CHAPTER 1

An Introduction to Dialectical Behavior Therapy and Skills Training

DBT Skills Manual for Adolescents offers a guide for mental health practitioners working with adolescents who struggle to control their emotions and behaviors. Emotional and behavioral dysregulation often contribute to an adolescent's difficulties in establishing a stable sense of self and forming fulfilling and stable relationships with peers and family members. Furthermore, problematic impulsive or avoidant behavior is often a consequence of emotion dysregulation or an effort to re-regulate. The five sets of skills in this book directly correspond to the five major problems that are associated with emotional dysregulation in adolescents. Mindfulness skills help adolescents increase their self-awareness and attentional control while reducing suffering and increasing pleasure; distress tolerance skills offer tools to reduce impulsivity and accept reality as it is; emotion regulation skills help increase positive emotions and reduce negative emotions; interpersonal effectiveness skills help adolescents improve and maintain peer and family relationships and build self-respect; and walking the middle path skills teach methods for reducing family conflict by teaching validation, behavior change principles, and dialectical thinking and acting.

We divide this book into three sections. The first section (Chapters 1–4) contains information for understanding dialectical behavior therapy (DBT) and its skills training mode, and for setting up and running a DBT skills training program. It explains the structure of skills training programs, describes the running and management of DBT multifamily groups and other skills training formats, and highlights the art and style of conducting DBT skills training. The second section (Chapters 5–10) contains the teaching notes, lecture points, examples, and strategies for orienting clients and teaching the specific DBT skills. The third section contains the skills training handouts for teens and families in the Orientation, Mindfulness, Distress Tolerance, Walking the Middle Path, Emotion Regulation, and Interpersonal Effectiveness Skills modules.

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ADOLESCENTS WHO CAN BENEFIT FROM DBT SKILLS TRAINING

Adolescents can be categorized along a continuum from typical, relatively asymptomatic adolescents to severely emotionally and behaviorally dysregulated teens who may require a restrictive setting (i.e., inpatient or residential treatment). We believe that DBT skills can be beneficial to all these populations, applied within a primary, secondary, or tertiary prevention framework. Primary prevention programs are intended to ward off future problems for a general population who are not presently at risk or seeking mental health services. From this vantage point, DBT skills can be applied broadly to middle school, high school, and early college-age youth with normal moodiness, occasional relational difficulties, and perhaps experimentation with risk behaviors. Many normal adolescents exhibit some degree of emotional dysregulation, and training in DBT skills, by itself, may benefit these teens. Secondary prevention programs are intended to protect against the full blossoming of mental health disorders for at-risk individuals characterized by mild or early indicators of mental health needs (e.g., school difficulties, attentional problems, sad or anxious mood, family conflict). DBT skills can be applied to these individuals in schools or clinical settings.

Tertiary preventions target individuals with significant emotional and behavioral disorders in order to actively treat the disorders while improving functioning. For this population, practitioners often apply DBT skills as part of a comprehensive DBT treatment program in outpatient, inpatient, residential, and juvenile justice settings. Linehan (1993a, 1993b) designed DBT as a comprehensive treatment program for high-risk clients diagnosed with borderline personality disorder (BPD). Comprehensive DBT with severely dysregulated adolescents follows Linehan's original model, with multiple treatment modalities. Many of the youth treated with comprehensive DBT typically carry two to four DSM-5 disorders as well as many other life problems not captured by these diagnoses. Such severely dysregulated teens are typically not able to fully benefit from skills training without a more comprehensive DBT program that usually includes individual therapy, telephone coaching of skills, and a consultation team of therapists working together, in addition to skills training. For example, individual therapy in DBT requires adolescents to intensively self-monitor their behavioral urges, actions, and skills on a diary card as well as to practice using skills in place of problem behaviors. When problem behaviors show up on a teen's diary card, the individual DBT therapist conducts what we term *behavioral chain* and *solution analyses* with the teen. This process identifies places in the behavioral sequence where skills can be used to replace the problem behaviors. Teens are encouraged to call their individual DBT therapists for intersession telephone coaching of skills to interrupt their impulse to engage in problem behaviors. At a minimum, severely emotionally dysregulated teens at risk for suicidal behavior need a practitioner other than the skills trainers to intensively oversee their treatment, remain available to them when needed, assess for suicidal behavior, and manage risk. This person, ideally, would be trained in an empirically validated suicide risk management protocol such as the Linehan Risk Assessment and Management Protocol (LRAMP; Linehan, Comtois, & Ward-Ciesielski, 2012).

HOW DBT CONCEPTUALIZES THE EMOTIONALLY DYSREGULATED ADOLESCENT

DBT can be applied to youth presenting with multiple, serious problems that may include suicidal behaviors, nonsuicidal self-injury, high-risk sexual behaviors, disordered eating, illicit

drug use, binge drinking, and other harmful behaviors. Youth may also have less severe problems such as light social drinking; first signs of nonsuicidal and nonsevere self-harm behavior; anger dyscontrol; school avoidance; impaired self-awareness of emotions, goals, and values; and frequent relationship breakups. DBT views all these problems as consequences of emotional dysregulation or as attempts to cope with emotional dysregulation. In other words, emotional dysregulation can lead to interpersonal, behavioral, cognitive, and self-dysregulation.

From a DBT perspective, many problematic adolescent behaviors, including suicidal behaviors, are influenced by two significant factors: (1) the lack of important interpersonal, self-regulation, and distress tolerance capabilities; and (2) personal and environmental factors that inhibit the use of those skills teens may already have. These personal and environmental factors also interfere with the development of new skills and capacities, in addition to reinforcing inappropriate, dysregulated, and dysfunctional behaviors.

Comprehensive DBT directly addresses these factors by:

1. Increasing teens' (and families') capabilities by teaching specific skills for self-regulation (including emotion regulation and mindfulness), interpersonal effectiveness, distress tolerance, and balanced thinking and acting ("Walking the Middle Path"), as shown in Table 1.1.
2. Structuring the environment to motivate, reinforce, and individualize appropriate use of the skills.

