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

The Many Layers of Complexity in DBT: Reconstructing a Crucial Theme in the Therapy of "Jane"

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ABSTRACT

This article presents my responses to two Commentaries on my DBT case of "Jane" (Marks, 2022): one by Gillian Galen, Blaise Aguirre, and Julianne Wilner Tirpak (2022); and one by Allison Ruork (2022). While both Commentaries acknowledge that my therapy with Jane was ultimately quite helpful to her, both point to the turbulent and conflictual nature of a substantial portion of our therapeutic relationship. Galen et al. attribute this struggle in part to the DBT equivalent of "countertransference" dynamics in my therapeutic relationship with Jane; and Ruork attributes this struggle in part to my under use of the DBT concept of "secondary targets." I found both of these perspectives very on target, and they stimulated me to reconstruct a crucial theme in the therapy from excerpts of therapy process in sessions 14-24 of my case study of Jane. I end the article by reflecting on the value of writing up systematic case studies with sufficient descriptive clinical detail so that valuable secondary analyses can be conducted, like those by Galen et al., by Ruork, and by me based on the former two.

Key words: Dialectical Behavioral Therapy (DBT); Borderline Personality Disorder (BPD); countertransference in DBT; "secondary targets" in DBT; therapist emotional experiencing; case studies; clinical case studies.

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INTRODUCTION

I want to thank Galen, Aguirre, and Tirpak (2022) and Ruork (2022) for their very insightful Commentaries on my case study of "Jane" (Marks, 2022). From my description of the process of the case, it's clear that my therapy with Jane was ultimately quite helpful to her, "increasing [Jane's] willingness to engage in accurate expression and needs assertion in her romantic relationships, and decreasing hopelessness, which subsequently decreased suicidal ideation" (Ruork, p. 102). However, the therapy process was fraught with struggle between us—in the words of Galen et al, it was a "roller coaster ride" (p. 95), and in the words of Ruork, it

was filled with "therapy-interfering behaviors" (TIBs), including "polarization, and painful and frustrating interpersonal transactions" (p. 102).

My therapeutic struggles with Jane occurred in spite of my extensive use of DBT concepts and strategies, including, in Galen et al.'s words, "use of case conceptualization, validation, metaphor, after hours skills coaching, chain analysis, review of diary card, skills teaching, use of his consultation team, addressing his and his patients therapy interfering behaviors (TIBs), irreverence, problem solving, acceptance and change strategies and more" (p. 95). What then led to my therapeutic struggles with Jane? The two Commentators suggest different but complementary answers to this question, as described below.

GALEN ET AL. ON "COUNTERTRANSFERENCE" IN DBT, INCLUDING THE PRESSURES OF DOING THERAPY AS A STUDENT UNDER SUPERVISION

Galen et al. point out that researchers in Dialectical Behavior Therapy (DBT) have adapted to DBT the psychoanalytic concept of "countertransference," defined as the therapist's at times powerful emotional, cognitive, and behavioral reactions to the client, of which frequently they do not have full awareness. Citing Gabbard and Wilkinson (2000), Galen report that when asked about their work, therapists including DBT therapists have reported feeling: "anxiety, guilt, rage, helplessness, worthlessness, rescue fantasies, and even terror, when working with patients with borderline personality disorder" (Galen et al., 2022, p. 97).

What particularly struck me were the emotional challenges of working with Jane around my feelings of personal failure. In the Galen et al. Commentary, the third author, Julianne Wilner Tirpak is a postdoctoral student who is particularly attuned to the special pressures that were on me during Jane's therapy, since I was a fellow student in therapy training. Specifically, in the DBT-RU Clinic, Tirpac highlights that I was required to record my therapy sessions and to share them in individual and group supervision, and to participate in consultation group; and that in all these situations, I was subject to evaluation anxiety. Moreover, while seeing Jane in therapy I believed I would likely do my doctoral dissertation on a case study of my therapy with her, and thus there was additional evaluation anxiety about my performance in the dissertation.

