

CHAPTER **One**

Applying Dialectical Behavior Therapy: Toward Access for Diverse Client Needs

Gifts of Dialectical Behavior Therapy

The tools and lessons of dialectical behavior therapy (DBT) may be seen as gifts for taking care of the self. Instead of suffering with a mind hijacked (Goleman, 1995) by emotional reactivity, pervasive and troublesome thoughts, and mood states, DBT clients learn to effectively deal with, cope with, and embrace life and arising moment-to-moment experience. There are two elements of DBT—a dialectic orientation and mindfulness—that are revolutionary in terms of a therapeutic method. We will briefly address these elements here but will explore them in more detail later.

A dialectic orientation squarely addresses and integrates a fundamental paradox of engaging in therapy. It identifies that at the core of the therapeutic process is the dynamic relationship between acceptance/validation and change. Other therapeutic modalities may emphasize that validation is important within the practitioner–client partnership in order to lay the groundwork for the real work of the endeavor: change. In DBT, the real work is both acceptance/validation and change.

In general, clients become clients because either they or people in their environments believe that they are in need of change. Distress and anxiety may be profound; depression or mania may be debilitating and/or dangerous; anger or reactivity may be difficult to contain. Troublesome emotions lead to negative and destructive behavior that has painful consequences for the client and for persons with whom the client is somehow connected. Therapy becomes part of a change project directed toward the client so that her or his emotions may become less troublesome and the resultant behavior less destructive. Cognitive-behavioral therapy (CBT) is the strategy most often pursued to create this change.

CBT emphasizes changing the thoughts or beliefs—“cognitive distortions”—that are seen to be at the source of troubling emotions and their resultant behaviors. The traditional sequence is outlined as dysfunctional thought → emotion → behavior. The client’s job is learning how thoughts contribute to feelings and behavior and then, sometimes in the midst of challenging circumstances, to examine underlying thoughts. When the thoughts or thought patterns are identified that lead to troublesome emotions and behaviors, the task is to convert the thought or thoughts to ones that are more health promoting. The client may be fairly successful examining, deconstructing, then replacing thoughts in a practitioner’s office; the trick is to stop the thought → emotion → behavior chain outside the office and to insert alternative cognitions as life unfolds.

DBT emerged partly from the discovery that CBT could be experienced by clients as invalidating. Let us consider the example of a female client who is struggling with her partner’s remark regarding her weight. There may be various cognitions that, depending on the actual circumstances and client cognitive patterns, could be inserted in order to mediate against the distress provoked by the insulting comment: “I have had recent compliments about how beautiful I am, so I have a lot of evidence that I am in fact beautiful”; “my weight is not important—it’s what’s

inside that counts"; I don't have to meet Western, patriarchal standards of thinness, I am fine just the way I am"; "my partner's comments are really about his/her hangups, I don't need to personalize them"; or "this is one negative comment, I am creating my own distress because I am catastrophizing" (personalizing and catastrophizing are two examples of distorted cognitive patterns). These kinds of cognitive affirmations or attempts at replacing negative thinking may be effective. At times, however, the practitioner's suggestion of these approaches implies to the client that her suffering is superficial or self-induced and could easily be relieved if she "just got her head on straight." In fact, this kind of unintended message has a way of sometimes reinforcing or adding on to problems; "not only am I always feeling hurt and hyper about my weight, but I am stupid for feeling this way."

In this cycle of shame and pain, the person continues attempting to replace one thought for another. While at a party her insecurity is traced to the thought of "I am unattractive, and I will never find a partner" and is replaced with "I am attractive and desirable," or some other related cognitive strategy. As Linehan (2005) has remarked, this kind of cognitive dance may actually reinforce the power and impact of the negative thought. It is sometimes difficult to defeat negative thinking with thought replacement or self-admonishments to basically "not think this way." A client has told me that for years—with the guidance of one therapist or another—she has attempted to replace thoughts related to how much of a loser she was. Despite temporary reprieves, the strategy fundamentally did not work. She would, in essence, push the negative, self-defeating thought into the closet and bring in alternative thoughts to occupy its place, only to have negative thoughts consistently reemerge demanding their place in the center of her mind.

