADHD (Fleming, McMahon, Moran, Peterson, & Dreessen, 2014; Hirvikoski et al., 2011), bipolar disorder (Van Dijk, Jeffrey, & Katz, 2013), and other mood and anxiety disorders (Neacsiu, Eberle, Kramer, Weismann, & Linehan, 2014).

In an RCT comparing standard DBT with TAU, participants randomized to standard DBT were more likely to start therapy by coming for the first session. Specifically, 100 % of individuals referred to DBT started the treatment compared to 73 % in TAU. For participants who started therapy, a greater percentage remained in DBT therapy with the same therapist for 1 year of treatment (83.3 % in DBT compared to 42 % in TAU) (Linehan et al., 1991). Compared to community treatment by experts, participants in the DBT condition were three times less likely to drop out of therapy with the first assigned therapist or to drop out of therapy altogether (Linehan et al., 2006). No differences were found in rates of drop-outs for participants in DBT compared to psychodynamic treatment supervised by experts (Pistorello et al., 2012) or to general psychiatric management plus emotion-focused psychotherapy (McMain et al., 2009).

Participants with high emotion dysregulation who met criteria for one or more mood or anxiety disorders in DBT skills-only group were less likely to drop out compared to participants in an activity-based support group (32 % dropped out in the DBT skills-only group versus 59 % in the activity support group (Neacsiu et al., 2014). No reliable differences were found in drop-out rates among BPD veteran participants in DBT skills-only group compared with TAU control condition (23 % versus 17 %) (Koons et al., 2001). In a study comparing DBT skills for participants meeting criteria for BPD a greater number dropped out from the standard group therapy (the control condition) compared to the DBT skills-only group (63.4 % compared to 34.5 %). A study teaching DBT skills-only to individuals with bulimia experienced no drop-out for the DBT condition (Safer et al., 2001). Another study focusing on binge eating experienced a 15.5 % drop-out rate in the DBT skills group (Hill et al., 2011).

DBT Strategies for Engagement in Beginning Stages of Treatment

As mentioned above, DBT initially targeted a clinical population that was notoriously difficult to engage and retain in treatment. DBT targets engagement from the very beginning of treatment. First, for individuals identified as high risk for suicide (e.g., recently discharged from emergency room or an inpatient unit), DBT therapists are proactive and attempt to schedule and hold a first session as soon as possible. Although minimizing the time between referral and a first session is particularly relevant for suicidal clients, such an approach is likely to increase first session attendance for the majority of clients.

Engagement and Commitment Strategies Used During the First DBT Sessions

Treatment engagement is at the forefront of the initial therapeutic interactions with any therapy client. In a very real sense, the goal of the first session is the second session. If clients do not engage very early on, all other therapeutic tasks may not matter. The first four sessions of individual therapy in DBT are specifically focused on obtaining commitment to therapy, increasing engagement with treatment, and generating hope. For example, DBT therapists schedule the first four sessions of therapy when the client starts therapy eliciting an implicit commitment from the client to attend to more than the first session. No less importantly, advanced scheduling provides a structure to enhance the likelihood of attending a future therapy session (in essence, clients "opt-out," rather than "opt-in," future sessions). These 1–4 initial sessions are considered "pretreatment." Several specific techniques borrowed from social psychology are utilized in the first few DBT sessions to assist with those goals. These techniques are specifically used in the initial DBT sessions, but can be revisited at any point in therapy when progress is blocked due to lack of commitment from the client (the therapist, of course, has to first assess and determine that low commitment is the interfering factor to advancing treatment).

Eliciting Client's Goals for Therapy

The first session starts, as in other cognitive behavior therapies, by exploring reasons for seeking treatment and eliciting treatment goals. It is common for clients to have difficulty in the beginning to generate any goals. That can happen due to high hopelessness or fear of disappointment if goals are not met, particularly in the context of past failures in therapy. Any treatment goals throughout the first session are

linked to the client's goals. For example, therapists may have to articulate how engaging in suicidal, or other destructive behaviors, is ultimately incompatible with the client's goals and a life experienced as worth living. The therapist works to achieve client commitment to stop specific ineffective behaviors (e.g., self-injurious behaviors, substance use, binge-eating) and to engage in treatment for a specified period of time that may be renegotiated at the end of the contracting period. The public commitment is one strategy to enhance engagement that is supported by consistency theory and research on social psychology of public commitment (e.g., Heider, 1958; Schlenker, Dlugolecki, & Doherty, 1994). Engagement is increased when therapy tasks are specifically and transparently linked to clients' goals. Therefore, linking therapy tasks to these goals is used throughout treatment to increase client engagement and adherence (e.g., discussing the need to understand recent self-injurious behavior through a chain analysis to build a life free of self-destructive behaviors).

Pros and Cons Technique

The next step is to elicit commitment to the work of therapy by asking clients for their own reasons for engagement in treatment. If clients cannot articulate such reasons, therapists engage in a *Pros and Cons* technique of discussing with clients why therapy makes sense given the clients' goals as well as drawbacks of engaging in therapy (such as the time commitment involved, the hard work required, the discomfort of changing your behavior).

Devil's Advocate Technique

Once the client generates some reasons supporting commitment to treatment the therapist engages in a different technique called the Devil's Advocate in which the therapist challenges the client's reasons with the goal of eliciting from the client more reasons to back up the commitment (Goldfried, Linehan, & Smith, 1978). The essence of this strategy is to strengthen client commitment through argument against it. Once a client expresses a commitment to engage in, or to stop, a particular behavior, the therapist questions and challenges that commitment. The idea is to get the client to argue for the commitment and verbalize personal reasons for this treatment goal. The therapist strategically strengthens or backs away from challenging the client according to the client's responses until a firmer commitment is achieved. By articulating specific reasons why the client chooses to commit to treatment goals, the client also rehearses those reasons making it more likely that these would be accessible to memory in the future when doubts about treatment might surface.

Devil's Advocate Example:

"Therapist: So it seems purging has been a problem for you for quite some time now.
Client: Yes, but now I am determined to stop it completely.
Therapist: Why in the world would you do that? You've done it for so long now, wouldn't you prefer to be able to purge if you feel you ate too much? Wouldn't that make you feel better?
Client: Yes, it makes me feel better on the spot but then I feel so guilty and ashamed. And I saw my doctor recently and she told me I am really damaging my health.
Therapist: Fair enough, feeling guilty and ashamed is definitely not pleasant. And it is damaging your health. But wouldn't you want to purge and try to not feel guilty and ashamed afterward? And you've done this for a long time and your body has taken it so far.
Client: I really want to stop feeling so bad about myself all the time. And I want a normal life when I don't focus on food and purging all the time. I want a family and kids. I can't do that if I spend so much time and energy on my eating.
Therapist: OK that makes sense. We'll have to remember those reasons if things get tough in treatment."

Figure 4.1 describes a workflow of sequencing the strategies presented above in the first DBT sessions.

