

Cognitive Behavior Technique

Dialectical Behavior Counseling

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INTRODUCTION

While children and adolescents are not often diagnosed with borderline personality disorder, the circumstance that lead to such disorders are often apparent. The format of this counseling endeavor is well thought out and has merit particularly for adolescents who manifest some of the characteristics listed at the end of this material.

While the percentage of adolescents who meet these characteristics may not be large, they are generally the most difficult to serve and are resistant to most service offerings. It is from that standpoint that we encourage the use of this material for the very difficult to serve adolescent.

DIALECTICAL BEHAVIOR COUNSELING¹

In the late 1970s, Marsha M. Linehan (1993) attempted to apply standard **Cognitive Behavior Counseling** to the problems of adult women with histories of chronic suicide attempts, suicidal ideation, urges to self-harm, and self-mutilation. Linehan was keenly interested in investigating whether or not it would prove helpful for individuals whose suicidality was in response to extremely painful problems. As she and her research team applied standard services, they encountered numerous problems. Three were particularly troublesome:

- 1) Clients found the unrelenting focus on change invalidating. Clients responded by withdrawing from engagement, by becoming angry, or by vacillating between the two. This resulted in a high dropout rate.
- 2) Clients unintentionally reinforced their counselors for ineffective intervention while punishing their counselors for effective services. In other words, counselors were unwittingly under the control of consequences outside their awareness. For example, the research team noticed through its review of audiotaped sessions that counselors would 'back off' pushing for change of behavior when the client's response was one of anger, or emotional withdrawal, or shame, or threatened self-harm. Similarly, clients would reward the counselor with interpersonal warmth or engagement if the counselor allowed them to change the topic of the session from one they didn't want to discuss to one they did want to discuss.

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In keeping with an avoidance of the medical model terminology, we will replace these terms whenever possible.

- 3) The sheer volume and severity of problems presented by clients made it impossible to use the standard format. Individual counselors simply did not have time to address both the problems presented by clients – suicide attempts, urges to self-harm, urges to quit treatment, noncompliance with homework assignments, untreated depression, anxiety disorders, etc, -- AND have session time devoted to helping the client learn and apply more adaptive skills.

Adding Validation and Dialectics

In response to these key problems, Linehan and her research team made significant modifications. They added new types of strategies and reformulated the structure of the intervention. In the case of new strategies, *Acceptance-based* interventions, frequently referred to as validation strategies, were added. Adding these communicated to the clients that they were both acceptable as they were and that their behaviors, including those that were self-harming, made real sense in some way.

Further, counselors learned to highlight for clients when the client's thoughts, feelings and behaviors were 'perfectly normal', helping clients discover that they had sound judgment and that they were capable of learning how and when to trust themselves. The new emphasis on acceptance did *not* occur to the exclusion of the emphasis on change: Clients also *must* change if they want to build a life worth living. Thus, the focus on acceptance did not occur to the exclusion of change based strategies; rather, the two enhanced the use of one another.

In the course of weaving in acceptance with change, Linehan noticed that a third set of strategies – ***dialectics*** - came into play. Dialectical strategies gave the counselor a means to balance acceptance and change in each session *and* served to prevent both counselor and client from becoming stuck in the rigid thoughts, feelings, and behaviors that can occur when emotions run high, as they often do in the services of clients with severe and persistent problems in living. Dialectical strategies and a dialectical world view, with its emphasis on holism and synthesis, enable the counselor to blend acceptance and change in a manner that results in ***movement, speed, and flow*** in individual sessions and across the entire process. This counters the tendency, found in services with clients diagnosed with BPD and many other disorders, to become mired in arguments, polarizing positions, and extreme positions. Thus, these three sets of strategies and the theories on which they are based are the three foundations of DBC.

Restructuring the Services

As noted above, very significant changes were also made to the structure of the intervention process in order to solve the problems encountered in the standard application. Below we discuss how DBC is organized by ***Functions*** and ***Modes*** and by ***Stages*** and ***Targets***. The process we are describing is considered to be Standard and Comprehensive DBC. It is the form of DBC that has been subject to the most rigorous **research** in terms of randomized clinical trials (RCTs). The variations of DBC that differ from the structure described below is being researched but has not yet been subjected to as rigorous a test as standard DBC. The reader should keep in mind that this is how comprehensive DBC is defined and that variations from this structure are *not* considered comprehensive or standard.

