CHAPTER 4

SOLUTION ANALYSIS

DBT therapists conduct solution analyses to identify and implement the most effective CBT procedures to change the controlling variables identified through the BCA. The aim in DBT is not just to stop the target behavior and leave the client suffering, but to resolve the issues that contribute to the behavior and relieve the client's suffering as well. This chapter focuses on the general components of solution analyses and common problems in conducting them. Subsequent chapters focus on the application of specific CBT procedures.

SOLUTION ANALYSIS: GENERAL GUIDELINES

Conceptualization and Strategies

Include All Components of a Solution Analysis

Generally, therapists divide a solution analysis into three basic components: the generation, the evaluation, and the implementation of solutions. After selecting a specific link from the chain analysis, the therapist and client generate solutions for that link. The therapist and client may generate as many solutions as possible before evaluating them or evaluate the solutions as they arise. The procedure used will depend on whether interweaving evaluation disrupts solution generation or makes it more efficient. Following the evaluation, the solution is often implemented during the session, although trying the solution first can sometimes provide the best opportunity for evaluation. After the therapist and client have completed the analysis for one link in the chain, they then proceed to select another link. The degree of generation, evaluation,

and implementation for each link will vary, but all components should be included in the analysis as a whole. While utilizing the components of solution analyses as therapeutic strategies to treat a specific target, therapists also teach clients how to use these therapeutic strategies as skills to solve other problems themselves and thus reduce the need for prolonged psychotherapy.

Select a Controlling Variable to Resolve

To begin the solution analysis, the therapist and client select a link identified as a controlling variable in the BCA. Factors that influence the selection include how strongly the link appears to control the target behavior, the link's frequency in BCAs, the ease of treating the link, the link's connection to the client's goals, and the client's willingness to address that link (see Table 4.1). For example, a BCA from Anna (the depressed client from Chapter 1 with serotonin problems) identified biochemical changes, depressed mood, social withdrawal, self-invalidation, familial invalidation, shame, the availability of medication for an overdose, and inpatient staff validation all as contributors to her suicide attempt. The therapist wanted to focus first on removing access to sufficient medication for an overdose because this seemed the most critical controlling variable, but Anna adamantly refused to address this because having the medication "made her feel safe." Weighing the relative dangers of letting Anna keep lethal means versus losing Anna's in-session collaboration, the therapist agreed to focus on solving other links first, but added that if Anna persisted in misusing the medication (which she did), they would have to treat access to medication as well (which they did). The therapist then proceeded to the shame link, as the behavioral analysis suggested that the last suicide attempt functioned primarily to reduce shame; the client willingly agreed to focus on this link. They also decided to treat the closely related self-invalidating links because they occurred more frequently than many other links in this chain, as well as in other chains and during therapy sessions. Furthermore, Anna could implement the solutions for self-invalidating thoughts with relative ease. In contrast, Anna's history in other treatments revealed the substantial challenge of changing her depressed mood. Also, the depressed mood was not a good predictor of suicide attempts; though always depressed when attempting suicide, she spent even more time depressed and not attempting suicide. They therefore decided not to work initially on the depressed mood.

The number of links treated in a session will depend on several factors. With newer clients, solution analysis for a single link often

TABLE 4.1. Factors to Consider When Selecting a Link for Solution Analysis

- How strongly the link controls the target behavior.
- The link's frequency across multiple BCAs.
- The ease of treating the link.
- The link's connection to the client's goals.
- The client's willingness to address the link.

progresses slowly, as the therapist must spend more time teaching the client the basics of any new skill or CBT procedure and more time shaping the implementation of the solution. At any point in treatment, TIBs can slow a solution analysis. Some solutions inherently require a substantial time to implement, whereas others require a relatively brief time to implement once the client has learned the basics. For example, formal exposure might require a significant portion of the session, or even its own session. In contrast, changing body posture to change an in-session emotion requires very little time. Breathing exercises and progressive relaxation require only a few minutes. Once learned, mindfulness of judgments, interpretations, and other cognitions require only a minute or two, allowing therapists enough time to ask clients to practice mindfulness multiple times during a session if necessary. Contingency management for in-session TIB may occur almost instantaneously, whereas implementing a contingency management plan for other targets may require substantial planning.

Interweave the Solution Analysis into the BCA

Though the therapist and client can begin the solution analysis after completing the BCA, therapists usually try to interweave the solution and BCAs. Interweaving the two types of analysis has several advantages. It decreases the likelihood that the therapist spends too much time analyzing the causes of the target behavior and consequently fails to have any time for solutions. Clinical experience suggests that it also tends to help the client more quickly begin to identify the link as problematic. Finally, it seems to create a more automatic association between the problematic link and its possible solutions. To decide when to interweave solutions, therapists generally apply the same principles that they use to determine when to treat a controlling variable at all, as described above. In addition, therapists immediately treat variables in the BCA

when those variables arise in session during the analysis itself. For example, many clients relate a judgmental thought that occurred during a chain but describe it as a fact rather than as a judgmental thought. In such cases, therapists would weave in practice of noticing judgments, both to change the link in the chain and to block in-session rehearsal and possibly reinforcement of judgmental thinking.

Weave Orienting Strategies into the Solution Analysis

Therapists also interweave solution analyses with orienting strategies (Linehan, 1993a) whenever a solution involves learning about a new skill or a new CBT technique. In the context of the solution analysis, these strategies aim to enhance effective collaboration by teaching clients about the essential elements of any novel solution. Orienting strategies include clarifying the function of the solution, providing relevant theoretical information, specifying the required steps or tasks and highlighting possible temporary side effects. Therapists often use different orienting strategies for different components of the solution analysis. For example, in the case of exposure, a therapist might only orient the client to the function of exposure during solution generation and then review the course of the procedure during solution evaluation. Finally, in preparation for solution implementation, the therapist would clarify the steps or tasks of exposure and alert the client to the possibility of the emotion intensifying before it subsides.

Offer Clients Choices during the Solution Analysis

To enhance collaboration, therapists allow the client as much decision-making control as possible during the solution analysis. A recent review of the empirical literature (Leotti, Iyengar, & Ochsner, 2010) not only validates the "common knowledge" that humans prefer to perceive themselves as in control of a situation, but also presents evidence of an adaptive biological basis for valuing control and having choices. Other recent research (Leotti & Delgado, 2011) has revealed that simply anticipating an opportunity to have a choice increases the activity in areas of the brain associated with reward processing. In DBT, therapists offer clients the opportunity to select the controlling variable for analysis whenever possible. They also usually first ask clients to generate solutions before generating any themselves and allow clients to choose which solutions to implement. Of course, not doing a solution analysis at all is not an option on the menu.

An Illustration: Solution Analysis for Rita

Rita's solution analysis for the target of threatening, in Box 4.1, illustrates a number of these principles. Even before beginning the BCA, the therapist thought of repair as a contingency management solution for the threatening behavior, but she also thought that Rita would remain more collaborative if they first addressed the variables related to the function of the threatening. They started the BCA with a brief summary of the vulnerabilities and then proceeded through the details of the chain. When Rita rated anxiety at "3 out of 5," her therapist replied with "This sounds important. I have a couple of solutions, but they're a bit complex. Shall we continue with the chain now and watch for simpler solutions and then return to the anxiety?" Rita readily agreed.

At the first assumption ("He thinks I'm getting worse, that I don't deserve to be here"), the therapist highlighted it and suggested practicing mindfulness, as she thought that this skill needed substantial strengthening and that they could practice it quickly. Rita objected, declaring, "Everything is about skills. I've had enough of skills." The therapist responded by saying, "Well, we can troubleshoot 'having enough,' or we can do cognitive restructuring, or we can return to the anxiety and do something called 'exposure,' which is difficult but very effective." Rita chose cognitive restructuring and successfully implemented examining the evidence, which the therapist reinforced with her knowledge of the psychiatrist's intentions. For the first thought about others not understanding, Rita initially chose examining the evidence again, but when the implementation seemed more complex than expected, the therapist offered the choice of generating alternative interpretations instead or proceeding to the next link. Rita chose to proceed with the BCA.

The therapist had to inhibit her own urge to plunge in with the emotion regulation skill of "opposite action" when Rita identified anger as a link. In an earlier, similar analysis, the therapist had generated a number of solutions for anger and its related links, but later learned that the anger had occurred as a secondary emotion that functioned to distract Rita from anxiety. Treating the anger rather than the anxiety had proven an inefficient use of time. The therapist thought that anger served the same function in this chain and so continued the BCA without generating more solutions until the target behavior. She again considered repair as a contingency management strategy, but decided to postpone this solution. When the therapist learned that the psychiatrist's response dramatically decreased Rita's anxiety, she thought about trying to implement extinction, but quickly decided that this solution would

Box 4.1. Solution Analysis for Rita's Threatening

Links	Generated solutions
Psychiatrist says, "I notice that you have self-harmed three times recently on the unit. I'm wondering how you feel things are going here?"	
Anxiety (3/5).	**Exposure.**
Urge to leave (3/5).	
Thinks, "He thinks I'm getting worse, that I don't deserve to be here."	Mindfulness, **examining the evidence**.
Anxiety increases (5/5).	**Exposure.**
Thinks, "I'm working as hard as I can."	
Thinks, "They don't understand how hard I'm working."	**Examining the evidence**, generating alternative interpretations.
Thinks, "People never understand me."	**Dialectical thinking.**
Thinks, "My team should understand me."	
Anger (3/5).	
Says, "I'm working as hard as I can, but nobody understands me. Everyone just keeps pushing and pushing."	"DEAR MAN GIVE FAST" skills.
Anger (4/5).	
Psychiatrist says, "I'm sure people do realize that it's difficult."	
Anger (5/5).	
Says, "No they don't. My therapist just keeps telling me to stop harming and to use skills, skills, skills. What the f**k does she know?"	"DEAR MAN GIVE FAST" skills.
Says, "I'm going to complain about her bullying me. You all bully me. I'll complain to the hospital managers about the lot of you."	**Repair**, "**DEAR MAN GIVE FAST"** skills.
Anxiety decreases (4/5).	
Psychiatrist says, "This is obviously all a bit difficult for you today. Maybe we should end now," and then ends the meeting.	Extinguish threatening by no longer ending the meeting (and related anxiety) as a consequence of threatening.
Anxiety decreases (2/5).	
Nurse offers her an as-needed medication and a warm drink.	