Additional Commitment Techniques

Several other strategies are used to "sell" a commitment, particularly when clients express little motivation to change their behavior, and when they emphatically view their maladaptive behaviors as a result of a life of misery, not the cause of it (the DBT stance is that both are likely to be true). The "foot-in-the-door" (Freedman & Fraser, 1966) and "door-in-the-face" (Cialdini et al., 1975) are established social-psychological techniques to increase compliance with requests and previously made commitments. The first technique consists of making an easy request that is likely to be met with little to no resistance, only to be followed by a more difficult request. The second technique consists of asking something very hard and more than one anticipates clients to agree to, and subsequently asking for something easier. Another strategy that is often used is the "*freedom to choose and the absence of alternatives*," based on the notion that commitment and adherence are increased when people believe they have freely made a commitment and when there is no viable alternative path to their goal. Therapists may use this strategy to highlight to clients that they are free to cope with difficult life circumstances through self-injurious behaviors, but that alternative therapy would need to be found, as DBT requires the reduction of these coping mechanisms to be a goal in therapy.

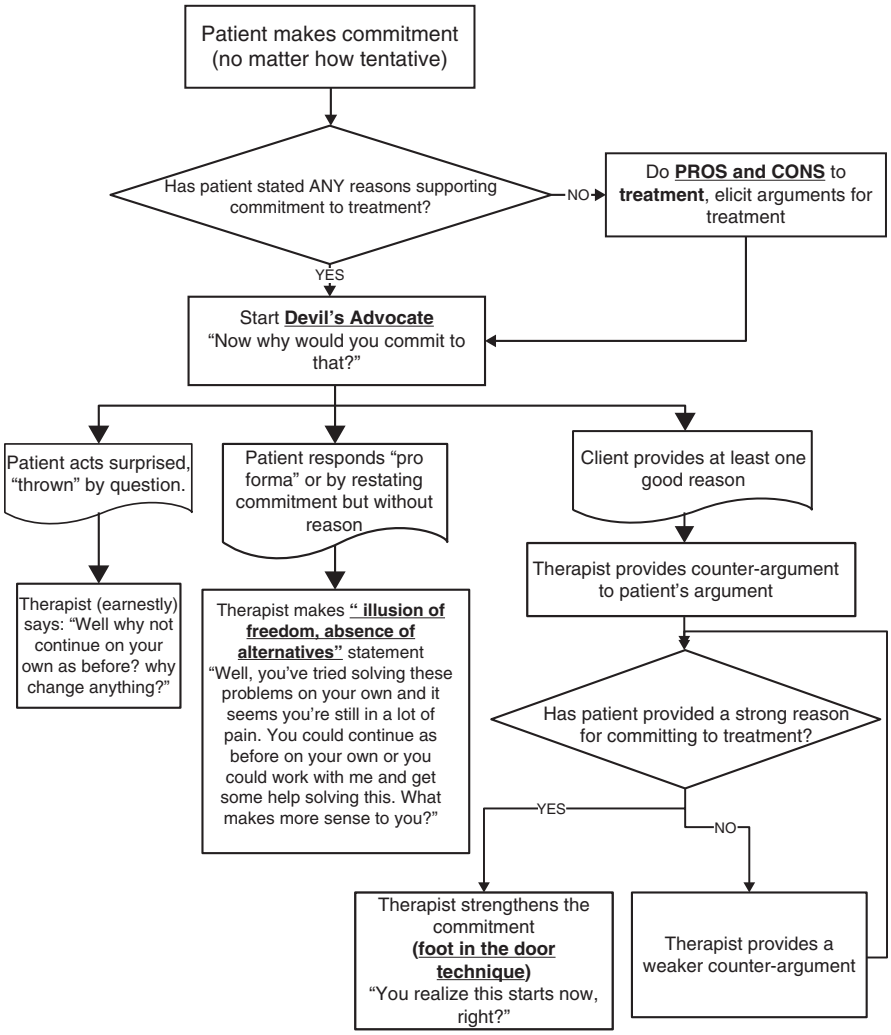

Fig. 4.1 Flow chart of getting commitment for treatment in initial sessions

Orienting the Client to Therapy Interfering Behaviors (TIBs)

From the first session, DBT pays attention to behaviors that could get in the way of therapy. While this approach has its roots in working with a clinical group that was hard to engage and keep in treatment, we hypothesize that observing and addressing such behaviors as they happen is likely to benefit psychotherapy with any clinical group. In DBT, the therapist orients the client to the idea of therapy-interfering behaviors from the pretreatment sessions. More precisely, the message is conveyed that the therapist and client will function as a team to be mindful of behaviors from

the client, the therapist, or the greater environment that can get in the way of the client getting therapy. Client are therefore invited to share the responsibility to notice and discuss TIBs from therapists, the environment, or themselves. TIBs are described at length below.

Engagement Strategies Used Throughout Treatment

Validation Techniques

Balancing acceptance and change represents the fundamental dialectic in DBT. Such balance does not entail allocating equal time and effort to acceptance and change but rather finding the right amount of acceptance and change that keeps the client and therapist advancing most effectively toward treatment goals. Validation strategies form the primary acceptance-based therapeutic strategies in DBT that function as a balance to the change-based cognitive-behavioral treatment strategies. They are typically used with greater frequency and intensity early in treatment with the expressed goal of increasing treatment engagement and strengthening the therapeutic relationship.

Validation can be conceptualized as any form of therapist communication that the client's behavior is somehow valid, true, meaningful, or relevant; that the behavior (including under this term thoughts, emotions, actions, physical reactions) makes sense. Validation strategies in DBT have been largely influenced by humanistic psychology, and Carl Rogers in particular (Rogers, 1959; Rogers, 1946) (see Linehan, 1997) for a thorough discussion of similarities and differences between Rogerian strategies and DBT validation strategies).

In addition to the influence of the humanistic traditions, validation strategies in DBT have their roots in the tradition of consistency theories, particularly the self-verification theory (Swann, 1983; Swann & Ely, 1984; Swann et al., 1992) which posits that individuals seek out information and relationship partners who help to confirm what they already believe, particularly about themselves.

Self-verification theory was applied in the context of DBT in a study evaluating whether it would have incremental utility in predicting two outcome variables intimately tied to treatment engagement: treatment dropout and therapy nonattendance (i.e., likelihood of missing future therapy sessions) (Lindenboim, 2009). The study focused on two populations notoriously difficult to engage in treatment: individuals who met criteria for BPD and either chronic suicidality or opioid dependence. Therapist verification was indexed using clients' subjective ratings, independent observers' ratings, and an objective measure of verification based on discrepancy between client and therapy ratings of client behaviors. Results indicated that objective measure of verification was associated with lower likelihood of dropout and longer duration in treatment prior to dropout. Interestingly, client-perceived verification was associated with reduced likelihood of missing future sessions, while the objective verification was not.

Results from the first randomized controlled trial assessing the efficacy of DBT for BPD and opioid dependence (Linehan et al., 2002) lend support to the importance of validation in facilitating treatment retention for this clinical group. DBT was compared to a 12-step facilitation in combination with Comprehensive Validation Therapy (CVT), which essentially comprised of the validation and acceptance strategies in DBT without the change-based strategies. While DBT condition had a relatively low dropout rate for this population, the CVT condition had an unprecedented 0 % dropout rate. Although overall standard DBT was more efficacious than CVT, CVT was quite effective in keeping clients in treatment.

