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Commentary on A Short-Term Training Clinic Model for Dialectical Behavior Therapy (DBT) in Treating Borderline Personality Disorder (BPD): The Case of "Jane"

Secondary Targets Are Not So Secondary: Commentary on Michael Marks' Case Study of "Jane"

ALLISON K. RUORK [a,b]

[a] Graduate School of Applied and Professional Psychology, Rutgers University-New Brunswick, New Jersey

[b] Correspondence regarding this article should be sent to: Allison Ruork, Graduate School of Applied and Professional Psychology, Rutgers University-New Brunswick, Piscataway, NJ 08854

Email: Allison.ruork@rutgers.edu

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ABSTRACT

Michael Marks (2022) describes the case of "Jane," a client presenting with multiple concerns and targets for treatment, who was treated over six months using Dialectical Behavior Therapy (DBT) at the DBT Clinic at Rutgers University (DBT-RU). Treatment of Jane was consistent with the principles of DBT and represented significant progress in treatment broadly and, more specifically, clear gains in addressing therapy interfering behaviors, increasing willingness to engage in accurate expression and needs assertion in her romantic relationships, and decreasing hopelessness, which subsequently decreased suicidal ideation. Despite this significant progress Marks reports ongoing struggles with noticing change as it was happening, polarization, and painful and frustrating interpersonal transactions. In this commentary, I propose that many of the transactional (and highly understandable) pitfalls experienced by Marks and Jane may have been addressed by a case conceptualization that more actively integrated the "secondary targets" in DBT, which are anchored in the dialectical dilemmas represented by three continua: Emotion Vulnerability versus Self-Invalidation; Unrelenting Crises versus Inhibited Grieving; and Active-Passivity versus Apparent Competence. Specifically, I suggest that consistent and thorough inclusion of secondary targets in treatment can decrease the potential for polarization and transactions that lead to stagnation and can make therapy more efficient. In addition, I address some of the challenges to such a conceptualization.

Key words: Dialectical Behavioral Therapy (DBT); Borderline Personality Disorder (BPD); DBT Clinic; "secondary targets" in DBT; dialectical dilemmas; case formulation in DBT; case study; clinical case study

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Michael Marks (2022) describes the case of "Jane," a client presenting with multiple concerns and targets for treatment, who was treated over six-months using Dialectical Behavior

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Therapy (DBT; Linehan, 1993) at the Dialectical Behavior Therapy Clinic at Rutgers University (DBT-RU). Jane entered treatment as 32-year-old woman, meeting DSM-5 criteria (APA, 2013) for borderline personality disorder (BPD) and was struggling with chronic suicidal ideation; difficulties related to body dysmorphic disorder; and significant interpersonal dysfunction in both romantic relationships and with her 7-year-old son. Over the course of treatment, Marks and Jane primarily focused on decreasing suicidal ideation and increasing effective interpersonal behavior with sexual/romantic relationships. Direct targeting of these life-threatening-behaviors (LTBs) and quality-of-life-interfering behaviors (QOLIBs) was often interrupted by therapy-interfering behaviors (TIBs), particularly related to treatment engagement. Thus, these TIBs also became a focus of treatment, consistent with the treatment target hierarchy in DBT. Marks' conceptualization of Jane's targets and their relation to Jane's goals are both thoughtful and consistent with the DBT treatment model.

It is also apparent that Marks, Jane, and the broader DBT team made significant progress throughout treatment, particularly in the areas of reducing TIBs, increasing willingness to engage in accurate expression and needs assertion in her romantic relationships, and decreasing hopelessness, which subsequently decreased suicidal ideation. It is also apparent that Marks and the client both struggled with noticing change as it was happening, likely because of polarization and transactions between them that appear to have been experienced by both as painful and frustrating. In this commentary, I propose that many of the transactional (and highly understandable) pitfalls experienced by Marks and Jane may have been addressed by a case conceptualization that more actively integrates the secondary targets in DBT, which are anchored in the dialectical dilemmas represented by three continua: Emotion Vulnerability versus Self-Invalidation; Unrelenting Crises versus Inhibited Grieving; and Active-Passivity versus Apparent Competence. Specifically, I suggest that consistent and thorough inclusion of secondary targets in treatment can decrease potential for polarization, transactions that lead to stagnation, and make therapy more efficient. In addition, I address some of the challenges to such a conceptualization.