TABLE 1.1. Characteristics of Dysregulation and Corresponding DBT Skills Modules

Some characteristics of dysregulation	DBT skills modules
Emotion dysregulation	
Emotional vulnerability; emotional reactivity; emotional lability; angry outbursts; steady negative emotional states such as depression, anger, shame, anxiety, and guilt; deficits in positive emotions and difficulty in modulating emotions.	Emotion Regulation
Interpersonal dysregulation	
Unstable relationships, interpersonal conflicts, chronic family disturbance, social isolation, efforts to avoid abandonment, and difficulties getting wants and needs met in relationships and maintaining one's self-respect in relationships.	Interpersonal Effectiveness
Behavioral dysregulation	
Impulsive behaviors such as cutting classes, blurting out in class, spending money, risky sexual behavior, risky online behaviors, bingeing and/or purging, drug and alcohol abuse, aggressive behaviors, suicidal and nonsuicidal self-injurious behavior.	Distress Tolerance
Cognitive dysregulation and family conflict	
Nondialectical thinking and acting (i.e., extreme, polarized, or black-or-white), poor perspective taking and conflict resolution, invalidation of self and other, difficulty effectively influencing own and others' behaviors (i.e., obtaining desired changes).	Walking the Middle Path
Self-dysregulation	
Lacking awareness of emotions, thoughts, action urges; poor attentional control; unable to reduce one's suffering while also having difficulty accessing pleasure; identity confusion, sense of emptiness, and dissociation.	Core Mindfulness

Note. From Miller, Rathus, and Linehan (2007, Table 2.1, p. 36). Copyright 2007 by The Guilford Press. Adapted by permission.

3. Improving teens' motivation to increase the use of new skills, reduce the use of prior dysfunctional behaviors, and identify the factors (e.g., thoughts, feelings, behaviors, contextual variables) that maintain problematic behavioral patterns and inhibit more skillful ways of responding.
4. Providing methods to encourage the generalization of new skill capabilities from therapy to the life situations where they are needed.
5. Providing support for therapists treating multiproblem adolescents.

To fulfill the above functions, Linehan (1993a) developed treatment modes that may vary across treatment settings. Comprehensive DBT for pervasive emotional dysregulation typically includes four modes: individual therapy, group skills training, between-session telephone coaching, and a therapist consultation team. Comprehensive adolescent outpatient DBT slightly modifies these modes by conducting skills training groups with both adolescents and parents present in a multifamily skills group, providing phone coaching not only for adolescents but also for parents, offering family therapy sessions as needed, and offering parenting sessions as needed (Miller, Rathus, & Linehan, 2007). See Table 1.2 for a summary.

Other core elements of DBT include a biosocial theory of emotion dysregulation; an overall dialectical stance that emphasizes the transactional nature of the therapeutic relationship; a framework of treatment stages and, within each stage, a hierarchical prioritizing of behavioral treatment targets; and sets of acceptance, change, communication, structural, and dialectical strategies to achieve the behavioral targets. In the sections below, we briefly describe these elements and then review the skills modules taught. The chapter concludes with a brief summary of the outcome literature on DBT with an emphasis on DBT with adolescents.

DBT'S BIOSOCIAL THEORY

DBT (Linehan, 1993a) theorizes that the problem behaviors of emotionally dysregulated individuals stem from a combination of biological and environmental factors. Specifically, these factors are a biological vulnerability to emotional dysregulation and an invalidating social environment (an environment where coaching in emotion regulation is inadequate and dysfunctional learning takes place)—hence the term *biosocial* theory.

TABLE 1.2. Modes in Comprehensive Outpatient DBT with Multiproblem Adolescents

- Multifamily skills training group
- Individual DBT therapy
- Telephone coaching for teens *and* family members
- Family sessions (as needed)
- Parenting sessions (as needed)
- Therapist consultation team meeting
- Possible ancillary treatments
  - Pharmacotherapy
  - Therapeutic/residential schools

Biological Vulnerability

Linehan (1993a) theorized that biological factors play a primary role in the initial vulnerability to emotional dysregulation. Emotional vulnerability is defined as a high sensitivity to emotional stimuli, high reactivity (i.e., intense emotional responses), and a slow return to emotional baseline. A person may be vulnerable to intense emotion across several (perhaps all) emotions, positive and negative, combined with difficulties in modulating emotional reactions. However, most individuals with an initial biological vulnerability do not develop persistent emotional dysregulation. According to the theory, persistent emotional dysregulation occurs when an emotionally vulnerable individual is exposed to a pervasively invalidating environment.

Invalidating Environment

The invalidating environment is defined by the tendency of (often well-meaning) others (typically family members, but also teachers and other school personnel, peers, health professionals, etc.) to negate and/or respond erratically and inappropriately to private experiences, particularly private experiences not accompanied by public signs (e.g., feeling sick without having a high temperature). Private experiences, especially emotional experiences, are often not taken as valid responses to events. The person's experiences are punished, trivialized, ignored, dismissed, and/or attributed to socially unacceptable characteristics such as overreactivity, inability to see things realistically, lack of motivation, or failure to adopt a positive (or discriminating) attitude. Yet at times, the environment may reinforce escalating communications of distress, such as by attending to a family member lovingly and removing demands after a suicidal communication. In this regard, the invalidating environment also intermittently reinforces escalated emotional displays. Invalidating environments emphasize the need to control emotional expressiveness, oversimplify the ease of solving problems, and are generally intolerant of displays of negative affect.

The transactional nature of biosocial theory implies that individuals may develop patterns of dysregulation via somewhat different routes. A person with extreme emotional vulnerability may develop patterns of dysregulation in a family with a "normal" level of invalidation, and may even inadvertently elicit invalidation from the environment. Conversely, a highly invalidating environment might transact with a moderate to low level of emotional vulnerability to yield persistent emotional dysregulation. A different scenario might involve an anxious, school-refusing adolescent who finally musters the nerve to go to school and shows up late. When he arrives late to class, the teacher scoffs at him, telling him he failed to get a late pass and needs to check in with the assistant principal. The assistant principal berates the student for having missed days of school and speculates judgmentally that he has been out due to drug use. The student feels increasingly ashamed and walks back to class with his head down, only to be bullied by a group of teenagers who call him a loser. Too upset to return to class now, the security guard catches him "cutting class" and reports him to the principal for detention. When this type of school scenario repeats itself, it becomes an independent, pervasively invalidating environment. It is important to recognize the manifold potential sources of invalidation in an adolescent's life, while also remembering the transactional nature of this invalidation with the adolescent's biological emotional vulnerability. From this perspective, we aim to increase validation from the teen's environment (as well as toward the environment from the teen), and at the same time we aim to increase the teen's capacity for emotion regulation. Although all DBT skills are relevant

when addressing these goals, we emphasize validation skills and emotion regulation skills to target invalidation and emotional vulnerability, respectively.