Functions and Modes.

Briefly, Linehan hypothesizes that any comprehensive service must meet five critical functions. It must:

- enhance and maintain the client's motivation to change,
- enhance the client's capabilities,
- ensure that the client's new capabilities are generalized to all relevant environments,
- enhance the counselor's motivation to treat clients while also enhancing the counselor's capabilities, and,
- structure the environment so that treatment can take place.

Due to space considerations, we will not review every possible method that can meet these functions. Rather, we offer the most common examples of how these functions are met. It is typically the individual counselor who maintains the client's motivation for services, since the individual counselor is the most salient individual for the client. Skills are acquired, strengthened, and generalized through the combination of

- skills groups,
- phone coaching (clients are instructed to call counselors for coaching prior to engaging in self harm),
- *in vivo* coaching, and
- homework assignments.

Counselors' capabilities are enhanced and burnout prevented through weekly ***consultation team meetings***. The consultation team helps the counselor stay balanced in his or her approach to the client, while supporting and encouraging the counselor in applying effective interventions. In DBC, a

counselor is not considered to be meeting the requirements unless s/he meets weekly in a DBC consultation team. Finally, the environment can be structured in a variety of ways, e.g., by the client and counselor meeting with family members to ensure that the client is not being reinforced for maladaptive behaviors or punished for effective behaviors in the home.

Stages and Targets.

DBC also organizes the process into stages and targets and, with very few exceptions, adheres strictly to the order in which problems are addressed. The organization into stages and targets prevents DBC being a service that, week after week, addresses the crisis of the moment. Further, it has a logical progression that :

- first addresses behaviors that could lead to the client's death,
- then behaviors that could lead to premature termination,
- to behaviors that destroy the quality of life,
- to the need for alternative skills.

In other words,

- the first goal is to ensure the client stays alive,
- so that the second goal (staying in service),
- results in meeting the third goal (building a better quality of life),
- partly through the acquisition of new behaviors (skills).

In short, we have just described the targets found in **Stage I**. To repeat, the first stage of intervention focuses, in order, on decreasing life threatening behaviors, behaviors that interfere with continuing service, quality of life threatening behaviors and increasing skills that will replace ineffective coping behaviors. The goal of Stage I DBC is for the client to move from behavioral dyscontrol to behavioral control so that there is a normal life expectancy.

In **Stage II**, DBC addresses the client's inhibited emotional experiencing. It is thought that the client's behavior is now under control but the client is suffering "in silence". The goal of Stage II is to help the client move from a state of quiet desperation to one of full emotional experiencing. This is the stage in which post-traumatic stress disorder (PTSD) would be treated.

Stage III DBC focuses on problems in living, with the goal being that the client has a life of ordinary happiness and unhappiness.

Linehan has posited a **Stage IV** specifically for those clients for whom a life of ordinary happiness and unhappiness fails to meet a further goal of spiritual fulfillment or a sense of connectedness of a greater whole. In this stage, the goal of treatment is for the client to move from a sense of incompleteness towards a life that involves an ongoing capacity for experiences of joy and freedom.

Client Characteristics

Linehan groups client characteristics in a particular way, describing the client as showing dysregulation in the sphere of emotions, relationships, behavior, cognition and the sense of self. She suggests that, as a consequence of the situation that has been described, they show six typical patterns of behavior, the term 'behavior' referring to emotional, cognitive and autonomic activity as well as external behavior in the narrow sense.

- First, they show evidence of '**emotional vulnerability**'. They are aware of their difficulty with coping with stress and may blame others for having unrealistic expectations and making unreasonable demands.
- On the other hand they have internalized the characteristics of the invalidating environment and tend to show '**self-invalidation**'. They invalidate their own responses and have unrealistic goals and expectations, feeling ashamed and angry with themselves when they experience difficulty or fail to achieve their goals.

These two features constitute the first pair of so-called '**dialectical dilemmas**', the client's position tending to swing between the opposing poles since each extreme is experienced as being distressing.