DBT validation strategies have been described in detail elsewhere (Koerner & Linehan, 2003; Linehan, 1997), we briefly outline them below. Validation in DBT is conceptualized as occurring at different levels, increasing in depth and meaning; the first four levels are considered essential for all competent and effective psychotherapies, while the last two levels are considered essential to DBT, and may not be regularly practiced across other forms of therapy.

Level 1—Unbiased Active Listening and Observing ("staying awake")—This level of validation essentially consists of mindful attunement to the client. It is operationalized as verbal and nonverbal communication of interest and responsiveness to the client. Posture, curiosity, encouraging statements, and clarifying questions are the hallmark of this level of validation. Fundamentally, its function is to communicate to clients that they are important and worthy of being understood.

Level 2—Accurate Reflection ("highlighting")—At this level of validation, the therapist highlights and summarizes the client's narrative. It functions to communicate that the client's experiences are understandable and that the therapist cares to understand them. It also facilitates increased awareness of covert experiences (thoughts and feelings) and greater coherence of experience—a particularly helpful function for individuals that perceive themselves as lacking a sense of self independent of their immediate social context.

Level 3—Articulating the Unverbalized ("mindreading")—This level is defined as therapist articulation of the unarticulated. Therapist validation at this level essentially communicates understanding of thoughts and emotions clients likely experienced or behaviors they engaged in and did not verbalize (e.g., "you must have felt humiliated when he said that in front of your work group"). Its function is to communicate to clients that their responses are understandable and often "normal" ("if my therapist can guess what I'm feeling, maybe I'm not crazy").

Level 4—Validating in Terms of Past Learning History and/or Biological Disorder ("Validating in terms of sufficient causes")—This level of validation is based on the fundamental truth that all behaviors and experiences are caused and therefore understandable, even when they are somehow distorted or caused by faulty perceptions, logic, or disordered biological functioning.

Level 5—Validating as Reasonable in the Moment ("Validating in terms of normative causes")—At this level, the therapist affirms behavior that has validity given current circumstances. The behaviors to validate could be normative human response to a particular circumstance (at times normal response to abnormal circumstances), are effective as a step toward achieving a particular long-term goal (i.e., "skillful

means"), or effective toward short-term goals, even when the behavior interferes with long-term goals. In the latter case, the validation is similar to "yes, but" communication, acknowledging both the validity and the limited effectiveness of the behavior. It is at this level that the wisdom in client's behavior is acknowledged and amplified.

When the same behaviors can be validated at both Level 4 and Level 5, it is preferable for the DBT therapist to validate at Level 5. In these circumstances, validating at Level 4 may be experienced as invalidating because it tends to highlight the client's disordered history, rather than its normative basis. For example, after a client describes being very upset during a first date that included going to a movie that prominently featured complex, dysfunctional and abusive relationships, a therapist's Level 4 response could be "it must have been incredibly difficult for you given your relationship history." This communication may be experienced as validating; however, from a DBT perspective, not as validating as a Level 5 validation, "no wonder…that sounds like a disastrous movie for a first date; what's the plan for the second date – a wake?"

Level 6—Radical Genuineness ("treating the person as valid")—At the highest level of validation, therapists communicate to clients both in statements in actions that they are valid as whole beings, and that the therapeutic relationship is a real relationship among equals. The equality here refers to importance rather than knowledge base or power. This level of validation also includes communication of faith in the client's future capabilities, and cheerleading clients while challenging them in difficult therapeutic tasks. Interestingly, at this highest level of validation some Level 6 communication can feel invalidating in the moment when therapists communicate to clients that they view clients as more capable than clients view themselves. It is therefore imperative to explicitly acknowledge this difference, and to embody faith in the client similar to the faith that coaches have in their teams.

Verbal vs. Functional Validation

Therapists can validate in two basic ways, the first is by making verbal statements that serve to validate the clients' emotions, thoughts, or actions. The second way therapist can validate their clients is by responding as if these clients' experiences or actions are indeed valid. In effect, the second method of validation communicates to clients through actions that their behaviors are valid. Similar to the aphorism "actions speak louder than words," when appropriate, functional validation is preferable to verbal validation. For instance, a therapist may communicate understanding of a client's disappointment in her own behavior (e.g., recent heroin use after a few months of abstinence), which would constitute verbal validation. However, the therapist may also spend time with the client on understanding the factors leading to the behavior, and problem-solving those causal factors—in essence, functionally validating the communication function of the client's distress. Another example involves therapist responses to clients' complaints about their behavior. If the therapist assesses a complaint to be valid (e.g., being regularly and significantly late for

sessions), it would be imperative to verbally validate the client's perspective (e.g., "You must be upset about this. I know I would be if I were you"); it would be better, however, to do so functionally (i.e., actually work on solving this problem).

Engagement with Substance-Using "Butterfly Clients"

While validation strategies are effective in facilitating engagement and retention of many clients seeking DBT treatment, others are harder to draw into and to keep in treatment, and require additional attachment strategies. Often exhibited in substance using population, these are affectionately called "butterfly clients" (Dimeff & Linehan, 2008; Linehan, 1993; Linehan et al., 1999), as they appear to fly in and out the therapist hands. They exhibit episodic engagement, often not returning phone calls, have inconsistent attendance to individual therapy and skills training, and often leave treatment prematurely. DBT therapist may feel like they have to "compete with" substances as reinforcers in the clients' lives (Linehan et al., 2006).

DBT specifically geared toward substance using population includes strategies that aim to increase consistent engagement in the "butterfly client." First, this issue is raised early in treatment before the client engages in "butterfly behaviors," and the client is oriented to the therapist and team's efforts to find "lost clients." Therapists are encouraged to use flexibility and nontraditional format of therapy. For example, therapists consider longer, or more likely, shorter sessions, frequent phone calls and voice messages, and use of agreed upon list of family and friends to help reach the client. Clients are asked to complete "Where can we find you" worksheet that includes physical location and phone numbers where clients can be reached both when clean and when using.

Once clients are lost, therapists may try various strategies to find them and help them reengage in treatment. They may leave messages with a bartender at bars they frequent, with family members, or anyone else clients have agreed to in advance. They may leave multiple voicemails that vary from earnest to irreverent, trying to get the clients' attention. For example, in our clinic, therapists used to send letters with sticky notes with the message "stick with us" on them. Finally, therapists may decide to bring therapy to the client, by conducting therapy in the client's natural environment such as the client's home, in a park, in a car etc. Naturally, this decision has to be thoughtful and therapists need to consider and consult with their team regarding safety, privacy, and reinforcement concerns.

Additional Engagement and Commitment Strategies Used Throughout DBT Treatment

The strategies mentioned above are used at the beginning of therapy in the first 1–4 commitment sessions, but are also incorporated as needed throughout the entire DBT treatment.