(*continued*)

Box 4.1. (*continued*)

Nurse tells her that the psychiatrist is "very concerned" about her and asks if she understands the complaints procedure.	Extinguish threatening by no longer responding to it with validation that reduces anxiety or anger.
Thinks, "They understand how difficult it is for me now."	
Anxiety decreases (0/5).	
Anger decreases (0/5).	

Note. **Bold font = solutions implemented;** standard font = solutions generated only.

require a significant investment for an uncertain return. She had the same thoughts about the nurse's intervention.

With a clearer understanding of the function of Rita's behavior at this point, the therapist offered Rita help to address her anxiety or to use interpersonal effectiveness skills to achieve her goal of obtaining validation from the psychiatrist about her distress and her difficulties. Rita still disliked the idea of skills, though connecting them to her goals did interest her. She decided to address the original anxiety, focusing particularly on reducing the unwarranted portion of her anxiety. The therapist began by saying, "I would have suggested acting opposite, but if you don't want more skills, we can apply a procedure called exposure instead," and she then oriented Rita to the procedure. When Rita rejected exposure because it would initially increase her anxiety, her therapist connected the solution to Rita's long-term goals and guided her through an objective evaluation of the solution. With Rita's agreement, they implemented the solution. Finally, the therapist returned to the contingency of a repair and helped Rita to apply her interpersonal skills to write an apology.

Common Problems with Solution Analysis in General

As with conducting BCAs, conceptual and strategic problems commonly occur when therapists analyze solutions. Although many of these problems relate to a specific component of solution analyses, some problems relate to solution analyses more generally. These problems include failing to conduct a solution analysis, conducting an overgeneralized analysis, and focusing the solution analysis on a less causal portion of the BCA. They also include not interweaving the solution analysis with the BCA, not providing sufficient orientation to solutions, and not connecting the analysis to the client's goals.

Failing to Conduct a Solution Analysis

The biggest problem, particularly common among novice therapists, is failing to include any solution analysis at all. This problem occurs for several reasons. Therapists with a background in insight therapies may become absorbed in the BCA instead of pursuing the solution analysis. DBT, however, does not propose that insight functions as the primary mechanism of change. Some therapists aim to complete a perfect chain analysis or find *the* key controlling variable (both impossible) before pursing the solution analysis. Successful problem solving in DBT requires that the therapist remember that the chain analysis serves the solution analysis, and not the other way around. If the therapist knows the function of the behavior and the link most closely related to the function, the therapist has enough links to begin a solution analysis. Sometimes, time seems simply to slip away. If this problem occurs regularly, external prompts can help. For example, therapists might set an alarm to buzz midway through the session as a prompt to do at least some solution analysis before returning to the chain analysis. Therapists with no or little CBT experience often prolong the chain analysis to avoid the solution analysis because they do not know which solutions to generate or how to implement the solutions. Similarly, these therapists often fear how the clients will react to the solution analysis. The consultation team can help significantly with this problem. For example, one therapist admitted to her team that she avoided the solution analysis because she often had the experience of "running out" of solutions. To address this issue, the team first reviewed the principles of solution generation (covered later in this chapter) and provided the therapist with several models of comprehensive solution analyses. They also assigned relevant homework, namely, that the therapist practice generating as many solutions as possible for a set of BCAs that they had given her. Next, they shaped her new solution generation and continued with similar assignments until the therapist no longer struggled to generate solutions during sessions.

Generating Solutions Only at a General Level

Some therapists produce only a general set of solutions, a set that focuses on the BCA as a whole rather than on specific links. In these circumstances, therapists have usually completed the BCA and then begun the "solution analysis" with a global question such as "What could you have done differently?" rather than questions such as "Which link would be the most useful to work on first?" or suggesting a link to begin the analysis. These global sets of solutions fail to benefit from the analytical

aspect of problem solving, which identifies particular variables as having more of a controlling or mediating impact. The global approach therefore risks wasting time on less important links. General solution generation also increases the likelihood of producing solutions that do not fit links in the chain. For example, one therapist had correctly identified all of the cognitive links during the BCA, but rather than analyze appropriate solutions, she globally suggested mindfulness and cognitive restructuring for all of the cognitions. In reviewing her solution analysis, the consultation team highlighted several cognitions, particularly judgmental thoughts, for which DBT would not suggest cognitive restructuring. Another therapist recommended mindfulness and acting opposite as global solutions for the client's emotions and failed to evaluate the appropriateness of these solutions for each emotional link. The consultation team, however, highlighted that the circumstances warranted one of the emotional responses and that stimulus control would likely prove more effective, as well as more validating to the client.

Focusing Analysis on Distal Variables

Other therapists tend to focus their solution analysis on a behavioral chain's more distal variables that have a relatively weak causal connection to the target behavior. This problem often occurs when therapists overly emphasize the vulnerability factors during the BCA, as discussed in Chapter 3. The problem can also occur when therapists complete the BCA and then arbitrarily start the solution analysis with the beginning of the chain rather than first analyzing which variables have the strongest causal relationship to the target behavior. Consultation teams can help to address these two reasons by reviewing solution analyses and reminding therapists to start these analyses with the links that have the strongest causal relationship to the target. Trying to interweave solutions can also lead to this problem if the therapist begins the BCA with the prompting event and works forward chronologically. In this case, the problem usually does not result from a conceptual error but from simply not having enough time to complete the BCA while interweaving solutions from beginning to end. Therapists can reduce the likelihood of this problem occurring by starting the BCA closer to the target behavior and then working back toward the prompting event. Alternatively, the therapist could continue to work forward with the BCA, but become more selective about when to interweave solutions. This often happens naturally, as multiple analyses with a client allows the therapist to recognize when interweaving solutions will prove most efficient.

Not Interweaving Solutions into the BCA

Many therapists struggle to interweave the solution analysis with the BCA. Novice therapists particularly experience the interweaving of the two tasks as overwhelming. Though the literature on learning new skills would validate any decision to separate the two analytical tasks at first, therapists need not wait until they have mastered each task before beginning to combine them. Therapists often benefit from initially trying to interweave only a few types of solutions, such as those solutions that they know best. Some therapists decide to focus first on solutions that seem to have the most immediate impact on clients or that they can implement most easily or quickly. For example, regulating breathing and changing body posture has an immediate impact on many clients, and most therapists elicit these skills from clients with relative speed and ease. Many therapists focus initially on weaving in mindfulness because, with a little more practice, it too can require little time to implement but have an immediate impact.

Failing to Orient Clients to Solutions

Some problems that occur during solution analyses result from not including sufficient orientation to the solutions. For example, many therapists have assumed that their clients have had sufficient orientation to mindfulness because their clients attended the relevant skills training groups. During solution evaluation, however, many clients reject mindfulness as a solution due to a problem with orientation to the skill. Some clients have experienced mindfulness as ineffective because they have misunderstood the function of mindfulness and expect it to function as an emotion regulation skill or a "thought-stopping" technique, and thus they reject the skill when it does not meet their inaccurate expectations. Other clients have believed that they cannot succeed at mindfulness because they have noticed becoming distracted when trying mindfulness, and they have assumed that this indicates failure rather than realizing that this indicates success at noticing distraction. During solution implementation to exposure, therapists sometimes fail to orient to, and consequently prepare for, the likelihood that the intensity of clients' emotions temporarily will increase further. This failure of orientation decreases the likelihood that clients will tolerate the increased emotional intensity. If therapists omit orientation only occasionally, they can correct the omission as it occurs. If the problem occurs regularly, however, therapists may benefit from reviewing the orientation points for each type of solution and role-playing orientation with the consultation team.

Failing to Link Solutions to Client Goals

Finally, conflict between a therapist and client frequently arises if the therapist pursues some aspect of the solution analysis that distresses the client without sufficiently establishing a connection between that aspect of the analysis and the client's goals. For example, early in treatment with Amanda, an outpatient, her therapist tried to focus the solution analysis on Amanda's judgmental thoughts. Amanda, however, refused to generate any solutions because she viewed these thoughts as a fundamental part of her personality that she did not want to change. The therapist then realized that he had failed to connect changing the judgmental thoughts with either Amanda's immediate goal of reducing her self-harm urges (the target of the analysis) or her longer-term goal of establishing lasting relationships. After he highlighted how the judgmental thoughts related to these goals, Amanda's willingness to address the judgmental thoughts notably increased. To further enhance Amanda's willingness to treat the judgmental thoughts, the therapist then attended to her thoughts about changing her personality.

SOLUTION GENERATION

Conceptualization and Strategies

Having selected a controlling variable for treatment, the therapist and client begin the process of generating solutions. The therapist and client generate as many solutions as possible from the full range of CBT procedures that match the controlling variables and the context in which they occur. Within the analysis as a whole and frequently for a single link, therapists attend to balancing acceptance and change solutions. Often therapists must treat clients' difficulties with solution generation itself. Key points in solution generation are listed in Table 4.2.