The Dialectic Orientation

As an alternative to the notion that "I am thinking the wrong way" or the orientation of beating back thoughts with other

thoughts, DBT begins with the idea that the experience of acceptance/validation lays the groundwork for change, fuels change, and makes meaningful change more likely. Thoughts arise and we see them for what they are—thoughts. Mindfulness, as we will discuss later, gives us clarity as to the nature of thoughts. We begin to realize that thoughts come into consciousness in a manner over which we have little control. This reality is brought home during any attempt at doing a mindfulness exercise and focusing on our breath. Despite our intentions, the brain continues to do its job and secrete thoughts in the same way that the liver secretes bile. There is no being, or ego, or separate self—a person with name X—that has ultimate control over this process.

We begin to realize that thoughts are insubstantial: they arise, they disappear, they trigger other thoughts, and they change. We accept that thoughts are thoughts, and this acceptance creates space around them. We do as Rumi suggests, invite them in for tea (i.e., accept them) but not beyond. We do not have to believe thoughts, and we do not have to ruminate. It is the ruminating and belief in our thoughts as truths that give thoughts the appearance of having solidity or substance. In DBT, if we do start ruminating or we notice that we are paying a lot of attention to unhelpful thoughts, we accept that we are doing just that—ruminating and engaged in hurtful thinking—and we make a decision to take care of ourselves.

Radical Acceptance as a Basis for Change

Emotional states may also be the starting point and source of thoughts and thought patterns (see Goleman, 2004). One time I was at a convocation of master's students and none of the students approached me to investigate whether they would want, in the following academic year, to do a thesis or research project with me. While I was standing in a large room alone, other faculty members had students gathered near them. I started telling myself the story of how other faculty members knew the students; I did not because I did not teach first-year master's students that

year. That story was my attempt at feeling okay. Then my story moved to how economical and thoughtful I had been presenting my research interests at this meeting. Other narcissistic and less time-conscious faculty successfully self-promoted themselves, and now they were reaping the rewards of their efforts. During the next faculty meeting, I thought self-righteously, I will bring up how we need to have a short time limit to discuss our research interests so that the gathering does not last so long. I alternated between my thoughts about not knowing the students as the justification for their limited interest in making contact with me, and the thoughts about my higher level of consideration—relative to other faculty members—in an attempt to deal with my discomfort. I took a deep breath and allowed myself to notice the underlying emotion related to standing alone at this gathering. *I was feeling insecure*. From this place of insecurity or vulnerability I had launched into thoughts and stories that were actually enhancing my suffering and doing little to assuage my insecurity. I accepted or, as we will discuss later, *radically* accepted my insecurity. There was nothing more to do. Acceptance teaches us that we can hold these emotional states as they are. In this case, that was where the relief was located. I lightheartedly acknowledged and accepted that I had been all bound up in a story of excuses and self-righteousness because that's what humans do—make desperate, reactive attempts at feeling okay. In the end, I *regulated my emotions* through radically accepting all of it: the insecurity, the small me that was making up stories, the comparing mind that noticed who had more or fewer students near them.

From this place of acceptance, change occurs. We develop confidence that we have the ability to *respond* to life as it is and feel a sense of peace (or maybe just get a glimpse of peace) about thoughts, emotional states, and situations as they arise. Even if we are highly agitated or distressed, we cultivate the capacity to accept that we are agitated or distressed. Acceptance fuels a sense of compassion for ourselves and

others. We become open to change, not so much because we are ashamed of ourselves or because we want other people to “get off our case” about changing, but *because we want to take care of ourselves*. We let go of some of the debilitating judgments and stories that we have about who we are, and realize that the best we can do is to respond today to live in a manner that is healthy and life promoting.