- Next, they tend to **experience frequent traumatic environmental events**, in part related to their own dysfunctional lifestyle and exacerbated by their extreme emotional reactions with delayed return to baseline. This results in what Linehan refers to as a pattern of '**unrelenting crisis**', one crisis following another before the previous one has been resolved.
- On the other hand, because of their difficulties with emotion modulation, they are unable to face, and therefore tend to inhibit, negative affect and particularly feelings associated with loss or grief. This '**inhibited grieving**' and the 'unrelenting crisis' constitute the second 'dialectical dilemma'.

The opposite poles of the final dilemma are referred to as '**active passivity**' and '**apparent competence**'. People with BPD are active in finding other people who will solve their problems for them but are passive in relation to solving their own problems. On the other hand, they have learned to give the impression of being competent in response to the invalidating environment. In some situations they may indeed be competent but their skills do not generalize across different situations and are dependent on the mood state of the moment. This **extreme mood dependency** is seen as being a typical feature of patients with BPD.

A pattern of self-mutilation tends to develop as a means of coping with the intense and painful feelings experienced by these clients and suicide attempts may be seen as an expression of the fact that life, at times, simply does not seem worth living. These behaviors in particular tend to result in frequent episodes of admission to psychiatric hospitals. Dialectical Behavior Counseling focuses specifically on this pattern of problem behaviors and, in particular, the parasuicidal behavior.

The term 'dialectical' is derived from classical philosophy. It refers to a form of argument in which an assertion is first made about a particular issue (the 'thesis'), the opposing position is then formulated (the 'antithesis') and finally a 'synthesis' is sought between the two extremes, embodying the valuable features of each position and resolving any contradictions between the two.

This synthesis then acts as the thesis for the next cycle. In this way truth is seen as a process which develops over time in transactions between people. From this perspective there can be no statement representing absolute truth. Truth is approached as the middle way between extremes. The dialectical approach to understanding human problems is therefore non-dogmatic, open and has a systemic and transactional orientation.

The dialectical viewpoint underlies the entire structure of the intervention, the key dialectic being '*acceptance*' on the one hand and '*change*' on the other. Thus, DBC includes specific techniques of acceptance and validation designed to counter the self-invalidation of the patient. These are balanced by techniques of problem solving to help him/her learn more adaptive ways of dealing with his/her difficulties and acquire the skills to do so. Dialectical strategies underlie all aspects of the service to counter the extreme and rigid thinking encountered in these clients. The dialectical world view is apparent in the three pairs of 'dialectical dilemmas' already described, in the goals of intervention and in the attitudes and communication styles of the counselor. The service is behavioral in that, without ignoring the past, it focuses on present behavior and the current factors which are controlling that behavior.

Counselor Characteristics

The success of intervention is dependant on the quality of the relationship between the client and the counselor. The emphasis is on this being a real human relationship in which both members matter and in which the needs of both have to be considered. Linehan is particularly alert to the risks of burnout and support and consultation is an integral and essential part of the process. In DBC, support is not regarded as an optional extra. The basic idea is that the counselor gives DBC to the client and receives DBC from his or her colleagues. The approach is a team approach.

The counselor is asked to accept a number of working assumptions about the client that will establish the required attitude for involvement:

1. The client wants to change and, in spite of appearances, is trying his/her best at any particular time.
2. His/her behavior pattern is understandable given the background and present circumstances. His/her life may currently not be worth living (however, the counselor will never agree that suicide is the appropriate solution but always stays on the side of life. The solution is rather to try and make life more worth living).
3. In spite of this s/he needs to try harder if things are ever to improve. S/he may not be entirely to blame for the way things are but it is his/her personal responsibility to make them different.
4. Patients can not fail in DBC. If things are not improving it is the service that is failing.

In particular, the counselor must avoid at all times viewing the client, or talking about him/her, in pejorative terms since such an attitude will be antagonistic to successful intervention and likely to feed into the problems that have led to the development of BPD in the first place.

Linehan has a particular dislike for the word "**manipulative**" as commonly applied to these folks. She points out that this implies that they are skilled at managing other people when it is precisely the opposite that is true. Also, the fact that the counselor may feel manipulated does not necessarily imply that this was the intention of the patient. It is more probable that the client did not have the skills to deal with the situation more effectively.