Match the Solution to the Type of Link and the Context

Matching controlling variables with their respective solutions first assumes, of course, that the therapist and client have correctly differentiated and labeled affect, cognitions, and impulses. DBT solution generation also requires therapists to apply behavioral theory to determine which type of CBT procedure or other solution best matches the selected controlling variable. The standard CBT procedures used in DBT include skills training, stimulus control, exposure, cognitive restructuring, and contingency management. If the selected link in the chain occurs because

TABLE 4.2. Key Points in Solution Generation

- Match solutions to links.
  - Match type of CBT procedure(s) to type of link.
  - Match solution to intensity of link.
  - Match solution to environmental context for use.
- Generate specific, rather than general, skills and other CBT procedures.
- Generate multiple solutions for a single link when possible.
- Balance change and acceptance solutions within an analysis.
- Include a range of skills and other CBT procedures across solution analyses.

the client lacks the skills to respond more effectively, the therapist teaches the required skills. If the client has the required skills but does not use them because of motivational issues, the therapist considers other CBT solutions. For example, when external or internal stimuli motivate problematic behavior or inhibit skillful behavior, the therapist could suggest stimulus control. If a stimulus elicits an unwarranted emotion that then motivates a target behavior or inhibits skills use, the therapist could apply exposure procedures. For faulty cognitions, the therapist could use cognitive modification. If the environment has either punished or not reinforced skillful behavior or has reinforced problematic behavior, then the therapist could consider contingency management procedures.

After choosing the general type of CBT procedure, therapists and clients select more specific techniques within the general procedure. For example, Rita's solution analysis in Box 4.1 specifies examining evidence rather than the broad category of cognitive restructuring, "DEAR MAN GIVE FAST" skills rather than interpersonal effectiveness skills, and extinction rather than contingency management (see Linehan, 2014, for details of the acronym). This refinement often continues throughout the analysis. Selecting the best matching solutions requires that the therapist have a thorough understanding of the function of each specific CBT procedure, including each skill.

A successful analysis also requires therapists to generate solutions appropriate to the contexts in which clients will apply the solutions. Contextual factors include internal and external factors. For example, a client might need to use different interpersonal skills depending on whether he or she is speaking with family members, a physician, or a drug dealer. Mindfulness and emotion regulation techniques that work at home may not work while driving or dining in a restaurant. Clients usually need different emotion regulation skills when they have high

emotional intensity compared with low intensity. Though selecting from such a relatively broad spectrum of procedures to find the best match for the diverse causes and contexts of target behaviors makes the therapy more difficult to learn, considering multiple problem-solving options is consistent with research indicating that individuals who flexibly use different types of solutions in different situations both cope better in specific stressful situations and have better general mental health (see Kashdan & Rottenberg, 2010, for a review).

Combine Different Solutions for the Same Link

Many links warrant a combination of different types of solutions. For example, when Anna and her therapist addressed the shame elicited by her family's criticism, they decided that the facts did not justify shame because Anna had not done anything "wrong." For this unjustified shame, they generated the skill of acting opposite and exposure as solutions. When they generated solutions for Anna's self-invalidating thoughts, they included mindfulness skills (e.g., mindfully labeling the thought, describing the facts) and cognitive restructuring (e.g, examining evidence for the thoughts, increasing validating thoughts). Of course, the delineation between what constitutes a skill versus another CBT procedure differs according to theoretical perspective. For example, from a skills training perspective, much of cognitive restructuring involves teaching clients cognitive skills, whereas a cognitive therapist might consider the mindfulness skills as a particular type of cognitive modification. The emotion regulation skill of "acting opposite" closely resembles key elements of exposure. DBT therapists do not try to resolve these theoretical debates and instead concern themselves with how each theory and its techniques can help to solve part of the clinical puzzle.

Balance Acceptance and Change Solutions

When conducting the solution analysis, therapists attempt to generate a dialectical set of solutions that balance acceptance and change. The combination of mindfulness as an acceptance skill and cognitive restructuring as a change procedure for Anna's self-invalidating thoughts exemplifies such a dialectical balance. Emma, an inpatient, assumed that the other female patients in her skills training group disliked her because they knew about her extramarital affairs. The thought elicited shame during the group, which then caused the patient to miss group. Like

Anna's therapist, Emma's therapist suggested the dialectical pairing of cognitive restructuring and mindfulness for the problematic cognition. The cognitive restructuring included examining the evidence for Emma's assumption and challenging her catastrophic thinking. Mindfulness included identifying the thought as a thought and instead focusing on the task at hand (i.e., either preparing for, going to, or participating in group). Implementation of these solutions revealed that examining the evidence worked well when Emma had no evidence (most clients did not dislike her), but that the mindfulness worked better when she did have evidence. Challenging the catastrophic thinking did not help either way. Emma also experienced intense guilt about her affairs because of the impact that they had on her husband. She had repeatedly attempted suicide to stop the guilt.

The emphasis on considering both acceptance and change-based solutions may prove particularly important when treating emotional links. Research (Bonanno, Papa, Lalande, Westphal, & Coifman, 2004; Westphal, Seivert, & Bonanno, 2010) has indicated that individuals who flexibly choose between enhancing versus suppressing emotional expression based on the situation have better long-term adjustment. In contrast to Anna's unjustified shame, the facts did justify a substantial portion of Emma's guilt, as her behavior had harmed her husband psychologically and professionally. For the warranted guilt, Emma and her therapist generated solutions to increase the acceptance of the emotion (e.g., mindfully allowing the emotion, radically and willingly accepting it as a consequence of her past behaviors) and to repair the damage to her husband (e.g., becoming more validating toward him, helping him with his work during home visits). Emma also experienced guilt about her husband in situations that did not warrant it. During a home visit, for example, Emma had experienced justified guilt earlier in the evening, but later at night she remained awake staring at her peacefully sleeping husband and ruminating on the impact of her affairs until she felt so guilty that she harmed herself. As the cue (a peacefully sleeping husband) did not justify the emotional response, Emma and her therapist emphasized solutions designed to change the emotion. For the guilt at this point in the chain, they combined stimulus control and exposure. Stimulus control (i.e., shifting the client's attention away from her husband) provided a short-term solution to prevent self-harm, but it did not change the classically conditioned relationship between the husband's presence and guilt. Exposure did change the conditioned relationship, but it required a longer time to implement.

Treat Clients' Solution-Generation Difficulties

Many clients with BPD struggle with generating solutions. As a result of growing up in invalidating environments, some clients never received adequate modeling of how to generate solutions. Other clients have acquired the basics of solution generation but the behavior remains weak or inhibited because in the past their solutions have failed or have been punished by others. For example, when Joanne, an unemployed client who had just turned 20, suggested higher education as a way to improve her quality of life, her uneducated parents responded by asking "Who do you think you are? Do you think that you are better than us?" Thus, clients' difficulties with solution generation can result from either skills deficits or motivational issues. Clients who lack the relevant skills may benefit from some basic teaching on how to generate solutions (e.g., learning where to look for ideas). Therapists address motivational issues with the corresponding strategies. For example, the client described above inhibited solution generation in the session because she feared that her therapist would invalidate her as well. Because the fear was unwarranted in the context of therapy (i.e., the therapist would not invalidate her), the therapist used exposure, asking the client to continue generating solutions, including unrealistic ones, until the fear subsided. To shape solution generation more generally, therapists reinforce any reasonable attempt by clients to generate solutions and encourage clients to generate as many solutions as possible before evaluating them.

Two Illustrations: Solution Analyses for Jane and Susan

Jane's case exemplifies several principles of solution generation. Box 4.2 illustrates a summary of Jane's solutions generated across multiple BCAs of the target behavior. Jane and her therapist generated specific solutions (e.g., be nonjudgmental, opposite action, examining evidence), indicated by boldface, during the course of the BCA summarized in Box 4.2. During subsequent, but similar BCAs of vomiting, Jane and her therapist generated the solutions in regular text. Compared with Rita, Jane had a longer session and she had learned (but not generalized) a number of solutions through previously targeting suicidal behaviors. Consequently, Jane and her therapist had more time to generate more solutions during her initial solution analysis for vomiting, although they did not implement all of the solutions during the session. Although the initial solution analysis did not contain the full range of CBT interventions (it lacked exposure), the summary of all solution analyses for vomiting did include the full range. During the initial analysis, Jane and her therapist did

Box 4.2. Solution Analysis for Jane's Vomiting

Links	Generated solutions
Poor sleep.	
Argument with mother.	Many interpersonal effectiveness skills.
Rumination.	Mindfulness of present moment.
Guilt.	Repair.
Views television program about dieting.	**Remove stimulus.**
Anxiety (2/5).	
Scans body.	Urge surfing.
Views advertisement on television.	
Urge to check whether jeans fit.	**Urge surfing.**
Tries on jeans.	Remove stimulus.
Feel and sight of jeans not fitting.	
Fear (3/5).	Exposure, opposite action.
Feels queasy.	
Thinks, "It's no good; I'll always be fat."	**Mindfulness**, examining the evidence.
Looks at herself in the mirror, scanning for evidence of "fat places."	Urge surfing, reorient attention.
Repeatedly labels "fat" areas.	Be nonjudgmental.
Fear increases (4/5).	**TIP skills for physiology**, opposite action.
Thinks, "I'm always going to be fat."	**Mindfulness**, examining the evidence.
Thinks, "I have no control."	**Build mastery**, examining the evidence, dialectical thinking.
Shame (3/5).	
Thinks, "Mom's right. I'm selfish, hopeless, and too focused on myself."	Be nonjudgmental.
Guilt (3/5).	**Repair,** radical acceptance.
Sits on bed with head in her hands.	**Opposite action.**
Notices her stomach "spilling out" of the jeans.	
Thinks, "See that just proves I'm out of control. Look at me. Mom was right."	Mindfulness, examining the evidence.
Shame increases (4/5).	**Opposite action.**
"Replays" the previous days argument with her mother.	**Focus on present task of implementing repair.**
Thinks, "How can I be so critical of Mom? She just tries to help me."	