Monitoring Urges to Quit

DBT therapists pay close attention to a range of behaviors that can get in the way of the client receiving treatment. A set of questions are posed to the client at the beginning of each session, and the client is oriented that these are similar to measuring temperature and blood pressure at a physician's office (i.e., "therapy vital signs"). The client is asked about urges to suicide, urges to escape (by using substances), and about urges to quit treatment. Asking about these urges each session maximizes the chance that they will be addressed and problem-solved in the session before the urges lead to maladaptive behaviors. In case urges to quit are high, the therapist performs an assessment to better understand what generated this change, and revisits commitment strategies if needed.

Therapy-Interfering Behaviors

Defining and Describing TIBs

A truism of therapy work is that a client can benefit from therapy only if he or she actually receives therapy and is engaged with it. The concept of Therapy-Interfering-Behavior (TIB) has been introduced in DBT to organize assessment and intervention around any behavior that can get in the way of the client receiving and engaging with therapy. The complex, multidiagnostic clients who typically seek DBT treatment often present with a host of problems and seemingly unrelenting, ever-changing crises. To maximize the efficacious use of therapy time, DBT specifies a hierarchy of primary targets to be followed in each session and in conceptualizing treatment for each client (see Fig. 4.2). At the top of the hierarchy are life-interfering behaviors, followed by therapy-interfering behaviors, then by quality of life-interfering behaviors, and increasing behavioral skills. The target hierarchy illustrates the importance of TIBs in DBT by placing their priority second only to life-threatening behaviors.

It is important to describe how DBT conceptualizes and operationalizes TIBs. TIB is defined as any behavior that gets in the way of therapy. DBT classifies TIBs as being produced by the therapist, client, or the greater environment. Essentially, TIBs are seen as problems to be noticed, understood, and solved to prevent therapy coming to an end prematurely. Focus on TIBs is also intended to improve therapy outcomes by fostering more productive engagement in treatment. The therapy work on TIBs is performed as any other therapy task from a nonjudgmental stance. Thus focusing on TIBs is not done to blame or to shame the client, the therapist, or the environment, but to assess and solve a problem.

Paying attention to how the therapist's behaviors might interfere with therapy is in line with DBT's view that the therapeutic relationship is a relationship among (fallible) equals. Therapists presumably have greater knowledgebase in their area of expertise—the application of theory and science of human behavior to elicit behavior

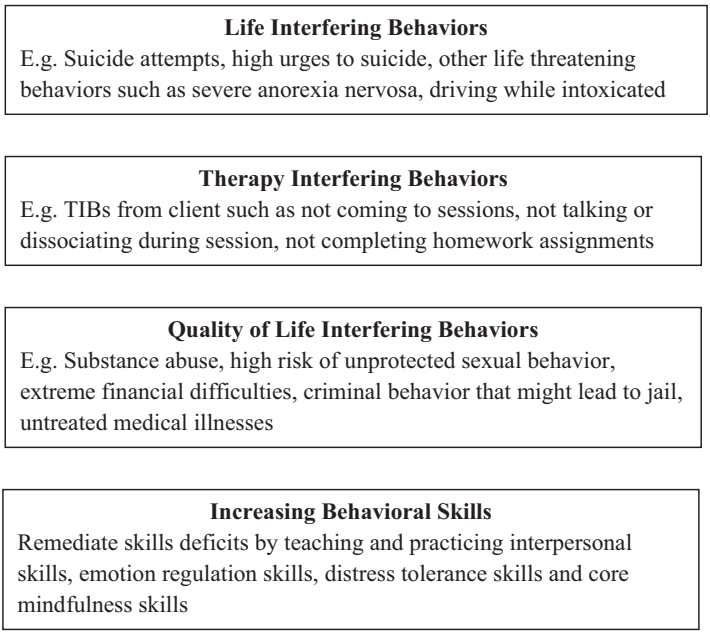

Fig. 4.2 Hierarchy of targets in DBT

change and alleviate human suffering. This knowledge notwithstanding, the laws of human behavior affect therapists and clients alike, and therapists, therefore, are also likely to behave in ways that interfere with therapy. Furthermore, this knowledgebase does not imply special status from the DBT perspective—therapists' TIBs are just as important to address as clients', or environmental, TIBs.

Client TIB

DBT recognizes three categories of Client TIBs. The first is any behavior that interferes with the client receiving the therapy offered. This category includes nonattentive behaviors, non-collaborative behaviors, and noncompliant behaviors. Nonattentive behaviors typically refer to missing sessions, coming late to sessions, cancelling sessions for nontherapeutic reasons, etc. They also refer to attending treatment physically but not psychologically such as using mind-altering substances before therapy sessions, dissociating, daydreaming, etc. In DBT, collaborative behaviors are both necessary for effective treatment, and are themselves a goal of treatment. Non-collaborative behaviors are therefore particularly targeted. These include inability or unwillingness to work in therapy, lying, refusing to talk or

answer questions, withdrawing emotionally during sessions, arguing incessantly, and dismissing therapeutic suggestions ("yes butting"). Noncompliant behaviors typically consist of non-completion of homework assignments, refusing to comply with previous agreements with the therapists and refusing to comply with treatment recommendations.

The second category of client TIBs consists of behaviors that interfere with other clients receiving therapy. This type of TIBs is most relevant in skills group setting, and in residential and inpatient treatment programs. These often include outwardly hostile, critical, and judgmental remarks toward other clients. They may also include a host of behaviors that are harmful to the milieu.

The third category of client TIBs consists of behaviors that burn out the therapist including those that push the therapists' personal limits or decrease therapists' motivation to continue therapy. Perhaps the most important of the common limit-pushing client behavior is refusal to engage in, or accept, therapeutic strategies that the therapist views as essential for therapeutic process (Linehan, 1993, p. 135). Other common TIBs that are likely to push the therapists' limits include misuse or overuse of coaching phone calls, interacting with therapists in overly familiar way, interacting with therapist's family and interpersonal relationships, among others. Not uncommon among clients seeking DBT treatments are behaviors that "push organizational limits"—those behaviors that interfere with unit or program functioning to warrant an intervention (e.g., client vandalizing the unit, creating financial burdens on top of adverse staff reactions). Finally, most client behaviors that function to reduce therapist, group, or family member's motivation to treat the client are a form of client TIB.

Treating Client TIBs

Noticing TIBs

It is the task of all entities directly engaged in treating the client to keep track of, and notice TIBs. The client is oriented, during the pretreatment stage, to sharing in the responsibility to bring TIBs to the table by adding them to the session agenda. This might be very hard for some clients who have difficulties being assertive, hence reinforcement and shaping of bringing up TIBs to the agenda might be needed from the therapist. Modeling can be helpful in this regard. Therapists are encouraged to notice and highlight their own TIBs and offer solutions. This can have a twofold benefit of normalizing objective critique of the therapist's behavior, and vicariously, the clients may learn nonjudgmental critique of their own behavior. While clients are encouraged to attend to TIBs, it is ultimately the therapist's responsibility to monitor and work on TBIs. The DBT therapist consultation team is also responsible for pointing out TIBs as they happen.