DBT AND THE NEED FOR A STRONG CASE FORMULATION

DBT is a multi-component treatment for chronic suicidality, chronic emotion dysregulation broadly, and is the gold standard treatment for BPD (a disorder characterized by chronic emotion dysregulation (Linehan et al. 1991, 1993, 2006). DBT aims to treat client problems by addressing five functions: (1) enhancing client motivation and capability, (2) skill acquisition, (3) skills generalization, (4) environmental intervention, and (5) enhancing therapist capability and reducing therapist burnout. As Marks points out, this is achieved through four

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modes of treatment: individual therapy, DBT skills training[1], in-vivo phone coaching, and consultation team for therapists. However, it is worth noting that it is the rule, rather than the exception, that different modes serve multiple functions in DBT. Moreover, despite Linehan's seminal book on the provision of DBT (1993) often being referred to as a manual, it is not a manual in the standard session-by-session sense. Rather, it can be conceptualized more as a guidebook organizing the principles and loose structure of DBT, and only the skills training component of DBT is manualized (Linehan, 2015). One of the greatest challenges to training and implementation of DBT is this flexibility and principle-driven format (Sayrs & Rizvi, 2020).

This flexible, principle-driven approach is grounded in, and facilitated by, case formulation based on behavioral assessment (Sayrs & Rizvi, 2020). As Marks notes, case formulation in DBT is based on an understanding of the client's goals, targets, and where they fall on the target hierarchy as (corresponding to the stage of treatment they are in (Linehan, 1993; Rizvi & Sayrs, 2020). Behavioral assessment and development of case formulation is an ongoing, dynamic process in DBT. Every session is an opportunity for further assessment and refinement of behavioral case formulation based on (but not limited to) data from diary cards and information collected during chain analysis. Case formulation in DBT is heavily emphasized for two (interconnected) reasons: (1) DBTs flexibility and reliance on principles, and (2) the multi-problem presentations common to DBT.

DBT's principle-driven approach means there is rarely a "required" or "correct" pathway in treatment, rather treatment is often a series of decision points. Strong case conceptualization presents an anchor for these decision points. It allows the therapist to respond effectively, and efficiently, to client behaviors in session and organize session targets in a way that maximizes opportunities for collaboration and minimizes distractions (e.g., problem of the week versus ongoing life-worth-living goals). In contrast, adherence to rules in DBT increases the likelihood of rigid therapist responses, decreases therapist effectiveness, and increases instances of polarization without synthesis. For instance, in Marks' treatment of Jane, in the context of Jane's interpersonal dysfunction and poor repertoire of needs assertion, there was an apparent (although not explicit) rule: in all instances where the client does not know how to ask for help, the solution is a DEAR MAN (effectively asking for what you want; see Marks [2022, Table 1, item 21]). While understandable, given that DEAR MAN is a skill for increasing effective needs assertion, Marks notes that the rule led to rigidity (i.e., repeated suggestions to use the DEAR MAN skill despite evidence it was not working); struggles to move forward; and increased client hopelessness. It was only when Marks moved toward a more conceptualization-driven approach (i.e., one emphasizing acceptance) that Marks had increased opportunities for collaboration with

[1] Note that in the DBT model used in the case study of "Jane," skills were taught in a group. And while groups are the most common means in DBT of delivering skills training, it is not a rule. In some settings skills training is done as an individual appointment, and in some cases where there is a high-degree of therapy-interfering behavior that interferes with others ability to learn in group it can be done individually even when groups are available.

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Jane; Marks had greater understanding of Jane's experience, and (eventually) Jane showed an increase in her willingness and ability to engage in needs assertion during the partner session. Reliance on rules in DBT is understandable, yet a solution that works very effectively with one client may not with another. Case formulation helps explain why this is the case and can help point the therapist to strategies that may lead to more effective treatment.

The ability to use case-conceptualization-driven reasons to move with clarity and precision in a flexible treatment is made more challenging by the multi-problem presentations commonly treated with DBT. For example, Jane's case with targets including suicidality, non-suicidal self-injury (NSSI), substance use, anxiety, depression, body dysmorphia, traumatic experiences, academic/work functioning, and interpersonal difficulties are common in DBT. DBT clients often have behaviors that are topographically dissimilar but serve similar functions (e.g., substance use and suicidal ideation may both function as escape behaviors). A case conceptualization that incorporates functional assessment and patterns of responding is critical to tailor intervention strategies, otherwise treatment can stall, or become a game of "whack-a-mole" that is frustrating and oftentimes disappointing to both client and therapist. One way in which attention to function rather than topography is accomplished in DBT case conceptualization is through the incorporation of secondary targets.

SECONDARY TARGETS: NOT SO SECONDARY….