(*continued*)

Box 4.2. (*continued*)

Guilt (4/5).	Repair, opposite action.
Thinks, "I owe her everything."	Dialectical thinking.
Thinks, "Just think of all the trouble I've caused."	**Focus on present task of implementing repair,** radical acceptance.
Ruminates about past events.	**Focus on present.**
Thinks, "John [her brother] left because of me. He blames me for mom being so upset."	Radical acceptance, focus on present moment.
Guilt increases (5/5).	**TIP skills, opposite action.**
Thinks, "I have an unpayable debt to Mom. There's nothing I can do."	Dialectical thinking.
Thinks, "I should be punished for what I've done."	Be nonjudgmental.
Urge to vomit (4/5).	**Urge surfing**, **phone therapist**, review negative consequences.
Goes to the bathroom to vomit.	**Walk away from bathroom.**
Vomits spontaneously at the sight of the toilet.	
Fear decreases (3/5).	
Queasiness decreases.	
Thinks, "Now I'm in control."	**Extinguish overdosing by restructuring belief about being in control that subsequently decreases shame.**
Shame decreases (3/5).	
Thinks, "It's not enough."	
Puts fingers down her throat and vomits twice.	Opposite action.
Feels tired.	
Fear decreases (1/5), shame decreases (1/5).	
Thinks, "This is the punishment I deserve."	**Extinguish overdosing by restructuring belief that punishment has occurred and justifies decreased guilt.**
Guilt decreases (1/5).	
Returns to the bedroom and goes to sleep.	

Note. **Bold font = specific solutions generated in initial analysis;** standard font = solutions generated in subsequent analyses of similar episodes.

succeed, however, in producing a dialectical set of solutions, including radical acceptance and mindfulness-based solutions on the acceptance side and emotion regulation-based solutions, challenging cognitions, and extinction on the other.

The selection of links for solution generation, and the generated solutions, depended on many of the factors described in the introduction to solution analysis. In the initial analysis, Jane and her therapist focused on links in the chain rather than vulnerability factors, as the former had a clearer causal relationship to the vomiting. The therapist further focused her initial solution generation on solutions that had a likelihood of being relatively easy or effective for Jane. Both the client's existing capabilities and the time required for implementation affected the therapist's assessment of ease. Jane often experienced mindfulness as easier than cognitive restructuring, so her therapist suggested mindfulness more in the initial analysis. Because exposure would have required more time than changing physiology and opposite action, the therapist waited until subsequent analyses to suggest exposure. Jane's history of success with solutions, both prior to and during the session, and the intensity of her emotions and urges in the BCA influenced the therapist's assessment of probable effectiveness. Previous BCAs of other targets had revealed that Jane struggled to use mindfulness more whenever she thought "Mom's right," so neither Jane nor her therapist suggested mindfulness for such links in the initial analysis. Within the session itself, the therapist suggested urge surfing for the urge to try on the jeans, but Jane anticipated that she would struggle to implement this solution, so the therapist did not suggest it for the scanning urge. They did return to the solution, however, for the vomiting urges because these urges so strongly controlled the target behavior that the therapist thought that they needed a solution for that link. Finally, the intensity of Jane's emotions and urges influenced the solutions generated for a particular link. In general, the therapist emphasized solutions requiring cognitive capacity (e.g., mindfulness, radical acceptance) when the emotions remained lower and emphasized changing physiological arousal more when the emotions had escalated. She did not generate dialectical thinking as a solution in the initial analysis because the links for which it could have proved helpful all occurred during times of high emotional intensity when Jane would have had great difficulty implementing the solution.

Susan's case also demonstrates solution-generation principles. Box 4.3 shows a summary of the solutions generated across multiple BCAs of suicidal behaviors involving infidelity. Susan had familiarity with some of the solutions from previous BCAs of suicidal behaviors prompted by

other events. She and her therapist generated the solutions in boldface during the initial solution analysis for the overdose involving infidelity and the other solutions during subsequent, but similar BCAs. The solutions in bold from the initial analysis illustrate how a single solution analysis can contain a range of solutions; Susan's analysis includes all types of CBT solutions except exposure. Furthermore, the analysis refines the solutions beyond their broad CBT category. For example, Susan's analysis specifies being nonjudgmental and urge surfing rather than mindfulness, radical acceptance and distraction rather than distress tolerance, and extinction rather than contingency management. The original solutions also demonstrate a dialectical balance that includes mindfulness and distress-tolerance skills on the acceptance side and emotion regulation skills, cognitive restructuring, and contingency management on the change side. During the initial analysis, Susan and her therapist did not generate solutions for the vulnerability factors, except for the link of agreeing to take the man home, which was a key controlling variable in the BCA. Like Jane's therapist, Susan's therapist generally emphasized fewer cognitive solutions at points of higher emotional intensity, but she made an exception for the "don't deserve to live" link because the urge to overdose followed immediately. Though she knew that the thought could have resulted from the guilt or fear with no causal relationship to the urge, she hypothesized that such a causal relationship had existed.

Common Problems in Solution Generation

Conceptual Errors

One set of common problems with solution analyses results from conceptual errors regarding solution generation. These errors can result in solutions that do not match the causal variables, oversimplify the complexity of the problem, or have insufficient specificity. As a group, these errors decrease the likelihood that clients will have sufficient solutions to achieve their goals, that their solutions will prove rewarding, and that they will persist with solution implementation. Reviews of solution analyses often provide an efficient means for consultation teams to identify and subsequently treat such errors.

MISMATCHING CONTROLLING VARIABLES, SOLUTIONS, AND CONTEXTS

A mismatch between a controlling variable and the solutions generated for it can occur if the therapist mislabels the controlling variable, does not attend to the emotional intensity or environmental context of the

Box 4.3. Solution Analysis for Susan's Overdose

Links	Generated solutions
Argument with her boyfriend.	Many interpersonal effectiveness skills.
Thinks relationship will end.	Mindfulness, examining the evidence.
Anxiety.	
Disagreement with individual therapist.	
Anger.	
Drinking.	
Agrees to take a male stranger home.	**Review negative consequences**, **say "No," stimulus control.**
Happy.	
Has sex with man at home.	Say "No."
Thinks, "I shouldn't have sex with someone else."	Letting go, radical acceptance.
Guilt (4/5).	**TIP skills to change physiology, reorient attention/distraction**, **repair.**
Urge to self-harm (3/5).	Urge surfing.
Thinks, "I'll feel better if I harm."	Review negative consequences.
Curls up in bed.	
Hears man move.	**Remove stimulus with "DEAR MAN" skills.**
Thinks, "I'm a cheat."	Radical acceptance.
Guilt increases (5/5), shame (5/5).	**TIP skills to change physiology, reorient attention/distraction, opposite action.**
Thinks, "I don't deserve him anyway."	Be nonjudgmental.
Thinks, "I don't even deserve to live."	**Be nonjudgmental.**
Urge to self-harm increases (4/5).	Review negative consequences.
Goes to the bathroom to overdose.	
Takes 30 antidepressant pills.	**Keep minimal pills** and list of negative consequences with pill bottle.
Guilt decreases (3/5), shame decreases (3/5).	
Man enters bathroom, appraises situation, calls paramedics, and leaves.	
Sensation of sickness and wooziness.	

(*continued*)

Box 4.3. (*continued*)

Paramedics arrive, administer treatment, and take her to the hospital.	
Assessed and admitted to the psychiatric ward.	
Thinks, "I deserve being stuck here as a punishment."	**Extinguish overdosing by restructuring belief that punishment has occurred and justifies decreased guilt.**
Guilt decreases (2/5).	
Boyfriend visits and tells her that he's learned the "whole story," but forgives her because she "must have been really sorry" if she "tried to kill" herself.	Extinguish overdosing by no longer responding to it with forgiveness that reduces guilt or shame or creates a sense of connection.
Guilt decreases (1/5), shame decreases (2/5).	
Experiences strong connection to boyfriend.	

Note. **Bold font = specific solutions generated in initial analysis**; standard font = solutions generated in subsequent analyses of similar episodes.

variable, or does not consider the CBT principles of when to use which type of solution. The section above on solution generation highlights the general principles of when to use which solutions. Even if a therapist correctly applies CBT principles to match solutions with controlling variables, however, a mismatch can occur if the therapist tries to generate solutions for a mislabeled controlling variable. For example, if the therapist just labels "feeling abandoned" as an emotion rather than differentiating the thought from the emotion, the therapist might fail to consider cognitive restructuring. The therapist might also generate emotion-based solutions that will not work because thoughts of abandonment can elicit a variety of emotions, each with its own specific solutions, and the therapist has not identified the specific emotion. Similarly, if a client says "I had an urge to hit him," the therapist might just label this as a thought and suggest only cognitive solutions, not realizing that the client used this statement to communicate an impulse or action urge. As impulses and cognitions arise from different parts of the brain, they often respond better to different solutions. Finally, a therapist might mislabel a valid

link as invalid, or vice versa. In Emma's case, her thoughts that the other female patients in her skills training group disliked her because of her extramarital affairs had little to no validity, so cognitive restructuring matched the problem. In another case, however, Jack, a patient in a long-term secure psychiatric unit, believed that all of the unit staff hated him and wanted him off of the unit. The belief frequently appeared as a link leading to suicidal and assaultive urges. Initially, Jack's therapist identified the belief as a cognitive distortion and consequently tried cognitive restructuring. This solution failed, however, as a review of the evidence revealed that about 80% of the staff disliked Jack and wanted him moved off of the unit because of his assaultive, threatening, and otherwise disruptive behaviors on the unit. Thus Jack's beliefs had significant validity. The therapist still wanted to decrease the ruminating because of the link to self-harm, but did not want to invalidate the valid and thus excluded traditional cognitive restructuring. The therapist began by accepting the valid aspects of Jack's thoughts, but then highlighted the ineffective consequences of ruminating, even on valid beliefs. With coaching, Jack learned to describe the thoughts and their consequences more mindfully and to refocus his attention on more effective ways of resolving his conflict with the staff.