Understanding TIBs

DBT offers prescriptive guidance to therapist behavior, style, and attitude in dealing with TIBs, and it also includes guidance for those behaviors, styles, and attitudes that are antithetical to DBT, and therefore proscriptive. The general approach to treat TIB is first to clearly and behaviorally define what the client is doing to interfere with therapy. The second step is to do a thorough assessment of the TIB using a behavioral chain analysis. The third step is to adopt a problem-solving plan including trouble-shooting. Whether conducting a chain analysis or assessing for a broad pattern of behavior, DBT therapists are rooted in behavior therapy, and are therefore committed to behavioral assessment rather than a priori theory about the adaptive and maladaptive nature of client behaviors or their causes. The DBT therapist therefore assesses rather than assumes. Clarifying questions, "what" rather than "why" questions, and presentation of hypotheses are common when starting to understand the nature of the problem.

The anti-DBT approach includes therapist assumptions about the client's lack of motivation to change or to make progress, or any other a priori assumption about the TIB. Blaming the client or rigidly interpreting client's behavior is also antithetical to DBT. The stereotypical example of this is the inflexible insistence that client's behavior is an intentional self-sabotage. Another proscriptive behavior is refusal to acknowledge the therapist's own contribution to the TIB when it exists. And finally, it is the placement of responsibility for change entirely on the client.

Chain Analysis of TIBs

An important stance in DBT is that a problematic behavior needs to first be understood and only then treated. This stance stems from a belief that many therapeutic mistakes are made when therapists jump into treating a behavior before understanding its generating and maintaining causes. DBT therapists utilize a behavioral chain analysis to understand and treat any behavior targeted to increase or decrease in treatment including TIBs. Chain analysis is an investigation of moment-to-moment events and (both overt and covert) behaviors that precede a problem-behavior, as well as its immediate and delayed consequences. It is therefore a strategy to help therapists formulate hypotheses about the controlling variables of the problem behavior (see Fig. 4.3).

Chain Analysis Step-by-Step

There are essentially eight major steps to a chain analysis (steps 1–5 are focused on assessment and steps 6–8 focused on treatment) (Linehan, 1993, 2014a). The first step is defining exactly what the problem behavior is. At times, this is very simple (e.g., calling last minute to cancel a session following an episode of self-harm), at times requires some refinement (e.g., appearing to show minimal effort in

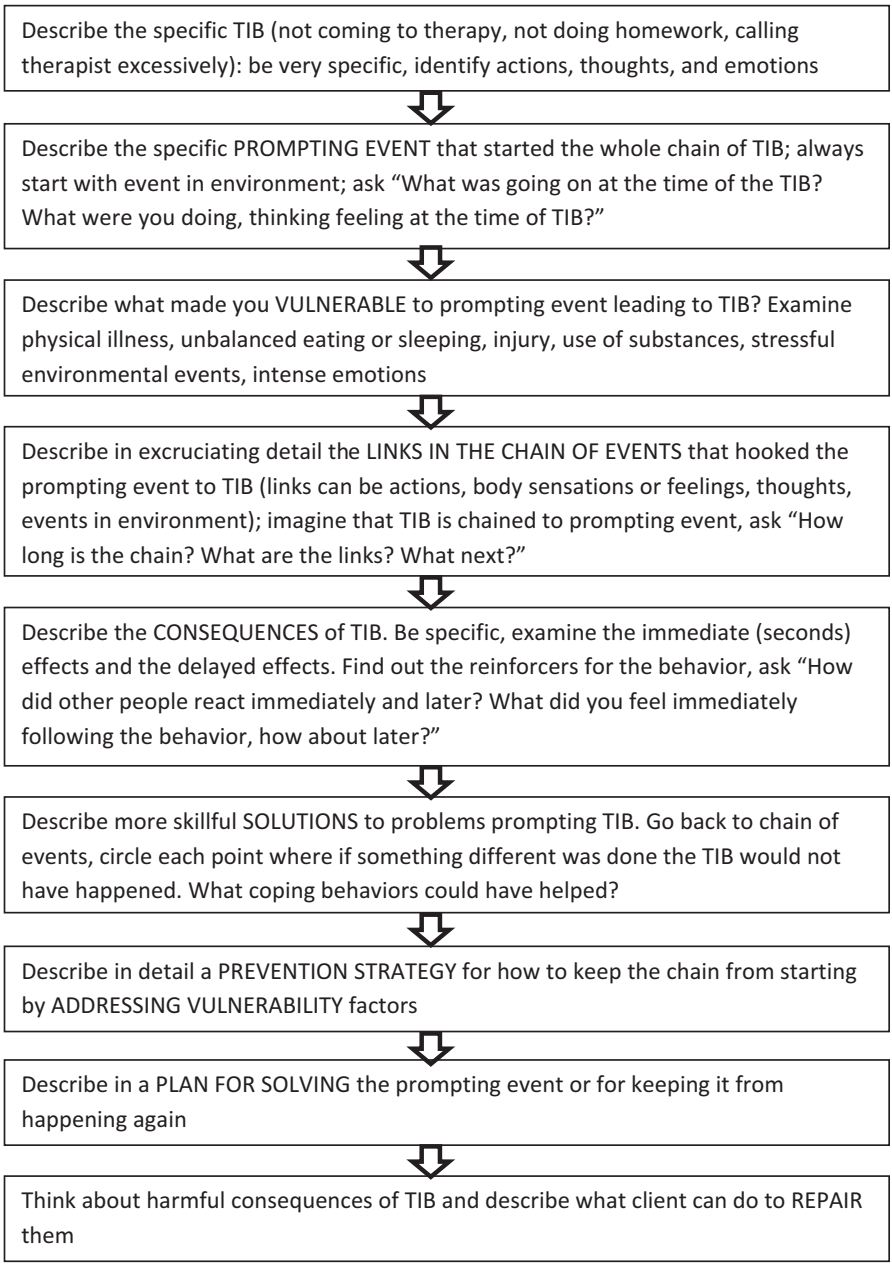

Fig. 4.3 Conducting a chain analysis for TIB

completion of homework assignments). The second step is assessing and defining what environmental event started the chain of events (i.e., the prompting event). The key here is to search for external, rather than internal stimuli as the beginning of the chain. The third step is identifying what factors made the client more vulnerable for

the problem behavior that day (e.g., lack of sleep, previously stressful interpersonal interaction, forgetting to take medications). The fourth step is identifying the links in the chain from the prompting event to the target behavior. This is probably the most difficult step, which requires attention to both external events, and to relevant thoughts, feelings, and behaviors that likely play a causal role leading to the problem behavior. Only after a thorough assessment, or often several, can the important causal links be identified. The fifth step is identifying the immediate and delayed personal and environmental consequences of the behavior. Clients often need help in identifying both the negative and positive consequences of the behavior for themselves and others. This crucial step, however, often helps to reveal the functional aspect of the behavior that helps to maintain it; it also helps in gaining insight into its destructive nature.