Secondary targets are conceptualized as functional patterns of response; that is, they represent a way of organizing a variety of behaviors that may be topographically dissimilar but function in similar ways. The term secondary can be a bit misleading, and may be why, as others have noted (Rizvi & Sayrs, 2020), they are frequently not included in written case formulations or are given relatively little attention. Even with Marks' very thorough discussion of treatment, including the rationale for many treatment decisions and problems experienced in treatment, relatively little attention is given to the secondary targets.

As mentioned above, secondary targets are anchored in the dialectical dilemmas and are represented by three continua: Emotion Vulnerability versus Self-Invalidation, Unrelenting Crises versus Inhibited Grieving, and Active-Passivity versus Apparent Competence. Additional dilemmas for adolescents and families have also been proposed; however, for the purposes of this commentary only the original dilemmas will be considered (for a discussion of these expanded secondary targets see Rathus & Miller, 2000). While a complete description of the dialectical dilemmas, associated behavior and problematic transactions that can occur because of them is beyond the scope of this paper (see Linehan, 1993 for a review), a brief description of each of the poles and their transactional nature may be helpful for understanding their importance to case conceptualization and treatment.

Emotional vulnerability is ongoing emotional sensitivity, reactivity, and slow return to baseline, that is either biologically (e.g., temperament) or situationally (e.g., having the same

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disagreement multiple times) derived. Clients with emotional vulnerability are often described as emotional burn victims, where even the lightest touch of emotion causes intense suffering. Emotional vulnerability is countered by *self-invalidation*, which is communication to oneself that one's experiences (emotions, beliefs, efforts) are illegitimate and unacceptable.

Unrelenting crises is a state of pervasive and perpetual crisis, which further prevents the client from returning to their own emotional baseline. At the other end is *inhibited grieving* wherein a client attempts to inhibit or avoid emotional experiences.

On one end of the final continua, *active-passivity* is a passive, helpless, and hopeless approach to problem solving that activates others in the process of solving the problem. In contrast, *apparent competence* involves behaviors that lead to the perception that there is competency and an ability to cope, when in fact the client is either completely unable to or struggling to do so.

There is a transactional relationship between each dialectical pole of the three secondary goals. The two ends of the continuum are in transaction, as the one increases the likelihood for the other and vice versa. Increased *emotional vulnerability* may lead a client (a) to perceiving themselves as over-reacting and being overly dramatic, or (b) to making comparisons about the effort it takes and the difficulty of managing emotions, with such comparisons often being *self-invalidating* (e.g., "Nobody else seems to struggle, I'm just being dramatic again."). Conversely denying and suppressing emotional experiences (e.g., "I should not feel this way") increases vulnerability to them. Being perceived as competent may lead others to assume that the client is coping, when they are in fact finally overwhelmed and unable to do so, in which case the environment may rush in to provide aid in the absence of effective communication. The diminished ability to engage in active problem solving often increases shame and decreases needs assertion, leading to inaccurate expression and the perception that the client is doing alright. Finally, the experience of *chronic crises* may lead to desires to avoid emotions altogether so that the client feels less out of control. However, unfortunately this desire to avoid emotions frequently leads to diminished social support and experience with effective coping when a crisis inevitably comes.

The continuum of *emotional vulnerability* to *self-invalidation* is considered to be the core dialectic, while the other two continua are considered to flow from this dilemma (e.g., *apparent competence* is a specific form of self-invalidation, emotional vulnerability contributes to *unrelenting crises*). Importantly, the dialectical dilemmas are not mutually exclusive continua (e.g., either apparent competence or active passivity), rather there may be clients who exhibit none of the identified patterns of response, clients that have a predominant presentation (e.g., high degrees of inhibited grief), or clients that alternate, sometimes rapidly, between the ends of the continuum (Rizvi & Sayrs, 2020). For example, a client may frequently inhibit emotion, but this then leads to an increased likelihood of poor coping and ineffective responding that begins a cascade of problems when emotion cannot be avoided (i.e., *unrelenting crises*).

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BENEFITS OF INCORPORATING SECONDARY TARGETS INTO CASE CONCEPTUALIZATION: SPECIFIC EXAMPLES IN THE CASE OF JANE

Understanding of secondary targets can be helpful in a number of ways. By definition, it aids in conceptualizing controlling variables for behaviors on the target hierarchy. In addition, it can also be useful in generating solutions more likely to be successful in that it can increase the therapist's ability to validate more effectively, and it can lead to polarization that *facilitates* change (i.e., synthesis).