Therapists can also generate inappropriate solutions if they fail to attend to the intensity of a controlling variable, particularly emotions. In their work on the tasks of emotion regulation, Gottman and Katz (1990) describe how the intensity of an emotion impacts the ability to accomplish the tasks of emotion regulation. As an emotion escalates, the ability to accomplish tasks with a more cognitive element diminishes. Individuals at the height of an emotion often first need solutions requiring few cognitive demands. For example, when Alexandra's boyfriend made invalidating comments, she always became angry and sometimes became violent. If she experienced moderate anger, she could inhibit any violent urges and reduce her anger by using a variety of stimulus control and emotion regulation skills, including modifying both the salience and the meaning of the stimulus (the invalidating statements), and replacing her own judgmental thoughts with validating thoughts, all of which required a notable amount of thinking. If she experienced extreme anger, however, she had to rely first on skills that directly decreased her physiological arousal (e.g., breathing and relaxation exercises, walking) and skills that removed or distracted her from the stimulus (e.g., leaving the house) to decrease her anger to a moderate level, at which point she could again use a variety of solutions.

Similarly, therapists can generate solutions that conceptually match

the controlling variables but mismatch the environmental contexts in which clients will use the solutions. For example, Harmon-Jones and Peterson (2009) reported that students in a supine body position had significantly lower neural responses to negative feedback about themselves and their performance compared with students in an upright position. Suggesting that a client lie down in order to decrease verbally aggressive urges may prove effective at home during a phone call with a family member, but could cause new problems if used at the office while receiving critical feedback from a boss. Many skills that orient clients away from the current context can have negative or even potentially catastrophic consequences in some situations. For example, focusing on breathing effectively reduces emotional arousal, and mindfulness "exercises" (as opposed to being mindful of the current context) effectively reduce judgmental thinking, but practicing these skills in the context of driving could endanger the client and others alike. In some instances, clients may be able to change the context in order to implement the solution (e.g., a driving client could leave the road temporarily), but solutions that work in the current context may prove more effective in the long term.

RESTRICTING THE RANGE OF SOLUTIONS

Just as the biosocial theory proposes that invalidating environments oversimplify the ease of problem solving in general and regulating emotions and impulses in particular, so too can individual therapists oversimplify the solutions required to change target behaviors by restricting the range of solutions. A restricted range of solutions occurs when therapists overrely on one type of solution or generate too few solutions altogether to successfully change the target behavior. Though effective solution generation in DBT does not require every type of CBT solution or a solution for every link in the chain and though some sessions may require more solution implementation and have less time for solution generation, effective *long-term* solution analysis does require that the therapy generate sufficient solutions to address the target behavior's primary function. A single solution seldom proves sufficient in the long term. For example, applying an aversive consequence alone may successfully suppress the behavior in a single context, but such solutions often do not generalize well to other contexts. Removing lethal means from a suicidal client removes the immediate risk, but it does nothing to address the function of the suicidal behavior. If the client does not acquire a solution that addresses the behavior's function as well, the client will likely acquire new lethal means instead.

Overrelying on one type of solution can occur when either the client offers the same default option repeatedly or the therapist suggests a limited set of solutions. Many clients consistently rely on crisis survival skills, particularly at the beginning of treatment. Most clients already know and use some of these skills, and many of these skills have a relative simplicity and immediate impact that makes them appropriate solutions for therapists struggling to coach new clients through crises. Unfortunately, most of the crisis survival skills provide only short-term relief, rather than long-term solutions, and thus, overreliance on these skills will interfere with therapeutic progress. They only help clients to survive crises and not to prevent or resolve crises. As soon as possible, DBT therapists balance these short-term skills with long-term solutions. Clients with BPD also have a tendency to generate solutions that require someone else, such as therapists, social services, or family members, to solve the problem rather than solving it themselves, a pattern that Linehan (1993a) refers to as active passivity. Though such an intervention by others may effectively solve the problem, solutions that rely on external intervention usually do not generalize as well because they require the continued availability and willingness of a third party. For example, Blanche, a psychiatric inpatient on a high-security unit, engaged in several TIBs (e.g., arriving late for therapy, not completing homework, and not implementing skills) that resulted partly from Blanche's "forgetting." Whenever her therapist asked what solutions Blanche could implement to decrease the "forgetting," Blanche always responded that staff could prompt her to engage in the relevant behaviors. Though a prompt from staff would have decreased the immediate instances of the TIB, allowing Blanche to rely on this solution alone would have reinforced her active passivity and would have prolonged her stay on this unit, as less secure units would not have had the resources to provide this level of intervention. In addition to Blanche's solution, her therapist included several solutions that required Blanche doing something different, such as creating visual prompts and alarm reminders. They also arranged some contingency management with the staff such that Blanche received more help from staff when she first actively implemented solutions herself rather than when she just passively waited for others to intervene.

Like clients, therapists sometimes develop an overreliance on certain types of solutions. In some cases, this overreliance occurs because therapists have not yet adequately learned the full range of DBT solutions. For example, a new individual therapist who has no CBT training but has experience coleading a DBT skills group might suggest only skills as solutions and thus treat clients' skills deficits but neglect their motivational

issues. A therapist with only cognitive therapy training might rely on cognitive restructuring and minimize skills training or totally neglect exposure or contingency management. Consultation teams can identify and treat such problems by reviewing therapists' solution analyses and then training (e.g., didactic teaching, modeling, role playing) therapists how to apply types of solutions that they have not previously learned. In other cases, overreliance results from therapists becoming especially attached to a type of solution and applying it as a panacea. For example, after learning mindfulness and experiencing the benefits for themselves as well as their clients, many therapists begin to generate mindfulness as a solution for almost every link. Though clients can apply mindfulness to almost any link, mindfulness alone does not change environments, interpersonal relationships, prompting events, and so on. Thus, relying on mindfulness (or any other solution) alone produces a nondialectical solution analysis. Though therapists can monitor and treat such attachments themselves, consultation teams may first notice such patterns and then analyze and treat them. In one case, a brief BCA revealed that the therapist had begun to rely on mindfulness in sessions because she had found mindfulness so helpful in her own life that she assumed that her clients would find it equally helpful. When the team challenged the assumption, the therapist realized that she had underestimated the extent to which she also used a variety of other psychological skills in her own life, but which her clients still lacked. In another case, a consultation team noticed that a therapist had begun to suggest mindfulness as almost the only solution. When simply describing the overreliance as a problem failed to stop the problem, the team conducted a more thorough analysis and discovered that the therapist enjoyed practicing this solution more than any other and that she focused on finding opportunities for it while generating solutions. The therapist agreed to a "ban" on using mindfulness as a solution until she had conducted a certain number of dialectical solution analyses that contained a variety of solutions. This intervention successfully inhibited the therapist from relying on mindfulness and motivated her to become more dialectical.

NOT SPECIFYING SOLUTIONS SUFFICIENTLY

Just as a professional golfer uses a specific club for a specific shot or a carpenter selects certain nails for certain jobs, DBT therapists suggest specific skills or other solutions. Problems often arise if therapists suggest vague solutions, such as an entire module of skills rather than one specific skill from the module. For example, some therapists have

simply suggested "emotion regulation skills" as a solution for emotional links in the BCA without proceeding to identify which specific emotion regulation skills will work best. Similarly, some therapists have tended to "challenge" clients' cognitions without clearly helping the client to identify which types of cognitive restructuring to use in which situations. In many cases, this lack of specificity decreases the likelihood that clients will effectively implement the solution during the session and later, either because they are confused by the vagueness of the solution, or because they select a more specific but less effective solution from the larger category. In one case, for example, the therapist simply suggested that the client challenge his cognitions. The client later tried to review the evidence for his beliefs but did not find this helpful because the evidence remained open to interpretation. Meanwhile, the therapist's consultation team had noted the vagueness in the therapist's solution generation and helped him to identify which types of cognitive restructuring to use in which contexts. The therapist then proposed "generating alternative interpretations" to the client, which the client found much more effective. Though in-session solution implementation will usually detect problems resulting from a lack of clarity, specificity during solution generation remains important as sessions seldom have sufficient time to implement all suggested solutions.