The *practitioner's* internalization and practice of acceptance for one's self as well as her acceptance of the client translate to how successfully the client will learn acceptance. (We will discuss ways in which the clinician's presence and personal work with radical acceptance can be developed.) We, as therapists or clinicians, can preach to our clients about acceptance or behave as if it is an elusive, mysterious state to be grasped and attained, or we can create a container in which the client experiences that she or he is radically accepted. This container is a base from which the client may begin to experience acceptance of her own thoughts, feelings, and responses. In an environment of acceptance there is less need to run from or avoid what is happening internally and less need to dress up, deny, or create a stir in order to hide one's internal life. The client senses that acceptance is available now, in this present moment. From this place of safety and from the enhanced capacity to face things as they are, change unfolds.

As we explore further in the book, we will see that mindfulness and acceptance are at the heart of emotion regulation and wellness. They slow down the reactive cycle and open possibilities for us to function in a manner that is calmer, less impulsive, more skillful, and less anxiety ridden.

The Relationship of Mindfulness and Acceptance

Mindfulness has a mutually reinforcing relationship with radical acceptance. When we are mindful, we attune to things as they are and begin to see clearly. The most fundamental mindfulness skill is to observe and describe phenomena without adding a

story or judgment to the description. This serves us in noticing, for example, the difference between thoughts and truths. Noticing that I am having a thought that I am incompetent is quite different from *fusing* with—that is, completely believing—I am incompetent (Hayes & Lillis, 2012). Mindfulness allows us to observe our emotional process and see, for example, the anger arising. We learn from mindfulness exercises that our breath can ground us and that the emotion of anger is not permanent and not as solid as we may imagine. We see anger for what it is: a passing emotional state, rooted in the body, that may be transformed through acceptance of its existence, a mindful return to the breath, and pursuit of a skillful response. Mindfulness allows us to see through the times when we believe that the narrative chatter or commentary about our lives is our actual life. We learn that we have choices about this kind of monologue, and we cultivate the capacity to return to the present moment. The framework and activities described in this book have statistically significant evidence supporting efficacy for enhancing client mindfulness, particularly with respect to the mindfulness component “acceptance without judgment” ($p < .001$) (Richards & Sehr, 2011).

In the preceding example, acceptance of my insecurity related to my capacity to be mindful. I could have continued on a path of reactivity and launched into a scathing mass e-mail directed at my colleagues about how they needed to be more sensitive about time parameters at major student–faculty gatherings. I could have become angry enough that I stormed out of the meeting or given off such a venomous vibe that no students would have wanted to approach me. (Some students did end up speaking with me; perhaps they were feeling sorry for me.) I could have internalized the distress and not acted out, instead feeling depressed and alienated about the event. With that alienated emotional state as a base, I may have built a mental monument about how superior I was relative to others. Being mindful of my distress, however, allowed me

to tune into what was occurring. I was able to see that my thoughts about myself and others were just thoughts and judgments and were not truths. I did not feel bad or ashamed at myself for having these thoughts. Then I sensed that insecurity—the best name I could come up with—was at the source of my distress. Accepting this process, allowed me to see and “stay with” the insecurity. Being mindful of things as they were was part of my acceptance of things as they were.

DBT was originally developed for people diagnosed with borderline personality disorder. Linehan’s vision to adopt mindfulness as a core skill was to help clients not get lost in reactivity, to attune—in the moment—to the nature of distress, and to provide opportunities for skillful response. Additionally, mindfulness is about engagement in the present moment, as she has described, throwing yourself into life, getting up to bat and hitting the fastballs that life keeps throwing at you (Linehan, 2005). Thoughts and feelings arise; they are to be seen, acknowledged, and accepted. Then our task is to come back to the *present moment* of our life where the situation is nearly always workable and freedom is possible. Our return to the breath in a mindfulness exercise is our return to this present moment and is a metaphor and practice opportunity for living a fulfilling life.

Dialectical Behavior Therapy for Wellness and Recovery (DBT-WR)

Some 20 years ago Marsha Linehan (1993) and dialectical behavior therapy (DBT) reached prominence. At the time, the treatment primarily targeted people suffering with borderline personality disorder and offered hope and real life results for many people who had previously been unresponsive to treatment. Linehan’s commitment to the empirical validation of DBT, mounting evidence of DBT effectiveness, and practitioner thirst and enthusiasm for mindfulness-based approaches has

meant the proliferation of DBT practice in all kinds of clinical contexts and situations.