Regardless of its source, a transactional pattern between emotion dysregulation and invalidating environments results in an individual who has never learned how to label and regulate emotional arousal, how to tolerate emotional distress, or when to trust his or her own emotional responses as reflections of valid interpretations of events (Linehan, 1993a). The individual learns to mistrust his or her internal states and instead scans the environment for cues about how to act, think, or feel. This general reliance on others results in the individual's tendency to self-invalidate, which is often depressogenic and may contribute to confusion about self—that is, about one's goals, values, interests, and emotions. Emotion dysregulation also interferes with the development and maintenance of stable interpersonal relationships, which depend on both a stable sense of self and a capacity to regulate emotions. Moreover, the tendency of the invalidating environment to punish or ignore the expression of negative emotion, while reinforcing negative expression at others, shapes an expressive style later seen in individuals who vacillate between suppression of emotional experience and extreme behavioral displays. Behaviors such as not showing up for a test, drug use, running away, and self-injury may have important affect-regulating properties and are sometimes quite effective in eliciting helping behaviors from an environment that otherwise may ignore expressions of emotional pain.

DIALECTICS AND A DIALECTICAL STANCE

A dialectical worldview considers reality as continuous, dynamic, and holistic. Reality from this perspective is simultaneously whole and consisting of bipolar opposites (e.g., an atom consisting of opposing positive and negative charges). Dialectical truth emerges through the combination (or "synthesis") of elements from both opposing positions (the "thesis" and "antithesis"). The tension between the thesis and antithesis within each system—positive and negative, good and bad, children and parents, client and therapist, person and environment, and so forth—and their subsequent integration, produce change. Following change through synthesis, the new state also consists of polar forces. Thus change is continuous, and contradictory truths do not necessarily cancel each other out.

From the point of view of therapeutic dialogue and relationship, "dialectics" refers to change by persuasion and by making use of the oppositions inherent in one's thinking and behaviors and within the therapeutic relationship. Through the therapeutic opposition of contradictory positions, both client and therapist can arrive at new meanings within old meanings, moving closer to the essence of the subject under consideration. The spirit of a dialectical point of view is never to accept a proposition as a final truth or an undisputable fact. Thus the question addressed by both client and therapist is, "What is being left out of our understanding?" Related to this question is the holistic consideration of a patient's environmental context and the disordered behavior occurring transactionally in relation to that context.

A dialectical therapeutic position is one of constantly combining acceptance with change, flexibility with stability, nurturing with challenging, and a focus on capabilities with a focus on deficits. The goal is to highlight the opposites, both in therapy and in clients' lives, and to provide conditions for syntheses. The presumption is that we can facilitate change by emphasizing acceptance, and acceptance by emphasizing change.

DBT TREATMENT STAGES AND PRIMARY TREATMENT TARGETS

DBT conceptualizes treatment in stages that correspond to the severity and complexity of the client's problems. As Table 1.3 shows, each stage has its own hierarchy of treatment priorities or targets.

In comprehensive DBT, the pretreatment stage is typically several weeks long and involves assessing the client, orienting the client to DBT, and securing commitment to treatment and to the treatment goals for each individual teen. Clients in Stage 1 are severely and pervasively

TABLE 1.3. Standard DBT Stages and Their Hierarchies of Primary Treatment Targets

Pretreatment stage: Orientation and commitment to treatment, agreement on goals

Targets:
1. Inform adolescent about, and orienting adolescent to, DBT.
2. Inform adolescent's family about, and orienting family to, DBT.
3. Secure adolescent's commitment to treatment.
4. Secure adolescent's family's commitment to treatment.
5. Secure therapist's commitment to treatment.

Stage 1: Attaining basic capacities, increasing safety, reducing behavioral dyscontrol

Primary targets in individual DBT:
1. Decrease life-threatening behaviors.
2. Decrease therapy-interfering behaviors.
3. Decrease quality-of-life-interfering behaviors.
4. Increase behavioral skills.

Primary targets in DBT skills training:
1. Decrease behaviors likely to destroy therapy.
2. Increase skill acquisition, strengthening, and generalization.
   a. Core mindfulness
   b. Interpersonal effectiveness
   c. Emotion regulation
   d. Distress tolerance
   e. Walking the middle path
3. Decrease therapy-interfering behaviors.

Stage 2: Increasing emotional experiencing, reducing traumatic stress

Primary target in individual DBT:
1. Decrease avoidance of emotional experience and posttraumatic stress.

Stage 3: Increasing self-respect and achieving individual goals, addressing normal problems in living

Primary targets in individual DBT:
1. Increase respect for self.
2. Achieve individual goals.

Stage 4: Finding joy, meaning, connection, and self-actualization

Primary targets in individual DBT:
1. Resolve a sense of incompleteness.
2. Find freedom and joy.

Note. From Linehan (1993a, Table 6.1, p. 167). Copyright 1993 and 2007 by The Guilford Press. Adapted by permission.

dysregulated and are at high risk for self-harm or suicide. Therefore, the main task with Stage 1 clients is to help them attain basic capacities that establish safety and behavioral control. This is the stage that comprises comprehensive, "standard DBT" and the vast majority of outcome data.

In Stage 1, skills training is typically separated from individual therapy, and each mode has somewhat different treatment priorities, as shown in Table 1.3. Aided by the client-completed diary card (Figure 1.1), Stage 1 individual therapy in DBT is structured to focus on its hierarchy of primary treatment targets: decreasing life-threatening behaviors, therapy-interfering behaviors, and quality-of-life-interfering behaviors and increasing behavioral skills. Each teen also works on specific, individualized treatment targets. Although increasing behavioral skills is a primary treatment target for the individual DBT therapist in Stage 1, it takes the lowest priority. The necessity of attending to crises, maintaining the patient in therapy, and reducing the severe behaviors that interfere with life quality make skills acquisition within individual psychotherapy nearly impossible. Trying to increase capabilities while addressing ongoing risky behaviors is like trying to build a shelter in the midst of a storm. One cannot address crises without skills; one cannot learn skills while responding to crisis. Thus, a separate component of treatment directly targets the acquisition of behavioral skills, and this component typically occurs in a group format. In DBT with adolescents, we recommend a multifamily skills group format, when possible.