The counselor relates to the client in two dialectically opposed styles.

- The primary style of relationship and communication is referred to as '**reciprocal communication**', a style involving responsiveness, warmth and genuineness on the part of the counselor. Appropriate

self-disclosure is encouraged but always with the interests of the client in mind.

- The alternative style is referred to as '**irreverent communication**'. This is a more confrontational and challenging style aimed at bringing the client up with a jolt in order to deal with situations where services seems to be stuck or moving in an unhelpful direction.

It will be observed that these two communication styles form the opposite ends of another dialectic and should be used in a balanced way as services proceed. The counselor should try to interact with the client in a way that is:

1. accepting of the client as s/he is but which encourages change
2. centered and firm yet flexible when the circumstances require it
3. nurturing but benevolently demanding

There is a clear and open emphasis on the limits of behavior acceptable to the counselor and these are dealt with in a very direct way. The counselor should be clear about his or her personal limits in relation to a particular client and should as far as possible make these clear from the start. It is openly acknowledged that an unconditional relationship between counselor and client is not humanly possible and it is always possible for the client to cause the counselor to reject him/her if s/he tries hard enough. It is in the client's interests, therefore, to learn to treat the counselor in a way that encourages the counselor to want to continue helping. It is not in the client's interests to burn him or her out. This issue is confronted directly and openly in counseling.

The counselor helps the services to survive by consistently bringing it to the client's attention when limits have been overstepped and then teaching him/her the skills to deal with the situation more effectively and acceptably. It is made quite clear that the issue is immediately concerned with the legitimate needs of the counselor and only indirectly with the needs of the client who clearly stands to lose if s/he manages to burn out the counselor. The counselor is asked to adopt a non-defensive posture toward the client, to accept that counselors are fallible and that mistakes will at times inevitably be made. Perfect services are simply not possible.

Client And Counselor Agreements

All intervention must be entirely voluntary and depends for its success on having the co-operation of the client. From the start, therefore, attention is given to orienting the client to the nature of the service and obtaining a

commitment to undertake the work. Before a client will be taken on s/he will be required to give a number of undertakings:

1. To work for a specified period of time (initially contract for one year) and, within reason, to attend all scheduled sessions.
2. If suicidal or parasuicidal behaviors are present, s/he must agree to work on reducing these.
3. To work on any behaviors that interfere with the course of intervention ('service interfering behaviors').
4. To attend skills training.

The strength of these agreements may be variable and a "take what you can get approach" is advocated. Nevertheless a definite commitment at some level is required since reminding the client about his/her commitment and re-establishing such commitment throughout the course of service are important strategies.

The counselor agrees to make every reasonable effort to help the client and to treat him/her with respect, as well as to keep to the usual expectations of reliability and professional ethics. The counselor does not, however, give any undertaking to stop the patient from harming him/herself. On the contrary, it should be made quite clear that the counselor is simply not able to prevent the client from doing so. The counselor will try rather, to help find ways of making his/her life more worth living. The service is offered as a life-enhancement process and not as a suicide prevention treatment, although it is hoped that it may indeed achieve the latter.

Modes Of Service Delivery

There are four primary modes of service provided:

1. Individual counseling
2. Group skills training
3. Telephone contact
4. Consultation

While keeping within the overall model, group work and other modes of intervention may be added at the discretion of the counselor, providing the targets for that mode are clear and prioritized.

The individual counselor is the primary counselor. The main work is carried out in the INDIVIDUAL sessions.

Between sessions the client should be offered TELEPHONE CONTACT with the counselor including out of hours telephone contact. This tends to be an aspect of DBC balked at by many prospective counselors. However, each counselor has the right to set clear limits on such contact and the purpose of telephone contact is also quite clearly defined. In particular, telephone contact is not for the purpose of counseling. Rather it is to give the client help and support in applying the skills that s/he is learning to real life situation between sessions and to help him/her find ways of avoiding self-injury. Calls are also accepted for the purpose of relationship repair where the client feels that s/he has damaged the relationship with the counselor and wants to put this right before the next session. Calls after the client has injured him/herself are not acceptable and, after ensuring her immediate safety, no further calls are allowed for the next twenty-four hours. This is to avoid reinforcing self-injury.