Unfortunately, emergent DBT practice is often loosely conceptualized, and clients seem destined to take away fragmented chunks of DBT that may or may not produce compelling experiences, lessons, and skill mastery. While Linehan's clients "generally stay(ed) in psychosocial skills training for at least 1 year" (Linehan, 1993, p. 11) and had therapists as well as "skills trainers," present practice realities seldom afford these kinds of client and practitioner resource opportunities and thus demand systematic thinking for making DBT application relevant.

The empirically supported DBT-informed practice approach offered here – *hereinafter referred to as DBT for wellness and recovery, or DBT-WR* – will address important client and service context realities and the questions and concerns that emanate from them.

➤ Clients may be exposed to a limited number of DBT groups or individual sessions. Crisis residential programs, in-patient hospital-based programs, intensive outpatient programs, and cycles within the calendars of community mental health agencies mean that clients receive something called DBT, but may be getting 5, 8, or 12 sessions. One ultra-prestigious psychiatric hospital, for example, has patients cycling in and out of the in-patient "DBT groups," and, whether they are diagnosed with schizophrenia or depression, haphazardly working through Linehan's (1993) manual. How can there be enough integrity to these kinds of experiences for them to be meaningful?

➤ Clients involved in some form of DBT practice have variant capacities for holding concepts in their day-to-day consciousness. Instead of multiple, abstract concepts and approaches helping the client to live, in Linehan's words, a life worth living, can there be a simple unifying approach that a client can call upon and remember in daily life and in the midst of emotional distress?

➤ Some DBT clients have disdain for “homework,” and there are psychological barriers (e.g., past school failure), cognitive challenges, limited literacy, and compromised environments (e.g., lack of home, chaotic families, or exhausting lives) that make doing homework improbable. In one ongoing DBT-WR group I conducted, group work was part of a women’s perinatal drug treatment program, which demanded individual work, 12-step attendance, weekly meetings with a sponsor, abstinence, maintenance of a constructive relationship with their Child Protective Services worker, individual therapy, daily 3-hour involvement with their peers, parenting skills training, and practical and/or emotional resolution of their trauma. These demands were over and above either ongoing child rearing of sometimes challenging children or regular supervised parent–child visits for children that were in foster care arrangements. Insisting on homework completion for these women would have been unreasonable and invalidating. How can we be responsive to the varying degrees to which homework completion makes sense?

➤ Mental health agencies increasingly embrace mental health recovery as the dominant framework for delivering services (see Slade, 2009; Walsh, 2013). Within this paradigm, we are admonished to tune into the aspirations of our clients, maintain a collaborative, nonexpert stance, celebrate gains, and move beyond traditional clinical boundaries that may be overly detached and impersonal. What kind of language can we use within DBT-WR applications that is more inviting and less triggering, and that flattens the hierarchy? How can the DBT-WR process solicit and incorporate client solutions, wisdom, and worldview rather than reproducing hierarchy and disempowerment through notions of depositing skills and expert knowledge?

➤ Client spirituality is increasingly seen as a significant force in client wellness and recovery. Not accounting for spirituality is argued to be clinically irresponsible (Hodge, 2005; Bein, 2008). How can DBT-WR incorporate spirituality in an inclusive

manner so that it may serve as an ongoing resource for emotion regulation and wellness?

➤ Mindfulness activities produce a variety of responses. Some people are encouraged with the possibilities while others are agitated with their sense of being inadequate mindfulness failures. Some people are suspicious that mindfulness interferes in some way with their religious traditions; others experience mindfulness as invoking an open field where invasive and frightening experiences may arise unimpeded. How can we approach mindfulness so as to reduce the client's familiar and discouraging thoughts related to performance and success or failure? How can we adapt mindfulness work to be inclusive of unique client needs and cultural belief systems, and what kind of clinician mindfulness practice is advisable in order to facilitate client progress?