In summarizing my presentation of therapy process in my case study, Galen et al. point out that

> While Marks beautifully describes his procedures and interventions, he tells us little about [the tool of employing] his own emotional experience and how he uses it in the treatment. … [For example,] as we read through the sessions we wondered if without using that tool he had a more difficult time allowing for pauses to support the patient's own emotional experiencing in the sessions. (p. 95).

Thus Galen et al. propose that the intensity of the emotional instability and resistance in Jane's response to my therapy, together with the performance anxiety mentioned above, caused me to defensively use some of the emotion-avoiding techniques that DBT describes BPD patients as defensively using. In contrast, Galen et al. point out that it is the very active awareness and grappling with difficult emotions that I could have employed as a modeling opportunity for Jane to deal with her own emotional dysregulation. In Galen et al.'s words, an important clinical tool for the therapist to use is to mobilize "the challenges that DBT therapists face around using their own emotional experience as part of the therapeutic intervention" (p. 96).

Importantly, Galen et al. remind me that what is

> fundamental as a core tenet of DBT is that clinicians are also expected to practice the very DBT skills that they teach; most importantly in order to build awareness of their moment-to-moment experience and then to regulate their emotions, to tolerate distress, and to be effective in therapy (p. 98).

RUORK ON SECONDARY TARGETS

As described in my case study of Jane, the "primary targets" in DBT consist of three particular types of behaviors, based on their function and in order of priority: Life-Threatening Behaviors (LTBs), Treatment-Interfering Behaviors (TIBs), and Quality-of-Life Interfering Behaviors (QOLIBs). In addition I described that in DBT there are three "secondary targets" that cut across all of the primary targets. These secondary targets are reflected in "Dialectical Dilemmas," including "Emotional Vulnerability" versus "Self-Invalidation"; "Active Passivity" versus "Apparent Competence"; and "Unrelenting Crisis" versus "Inhibited Grieving."

Ruork begins her Commentary by describing the difficulties I experienced in the therapy with Jane as follows:

> 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 (p.103).

Ruork then proposes that many of the struggles I experienced with Jane could have been reduced if I had employed a case conceptualization that more actively integrated the above-mentioned secondary targets in DBT. Ruork writes:

> Specifically, I suggest that consistent and thorough inclusion of secondary targets in treatment can decrease potential for polarization and transactions that lead to stagnation, and can make therapy more efficient (p. 103).

Ruork expands upon the nature of the secondary targets:

> 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 (p. 105).

Ruork points to a variety of ways in which I underutilized the concept of secondary targets in my ongoing case formulation understanding of the ongoing process of my therapy with Jane. For example Ruork writes:

> In Marks' treatment of Jane, in the context of the client's interpersonal dysfunction and poor repertoire of needs assertion, there was an apparent (though 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., emphasizing acceptance) that there were opportunities for collaboration, greater understanding of the client's experience, and (eventually) willingness and ability to engage in needs assertion during the partner session (p.104-105).

RECONSTRUCTING A CRUCIAL THEME IN THE THERAPY ILLUSTRATING BOTH THE PROCESSES OF COUNTERTRANSFERENCE AND OF SECONDARY TARGETS AT WORK

Introduction to the Reconstruction

As described in my case study and as reflected on by the Commentators, my all-too-frequent confrontational stance to Jane, especially around expressing her feelings to her partner, were counterproductive to the therapy. How then did I get to a point in the therapy where Jane reversed her resistance and agreed to a joint session with her partner, a session in which she expressed her problematic feelings to him, which in turn led to substantial therapeutic progress for Jane?

The answer to this question is that after a number of sessions where I kept butting heads with Jane, particularly around encouraging her to use the DEAR MAN skill with her boyfriend, my Supervisor and the Consultation Team repeatedly recommended a shift towards more acceptance-based interventions. I prioritized core acceptance strategies, like validation, and stylistic acceptance strategies like self-involving self-disclosure. And on multiple occasions, expressing my feelings, both in consultation team and therapy, turned out to be turning points that increased Jane's and my acceptance and willingness to progress. However, during this

process I was also distracted away from the focus on acceptance-based strategies, with a number of regressions to confrontation with Jane, extending the therapy time before Jane agreed to the joint session.