SKILLS TRAINING is usually carried out in a group context, ideally by someone other than the individual counselor. In the skills training groups clients are taught skills considered relevant to the particular problems being experienced. There are four modules focusing in turn on four groups of skills:

The '**core mindfulness skills**' are derived from certain techniques of Buddhist meditation, although they are essentially psychological techniques and no religious allegiance is involved in their application. Essentially they are techniques to enable the person to become more clearly aware of the contents of experience and to develop the ability to stay with that experience in the present moment.

The '**interpersonal effectiveness skills**' focus on effective ways of achieving one's objectives with other people: to ask for what one wants effectively, to say 'no' and have it taken seriously, to maintain relationships and to maintain self-esteem in interactions with other people.

'**Emotion modulation skills**' are ways of changing distressing emotional states and 'distress tolerance skills' including techniques for putting up with these emotional states if they can not be changed for the time being.

'**Distress Tolerance Skills**'

These skills, which are extensive and varied, are fully described in a teaching format in the DBC skills training manual (Linehan, 1993b).

Lineham recommends that counselors receive DBC from each other at the regular CONSULTATION GROUPS and, as already mentioned, this is regarded

as an essential aspect of providing the services. The members of the group are required to keep each other in the DBC mode and (among other things) are required to give a formal undertaking to remain dialectical in their interaction with each other, to avoid any pejorative descriptions of client or counselor behavior, to respect counselors' individual limits and generally are expected to treat each other at least as well as they treat their clients. Part of the session may be used for ongoing training purposes. Best practice would suggest that a counselor working with this population seek to find a way to fulfill this function.

Intervention Strategies

Within the framework of stages, target hierarchies and modes a wide variety of intervention strategies and specific techniques are applied.

The core strategies are 'validation' and 'problem solving'. Attempts to facilitate change are surrounded by interventions that validate the client's behavior and responses as understandable in relation to his/her current life situation, and that show an understanding of the difficulties and suffering.

Problem solving focuses on the establishment of necessary skills. If the client is not dealing with problems effectively then it is to be anticipated either that s/he does not have the necessary skills to do so, or does have the skills but is prevented from using them. If s/he does not have the skills then s/he will need to learn them. This is the purpose of the skills training.

Having the skills, s/he may be prevented from using them in particular situations either because of environmental factors or because of emotional or cognitive problems getting in the way. To deal with these difficulties, the following techniques may be applied in the course of counseling:

1. Contingency management
2. Cognitive process correction
3. Exposure based interventions

The principles of using these techniques are precisely those applying to their use in other contexts and will not be described in any detail. However, they are used in a relatively informal way and interwoven into the service delivery.

Particular note should be made of the pervading application of contingency management throughout services, using the relationship with the counselor as the main reinforcer. In the session by session course care is taken to systematically reinforce targeted adaptive behaviors and to avoid reinforcing

targeted maladaptive behaviors. This process is made quite overt to the client, explaining that behavior which is reinforced can be expected to increase. A clear distinction is made between the observed effect of reinforcement and the motivation of the behavior, pointing out that such a relationship between cause and effect does not imply that the behavior is being carried out deliberately in order to obtain the reinforcement. Didactic teaching and insight strategies may also be used to help the patient achieve an understanding of the factors that may be controlling his/her behavior.

The same contingency management approach is taken in dealing with behaviors that overstep the counselor's personal limits in which case they are referred to as 'observing limits procedures'.

Problem solving and change strategies are again balanced dialectically by the use of validation strategies. ***It is important at every stage to convey to the client that her behavior, including thoughts, feelings, and actions are understandable, even though they may be maladaptive or unhelpful.***

Significant instances of targeted maladaptive behavior occurring since the last session (which should have been recorded on the diary card) are initially dealt with by carrying out a detailed '***behavioral analysis***'. In particular every single instance of suicidal or parasuicidal behavior is dealt with in this way. Such a behavioral analysis is an important aspect and may take up a large proportion of time.