Clients' Challenging Responses

NOT TREATING CLIENTS' LACK OF SOLUTION GENERATION

Though therapists seldom have difficulty generating solutions when they conceptually understand the solutions, they frequently encounter challenges from clients when attempting to implement the strategy. They may first encounter challenges when asking clients to generate solutions. The most common problem that arises at this point is that clients respond with "I don't know" or something similar. Though an occasional "I don't know" may result from a client actually not knowing the answer, automatic or constant "I don't knows" usually function as an attempt to avoid solution generation or the subsequent implementation. If the client genuinely does not know, then the therapist should proceed to suggest solutions. Therapists sometimes make a strategic error at this point by pushing too hard or waiting too long for clients to generate solutions because the therapists believe that the solutions must originate from clients' insights. In DBT, however, the solution analysis relies less on clients' insights and more on clients' solution implementation. The source of the solution becomes secondary to having solutions. If the therapist

has previously taught the client solutions for a particular link, but the client cannot or does not try to remember them, then the therapist may prompt the client to review the diary card for solutions or develop some other type of prompt. For the client who cannot remember, this solution teaches the client a relevant skill; for the client who does not try to remember, this solution may help to manage any reinforcing contingencies. Similarly, if "I don't know" functions to minimize a client's problem-solving efforts, the therapist might implement contingencies that have the opposite effect. For example, one therapist oriented clients with this function to her policy that failing to generate solutions for an important link indicated to her that the relevant solutions remained weak in their repertoires and that they therefore needed more in-session practice of and homework for these solutions. This policy notably shifted the motivation to generate solutions during sessions for many clients; it also worked well for clients who genuinely did not know the relevant solutions by making those solutions more salient through practice. Frequently, clients do not generate any solutions because they fear that their solutions will seem foolish or that the therapist will judge them. Treatment in such cases can include teaching clients how to return mindfully to solution generation when distracted by solution evaluation; modeling irreverent, potentially foolish solutions (e.g., contacting the therapist with skywriting or singing telegrams if the phone fails); and establishing contingencies that reward clients for simply generating solutions.

MANAGING CLIENTS' PROBLEMATIC SOLUTION GENERATION

When clients do generate solutions, they sometimes suggest rather problematic solutions. They may suggest solutions that will probably not work well for the identified link, such as replacing negative judgments with positive judgments or using crisis survival skills when the situation requires emotion regulation skills. They may also suggest solutions that may cause new problems, such as asking for hospital admission any time they experience suicidal urges. Because therapists want to encourage rather than inhibit client solution generation, they often accept any reasonable option offered by the client during this step and add any more effective solutions themselves, waiting until the next step to evaluate the relative effectiveness of each solution. If a problematic pattern of poor solution generation emerges, however, the therapist may need to shape the behavior sooner rather than later. Occasionally, clients suggest using other target behaviors, such as abusing drugs instead of attempting suicide or using laxatives rather than vomiting. If this behavior appears

to function to derail the solution generation, therapists may effectively extinguish the behavior by responding matter-of-factly and continuing with the solution generation. For example, a therapist might respond by saying "Okay, that's one solution. What other solutions have you learned?" Often, however, clients intend nothing more than a bit of humor, in which case a reinforcing response may help the relationship and everyone's mood more than it will interfere with solution generation.

SOLUTION EVALUATION

Conceptualization and Strategies

After generating solutions for an identified controlling variable, therapists and clients proceed to evaluate the solutions for that variable. Although most individuals generally move rapidly between generating and evaluating solutions, problem-solving therapies distinguish between these two behaviors and often treat them as distinct steps to reduce the likelihood of one behavior impeding the other. Unmindfully or impulsively interjecting solution evaluation tends to inhibit solution generation in general and creativity in particular. Not all solutions, however, will prove equally viable. When clients try to implement inappropriate solutions, they fail to solve the current problem and risk having their solution generation and implementation behaviors extinguished or even punished. Thus, therapists teach clients how to evaluate solutions to maximize the likelihood that clients will successfully solve problems. Key components of solution evaluation include reviewing the probable outcomes of a solution to determine the solution's potential efficacy and assessing any factors that might interfere with the solution's implementation. Though discussions may suffice to determine a solution's efficacy or to identify factors that could decrease the effectiveness, an in-session implementation of the solution often allows therapists and clients to more accurately evaluate the solution.

Review the Solution's Probable Consequences

Therapists review the likely proximate and distal consequences of proposed solutions to determine the probability of those solutions successfully treating the relevant controlling variables and helping clients to achieve their goals. The evaluation considers the likelihood of a solution's success based on the conceptual match between the problem and the solution in a given context and on the client's personal experience of

using the solution appropriately. For example, cognitive restructuring as a solution conceptually matches an automatic assumption as a problem. Sometimes, however, clients have a history of applying cognitive restructuring correctly, but the assumption persists. In such instances, the evaluation would suggest focusing instead on mindfulness or another solution.

The review emphasizes examining the intermediate and long-term consequences of solutions, partially to correct the tendency of clients to focus on an intervention's immediate impact and neglect the longer-term effects. For example, many clients report that they self-harm because it immediately reduces their negative emotions. In the long term, however, self-harm usually leads to more problems that then elicit more negative emotions. Some clients consider hospitalization the best solution for suicidal urges because hospitalization prevents suicidal behavior for most clients and often provides them with an immediate sense of safety. Unfortunately, they seldom consider whether hospitalization as a response to suicidal urges may actually decrease their safety in the long term because elements of hospitalization have reinforcing consequences for becoming suicidal. Some clients will reject any new skill because they focus on the immediate consequences of learning (e.g., expending effort; experiencing worry, frustration, or disappointment), rather than the intermediate consequences of having learned a new skill (e.g., skillfully solving a problem). When clients compare new solutions with old target behaviors and judge the new solutions as more difficult, less immediate, or less reliable, therapists can still obtain favorable votes for the new solutions by connecting the new solutions to clients' more global, long-term goals.

Therapists also consider the viability of solutions with respect to whether a solution will likely generalize across contexts and time. For example, Blanche's solution of relying on hospital staff to remind her of appointments and homework would not generalize to an environment with fewer staff or less structure. Though not all solutions in the analysis require generalization, at least some of them require this quality. Thus, Blanche's solution analysis included a variety of solutions that she could continue to implement as she progressed to less secure units.

This review of probable consequences offers therapists the best opportunity to shape any questionable solutions generated by clients. It prompts clients to identify the potential problematic consequences before the therapist does so. If therapists need to highlight potential problems with clients' solutions, they balance the critical feedback with validation (of the valid, not the invalid), but avoid treating the client as too fragile to hear the feedback. For example, a therapist might say "Challenging

negative judgments with positive judgments might help in this moment, but I'm concerned that this solution keeps you judgmental and leaves you more vulnerable to having other negative judgments. Let's also try mindfully letting go of judgmental thoughts."

Assess Obstacles to a Solution's Implementation

Another component of solution evaluation is the assessment of any factors that will likely interfere with implementing solutions successfully. Clients may lack the skill, the motivation, or practical resources to implement a solution. When the therapist or client has identified an obstacle, they then can either remove or circumvent that obstacle or switch to another solution, based on the difficulty of tackling the obstacle and the viability of other solutions. For example, many clients automatically attend to potential negative outcomes more than potential positive outcomes and anticipate failure. If a client responds with such an automatic cognitive bias to most suggested solutions, then the therapist has little choice but to treat this bias. In contrast, an adult client may not yet have learned sufficient interpersonal skills to decrease the frequent invalidation of a sibling, but may have the capacity to minimize contact with and use mindfulness skills during contact with the sibling. In such a case the therapist and client may decide to forgo developing more advanced interpersonal skills at this time and instead focus on using the other solutions.

Sometimes clients have not yet learned the skills that therapists have suggested, whereas other times clients have partially learned the skills, but misapply them through a lack of either knowledge or practice. In either case, the individual therapist uses skills training to treat the skills deficit. For example, one client experienced problematic levels of conflict with her colleagues. When her therapist suggested using validation to improve her relationships, the client declared that validation would not work. The therapist then suggested that they rehearse validation anyway to better assess exactly why it would not work. This rehearsal immediately revealed that while the client used validating words, she also used what many would label as a "dismissive" tone. The therapist then coached her on how to alter her tone to increase the likelihood of her colleagues responding favorably to her attempts at validation.

Often clients have sufficient skills to use a solution, but motivational issues interfere. Cognitions or emotions may inhibit implementing the solution, or environmental contingencies may not reinforce or may even punish using the solution. Alexandra's case (the client with intense anger

and an invalidating boyfriend) illustrates how high emotional arousal creates an obstacle to solutions that require notable cognitive capacity and how therapists might remove this obstacle. Her cognitions also created obstacles themselves, initially leading to a refusal to rehearse the skill at all. When her therapist first suggested that Alexandra use validation as one solution to reduce interpersonal conflict with her boyfriend, Alexandra immediately rejected the solution. A brief analysis of the refusal revealed that Alexandra immediately had the thought "He doesn't deserve validation" when the therapist suggested the solution. The therapist highlighted the judgmental thought and suggested that Alexandra mindfully let go of it and focus on effectiveness, but Alexandra refused to practice these skills. Additional analysis revealed that Alexandra maintained the judgments because they provided her with self-validation. The therapist then encouraged Alexandra to practice other self-validating statements that did not involve judging her boyfriend or being ineffective. After this, Alexandra stopped objecting to validation as a solution.

Sometimes the motivational obstacle originates within the environment rather than within the client. Some environments ignore or even punish solutions that other environments would reward. Many clients have this experience when they use solutions related to assertiveness, even when they apply the solutions with some sophistication. As with other obstacles, the therapist and client can decide to try to remove the obstacle, move around it, or move on to other solutions. For example, Marie had chosen a career option that her talents justified but that her bank balance could not initially finance. The most obvious solution required her to ask her parents for short-term financial support, but the solution evaluation revealed that although her parents had financially supported her treatment since early adolescence, they had also dismissed most of her career goals as "too artsy." Because of the importance of the goal and the limited number of other solutions, however, she decided to try to remove the obstacle of her parents' dismissal. With the therapist's agreement, Marie invited her parents to a therapy session and presented her plan to them. Rather than passively waiting for their dismissal, she actively asked them for their critical feedback and thus partly reduced the aversive quality of their feedback by taking more control of it. She also reduced the extent to which their feedback punished her request by viewing the feedback as patrons considering an investment rather than as parents judging a child. Having neutralized the initial impact of her parents' responses, Marie validated their feedback and addressed the issues that they raised whenever possible. Her parents then agreed to

support her financially with certain reasonable conditions. In contrast, Joanne, whose parents ridiculed her higher-education goal, decided to move around the obstacle of her parents' objections by seeking financial and psychological support from other sources.