Understanding Controlling Variables

The importance of secondary targets, and thus the degree to which they are emphasized, is more accurately determined by their relationship to primary targets (Linehan, 1993). To that end, a particular pattern of responding that is consistently present across higher-order targets (i.e., life-threatening-behaviors [LTBs]) or multiple other targets (e.g., therapy-interfering behaviors [TIBs] or quality-of-life-interfering behaviors [QOLIBs]) is still considered to be a high priority for addressing in session. In his writing, Marks frames the secondary targets as behaviors primarily categorized as TIBs (e.g., self-invalidation led to dismissive responses to skills suggestions, emotional vulnerability led to in-session shut-down behavior). However, these behaviors could be conceptualized as occurring across a variety of targets, including higher order targets. In several instances in the case study Marks reports instances where Jane was highly vulnerable to emotion, self-invalidated her experience, and subsequently engaged in behavior that led to the environment (e.g., her boyfriend) solving the problem for her (e.g., engaging in re-connecting behavior). Such behaviors were associated with the relationship-withdrawal behavior identified as a QOLIB and were also antecedent to instances of suicidal ideation.

Improving Solution Analysis

While the active-passivity pole does indeed point to the use of skills to facilitate needs assertion behaviors (e.g., DEAR MAN), the constellation of emotional vulnerability versus self-invalidation in this context suggests the use of other skills taught to Jane in the group component of DBT (e.g., distress tolerance skills). These other skills could have directly counteracted those patterns of responding, such as skills to increase self-validation (e.g., mindfulness of current emotions) and skills to decrease emotional reactivity (e.g., the crisis survival skills included in the distress tolerance module of the DBT skills group) as necessary to facilitate more active problem solving. It is worth noting that is eventually where Marks arrived, but after numerous attempts to get the client to engage in change behaviors that were beyond her current level of distress, and after repeated self-identified instances of therapist TIBs around non-acceptance. Thorough and earlier assessment of these relationships may have also led to an effective solution analysis earlier, and also strengthened the rationale for emphasizing acceptance, even despite the understandable urge to push for change.

Greater Ability to Validate

Understanding of secondary targets can also increase the therapist's ability to validate both in terms of prior learning and in terms of current context. In the case of Jane, Marks provides a strong example of this when he expressed how numbness might make sense given the client's trauma history. One of the challenges in DBT is that the need for validation of clients in the presence of behavior can sometimes be confusing and frustrating to therapists. Jane's repeated absences from group, when the skills being covered were so clearly needed by her, might understandably frustrate her therapist. Yet, Jane's case conceptualization indicates that since inhibited grief and self-invalidation are frequent behaviors, avoiding group could be an encapsulation of that set of problems. It is possible, for instance, that she experienced the group as shame-inducing as it involved material she believed she "should already be doing."

Accepting that she needed that help (i.e., grieving that it does not come naturally to her) may therefore have been particularly aversive. Since emotional inhibition likely served her very well in a variety of contexts (e.g., while on military deployment, during a medical crisis at work), we can understand that while not effective in the current context, urges to avoid or suppress painful emotions made sense to her. Moreover, we can validate how painful shame, disappointment, and grief are when not being able to do things that appear easy to others.

In these ways, understanding of secondary targets can facilitate finding "kernels of truth" to validate when behavior is otherwise confusing and frustrating, thus helping to effectively manage polarization.

Polarization and Synthesis

Polarization is often treated as something to be avoided at all costs, or evidence that a therapist has done something wrong. However, the dialectical philosophy of DBT posits that polarization is natural and constantly occurring. Thus, polarization should not necessarily be avoided, as long as it is done in the service of treatment and facilitates synthesis (i.e., understanding and/or change). For instance, a client like Jane—who is intensely emotionally vulnerable, and alternates between assuming that she should have already solved all her problems and viewing herself as incapable of making change (potentially both self-invalidation and active-passivity)—may frequently become polarized with a therapist who is demanding that they make changes to their life. Indeed, we would expect that to be so, given the assumption within DBT that the most caring thing a therapist can do is push for change (Linehan, 1993). This assumption does not make that pushing any less painful, or potentially invalidating of how hopeless and stuck the client feels.

An important aspect of DBT is that this tension can be magnified, often using metaphor: "It is like you are in a lava field that is burning your skin, so you know you need to leave. You are so raw that any movement feels excruciating and staying where you are is also impossible, because then you keep burning!" This can help the client feel understood (i.e., validation) and,

paradoxically, allows space for change. Thus, it is only unresolved polarization that is antithetical to treatment in DBT.