In the course of a typical behavioral analysis, a particular instance of behavior is first clearly defined in specific terms and then a '***chain analysis***' is conducted, looking in detail at the sequence of events and attempting to link these events one to another. In the course of this process, hypotheses are generated about the factors that may be controlling the behavior. This is followed by, or interwoven with, a '***solution analysis***' in which alternative ways of dealing with the situation at each stage are considered and evaluated. Finally, one solution should be chosen for future implementation. Difficulties that may be experienced in carrying out this solution are considered and strategies of dealing with these can be worked out.

It is frequently the case that clients will attempt to avoid this behavioral analysis since they may experience the process of looking in such detail at their behavior as aversive. However, it is essential that the counselor should not be sidetracked until the process is completed. In addition to achieving an understanding of the factors controlling behavior, behavioral analysis can be seen as part of contingency management strategy, applying a somewhat aversive consequence to an episode of targeted maladaptive behavior. The

process can also be seen as an exposure technique helping to desensitize the client to painful feelings and behaviors. Having completed the behavioral analysis the client can then be rewarded with a 'heart to heart' conversation about the things s/he likes to discuss.

Behavioral analysis can be seen as a way of responding to maladaptive behavior, and in particular to parasuicide, in a way that shows interest and concern but which avoids reinforcing the behavior.

A particular approach is taken in dealing with the network of people with whom the client is involved personally and professionally. These are referred to as '**case management strategies**'. The basic idea is that the client should be encouraged, with appropriate help and support, to deal with his/her own problems in the environment in which they occur. Therefore, as far as possible, the counselor does not do things for the client but encourages the client to do things for him/herself. This includes dealing with other professionals who may be involved with the client. The counselor does not try to tell these other professionals how to deal with the client but helps the client learn how to deal with other professionals. Inconsistencies between professionals are seen as inevitable and not necessarily something to be avoided. Such inconsistencies are rather seen as opportunities for the client to practice interpersonal effectiveness skills. If s/he grumbles about the help s/he is receiving from another professional, s/he is helped to sort this out him/herself with the person involved. This is referred to as the 'consultation-to-the-client strategy' which, among other things, serves to minimize the so-called "**staff splitting**" which tends to occur between professionals dealing with these clients.

Environmental intervention is acceptable but only in very specific situations where a particular outcome seems essential and the client does not have the power or capability to produce this outcome. Such intervention should be the exception rather than the rule.

SUMMARY AND CONCLUSIONS

Dialectical Behavior Counseling is a comprehensive compendium of service built on a formal model designed to meet the needs of people with Borderline Personality Disorder. It directly addresses the problem of keeping these clients in service and the difficulty of maintaining professional motivation and well-being. It is based on a clear and potentially testable theory and encourages a positive and validating attitude to these clients in the light of this theory. The approach incorporates what is valuable from other forms of service, and is based on a clear acknowledgement of the value of a strong relationship between counselor and client.

The service is clearly structured in stages and at each stage a clear hierarchy of targets is defined. The method offers a particularly helpful approach to the management of parasuicide with a clearly defined response to such behaviors. The techniques used are extensive and varied, addressing essentially every aspect of service and they are underpinned by a dialectical philosophy that recommends a balanced, flexible and systemic approach to the work of counseling. Techniques for achieving change are balanced by techniques of acceptance, problem solving is surrounded by validation, confrontation is balanced by understanding. The client is helped to understand his/her problem behaviors and then deal with situations more effectively. S/he is taught the necessary skills to enable him/her to do so and helped to deal with any problems that s/he may have in applying them in his/her natural environment. Generalization is not assumed but encouraged directly. Advice and support is available between sessions and the client is encouraged and helped to take responsibility for dealing with life's challenges. The method is supported by empirical evidence which suggests that it is successful in reducing self-injury and time spent in psychiatric hospitalization.

The strength of the process is its thorough delineation of the structure and philosophy of a comprehensive service delivery process. The weaknesses include the failure to work with the members of the ecosystem. However, it must be noted that the design is specifically created and carried out with adults. We would strongly recommend the addition of a **social learning family intervention** as a means of addressing this issue.

We might also hope that the service delivery would include more **imagery based techniques** to help clients address the unsayable aspects of their experiences. Such techniques as **Coping Imagery** [CBT#09], **Changing Core Beliefs** with visualization [CBT#15], and **Six Step Reframing** [CBT#22] seem most appropriate.