The pattern I just summarized was not that clear at the time that I wrote the case study of my therapy with Jane. The Commentaries were very helpful in guiding me to re-read in detail my case study so as to see the above-summarized pattern. Below are selected quotes from the case study of Jane (Marks, 2022) and descriptions that track how it unfolded. Actual quotes from my case study are in italics and my comments on them are in non-italics and brackets.

The Reconstruction of Process in Sessions 14-24 (Marks, 2022, pp. 51-69).

Session 14

... Jane reported high urge to quit therapy. She reported "hopelessness" regarding the potential effectiveness of therapy and stated that she "did not see" how DBT would address her presenting problems effectively. I engaged in a discussion during which I attempted to convince Jane of the utility of DBT, a discussion that again became polarizing. I used metaphors to teach her DBT. I also used self-disclosure, sharing my frustrations that talking about DBT often resulted in us not enacting DBT methods. As had occurred in similar polarizing discussion in past sessions, it ended with Jane half-heartedly agreeing with my logic and committing to re-engage with treatment. Specifically, Jane committed to practicing mindfulness for homework as a means of "re-starting" treatment. Notably, I neglected to check in about the exposures Jane had agreed to perform two weeks prior. This represents TIB on my part. ...

[Supervision (Before Consultation Team)

With Jane's increasingly ineffective behaviors I felt our therapy had taken a downward turn. My supervisor agreed and highlighted the fact that Jane's increased ineffectiveness had led to intense suicidal ideation. The increased ineffective behaviors and strong suicidal ideation made it important that I present the case at consultation team.]

Consultation Team (Before Session 15)

*... My consultation team validated the difficulty of the problems I was bumping up against and the frustration I was feeling. They also validated my approach. They convinced me I did not need problem-solving. The approach was sound. The issue was my delivery. Though I would enter sessions intending to prioritize acceptance, by the end I was leaning on change tactics. The approach to Jane's problems did not need to change. Rather, a change needed to occur **within me**. I resolved to focus my efforts on maintaining an acceptance-based approach. ...*

[The shift to acceptance-based interventions led to increased commitment and engagement in treatment. Jane practiced more skills and was becoming more effective. However, there were many new behavioral patterns to learn and, in the meantime, Jane was

continuing to lean on old, maladaptive behaviors that were having more and more negative repercussions, including an influx in suicidal thoughts.]

Session 19

... During skills group the night prior, I had perceived Jane's behavior and body language as withdrawn and emotional, as if something was wrong. I conveyed these impressions and expressed my concern, as well as self-disclosing my "apprehension" about sharing my concern with her. Jane affirmed my impressions. She told me she disliked that I felt apprehensive about sharing my concern. The conversation facilitated acceptance of her issues and willingness to openly express how she had been feeling.

The ensuing discussion illuminated Jane's difficulty asserting her needs with her partner ...

I suggested we have [her boyfriend] join one of our sessions so I could support her acting opposite to shame by expressing her needs and emotions to him. Jane agreed...

Supervision (Before Session 20)

With Jane's increasingly ineffective behaviors I felt our therapy had taken a downward turn. My supervisor agreed and highlighted the fact that Jane's increased ineffectiveness had led to intense suicidal ideation. The increased ineffective behaviors and strong suicidal ideation made it important that I present the case at consultation team. ...

Consultation Team (Before Session 20)

[Consultation team modeled acceptance-based interventions by validating me and encouraging me to stick to the plan and continue to do what it took to maintain a stance of acceptance.]

When I described the current state of treatment, I expressed my feelings of frustration, inadequacy as a therapist, disappointment that we had "not accomplished anything," and stress about the limited time—six sessions—left in treatment. I became noticeably emotional. Members of the team reflected and validated my feelings of being overwhelmed. Their compassion and warmth helped regulate my affect. "I don't know what to do now, though," I said. I felt like there was too much to do and not enough time to do it. I rejected initial suggestions from team members by explaining why their proposed interventions would not be effective. Team members pointed out I had taken on my client's stance. I was overwhelmed, hopeless, and ruminating instead of actively problem-solving. Convinced, I assumed a more open and willing mindset and once again asked for their help problem-solving. ...