Emma's case demonstrates several components of solution evaluation in combination. Historically, whenever Emma threatened self-harm or sobbed in front of her husband, she quickly and reliably experienced a reduction in domestic demands and stress, with no immediate sense of guilt. When Emma's therapist suggested using interpersonal skills instead to reduce domestic demands, Emma immediately rejected the solution because she "would feel guilty" using them and they "probably wouldn't work." Emma's therapist then assessed the accuracy of "probably won't work" and discovered that using the skills would probably reduce domestic demands, though perhaps not as quickly or reliably as suicidal threats or sobbing. She also assessed whether using the skills warranted any guilt and determined that it did not on this occasion. Next, Emma's therapist compared the long-term consequences for Emma's marriage of applying assertion skills versus communicating suicidal urges and sobbing and reminded her of her goal of improving her marriage. When Emma refocused her attention on her long-term marital goals, her evaluation of assertion as a solution notably improved. Through a combination of mindfulness, acting opposite to the emotion and cognitive restructuring, Emma and her therapist then tackled her unwarranted guilt as an obstacle to using the skills. Finally, Emma and her therapist role-played the relevant interpersonal skills, so that her therapist could better evaluate whether they needed any shaping to maximize their effectiveness.

Common Problems in Solution Evaluation

A variety of problems interfere with effective solution evaluation including failure to conduct any solution evaluation. Though not every solution requires a substantial amount of evaluation, a lack of evaluation leaves clients vulnerable to not solving their problems effectively, abandoning problem solving, and returning to target behaviors as solutions. More often, therapists fail to implement one of the key components of solution evaluation or do not respond strategically when clients' behaviors interfere with the evaluation. The most severe or prevalent problems tend to occur when clients reject solutions without seeming to evaluate them first. Just as therapists sometimes question clients' suggestions for solutions, clients frequently consider therapists' suggestions to be more

problematic than useful. Most commonly clients express this opinion with a simple statement such as "That won't work" or "I can't do that." In response, therapists may fail to adequately assess the validity of such statements and make inaccurate assumptions about them. Therapists sometimes automatically accept clients' rejections and consequently miss targeting a TIB and instead reinforce invalid rejecting. Alternatively, therapists mistakenly reject clients' objections and consequently miss identifying valid obstacles and instead invalidate the client. Unfortunately, even when a therapist validates a client's valid objections, the solution evaluation may still go awry if the therapist fails to identify the specific obstacles that will impede implementation or to treat removable obstacles.

Rejecting Clients' Objections to Solutions without Evaluation

Although impulsive or repeated objections may require treatment as TIBs, therapists must guard against automatically dismissing these declarations as TIBs and treating them as such. Not only do such automatic assumptions invalidate the client, they derail the therapy from removing actual obstacles and send the treatment along the wrong track. For example, many therapists skip an evaluation of the rejection and just highlight the pros of using and cons of not using the solution to persuade clients to implement it. This response would succeed if a client rejected a solution due exclusively to insufficient orientation to the solution, but in many instances it is the cons of using a solution that control rejection. Some therapists automatically use cheerleading to convince clients to try the rejected solution. Cheerleading could succeed if a client refused because of self-doubts about using the solution successfully, but self-doubt is only one of many factors contributing to rejection. Occasionally a therapist persists in pushing a particular solution, believing that the client absolutely needs this solution and that with enough persistence the client will agree. Though such persistence sometimes pays, DBT views no single solution as essential and a strong attachment to any specific solution as a possible cause of suffering for therapist and client alike.

Certain factors tend to increase the likelihood of therapists dismissing or minimizing clients' objections. Quite understandably, therapists seem more likely to ignore oversimplified statements such as "That won't work" than specific statements such as "Whenever I try to assert myself, my boyfriend threatens to leave." Alternatively, a therapist might reject "That won't work" because the therapist has remembered the solution working for the client in another context, but has forgotten

the possibility of "apparent competence." Similarly, therapists sometimes make assumptions about clients' objections because they know that some client populations have a cognitive bias toward anticipating failure.

Therapists must discriminate between those occasions when clients' rejection of solutions constitutes a valid obstacle and when it constitutes a TIB. In addition to considering the impulsivity and pervasiveness of any rejection, therapists can best assess this distinction by asking for more specificity in response to a general rejection and trying the solution in the session whenever possible. For example, one therapist complained to the consultation team that her client consistently said, "I can't do mindfulness," despite having attended multiple skills training groups on mindfulness. The therapist had tried to treat this behavior by trying "to convince" the client of the benefits of mindfulness and that she could do it if she "just practiced more." The team highlighted that the therapist had not tried, however, to assess the accuracy of the client's statement by having the client try mindfulness during the session. They also highlighted the therapist's assumption that attending skills training leads directly to skills generalization. When the therapist assessed the client's actual ability through in-session practice, they discovered the validity in the client's assertion. Though the client noticed and labeled unmindful thoughts well, the thoughts returned when she tried to "let go" of them, and she genuinely did not know what to do next.

Failing to Evaluate and Treat Specific Obstacles to Implementation

Sometimes a therapist accepts a client's valid objection but then fails to further evaluate or treat the objection and drops the solution too quickly. Though therapists may strategically decide to focus on another solution or another controlling variable, therapists who do so nonstrategically (e.g., because of mindlessness or fear of challenging a client) leave clients handicapped. For example, if a therapist simply accepts a valid "I can't" without understanding exactly what the client cannot do, the therapist will not treat this capability deficit and the client will remain incapable. If Blanche's therapist had simply accepted Blanche's "I can't remember" rather than identifying the specific obstacles to remembering (e.g., a cueing deficit, dysfunctional contingencies), the solution analysis would have depended on environmental interventions only and thus reinforced Blanche's active passivity. In one case, the therapist accepted, without further analysis, the client's statement that the client could not afford to phone the therapist for coaching because he had no money for

his phone. When she reviewed her solution analysis with the team, the team suggested that the therapist further assess the client's inability to afford more minutes and troubleshoot this problem, particularly as the client had afforded several drinks with his friends earlier in the day. This analysis revealed that the client could remove the financial obstacle with better budgeting. In several cases, individual therapists have identified a specific skill deficit but have then waited for the skills training group to teach the relevant solution rather than teaching clients themselves. This may prove an efficient strategy if the skill plays a minor role in the solution analysis or the group plans to teach the relevant skill soon. If the solution reappears throughout the analysis or the group will not teach the skill for several months, however, the procrastinating can significantly weaken the solution analysis. DBT requires that individual therapists know how to teach all of the DBT skills as well as skills trainers do.

Accepting Clients' Objections to Solutions without Evaluation

Just as some therapists have rejected clients' valid objections, other therapists have accepted clients' invalid objections and have thus failed to treat a TIB. Accepting an invalid objection often leads the therapist to miss other obstacles to the solution, such as not evaluating clients' capabilities in the situation or missing motivational deficits. Many clients declare that they "can't" do something when they "don't want" to do something. In such cases, an evaluation could reveal not only a general motivational deficit, but also the specific factors that maintain the deficit.

When therapists notice a repetition of invalid objections, it usually proves more efficient to target the pattern of behavior than to treat each objection on its own. In such cases, therapists would employ a brief behavioral chain and solution analysis as they would with other TIBs. For example, when a therapist analyzed one client's pattern of "I can't," she discovered that the behavior functioned to elicit environmental support and that she had reinforced the behavior herself. As a primary solution, she reversed the contingency such that she decreased support in response to rejected solutions and increased support in response to accepted solutions. In particular, she arranged scheduled coaching calls in proportion to the number and difficulty of the solutions that the client agreed to implement.

If a therapist persistently fails to analyze such TIBs, then the consultation team would conduct a brief behavioral chain and solution analysis of the therapist's behavior. For example, when one therapist consistently

failed to analyze the client's repeated response of "That won't work," the analysis by the team revealed that the therapist believed that she "shouldn't invalidate" the client and worried how the client would respond to any invalidation. The team challenged the therapist's rule about invalidation and then addressed the worries by role-playing how to challenge the client with maximal effect and minimal conflict and how to resolve any conflict.

SOLUTION IMPLEMENTATION

Conceptualization and Strategies

In comparison to solution generation and evaluation, solution implementation involves more doing than thinking or conceptualizing. The client and therapist first choose a solution to implement. As described in the introduction to solution analysis, therapists encourage clients to choose the solution(s) whenever possible. A therapist might ask, "Which solution will you commit to using?" or "Which solution do you want to practice?" If the therapist believes that the client needs to try more than one solution for a controlling variable, the therapist might ask, "Which solution do you want to rehearse first?" DBT therapists, however, do not ask, "Do you want to try any solutions?"

If the selected solution is either new or a weak response in the client's existing repertoire, the therapy proceeds to implementing the solution during the session whenever possible. Such in-session implementation strengthens skills and challenges clients' expectations of failure. It also allows the therapist and client to identify and remove any obstacles that might interfere with the successful implementation of the skills outside of therapy. Clients may practice letting go of judgments, accepting reality as is, acting opposite to emotional urges, validating others, or a combination of all of these during a session. With the assistance of their therapists, clients may restructure dysfunctional cognitions and expose themselves to cues that elicit unwarranted emotions while preventing dysfunctional behavioral responses. Therapists may impose new contingencies to shape clients' behaviors or help clients do this for themselves. DBT often implements and interweaves these procedures more informally than traditional CBT does. For example, if a client avoids asking the therapist for help because the client fears that the therapist will respond with rejection, exposure would probably serve as the primary intervention. Rather than constructing a hierarchy of exposure cues, however, the therapist probably would apply exposure to the current

context only. In addition, prior to the exposure the therapist might coach the client on relevant interpersonal effectiveness skills training to increase the likelihood that the client will ask for help in a way that the therapist can reinforce. This less formal approach, however, does not mean that therapists forgo all orientation to the essential elements of a solution. For example, when rehearsing interpersonal skills, a therapist might focus the rehearsal on the skills relevant to the identified scenario but prompt the client to rehearse each of those skills (e.g., asserting wants, validating the other person) individually before combining them in a more natural role play.