Once the assessment is done, the sixth step focuses on identifying skillful behaviors to replace problematic links in the chain to reduce the likelihood of reoccurrence. The seventh step consists of developing a prevention plan to reduce the vulnerability to the prompting event. Finally, the eighth step consists of repairing the negative consequences of the problem behavior. The key to proper repair is to understand the actual harm of the behavior, and to try to repair in a functionally meaningful way the harm that was done. For example, if the behavior analyzed is yelling and cursing the therapist on the phone before hanging up during a coaching call, bringing flowers as a repair is not functionally related to the harm. A better repair would be any behavior that would change the valence of future call from the client (i.e., make them more reinforcing/less punishing for the therapist).

Because focus on maladaptive behavior often elicits strong negative emotions such as shame, fear, and anger, chain analysis is often met with active and passive client resistance. Overcoming this resistance is of utmost importance. While resistance can take many forms, three types of resistance to chain analysis are often seen, namely, active avoidance and shame expression, minimizing the problem behavior, and general expression of distaste of chain analyses. If the therapist assesses that the client resistance is based on emotional avoidance, the therapist identifies more specifically the emotions at the root of the avoidance. The therapist then orients the client to the value of exposure, response prevention, and opposite action, and proceeds with the chain. The second type of common resistance is one where the client does not view the behavior as a major problem. The therapist assesses whether that is in fact the case, and then highlights to the client the incompatibility of the problematic behavior with any major treatment goal. This is sometimes more difficult to accomplish with TIB, particularly when there is a problem in the therapeutic relationship, and therapists may need to explicitly highlight the negative consequences of the behavior, or use additional strategies described below. The third common resistance is when the client hates conducting chain analyses in general. In this case, the therapist orients to the rationale for problem-solving maladaptive behavior and the importance of chain analysis in that process.

Specific Strategies for Addressing TIBs

The Four-Miss Rule

DBT includes structural elements that are designed in anticipation of problems with treatment engagement; perhaps the most important is the four-miss rule. The rule in standard DBT is that missing 4 consecutive weeks of scheduled therapy of any required element of treatment (e.g., individual psychotherapy, skills training group) counts as treatment dropout. It is the only formal termination rule (Linehan, 1993). The rule creates a structure that helps to clarify what constitutes treatment dropout, and helps to differentiate between more minor engagement problems and therapy-destroying behaviors. Perhaps more importantly, it creates a context that increases treatment providers' (individual therapists, skills trainers, etc.) motivation to address therapy nonattendance and client's direct or indirect communication of displeasure with the therapy. It also allows both therapists and clients to "save face" after a particularly difficult exchange. Therapists communicate to clients from the outset that if clients miss group or individual therapy, the team will "pine for their return." Outreach efforts are then made by relevant treatment providers in an effort to reengage the client. It is expected that once clients do return, the controlling variables of the therapy-interfering behaviors will be discussed as mentioned above. As a general rule, clients who want to return to therapy with the therapist may pursue that option at the end of the original contracting period (see Linehan, 1993 pp. 112–114 for a thorough discussion of treatment termination).

Contingency Management

Contingency management is sometimes an appropriate and effective strategy to address TIBs. It is, however, an extraordinarily difficult strategy to implement, particularly with highly complex, vulnerable, and disordered clients, especially suicidal clients. DBT places great emphasis on non-reinforcement of maladaptive behavior, especially suicidal behavior. Therefore, one has to be exceptionally thoughtful about making a contingency management plan that one could apply without fear that contingencies would need to be changed or postponed if the client becomes more distressed or suicidal. It is often critical to orient clients to applications and rationale of contingency management procedures and to try to tie them to the clients' ultimate goals. Whenever possible, this discussion is done when clients are relatively emotionally regulated so they can process this information as something other than one more punishing interpersonal experience in a lifelong stream of such experiences, often from healthcare providers.

The therapeutic relationship is often the most natural and powerful tool in the therapist's arsenal. Consistent with self-verification theory, DBT therapists work to establish themselves as relationship partners with which clients prefer to interact, and whose opinions they trust. As such, they can become powerful social reinforcers that can be used strategically to enhance client engagement. Therapists can choose to increase or decrease length or frequency of contact with clients (therapy sessions, coaching calls, etc.) contingent on client's own engagement. This could be particularly useful in trying to increase lower probability behaviors such as completing difficult homework assignments, or adherence to in-vivo exposure to emotion cues in sessions. Although not necessary, ideally clients could be part of the contingency management discussion and may negotiate the contingencies. For example, if a major goal of therapy is for the client to get back to work, and the client repeatedly does not engage in agreed upon activities such as job searches or job applications, the therapist may choose to come up with a contingency plan for reduced or increased therapy time contingent on the client's productive behavior. The client and the therapist may negotiate the exact terms of the plan as long as the essence of the plan remains intact. One of the key efforts in DBT is to make increased therapy contact contingent on client progress or adaptive behavior rather than maladaptive behavior (see Linehan, 1993 pp. 292–326, for a more thorough discussion of contingent procedures in DBT).

Self-Involving Self-Disclosure

Clinicians often complain that borderline clients "know how to push our buttons." The DBT perspective is that these clients emit so many behaviors that can be interpersonally challenging that they are statistically likely to say or do something that providers may find particularly challenging, and may perceive as personally attacking. In other words, clients engage in many emotionally salient behaviors that they are likely to engage in some behaviors that any therapist would find challenging. Though detrimental, these behaviors are often unintentional. Furthermore, as discussed above, suicidal borderline clients often present with more wants and needs than any therapist can possibly meet, which has the effect of challenging therapists' own self-concept.

The self-involving self-disclosure strategy is a form of interpersonal contingency clarification. It essentially consists of communicating to the client the effect of his or her behavior on the therapist ("when you do x, I feel y"). This strategy puts the onus on therapists to discuss the effect of specific client behavior on the therapist. This can be helpful as clients are often unaware of the extent to which their behaviors are experienced as aversive and lead to burnout among many of their interpersonal relationships. In ideal circumstances, therefore, this strategy can also facilitate the acquisition of interpersonal effectiveness skills by helping clients gain relevant

insights. This strategy, though often difficult, can help to prevent the need to address an even more difficult conversation when client's behavior crossed the therapist's limits.

Observing Limits

DBT therapists observe their own limits rather than set arbitrary ones. Whether consistently asking for additional time in session while other people are waiting, cursing the therapist in session, or threatening to kill themselves over the phone before hanging up, client's behaviors can often step outside of the therapist's comfort. This is particularly true for chronically suicidal borderline clients for whom DBT was originally developed. The needs and difficulties of these clients at times require providers to stretch their limits when necessary, and at other times, hold firm to those limits. For example, a therapist may find it helpful to be available for more unscheduled calls and frequent sessions when a client is in suicidal crisis following a loss of a job or a relationship; at other times, however, the therapist may feel the need to adhere to established expectations. The therapist-guiding principle here is to evaluate risk, reinforcement principles, and their own comfort level. Consultation with supervisors and other team members is strongly encouraged.