My consultation team recommended I highlight how much there is to do and to start from the top. As a strategy to shake Jane away from hopeless rumination, it was advised I "enter the paradox" by explicitly stating there is a lot to do so we should take it slow. Though I still felt overwhelmed, I felt more regulated, organized, and prepared.

Session 20

... Next, we discussed planning the partner session. I asked Jane to practice requesting help by asking her boyfriend, "Ian," to join us on a specified date. Jane agreed to ask. ...

Session 21

... Next, we spoke about planning the partner session. I told her the purpose of bringing in her partner would be to assist her in achieving her therapeutic goals. We collaboratively discussed ways in which a partner session might help facilitate movement towards her goals (e.g., reducing or replacing relationship-withdraw behaviors and relationship-approach behaviors with healthier relationship behaviors; and increasing interpersonal effectiveness skills).

Jane's stance shifted. She said she was not sure what could be accomplished by having her partner join. [We became briefly polarized.] …

I drew a connection to her stated reasons for infrequently utilizing phone coaching. Jane had repeatedly told me some version of, "I am not really sure what I am calling for, so I don't call," or "I don't think there is a solution to my problem, so I don't call." I reflected back the paradox:

> Mike: It's like, "I don't know what I need so I cannot ask for it," or "I have already tried everything, and I know there is no solution, so I don't ask for help." You believe there is no solution and yet you believe you need a solution.
>
> [We sat in silence.]
>
> Jane: Yeah. So that's it.
>
> Mike: Yeah. That's it. I guess we have to accept it.

With an eye on "acceptance," [i.e., acceptance that she has a problem that needs to be solved and feels unsolvable] *we turned our attention to the chain* [about her skin "flaws" concerns.] *Jane had completed for homework….*

After reviewing the chain, I asked Jane, "What kind of skin 'flaws' are you referring to?"...

Here we began becoming polarized: she on the side of wanting to "hide" her skin and herself, and me on the side of wanting her to "expose" them." ...

Noticing we were polarized, I highlighted it:

Mike: I'm noticing us getting into a bit of a tug-of-war here. Let's drop the rope for now and return to the chain. Why don't you add "shame" to the chain. What action urges are associated with it?

Jane: My action urge is to hide. And also to break up [with my boyfriend] before he... You know what I mean?

Mike: [filling in the blank] Before you lose the relationship because of your flaws, which would be more painful than [you taking action and] breaking up with him preemptively?

Jane: [laughing] I agree.

We completed the chain and looked back at it together. We had identified several problematic behaviors leading up to the target "breakup behavior."…

I said,

I've always felt [like I am kept] at arms distance from you. It's like I am not getting to know "all of you" because you are holding back.

She agreed and said she does that, in part, because she already felt attached to me and knew our relationship would end so she felt she needed to "avoid opening up too much" to protect herself from the intensity of grief when the therapy inevitably came to an end. I strongly validated her feelings and connected it to her above chain by noting that "hiding" prevented her from feeling "shame" and from feeling "overly attached" and vulnerable to grief (see the above-mentioned dialectical dilemma pole of "inhibited grieving," that is, the tendency to avoid or control strong emotions associated with loss). With that being said, we agreed we were working on the correct treatment targets because shame and avoidance of future grief appeared to continually get in the way….