Finally, we would recommend the use of **Schema Focused Counseling**, CBT#39, as an appropriate addition as well.

Even with these deficits, the model provides for a comprehensive restructuring of the way the clients think about themselves in particular and other people, at least to the extent of the clinical staff.

If one examines the functional distortions outlined in this material, we would obtain a list something like the following:

- suicide attempts

- suicidal ideation
- parasuicidal behavior [self mutilation]
- urges to self harm
- avoidance of confrontation of problems: resulting in confrontations of counselors, failure to complete homework, and/or dropping out of the service
- sadness
- anxiety
- invalidation [nonpersonhood] - identifiable sense that perceptions and emotions are not appropriate; impaired judgement in many areas; emotional inhibition; and self-invalidation
- rigid thoughts, feelings and behaviors - escalated in intense situations
- ambivalence to change
- lack of connectedness
- blaming others
- shame and/or anger for failure to meet goals
- inhibited grieving
- active passivity - finding others to solve your problems
- extreme mood dependence
- lack of interpersonal skills
- lack of emotional modulation
- lack of distress tolerance
- lack of problem solving skills
- frequent psychiatric hospital admissions

This list of characteristics is obviously not limited only to people identified as having personality disorders. Many children with serious and persistent problems in living could benefit from this structure, focus and range of interventions. If we add imagery into the individual and perhaps groups session and a component of work with adults in the ecosystem, this appears to be an ideal arrangement to provide a cognitive restructuring process.

We include for your consideration, some tools from Joseph Santoro's book, *The Angry Heart*. These include the CBT#38-001 ***The Angry Heart Compass***, CBT#38-002 ***The Psychotraumatic Exposure Scale*** and CBT#38-003 ***Positive Attribution Practice***. Since these were developed for use with adults, it is not clear just what adjustments might need to be made for use with adolescents. However, we believe that they might be useful, and would also recommend a review of the book as a support to the Dialectic Behavior Counseling approach, particularly in the helpful exercises developed by Ronald Cohen.

Since Dialectic Behavioral Counseling is primarily defined by its structure and philosophy, it is useful to consider the list of techniques and procedures that

can be used effectively within that context. We have indicated a desire that image techniques, schema focused counseling techniques and the practices indicated in Santoro's book seem to be a good match and are worth pursuit.

CBT#38-001

Free Zone

Early Stage

- able to openly talk about past pain with loved one
- able to hold on to close relationships
- able to hold steady employment
- able to tolerate stress without resorting to addictive activities
- comfortable being affectionate toward a loved one

Recovery Zone

Early Stage

- able to write about pain
- able to cut short temper outbursts
- able to slow stress-accelerated mind
- able to accept your defects without anger

Borderline Zone

Early Stage

- addictive activities used [drugs, sex, cutting, etc.]
- poor control over your temper
- bouts of depression
- suicidal thinking or actions
- angry, rebellious, inconsistent

The Angry Heart Compass

Score/10

Late Stage

- word and actions are more consistent
- you know what you want from life
- you can love another without fear
- able to laugh about the past
- you feel optimistic about the future and you are more at peace with the past

Score/10

Late Stage

- able to tolerate feedback without anger
- able to show others appreciation for help given
- willing to follow the advice of a mentor
- able to accept the help of a counselor

Score/10

Late Stage

- moods change a lot and you feel bad
- stormy relationships
- feel as if you can't trust anyone
- feel as if you don't know who you are
- racing thoughts, impulsive actions

Your Location: Free Zone Recovery Zone Borderline Zone

This tool was designed to measure the degree of active involvement in disabling behaviors that an individual is manifesting at the point of beginning the counseling [or in the case of Santoro's book - self help], and as a benchmark test along the way. The three zones are indicative of the level of functioning at the moment, and one would hope that an adolescent who is operating in the borderline zone is able to demonstrate trends toward recovery and finally to become free of the problematic thoughts and behaviors.

Instructions

Ask the client to check off in each box the items that describe his/her current behavior and feelings. To score, simply add up the numbers in each box for each section and place the total next to the Score/10.