After the client has implemented the solution, the therapist assesses the client's experience and provides reinforcement and feedback. When necessary, the therapist further shapes the implementation of the solution by addressing any problems that have arisen and trying the solution again. Though the effectiveness of the solution ultimately determines whether clients continue to use it, therapists can also reinforce solution implementation, at least in the therapy context, through their responses. Effective reinforcement requires therapists to assess the reinforcing value of their responses rather than making assumptions about it. For example, praise reinforces some clients, but punishes others; more therapy time rewards some clients but not others. In addition to reinforcing clients' practice generally, therapists also highlight specifically what clients did well and how they can further increase the solution's effectiveness. For example, when Emma first rehearsed using interpersonal skills to reduce domestic demands, her therapist noticed that Emma used the "DEAR MAN GIVE" skills to obtain her objective while maintaining the relationship but that Emma did not use any "FAST" skills to maintain her self-respect. If the client has notable difficulty applying the solution, the therapist would troubleshoot the issue. This occurred when Alexandra finally agreed to rehearse validating her boyfriend. Before agreeing to rehearse validation, she had learned to label "He [her boyfriend] doesn't deserve validation" as a judgment and had worked on letting it go. Unfortunately, when she rehearsed validation, she became repeatedly distracted by the thought. Alexandra reported that she recognized the thought as a judgment, but did not know how to let it go when it seemed so constant. Her therapist then provided detailed coaching on how to refocus her attention and fully participate in rehearsing validation. When solution implementation reviews involve either significant feedback for improvement or significant troubleshooting, the solution will usually require additional in-session application. For example, Emma again rehearsed negotiating for a reduction of domestic demands,

but this time with an emphasis on maintaining her self-respect. Alexandra again rehearsed validating her boyfriend, this time mindfully focusing on the task and away from distracting judgments. Usually, practicing a few solutions with such shaping yields better results than practicing many solutions without any shaping.

Finally, if they have not done so earlier, therapists use commitment-strengthening strategies to increase the likelihood that clients will apply the solution outside of the therapy session. Linehan's (1993a) emphasis on commitment derives from social psychology literature, which reveals that using strategies to elicit and strengthen an individual's initial commitment to a behavior significantly increases the likelihood that the behavior will occur. Specific techniques include cheerleading (i.e., expressing confidence in a client's capacity to succeed) and connecting present commitments to prior commitments. Other commitment strategies require the therapist to behave dialectically, such as playing the devil's advocate against a solution and highlighting both the freedom not to use a solution and the absence of alternative solutions.

Common Problems in Solution Implementation

Even if therapists have successfully generated and evaluated solutions, the solution analysis as a whole can falter or even fail because of problems with solution implementation. Common problems include an absence of solution implementation, mistaking minimal for full implementation, insufficiently specifying the essential elements of the solution, not shaping the practice, and reinforcing clients' TIBs.

Failing to Implement Any Solution

The most serious problem is failing to include any solution implementation. Therapists tend to miss solution implementation for the same reasons that they fail to include solution analyses altogether. Fortunately, the same remedies apply. Some therapists simply learn solution analysis one component at a time, with solution implementation as the last component. Other therapists become inhibited when prompting clients to *do* something, rather than just discussing doing something. In such cases, the therapist or consultation team may need to analyze the inhibition and implement solutions for the key controlling variables. For example, one therapist admitted to her team that she avoided implementing key solutions because she "struggled" with shaping mindfulness and feared applying exposure. To solve this issue, the team assigned the therapist

relevant reading, modeled how to shape mindfulness and apply exposure, and then role-played these strategies with the therapist. They also coached her on which strategies to use if her clients responded poorly.

Failing to Implement Solutions Fully

Therapists often believe that they have fully implemented a solution during a session when they have only summarized or partially implemented the solution. For example, many therapists believe that they have implemented cognitive restructuring when they have only asked a series of challenging questions to which the clients have responded with "Yes" or "No." Such questioning can model one way to restructure cognitions, but at that point clients have rehearsed only saying "Yes" and "No" with any certainty. They have not rehearsed cognitive restructuring themselves, thus reducing the opportunity to shape new behavior and to identify and treat any obstacles to implementation. Fully implementing this solution during the session requires rehearsal by, not just agreement from, the client. Thus, the therapist might say, "So next time you have that thought, what are you going to say to yourself to change it?" In addition to mistaking modeling for fully implementing a solution, therapists sometimes confuse summarizing with practicing. For example, summarizing or listing relevant "DEAR MAN" interpersonal skills does not equate to rehearsing them in a session. To practice these skills, the client and therapist need to role-play them in a relevant scenario, with the client actually saying what he or she plans to say outside of the therapy session.

Failing to Specify the Solution's Essential Elements

Frequently, clients struggle or fail to implement a solution successfully, either during or after a session, because their therapists have not specified or structured the essential elements of the solution sufficiently. For example, many clients struggle to practice mindfulness because their therapists have not reviewed the required components. One therapist asked the consultation team for help with a client who reported that her judgmental thoughts returned whenever they practiced being nonjudgmental. While listening to a recording of the session, the team noticed that in structuring the practice, the therapist reminded the client to label judgmental thoughts but did not include any additional steps. The team then role-played with the therapist how to give the client instructions first to describe the facts of the situation and then to participate in the task at hand. When the therapist implemented this consultation, the

client reported that the judgments subsided better if she noticed them and then returned her attention to the task of the moment. Similarly, when another therapist reported that "acting opposite" did not decrease her client's unwarranted shame, the consultation team listened to the relevant recording and discovered that the therapist had not instructed the client to act opposite to all elements of the emotion. When the therapist reviewed each element with the client, they discovered that the client previously had not acted opposite to her shaming body posture and cognitions.

Not Shaping Implementation

Therapists sometimes effectively encourage clients to implement a solution during the session, but then do not adequately shape the implementation. Though therapists may decide to forgo shaping for strategic reasons (e.g., efficiency), they often fail to provide constructive feedback because they did not notice subtle issues, did not know how to address the issues, or became inhibited about addressing them. When implementing exposure, for example, some therapists focus on blocking obvious overt behaviors and miss more subtle facial, postural, or verbal behaviors. Similarly, when clients have used "DEAR MAN" skills competently in a role play but have not demonstrated the necessary "GIVE" skills, some therapists praise the former but fail to provide feedback and coaching on the latter. Alternatively, therapists may notice opportunities to shape a skill but they fear that any critical feedback will upset clients and so do not provide the feedback. To resolve these issues, therapists can analyze and treat them with the consultation team, but the more subtle aspects of some of these issues may require a review of actual session recordings. Finally, though the successful implementation of a solution may require no more feedback than a "Well done," clients often find a more detailed description of what they did well to be more helpful, more reinforcing, or both.

Client-Interfering Behaviors

As with the other components of solution generation, clients engage in a variety of behaviors that interfere with solution implementation. These behaviors include refusing to implement a solution, not fully participating in the implementation, and committing only to "trying" outside of the session. Ironically, therapists sometimes inadvertently prompt some of these behaviors when they prioritize polite speech over clear instructions. If a therapist thinks that a client needs to rehearse a skill but

instead "politely" asks, "Do you want to practice this skill?" then the client may respond honestly rather than helpfully with "No." The question does not ask what the therapist genuinely wants to know and it directs clients to attend to doing what they want rather than what will be effective. DBT highlights the importance of therapists being genuine and focusing on effectiveness in their communication with clients. Although therapists can quickly correct problematic prompts, they risk creating a bigger problem if they reinforce rather than treat clients' TIBs. For example, one therapist accepted an "I'll try" as a sufficient commitment, but the client did not fully implement the solution during the week. When the same pattern occurred the following week, the therapist expressed her frustration about the client "not keeping commitments to using solutions" to the consultation team. The team highlighted that the therapist had only obtained a commitment to "trying" and suggested that the therapist might have reinforced the client's avoidance of committing to the solution. The team then role-played commitment-strengthening strategies so that the therapist could treat rather than reinforce the problem. Often, the treatment of clients' behaviors that interfere with implementation requires nothing more than blocking those behaviors or applying solutions that have worked with other TIBs. At other times, the treatment will require a brief BCA and solution analysis. For example, when Jack (the inpatient disliked by staff) refused to rehearse interpersonal skills and added "They're stupid," his therapist initially tried to increase Jack's motivation by linking the skill to his goals. Jack still refused, and the therapist then realized that they needed to analyze what controlled the refusal. The analysis revealed that Jack already understood the utility of the solution, but that he anticipated "getting it wrong" during the rehearsal and felt notably embarrassed. Refusing to practice and labeling the skills as "stupid" functioned to decrease the embarrassment by dissuading the therapist from pursuing the rehearsal. When the therapist offered Jack the choice of first treating the anticipating or the embarrassment, Jack chose the anticipating. They decided to select mindfulness as a solution, particularly focusing on the moment and letting go of judgments. They then progressed to treating the embarrassment and decided to use acting opposite to the emotion, as the context did not warrant such intense embarrassment. They first focused on acting opposite to the postural and verbal elements of the emotion. In particular, the therapist had Jack act opposite to his refusal to rehearse by asking to rehearse the interpersonal skills. Finally, Jack rehearsed the interpersonal skills.

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