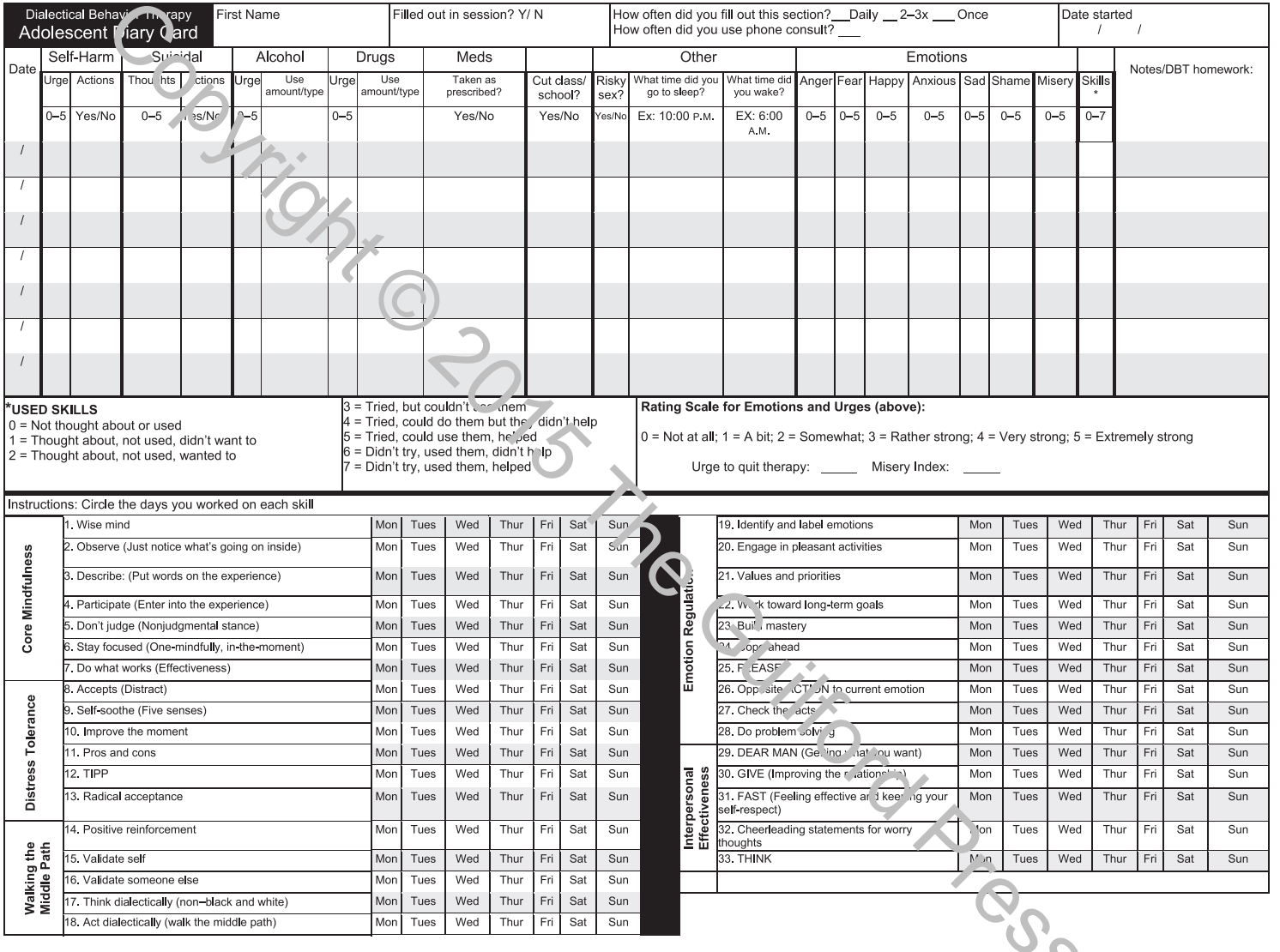
Stage 2 of DBT involves emotionally processing past trauma and grief, and typically denotes a departure from Stage 1 skills acquisition and the highly structured individual sessions. However, skills are to be used and strengthened throughout Stage 2 and all later stages of DBT. Stage 3 addresses ordinary happiness and unhappiness and problems in living. Stage 4 addresses the attainment of transcendence and joy, and making meaning. Linehan (1993a) fully explicates each treatment stage and its goals.

Stage 1 Secondary Treatment Targets: Dialectical Dilemmas

Individuals with pervasive emotional dysregulation learn to alternate between behavioral extremes that either underregulate or overregulate emotion. DBT views these patterns as dialectical dilemmas for the client: The client alternately tries each extreme approach to emotion regulation but is unable to make either work. The first three Stage 1 primary treatment targets (life-threatening behaviors, therapy-interfering behaviors, quality-of-life-interfering behaviors) are themselves expressions of these dialectical extremes. Because these behaviors endanger the client's life, the therapy itself, or the quality of the client's life, they must be immediately addressed. But the overall patterns help sustain the dysfunctional behaviors, and they can also derail the skills acquisition process. Therefore, the patterns themselves need to be targeted by treatment if there is to be long-term change. The standard DBT dialectical dilemmas are:

- Emotional vulnerability versus self-invalidation.
- Active passivity versus apparent competence.
- Unrelenting crises versus inhibited experiencing.