➤ Skills training may normalize struggle and challenge, and the acquisition of DBT-WR skills may facilitate a sense of mastery, competence, and stability. However, the very process of teaching already disempowered clients how to think, feel, and behave may be experienced as denigrating. One memorable Latina DBT client once asked me in a nonaccusatory tone, "Are you trying to teach us to behave more like White people?" Teaching skills in mandated settings may invoke ambivalent feelings; however, one finding from recent DBT-WR groups was that clients deeply appreciated being taught neuroscience. Not only did simple neuroscience explanations validate the emotional difficulties clients had faced as a result of trauma, but clients also reported that neuroscience discussions and being shown a model of the brain indicated respect for their intelligence (Richards & Sehr, 2011). How may we bring the riches of neuroscience into DBT in a way that (a) validates client struggles with emotion regulation, (b) enhances their enthusiasm for and belief in emotion regulation, and (c) clarifies and opens a window to the possibilities for developing an effective and balanced mind—referred to as Wise Mind?

➤ Client radical acceptance is a skill, is a goal, and ultimately is intimately connected to mindfulness practice. Clients cultivate

the capacity for radical acceptance through the didactic presentation of related skills and activities, and through their internalized experience of the practitioner's radical acceptance of them. How do we manifest, with challenging clients, a sense that we completely embrace them for who they are? How far-reaching is radical acceptance and what use-of-self orientations help us regulate boundaries and our emotional life as we interact with our clients?

➤ DBT founder Marsha Linehan asserts that practitioners present "unrelenting insistence on total abstinence" (Denning & Little, 2012). However, various service contexts providing DBT emphasize harm reduction. HIV-oriented programs, for example, may work with people to collaboratively evaluate the degree to which drug and alcohol use is either a threat to safety or is in some manner a resource helping the individual cope with trauma (Denning & Little, 2012). Other settings such as housing-first residences, community mental health programs, and universities are mandated to work with and not exclude clients who engage in varying degrees of harmful behavior. Embedded in this work are motivational interviewing approaches that may, in fact, enhance the degree to which clients experience radical acceptance. What kinds of DBT-WR adaptations can be made at agencies where the leadership and staff value motivational interviewing and will not insist on certain behavior in order to qualify for service? What may be the strengths and weaknesses, as it applies to the implementation of DBT, of this more permissive environment?

➤ Finally, the historical development of DBT proceeded on the foundation that creating change in the lives of desperate, emotionally dysregulated, and—in traditional clinical terms—highly resistant clients demanded clear boundaries and, as Shulman (1999) would say, a "demand for work." One manifestation of this orientation is the four-absence limit (Reynolds, Wolbert, Abney-Cunningham, & Patterson, 2007) that clients may not exceed in order for them to remain in a DBT program. At one community mental health clinic, I observed a fairly

talented clinician recruit clients and run a group with these attendance parameters. At the end of 6 months, her DBT “group” had a total of one client who completed treatment. In the name of treatment fidelity, the rigid adherence to attendance parameters, in essence, helped establish conditions for “creaming” the population down to one successful client. The inadvertent institutional contribution to creating drop-outs or push-outs meant that many community clients were left underserved. While observing this experience unfold, I radically accepted my sadness and decided on the skillful response of developing a pragmatic, responsive alternative to DBT delivery. Clients who have resource challenges—transportation issues, subsistence income, child care demands, waxing and waning energy or commitment to therapy, mental illness symptomology, medication problems, family crises, struggles with personal organization, and limited funding for formalized services—should be able to access the benefits of DBT even though they cannot participate in traditional delivery. In addition, agencies or settings that have shoestring or barely existent training budgets, crushing clinician or medical provider productivity demands, limited time for consultation and supervision, and practitioners playing multiple roles with clients should be able to offer clients the benefits of DBT. This book presents dialectical behavior therapy for wellness and recovery (DBT-WR), founded upon practice experience and supportive evidence. It is presented in the spirit of inclusivity, access, and pragmatism.