CHALLENGES IN THE ASSESSMENT AND UNDERSTANDING OF SECONDARY TARGETS

The importance of secondary targets and the degree to which they are critical to treatment requires further empirical research. However, conceptually they are an important part of case formulation and the delivery of DBT with fidelity. There are a number of challenges to incorporating them into treatment, particularly early on in treatment. As previously mentioned, some of the secondary targets may present in less obvious ways and require multiple chain analyses, or challenges to treatment, before they become apparent.

Secondary targets are also often more difficult to describe specifically, particularly for clients. While a client can speak to the topographical qualities of suicidal ideation (i.e., frequency, intensity, duration, characteristics) with some ease, it is more challenging to provide such clarity for something like active-passivity. In other cases, it is only with the acquisition of mindfulness skills that clients may begin to identify a behavior as self-invalidation and notice the impact it has on emotional vulnerability. Early, and explicit, introduction in treatment to the secondary targets may help provide some language for naming a process that occurs in and out of session. Creative assessment questions may also be beneficial (e.g., "What do the people around you do when they see you getting overwhelmed?")

It is also critical that hypotheses about secondary targets be treated as such. They must be monitored over time to gather evidence, and it is possible to get it wrong. For example, we might incorrectly label behaviors as actively passive when the client is in fact trying to problem solve actively but is doing so in an ineffective manner. A specific instance of this would be a client assigned to practice opposite action to fear by remaining in a feared situation who comments on their struggle (e.g., "It is not getting better!). A well-intentioned other, who does not understand the skill being practiced, might respond by removing the feared stimulus. It is possible that this could be evidence of active passivity, depending on the effort put into practice and other variables. It also may simply be evidence of an environment treating the client as fragile.

The Unique Setting of DBT-RU

DBT-RU provides comprehensive DBT (i.e., inclusive of all modes of DBT). However, unlike many other comprehensive programs (see Miga et al., 2019 for a review), DBT-RU is a 6-month program. Students complete a semester-long course on the fundamentals of DBT taught by Dr. Shireen Rizvi, prior to joining the two-year practicum. In addition to this foundational course, after joining the practicum students participate in (a) a weekly 1.25-hour didactic seminar covering more advanced topics related to DBT (e.g., advanced behavioral chain analysis, and adaptations for specific populations); (b) a weekly 1.25-hour consultation team; and (c) weekly

supervision meetings that are between 1.5 and 2 hours, depending on whether the student is also leading/co-leading skills group. Dr. Rizvi, who oversees and directly provides consultation and supervision, received graduate training from Dr. Linehan, has over 20 years of experience, and is an international trainer and consultant. Thus, DBT-RU is a unique opportunity for graduate students (many of whom have prior experiences with different theoretical orientations) to receive expert training and instruction in DBT, with relatively brief courses of treatment.

There is evidence that training and implementation of treatment at the DBT-RU are effective at reliably reducing mental health symptomology, and the gains made in this program are comparable to a benchmarked RCT (Rizvi, et al., 2017). However, the relatively short time in treatment, combined with the dynamic and ongoing process of behavioral assessment and case formulation, may impede thorough understanding of secondary targets. It is possible that while some dialectical dilemmas are apparent from the beginning (e.g., Jane's alternating between emotional vulnerability and self-invalidation), others are more subtle, requiring more evidence collected over time. A clear example of this that Marks identifies is Jane's consistent apparent competence that led to transactions where he was often pushing for change that was outside of Jane's current level of ability. Further research would benefit from determining what level of understanding of such targets is effective and necessary for treatment.

CONCLUSION

It is significantly easier to recognize the potential impact of secondary targets when one is outside the context of ongoing therapy, particularly when presented with such a detailed case study as provided in Mark's case of Jane. While more empirical study of secondary targets is important for understanding their importance and role, at a conceptual and theoretical level they are a critical, though often neglected, part of case formulation. They are a way of understanding client behavior, and they can facilitate more effective solution analysis, validation, and polarization that leads to synthesis—all of which support more effective and efficient treatment.

All of this is clearly beneficial for clients. It is also of value for therapists, since unresolved polarization and slow to minimal progress in therapy has been suggested as some potential causes of burnout in the treatment of BPD (Linehan et al., 2000). On the other hand, there are of course challenges to the assessment and inclusion in treatment of secondary targets. They may require significant hypothesis generation and testing (often facilitated by multiple chain analyses). These processes may well make an accurate and coherent understanding of secondary targets particularly challenging to achieve in shorter courses of treatment.

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