Emotional vulnerability refers to the experience of high emotional arousal, a central experience for people entering DBT. *Self-invalidation* refers to dismissal of one's own emotions, perceptions, and problem-solving approaches. *Apparent competence* refers to the tendency of clients with chronic emotional dysregulation to appear at times more competent and in control than they actually are. *Active passivity* refers to being passive and helpless in the face of



Dialectical Behavior Therapy
Adolescent Diary Card

First Name

Filled out in session? Y/ N

How often did you fill out this section?___Daily __ 2–3x ___ Once
How often did you use phone consult? ___

Date started
/ /

Date	Self-Harm		Suicidal		Alcohol		Drugs		Meds		Other			Emotions								Notes/DBT homework:
	Urge	Actions	Thoughts	Actions	Urge	Use amount/type	Urge	Use amount/type	Taken as prescribed?	Cut class/ school?	Risky sex?	What time did you go to sleep?	What time did you wake?	Anger	Fear	Happy	Anxious	Sad	Shame	Misery	Skills *	
	0–5	Yes/No	0–5	Yes/No	0–5		0–5		Yes/No	Yes/No	Yes/No	Ex: 10:00 P.M.	EX: 6:00 A.M.	0–5	0–5	0–5	0–5	0–5	0–5	0–5	0–7	
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*USED SKILLS
0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried, but couldn't use them
4 = Tried, could do them but they didn't help
5 = Tried, could use them, helped
6 = Didn't try, used them, didn't help
7 = Didn't try, used them, helped

Rating Scale for Emotions and Urges (above):

0 = Not at all; 1 = A bit; 2 = Somewhat; 3 = Rather strong; 4 = Very strong; 5 = Extremely strong

Urge to quit therapy: _____ Misery Index: _____

Instructions: Circle the days you worked on each skill

Core Mindfulness	1. Wise mind	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	2. Observe (Just notice what's going on inside)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	3. Describe: (Put words on the experience)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	4. Participate (Enter into the experience)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	5. Don't judge (Nonjudgmental stance)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	6. Stay focused (One-mindfully, in-the-moment)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	7. Do what works (Effectiveness)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Distress Tolerance	8. Accepts (Distract)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	9. Self-soothe (Five senses)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	10. Improve the moment	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	11. Pros and cons	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	12. TIPP	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	13. Radical acceptance	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Walking the Middle Path	14. Positive reinforcement	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	15. Validate self	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	16. Validate someone else	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	17. Think dialectically (non–black and white)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	18. Act dialectically (walk the middle path)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Emotion Regulation	19. Identify and label emotions	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	20. Engage in pleasant activities	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	21. Values and priorities	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	22. Work toward long-term goals	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	23. Build mastery	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	24. Cope ahead	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	25. PLEASE	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	26. Opposite ACTION to current emotion	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	27. Check the facts	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	28. Do problem solving	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Interpersonal Effectiveness	29. DEAR MAN (Getting what you want)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	30. GIVE (Improving the relationship)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	31. FAST (Feeling effective and keeping your self-respect)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	32. Cheerleading statements for worry thoughts	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	33. THINK	Mon	Tues	Wed	Thur	Fri	Sat	Sun

FIGURE 1.1. Diary card.

problems while actively eliciting the help of others to solve one's problems. *Unrelenting crisis* refers to the immediate and impulsive escape from emotional pain, a "crisis-of-the-week" syndrome. *Inhibited experiencing* refers to involuntary, automatic avoidance of cues that evoke past losses, trauma, or painful emotional states. It involves a shutting down of the normal processing of grief or the experiencing of other difficult emotions.

In addition, we developed three additional dialectical dilemmas, specific to adolescent–family interactions (Rathus & Miller, 2000):

- Excessive leniency versus authoritarian control.
- Normalizing pathological behaviors versus pathologizing normative behaviors.
- Forcing autonomy versus fostering dependence.

The Walking the Middle Path Skills module directly addresses these adolescent-specific dilemmas. Parents, therapists, and adolescents can all vacillate between being too loose or too strict, making too light of serious problem behaviors or making too much of normal, typical teen behavior, and forcing independence too soon or fostering dependence.

At each of the polar extremes above, there are two secondary treatment targets: one aimed at decreasing the maladaptive behavior, the other aimed at increasing a more adaptive response. Table 1.4 lists the dialectical dilemmas and corresponding secondary treatment targets in standard DBT, and Table 1.5 lists those developed for an adolescent population and their families. We say more about dialectical dilemmas in skills training in Chapters 4 and 8.

DBT TREATMENT STRATEGIES

DBT uses five sets of treatment strategies to address the specific treatment targets described above: (1) dialectical strategies, (2) validation strategies, (3) problem-solving strategies, (4) stylistic (communication) strategies, and (5) case management or structural strategies. Validation and problem-solving strategies, together with dialectical strategies, constitute the core strategies in DBT. Validation strategies focus on acceptance. Problem-solving strategies focus on change, and traditional behavioral therapy strategies fall under this set. Dialectical strategies primarily concern how the therapist structures interactions and defines skillful behaviors. As discussed

TABLE 1.4. Standard DBT Dialectical Dilemmas with Corresponding Secondary Treatment Targets

Dilemma	Targets
Emotional vulnerability versus self-invalidation	Increasing emotion modulation; decreasing emotional reactivity
Active passivity versus apparent competence	Increasing active problem solving; decreasing active passivity
Unrelenting crises versus inhibited experiencing	Increasing realistic decision making and judgment; decreasing crisis-generating behaviors

Note. From Miller, Rathus, and Linehan (2007, Table 5.1, p. 97). Copyright 2007 by The Guilford Press. Adapted by permission.

TABLE 1.5. Adolescent Dialectical Dilemmas, with Corresponding Secondary Treatment Targets

Dilemma	Targets
Excessive leniency versus authoritarian control	Increasing authoritative discipline; decreasing excessive leniency
	Increasing adolescent self-determination; decreasing authoritarian control
Normalizing pathological behaviors versus pathologizing normative behaviors	Increasing recognition of normative behaviors; decreasing pathologizing of normative behaviors
	Increasing identification of pathological behaviors; decreasing normalization of pathological behaviors
Forcing autonomy versus fostering dependence	Increasing individuation; decreasing excessive dependence
	Increasing effective reliance on others; decreasing excessive autonomy

Note. From Miller, Rathus, and Linehan (2007, Table 5.2, p. 98). Copyright 2007 by The Guilford Press. Reprinted by permission.

earlier, a dialectical therapeutic position is one of constantly combining acceptance of what *is* with a push toward change. Note that these strategies do not apply only to individual DBT therapy; group leaders employ them during skills training as well. Falling within change-oriented, problem-solving strategies are techniques based on traditional behavioral principles: positive and negative reinforcement, shaping, extinction, and punishment. These behavioral strategies permeate DBT along with acceptance-oriented ones such as validation. In Chapter 3 we say more about orienting and commitment strategies, which are types of change-oriented problem solving. In Chapter 4 we discuss other core strategies and their application to skills training.