There are a few philosophically important points about observing limits in DBT. First, it is the therapist's responsibility to observe her or his own limits—it is not the client's. Second, while ultimately therapists' observation of their limits may benefit their clients (ultimately by reduced risk of burnout), observing limits is done for the benefit of therapists and should be communicated as such. There are often valid needs and wants of clients that therapists may simply be unable, or unwilling, to fulfill. This does not delegitimize those needs. Therapists need to validate clients' needs while asserting their own limits. This is often one of the most difficult tasks for therapists, who can be uncomfortable when failing to meet client needs, and often falls outside of their self-concept as caring, helpful providers. This aversive incongruence may lead to a tendency to "blame-the-victim" rather than come to terms with the reality of treating these complex clients. It is imperative to avoid pathologizing this client behavior as it mirrors years of invalidation, and is often iatrogenic.

It is also important to understand that therapists' limits may change over time due to circumstances in the therapist's life (e.g., becoming a parent, changing workload, an illness). The DBT stance on changing limits is that it is the responsibility of therapists to communicate those, and to problem-solve with clients these changes as they occur (or preferably prior when these changes are foreseeable). When a client's lack of engagement crosses the therapist's limits, the therapist is tasked with addressing the issue directly as part of the principle of observing limits.

For example:

"T: This is the third week in row that you haven't completed the homework that we agreed upon. I'm afraid this therapy is not going to work without doing work outside our sessions, and the thing is, I'm not willing to provide therapy I believe is ineffective, so I think we need to figure this out. I'm afraid it's not going to make sense for us to continue engaging in ineffectual therapy.
C: OK, so you are dumping me like my previous therapist! Great...
T: I didn't say that. But I did say that we have to figure it out because I want to keep seeing you, and I don't want to get to the point of ending our therapy for this reason.
C: So it's all on me now...
T: It's on us.
C How so?
T: Well, we have to figure out what really gets in the way of completing these assignments. Are they too difficult? Do they seem pointless? Are you avoiding being uncomfortable? Are you afraid of failing? Are you afraid of succeeding and what success might entail for you?
C: What's the point of this interrogation? I told you I didn't do them already...
T: The thing is I simply don't know of a way to help you without specific practice outside our sessions. And on a personal level, I feel like I'm putting my all into our work together: being on time for our sessions, being prepared with an agenda, doing my best to be completely present when we meet, making myself available for you to call in for skill coaching etc. When you regularly report that you are not doing your homework, it communicates to me that I am more invested in your treatment than you are. I could be completely mistaken about it obviously, but if I'm not, it may eventually cause me to hold back more.
C: Well, to be honest with you, I did try the homework all of these weeks, but I get overwhelmed and feel like a failure so I stop. I think what's the point? It's not going to help me anyway.
T: I'm glad you told me. It helps me understand what's going on for you. I'm curious to hear more about the specifics of what you've done in each assignment. We should discuss what it would take to complete them, and how to communicate when you have specific reservations about an assignment when we discuss them together.

Metaphors

Perhaps one of the most effective strategies to change the context of engagement problems and other TIBs is with the use of evocative, memorable, and apt metaphors. While in DBT the use of metaphors is considered a quintessential dialectical

strategy, it can be particularly helpful in addressing problems with engagement. Therapists may draw upon any metaphor that appears to fit the situation and helps clients view the pattern of their behavior, or its effects, more clearly. It is often helpful to have the client engage in this discussion, as this discussion can sometimes more easily lead to dialectical synthesis, and insights for both the therapist and the client about the controlling variables of the TIBs.

For example:

T: It is as if we are traveling together. You picked the destination, which you keep saying was really important you. You are driving, while I'm in charge of the navigation. While we're on the road, I am trying to show you what the map says and highlight relevant road signs, and sometimes it feels like you completely ignore me. I'm telling you, 'you can't get there from here,' and you keep driving into dead ends, or in opposite directions. I think we have to find a way to better manage our journey together.
C: Well, maybe you're right sometimes, but you keep sending me in these scary treacherous roads. I just don't feel safe most of the time.
T: But you never tell me. How am I supposed to know? Sometimes, I could look for alternative routes. Other times I could help to support you, as we go through this together, perhaps a little more slowly.
C: Well that's the point? Everyone around me is just zipping by, and I feel I can't even get up to anything close to the speed limit.
T: That makes sense. It's your first time driving on some of these roads. Of course some of these mountain roads would feel scary. So tell me, what's more important to you right now, getting to our destination or how fast we get there?
C: Definitely getting there.
T: Great. We could work on finding some slower roads, while helping you navigate those scarier roads. At the same time, we need to work on accepting that you are going to travel in a speed that is safe and manageable for you, and we'll get there when we get there.
C: Deal!
T: But I do need you to alert me when you get scared.
C: Alright, I'll try to be more direct.

Therapy-Enhancing Behaviors

Consistent with a dialectical philosophy, DBT targets the polar opposite side of TIBs, namely, therapy-enhancing behaviors, or TEBs. These are any behaviors that enhance therapy process and outcome. Enhancing the therapeutic relationship and

increasing therapist willingness to treat clients is particularly important in the treatment of personality-disordered clients. The DBT stance is that these behaviors are to be taught and reinforced, rather than expected. For example, clients' efforts to complete therapy assignment are TEBs that are worth noticing and reinforcing. Keeping up other therapy agreements is another. Often, improvements over previous TIBs constitute TEBs. The principle of reinforcing just-noticeable difference is important. For example, clients' behaviors during telephone calls may often need to be shaped. For clients who typically do not utilize telephone coaching when it would make perfect sense to do so (e.g., in order to avoid engaging in self-injurious behaviors) encouraging any such efforts would be important, even if the initial calls are not particularly productive. On the other hand, clients who call too frequently, or at highly inconvenient times, are aversive or help-rejecting while on the phone, or utilize phone calls as the only coping mechanism, will need specific guidance for skillful use of those calls. These clients will need to be reinforced for any efforts to shape this behavior. For example, asking the therapist if this is a convenient time is TEB to be targeted, taking "no" for an answer, is another.

Therapist TIB

As mentioned above, therapists may engage in a host of behaviors that function to interfere with treatment. Any therapist behavior that unnecessarily causes distress or interferes with progress, or is iatrogenic, fits in that category, consistent with the dictum "*do no harm*." Similarly, defensiveness and rigidity when confronted with suggestions of TIB is in itself a form of therapist TIB. Reduced motivation, willfulness, and therapist hopelessness are particularly deleterious therapist TIBs that are unfortunately common in treating personality-disordered clients in particular. Finally, there are often logistical and institutional barriers that interfere with treatment (environmental TIBs). While these barriers are not considered therapist's TIB per se, it is nevertheless incumbent upon the therapist to problem-solve them to the extent possible. Table 4.1 summarizes typical therapist TIBs and contextual influences on the therapist that interfere with therapy.