If the highest score is in the Borderline Zone and it is at least 4 out of 10, this is indication of the need for continued intensive services. If the score in the other zones is 0 to 1, that is to be expected at this point and supports the need to commit to services. Obviously, if the Borderline score is less than 2 and the Free score is more than 4, this would indicate that the client is showing real improvement.

CBT#38-002		Psychotraumatic Exposure Scale		
Level	Psychotraumatic Event	Yes?	Months	Score
V	Sexual and physical abuse (from parent, peer, sibling, other)			X1 =
	Sexual abuse only (from parent, peer, sibling, other)			X1 =
IV	Physical abuse only (from parent, peer, sibling, other)			x.8 =
	Viewed physical or sexual abuse between parents			x.8 =
	Viewed severe physical or sexual violence to others			x.8 =
III	Parents were addicted to alcohol, drugs, gambling, sex			x.8 =
	Parent, peer, sibling or other verbally belittled you on a regular basis			x.6 =
	Parents emotionally manipulated on near daily basis			x.6 =
	Viewed severe, near daily verbal fights between parents			x.6 =
	Both parents resented your birth/adoption and having to care for you			x.6 =
	Parent went through a bitter, harsh divorce			x.6 =
	Either parent resented your birth/adoption and having to care for you			x.6 =
	You lived in more than eight places by age seventeen			x.6 =
	Same sex parent avoided close relationship with you			x.5 =
	Any parent aloof, disinterested, unaffectionate toward you			x.5 =
I	Any parent controlling, demanding, unaffectionate toward you			x.5 =
	Parents divorced before you were twelve (not bitter/harsh)			x.4 =
	Severe family financial problems (couldn't meet bill payments)			x.4 =
0	Very little hugging, kissing, or other types of healthy physical affection in the family			x.4 =
	None of the above applies to you in any way			0
	Weighted Number of Years of Exposure			

Instructions

1. Think back and try to remember the first memories of when you started school, when you played with your mother, father or stepparent; how you were disciplined; what you were praised for; when your caregivers were proud of you and so forth. Under the 'Yes' column, check off each psychotraumatic event that you experienced prior to eighteen or until now.
2. Then for each item checked in the 'Yes' column, record the number of months under the 'Month' column you think you were exposed to the psychotrauma you checked off. You probably will not be able to accurately recall how many months so you will need to estimate. Try to underestimate your exposure. DO NOT overestimate.
3. Starting with Level V, multiply by 1 - then record this number in the 'Score' Column.

Then do the same in all of the 'Score' column, e.g., Level III would be the number of months [25] times .6 or 15.

4. Add the total number of scores in the 'Score' column and divide by 12 to get the final score. This is the number of ***psychological years*** you were exposed to psychotraumatic stress.
5. Take the age of the client at the time of the completion and divide it into the number of psychological years to get a sense of the percentage of his/her life in such exposure. [NOTE: it is possible to have a percentage higher than 100% since many of the variables can be overlapping.]

The score can be considered a rough estimate of the amount of psychotrauma the client absorbed as a child. Since it is not a standardized score, it does not give a relative measure against other people.

CBT#38-003 Practice

Positive

Affirmation

Change requires a commitment before it can happen - a commitment forged by the mind and heart. A mind that says with an angry heart "I can't change, the world must change instead!" is closed to change. The world never changes for anyone. It is your responsibility to adapt your behavior to the world. You can protest all you like about this. Your rage changes nothing and you'll remain unhappy about your life.

Joseph Santoro

Twice daily, once in the morning just after you wake up and once at night, sit down in a comfortable place where you will not be disturbed. Take several slow deep breaths - close your eyes and repeat each positive affirmation ten times.

- ***I am not to blame for being the way I was.***
- ***I am responsible for changing myself.***
- ***I want to change.***
- ***I feel better when I face my inner pain.***
- ***I can change. I will change. I will never, never, never, give up!***
- ***I am a good person and I will prevail.***

After you have repeated all of them, say to yourself, "***I believe in who I am and what I think***". Repeat this ten times and take several slow deep breaths.

You can also plan Positive Affirmation breaks throughout the day [e.g., at lunch time] to help focus on recovery.

For best results do this twice a day for at least six weeks.

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Dialectical Behavior Therapy

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