MULTIFAMILY SKILLS GROUPS FOR ADOLESCENTS AND THEIR FAMILIES

For skills training with adolescents, we recommend a multifamily group format when possible. In this format, parents learn the same didactic content side by side with their adolescents. The group provides a forum that can improve interactions and enhance closeness. Including multiple families also helps maintain the didactic agenda, as opposed to drifting into a single family's problems of the week. Having multiple families in the room offers a built-in support network; provides powerful coping models, motivation, and hope; and tends to expand group members' repertoires of skill use. For example, when review of homework exposes each member to 10 other examples of a skill's application, members can develop a more thorough and flexible understanding of the skill's use. A multifamily format also allows for feedback and practice across families, such as a teen practicing a skill with another teen's parent, or a parent gently providing input to another parent's teen. In such interactions, clients' emotions tend to remain better regulated, and thus new learning can be enhanced (the goal would then be to work toward direct interactions with one's own family members, to enhance generalization). Additionally, individual members often benefit from feelings of mastery when they can explain a concept to a newer member. Teens and parents alike report feeling validated to hear of the similar struggles of others, especially after a period of feeling very much alone. Finally, at the graduation ceremony (see Chapter 2), teens and parents offer their parting constructive feedback and encouragement to one another, which powerfully affects the graduates themselves and the remaining group members. Receiving the repeated supportive comments crystallizes

family members' newly formed self-constructs as capable, effective, functional, goal-oriented, and hopeful about their progress, both individually and collectively. Most graduating members also report dramatic improvement in the relationships with their participating family members. These public expressions capturing the progress within each individual and family demonstrate to other members how life can be improved, and models the need for perseverance and commitment to the DBT skills training group. This experience validates the challenges and pain the remaining families are enduring while also inspiring them to work harder and remain hopeful.

DBT Skills

The skills taught are grouped within five modules: Mindfulness Skills, Emotion Regulation Skills, Interpersonal Effectiveness Skills, Distress Tolerance Skills, and Walking the Middle Path Skills. This fifth module was specifically developed for adolescents and their families (Miller et al., 2007), and it is generally not taught in DBT skills training for adults. One complete course through all the skills modules typically takes 6 months (24 weeks), the same time frame as standard DBT. However, the adolescent skills program has five skills modules rather than four and so less time is devoted to each module than in standard DBT. Table 1.6 lists the skills taught in our adolescent DBT program.

As the list in Table 1.6 shows, a number of specific skills are referred to by acronyms or other mnemonics. For example, DEAR MAN, an interpersonal effectiveness skill, is an acronym for the steps to follow in effectively asking for something or saying no (Describe, Express, Assert, Reinforce; stay Mindful, Appear confident, Negotiate). The word *improve* in the distress tolerance skill of "IMPROVE the Moment" is an acronym for a set of various ways that distress might be made more tolerable. Group members are taught all the strategies and encouraged to try them out in order to find some that prove helpful.

TELEPHONE CONSULTATION TO FAMILY MEMBERS

In running multifamily skills groups, we have observed that family members benefit from telephone coaching of skills as much as their adolescents. This creates a dilemma: Adolescents call their individual therapist for coaching, but parents in skills training do not have an individual therapist to call. Phoning their teen's therapist poses obvious problems involving privacy and trust. We thus offer parents the opportunity to call the skills group leaders or their parenting therapist (see the next section on parent training sessions), and to limit these contacts to as-needed phone coaching for skills generalization (as opposed to other purposes, such as repairing the relationship or sharing good news). In cases where one of the skills group leaders is the primary therapist for their child, the parents may call only the other group leader. In settings in which the primary therapist is also the sole skills trainer and there is no separate therapist for the parents, allowing the parents to call the adolescent's therapist puts the teen's trust at risk. In such situations, the parent and adolescent need to agree to clear guidelines on what can be discussed in the therapist–parent skills coaching call. The parent and therapist should routinely disclose to the teen any calls made. Alternatively, skills coaching for parents may need to be restricted to the context of skills training or family sessions. Even if the parent's phone coach is someone other than the adolescent's primary therapist, we encourage parents to tell their adolescent when such a phone contact has been made so the adolescent remains confident that the treatment team is not operating in a deceptive manner.

TABLE 1.6. Overview of DBT Skills by Module

Core mindfulness skills
- "Wise Mind" (States of Mind)
- "What Skills" (Observe, Describe, Participate)
- "How Skills" (Don't Judge, Stay Focused, Do What Works)

Distress tolerance skills
- *Crisis Survival Skills*
  - Distract with "Wise Mind ACCEPTS" (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations)
  - Self-soothe with six senses (vision, hearing, touch, smell, taste, movement)
  - IMPROVE the Moment (Imagery, Meaning, Prayer, Relaxing, One thing in the moment, Vacation, Encouragement)
  - Pros and cons
  - TIPP Skills (Temperature, Intense exercise, Paced breathing, Progressive relaxation)
- *Reality Acceptance Skills*
  - Half-Smile
  - Radical Acceptance
  - Turning the Mind
  - Willingness

Walking the middle path skills
- Dialectics
  - Dialectical Thinking and Acting
  - Dialectical Dilemmas
- Validation
  - Validation of Others
  - Self-Validation
- Behavior Change
  - Positive Reinforcement
  - Negative Reinforcement
  - Shaping
  - Extinction
  - Punishment

Emotion regulation skills
- Understanding Emotions
  - Observing and Describing Emotions
  - What Emotions Do for You
- Reducing Emotional Vulnerability
  - ABC (Accumulate positives, long and short term; Build mastery; Cope ahead)
  - PLEASE (treat PhysicaL illness, balance Eating, avoid mood-Altering drugs; balance Sleep, get Exercise)
- Changing Unwanted Emotions
  - Check the Facts
  - Problem Solving
  - Opposite Action (to the current emotion)
- Reduce Emotional Suffering
  - The Wave: Mindfulness of Current Emotion

(continued)

TABLE 1.6. *(continued)*

Interpersonal effectiveness skills
Goals and priorities
Maintaining relationships and reducing conflict: GIVE
(be Gentle, act Interested, Validate, use an Easy manner)
Getting what you want or saying no: DEAR MAN
(Describe, Express, Assert, Reinforce, be Mindful, Appear confident, Negotiate)
Keeping your self-respect: FAST
(be Fair, no Apologies, Stick to your values, be Truthful)
Wise Mind self-statements to combat worry thoughts
Factors to Consider in Asking or Saying No
Optional: Reducing conflict and negative emotion: THINK
(Think from the other's perspective, Have empathy, other Interpretations, Notice the other, be Kind)

Note. From Miller, Rathus, and Linehan (2007, Table 4.2, p. 74). Copyright 2007 by The Guilford Press. Adapted by permission.