Treatment of Therapist TIB Through the Therapist Consultation Team

While both therapists and clients are encouraged to bring up therapist TIBs, and therapeutic dyad is expected to work on solving these together, the primary source of support for solving therapist TIBs is the *Therapist Consultation Team*. The role of the DBT consultation team is to enhance therapists' capabilities to provide the treatment competently and their motivation to do so. Typically modeled after individual therapy target hierarchy, the team prioritizes life-threatening behaviors, therapy-interfering behaviors, quality of life-interfering behaviors, and therapist skills acquisition. Rather than focusing on specific clients during team meetings, the

Table 4.1 Summary of Therapist's TBIs

Therapist's personal factors leading to TBIs
Excessive travel
Not making needed arrangements for back-up when he or she is unavailable for therapy
Life stress at home or at work that is not managed well enough
Illness that is not managed well enough
Compartmentalizing clinical work to a small part of the week such that clinical demands are seen as intrusive during the rest of the week (especially relevant in academic environments)
Forgetting to have pager, cellphone, charged, and ready to be accessible to client as expected
Therapist's functioning in the broader therapeutic context leading to TBIs
Not bring up in DBT team items he or she needs help with in treating the client
For trainees: not getting the support needed from supervision (for example not challenging a supervisor who cancels supervision sessions or does not watch sessions, not calling the supervisor for guidance in the middle of a treatment crisis)
"Blaming the victim" attitude toward client
Fear of being sued by client controlling the therapy
Anxiety about client committing suicide controlling therapy
Reinforcing dysfunctional behaviors due to difficulty tolerating communication of distress from client
Not observing personal limits and not working on decreasing clinical burnout
DBT team interfering behaviors: – Not coming to DBT team and thus (a) not receiving the help needed to treat therapist's own clients and (b) not offering help to other therapists – Not asking for consultation from other DBT team members when needing it – Not responding to requests for consultation from other DBT team members
Not keeping documentation up-to-date to convey clinical context to therapists providing back-up
TBIs from therapist's behaviors creating therapeutic imbalance
Imbalance of change versus acceptance: – Excessive focus on change to the detriment of acceptance strategies – Excessive focus on acceptance strategies to the detriment of change strategies
Imbalance of flexibility versus stability: – Changing therapy strategies too quickly before allowing enough time for them to work; therapist modification of therapy according to non-theory-linked criteria due to impatience – Insisting on specific strategy despite evidence that it is not working for a particular client and other strategies are available
Imbalance of nurturing versus demanding change: – Disproportionate focus on doing things for the client and nurturing while not providing support to encourage and shape the client to do things for himself or herself; the client is often seen as too vulnerable, incompetent, or fragile to help himself or herself – Disproportionate focus on pushing the clients to solve their own problems assuming that if they are motivated enough the needed behaviors will happen
Imbalance of reciprocal versus irreverent communication: – Therapists becoming overly vulnerable in therapy sharing their personal problems outside of the context of what is helpful to the client – Overemphasizing the distance between therapist and client
Examples of a Therapist's Disrespectful Behaviors
Misses or forgets appointments, cancels appointments without rescheduling

(continued)

Table 4.1 (continued)

Arbitrarily changes his or her policies with the client (e.g., changes phone policy, fees, appointment times)
Does not return messages or phone calls, or delays calling back
Loses papers/files/notes, does not read the notes/papers client gives to him or her
Is late to appointments
Appears or dresses unprofessionally, has a messy/unclean office space
Eats/chews gum/smokes/talks on the phone during appointments
Does not close door during therapy sessions
Forgets important information (name, relevant history/information)
Appears visibly tired/fatigued, dozes off with the client
Ends sessions prematurely, visibly watches the clock
Refers to client in sexist, paternalistic, or maternalistic manner
Treats the client as inferior to the therapist

main focus is the therapist, or the client-therapist dyad. One way in which the DBT team keeps track of TIBs in a way that conveys their importance is to have a separate moment in team meetings where all therapists are prompted to add TIBs to the agenda. Utilizing any and all DBT strategies, the team is tasked with helping therapists in their relationships with specific clients, or in areas that more broadly affect their ability or willingness to provide the therapy consistent with the DBT model—in other words, the team provides therapy for the therapist.

There are several essential agreements that DBT providers are expected to adhere to, which provide the foundation for effective functioning of the consultation team. Although all of the agreements are relevant to the problem of TIBs, perhaps the most pertinent are *observing-limits, phenomenological empathy, and fallibility* agreements. Discussed at length above, *observing-limits agreement* states that DBT therapists agree to notice and respond to their own comfort level in treating clients rather than set arbitrary limits. In the context of the team, this agreement also respects the fact that therapists may have different limits from one another, and there are no "correct" limits for therapists to adhere to. The *phenomenological empathy agreement*, which may be the most important in dealing with client engagement problems (and other ineffective client behavior), states that DBT providers work to find empathic nonpejorative explanations for client behavior. In the clinical experience of these authors, this guidance is probably the most helpful in problem-solving clients' TIBs, as it helps in reducing difficult emotions in both therapists and clients. The same empathic stance is expected toward fellow team members and the therapist's own behavior. The *fallibility agreement* enshrines the obvious and uncomfortable truth that despite their best intentions, providers are ultimately fallible and often have done what they were "accused of." This agreement calls for therapists to drop their defensiveness and be open to complaints, advice, and corrective feedback. This agreement may be the most helpful in increasing therapists' willingness to seek consultation for their own TIB's and to accept other members' interpretation of their behaviors as therapy-interfering.

The consultation team is expected to model DBT individual therapy by embracing dialectical framework, balancing acceptance and change strategies, modeling non-defensive and nonjudgmental stance toward problematic therapist behaviors, assessing the controlling variables for therapist TIBs using behavioral change analysis, and offering emotional and instrumental support. For example, the slow pace of recovery of "difficult-to-treat" clients often feels demoralizing to both clients and therapists. It is precisely the ability to maintain unwavering beliefs in the clients' ability to improve and make progress toward clinical goals that is essential in keeping both therapists and clients engaged. Sometimes, it is incumbent upon the therapist to hold the "flag of hope and optimism" when the client has let it go. When the therapist finds it difficult to "hold the flag," it is the job of the consultation team to help him or her do so. Similarly, when clients miss 3 weeks of treatment and are at high risk of dropout (especially when this is repeated occurrence), therapists may convince themselves that clients are not interested in treatment, or "not ready," and may find it difficult to mobilize to prevent such an outcome. It is incumbent upon the team to help therapists reengage in treatment and problem-solve the clients' attendance and engagement problems.

Conclusion

DBT was developed to treat a high-risk complex clinical population that was notoriously difficult to engage productively and retain in treatment, namely, suicidal individuals who met criteria for borderline personality disorder. It has since evolved and been utilized in a wide range of clinical populations and problems. DBT includes several strategies aimed at building and maintaining treatment engagement. Nevertheless, the high frequency of problems in therapy with high-risk complex clients led to conceptualizing these problems as therapy-interfering behaviors. The realization that clients, therapists, and environmental factors can all contribute to these problems led to explicit targeting of therapy-interfering behaviors on all fronts. Clients, therapists, and the consultation team are all tasked with identifying and problem-solving these behaviors throughout the course of treatment.

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