PARENT TRAINING SESSIONS

Over the years many parents have told us they needed more guidance with the parenting skills we introduce in the Walking the Middle Path Skills module. They feel they need help not only with dialectics and validation but also with the behavior change skills of reinforcement, shaping, extinction/ignoring, and consequences. Many parents feel that their parenting is erratic, reactive, and extreme toward their emotionally dysregulated teens, and the parents often struggle with emotional dysregulation themselves while trying to implement parenting skills. We have thus made available optional, separate sessions for parents with a therapist on the treatment team who is not the adolescent's primary therapist. The therapist works with the teen's parent(s) to implement more consistent and effective parenting strategies, while bringing in other DBT skills as needed (e.g., mindfulness, distress tolerance). We offer this modality on an as-needed basis to individual families for the parenting challenges that arise regarding their particular teen. We typically offer parenting sessions as a short-term modality; many parents feel they receive substantial help in 6–12 parent-focused sessions, whereas some opt to continue longer. The parent-training therapist then becomes the parent's telephone skills coach. While we offer the model to one or both parents from a family, a team could consider offering walking the middle path-based parenting skills as a separate group modality for parents as well. Note that if a family does not opt for parent training sessions, one can still offer the parents telephone coaching with a skills trainer who is not the teen's primary therapist. Research is needed to investigate the incremental validity of parenting sessions in adolescent DBT.

A NOTE ABOUT MANAGING SUICIDAL BEHAVIORS

We believe it is imperative that clinicians working with emotionally dysregulated, multiproblem patients learn the components of assessing and treating suicidal behaviors. Even patients who at first present without suicidal ideation or behavior may become suicidal as circumstances change. Thus, if one is providing skills training without an individual therapy component, it remains critical for the skills trainer to assess for suicidal risk factors at intake, recognize signs and risk factors during treatment, refer for individual therapy when suicidal behavior emerges, and handle a

suicidal crisis competently should one arise. A detailed discussion of intervention for suicide risk is beyond the scope of this skills manual. However, many books and chapters on this topic exist, and we recommend, at a minimum, reading Linehan's original text (1993a); becoming familiar with more recent, comprehensive assessments, including the LRAMP (Linehan et al., 2012); and considering intensive training in DBT, as starting points to learning to manage suicidal behaviors.

We urge readers providing DBT skills training to read further and partake in intensive DBT training. Practitioners need to familiarize themselves with key treatment planning steps with suicidal patients (Linehan, 1999), including (1) knowing and assessing for long-term and imminent suicide risk factors, (2) obtaining detailed descriptions of suicidal behaviors, (3) monitoring ongoing behavior, and (4) conducting detailed behavioral chain analyses and solution analyses of suicidal behaviors. Solution analyses could include finding ways to prevent precipitants, replacing crisis responses with more skillful responses, and tolerating distress. Furthermore, they must include the adolescent's commitment to follow through on strategies developed with the therapist. Linehan's general guidelines for treating suicidal behaviors include being more active when suicide risk is high (Linehan, 1993a, 1999), being more flexible in considering responses, being more conservative, openly and matter-of-factly talking about suicide, remaining aware of individualized risk factors, presenting suicidal behavior as an ineffective response/solution to a problem, involving significant others (especially parents, in the case of teens), maintaining frequent contact, and scheduling sessions (and family sessions) as frequently as needed. Linehan recommends maintaining a strong therapeutic alliance with one's suicidal client and consulting with colleagues whenever managing a suicidal crisis.

OUTCOME RESEARCH ON DBT PROGRAMS

Research on DBT with Adults

Multiple randomized controlled trials (RCTs) have demonstrated DBT's comprehensive superiority to treatment as usual for problems associated with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan et al., 2006; Koons et al., 2001; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Verheul et al., 2003). DBT has been shown to improve treatment adherence rates, decrease inpatient psychiatric days, and reduce frequency and severity of suicide attempts, nonsuicidal self-injurious behaviors, and suicidal ideation (Bohus, Haaf, & Simms, 2004; Linehan et al., 1991, 2006; Lynch, Morse, Mendelson, & Robins, 2003; Koons et al., 2001; van den Bosch et al., 2005; Verheul et al., 2003). Reviews of this research can be found in Scheel (2000), Robins and Chapman (2004), and Lynch, Trost, Salsman, and Linehan (2007).

Research on DBT has been conducted with various adult populations, including outpatient (e.g., Linehan et al., 1991, 1993, 2006; van den Bosch et al., 2005; Verheul et al., 2003), inpatient (Bailey et al., 1993; Bohus et al., 2000, 2004; Linehan et al., 1999; Koons et al., 2001; Simpson et al., 1998), and forensic populations (Berzins & Trestman 2004; Bradley & Follingstad, 2003; Evershed et al., 2003). DBT has been shown to have applications for adults with comorbid BPD and substance abuse problems (Linehan et al., 1999, 2002; van den Bosch et al., 2005), comorbid BPD and eating disorders (Palmer, 2003), as an independent treatment for eating disorders (Safer, Telch, & Agras, 2001; Safer, Telch, & Chen, 2009; Telch, Agras, & Linehan, 2000), as an enhancement treatment for habit reversal treatment for trichotillomania (Keuthen et al., 2010), and as a treatment for depressed geriatric outpatients with mixed personality features (Lynch, 2000; Lynch et al., 2003).

Research on DBT with Adolescents

In a recently published review article, Groves, Backer, van den Bosch, and Miller (2012) summarized 12 adolescent DBT outcome studies published between 1997 and 2008. Since 2008, two additional adolescent DBT studies have been published. None of these studies was an RCT. However, three RCTs are now completed and another large RCT is under way.

Cooney and colleagues (2012) conducted a small randomized controlled feasibility study in New Zealand. These investigators assigned adolescents ($N = 29$) who had at least one suicide attempt or history of self-injury in the previous 3 months to either DBT ($n = 14$) or treatment as usual ($n = 15$) for 6 months. In this study DBT consisted of weekly individual therapy, weekly multifamily skills training, family sessions as required, telephone coaching to both teens and parents, and a therapist consultation team. These investigators used Linehan's (1993b) skills training materials and blended in some of our adolescent DBT handouts (e.g., Walking the Middle Path Skills). DBT sessions in this study were coded for adherence by expert raters. Cooney determined that the treatment was feasible to administer and well tolerated by adolescents and families in New Zealand.

Lars Mehlum and colleagues (2012, 2014) conducted a large randomized controlled trial in Oslo, Norway, comparing 16 weeks of outpatient DBT to enhanced usual care (EUC) for suicidal and self-harming adolescents who also met at least three out of nine BPD criteria. EUC consisted of any non-DBT therapy coupled with suicide risk assessment protocol training. In addition, the blinded research assessors would notify the EUC therapists any time an adolescent endorsed suicidality during the assessment. The Norwegian research team translated our adolescent DBT skills manual into Norwegian. Similar to our original outcome study (Rathus & Miller, 2002), their DBT condition consisted of weekly individual therapy, weekly multifamily skills training group, telephone coaching for adolescents, as-needed family sessions, and weekly therapist consultation team meetings.

The sample consisted of 77 adolescents with recent and repetitive self-harm and borderline features, treated at community child and adolescent psychiatric outpatient clinics. Treatment retention was generally good in both treatment conditions, and the use of emergency services was low. DBT was, however, superior to EUC in reducing self-harm, suicidal ideation, depression, and BPD symptoms. Effect sizes were large for treatment outcomes in patients who received DBT, whereas effect sizes were small for outcomes in patients receiving EUC. DBT sessions were coded for adherence to DBT by expert raters. Mehlum and colleagues intend to conduct a 1-year, 2-year, and 10-year follow-up study of these youth and their families.

Goldstein and colleagues (2012) conducted a small RCT of DBT comparing DBT ($n = 14$) to treatment as usual ($n = 6$) for suicidal adolescents diagnosed with bipolar disorder. Goldstein and colleagues used our adolescent skills manual and added several additional handouts containing psychoeducation on bipolar disorder. In this study DBT was delivered 1 week with an individual therapy session alternating with 1 week with a family skills training session, so that each was received every other week for 12 months. Results indicated that participants receiving DBT had significantly greater reductions in depression and trends toward significantly greater reductions in suicidal ideation and emotion dysregulation. The DBT group was more severe at baseline and the study was not adequately powered to expect significance. Thus, even the trends toward significant reduction were noteworthy.

Linehan, McCauley, Asarnow, and Berk are currently conducting a large multisite RCT (Collaborative Adolescent Research on Emotions and Suicide [CARES]) comparing comprehensive DBT to supportive therapy for recent and repeated suicidal behavior in adolescents with

at least three BPD features. The DBT intervention spans 6 months and employs a multifamily group format with telephone coaching for teens and parents. These investigators use Linehan's skills training materials coupled with some content from the Walking the Middle Path Skills module (Miller et al., 2007).

In addition to these RCTs, three quasi-experimental studies on DBT with adolescents have been conducted to date, all of which indicate that the treatment is promising in reducing numerous target behaviors found among suicidal multiproblem youth (Fleischhaker et al., 2011; Katz, Cox, Gunasekara, & Miller, 2004; Rathus & Miller, 2002). These studies demonstrated feasibility and promising outcomes, including the results from a 1-year follow-up conducted by Fleischhaker and colleagues (2011).

Numerous open trials have also been published of DBT with adolescents with various problems and disorders: (1) multiproblem, multidiagnosed adolescents with suicidal and nonsuicidal self-injurious behaviors (Fleishchhaker, Munz, Böhme, Sixt, & Schulz, 2006; James, Taylor, Winmill, & Alfoadari, 2008; Sunseri, 2004; Woodberry & Popenoe, 2008); (2) adolescents diagnosed with bipolar disorder (Goldstein, Axelson, Birmaher, & Brent, 2007); (3) adolescents diagnosed with externalizing disorders in both forensic (Trupin, Stewart, Beach, & Boesky, 2002) and outpatient settings (Nelson-Gray et al., 2006); and (4) adolescents diagnosed with eating disorders, including bulimia, binge eating, and anorexia nervosa (Safer, Lock, & Couturier, 2007; Salbach, Klinkowski, Pfeiffer, Lehmkuhl, & Korte, 2007; Salbach-Andrae, Bohnekamp, Pfeiffer, Lehmkuhl, & Miller, 2008).

Other open trials highlight the application of DBT to various treatment settings beyond traditional outpatient, short-term inpatient, and forensic settings. These include applying DBT to adolescent girls in a residential treatment facility (Sunseri, 2004); adolescents receiving long-term inpatient care (McDonell et al., 2010); children and adolescents in school settings (Mason, Catucci, Lusk, & Johnson, 2009; Pereplotchikova et al., 2010; Sally, Jackson, Carney, Kevelson, & Miller, 2002); and youth in a children's hospital who are noncompliant with treatment for their chronic medical conditions, such as renal disease, diabetes, sickle cell disease, and obesity (Hashim, Vadnais, & Miller, 2012).

The common denominator in all of these studies appears to be the adolescents' deficits in emotion regulation and the subsequent engagement in impulsive or avoidant behavior. The problematic impulsive or avoidant behavior is often a consequence of emotion dysregulation or an effort to re-regulate. As we described previously (Miller et al., 2007), we believe that the profile of emotional and behavioral dysregulation in adolescents makes DBT a relevant treatment modality across diagnoses and behavioral problems.

Results reported from experimental and quasi-experimental studies to date indicate that DBT appears to reduce suicidal behavior, depression, and BPD features, as well as have strong treatment feasibility, acceptability (i.e., well tolerated), and reasonably strong treatment retention rates (Cooney et al., 2012; Goldstein et al., 2007, 2012; Groves et al., 2012; Mehlum et al., 2014; Rathus & Miller, 2002). We anticipate the results from the Linehan and colleagues CARES study will further advance the evidence base of DBT for suicidal and multiproblem adolescents.

In the next chapter, we describe how skills training is organized, including the overall treatment course, the session structure, and the setting-up of a skills training group.

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