<u>Session 22</u>

… We then shifted to planning the upcoming partner session. I reminded Jane the goal we had identified was to practice Opposite Action (Table 1, row 18) in response to shame cued by interactions with her boyfriend. We also agreed on another goal of providing concrete behaviors her partner can do for Jane to facilitate treatment goals. Jane reiterated her difficulty identifying helpful behaviors for her partner to engage in. I offered several suggestions. Jane declined each suggestion and provided reasons why she believed they would be not helpful. …

I soon became aware we were becoming polarized. Rather than continue to "tug the rope," I decided to drop it. Instead, I modeled self-disclosure and described the frustration I was experiencing attempting to identify effective actions for her boyfriend. At my prompting, Jane confirmed she experiences similar frustration, even hopelessness, about getting what she needs from her relationships. We discussed what it might be like to share that with her partner: that she feels frustrated and hopeless, and possibly request her boyfriend be patient

*while she continues to work on her effectiveness in obtaining needs within the relationship.
…*

[To summarize, our conversations tended to become polarized when we discussed what help to ask of Jane's boyfriend. Expressing my emotions led to a less defensive, more open and collaborative discussion about Jane's feelings. This collaborative discussion about our emotions led to the formation of a synthesis: The idea to include the expression of those feelings with Jane's boyfriend as a means to practice Opposite Action to shame.

The commentary of Galen et al. and Ruork provide frameworks for understanding how the synthesis was eventually formed. First, my emotional experience was a critical factor in arriving at a synthesis. Second, the incorporation of secondary targets into the synthesis-formation process made the intervention more effective. Sharing my emotions prompted an open and accepting discussion of Jane's struggles with self-invalidation and emotional vulnerability. Jane's self-invalidation invoked shame surrounding of her emotions and her need for help. Our open conversation about our emotions acknowledged that shame while simultaneously acknowledging her emotional vulnerability. The synthesis we collaboratively formed, which emerged through open inclusion of my own emotions and countertransference, thus addressed the secondary targets we previously failed to sufficiently incorporate in previous efforts.]

The plan would then be to practice Opposite Action in session by stating "I feel ashamed telling you about how I feel right now, and I feel ashamed at how difficult it is for me to tell you that."

Session 23

… Jane said, "I'm not sure [the partner session] is going to happen anymore." My heart sank. Jane confirmed she had requested he join a session and he was willing. However, a variety of logistical issues were making it difficult for him to attend.

After briefly attempting to problem-solve, it became clear Jane had not directly engaged in planning with her boyfriend. I noticed Jane appeared uncomfortable conveying to her boyfriend how important it was to her that he join. …

She expressed worry that her boyfriend would respond "impatiently" or in some way that would "hurt" because she was being "unreasonable" and burdensome.

I validated her concerns...I then challenged her inclination that expressing these emotions and needs would be inappropriate or excessive... Jane disagreed with my assessment of the situation. I replied, "Okay, maybe you're right. Here's how I might handle this situation. Tell me what you think."

[Jane requesting her boyfriend to figure out a way to attend the session, even though it might be inconvenient for him, was identified as shame- and anxiety-inducing. After trying to convince her with logic, I shifted to an experiential role-play exercise in which I played

the role of "Jane" and modeled a DEAR MAN as below. Being on the receiving end, she felt more confident that such a request might not be received as she feared it would be.]

I modeled an abbreviated DEAR MAN using GIVE skills (see Table 1, rows 21 and 22, respectively)….

Jane conceded she liked my approach and "might" try to ask him again in a more expressive way. "Might?" I prodded playfully. "Okay, okay, I'll do it!" she said and she laughed with light-hearted exasperation. I had Jane practice her own, impromptu DEAR MAN several times until it was expressed smoothly. She committed to delivering it to her boyfriend. She told me she would let me know later in the day. I set a contingency structure by telling her that I would call if I did not hear from her. ...

Jane texted later that day to confirm her boyfriend would indeed be joining our next session.

Session 24 – Partner Session

*… Jane, with my guidance, described the frequency and types of scenarios in which she becomes emotionally dysregulated. She quickly became visibly ashamed. Her eyes were downcast, infrequently flicking up toward her partner as she spoke to the floor. Yet her boyfriend leaned forward and appeared to angle himself as if to catch her eye and convey reassurance, in a validating and empathetic manner. Jane's boyfriend responded by thanking her and requesting, with warmth and sincerity, for her to communicate her emotions with him in those moments going forward. **In an ideal way, he was modeling direct communication.***

Jane's demeanor shifted. Her eye contact with Ian increased and she sat up in her chair. Jane expressed worries that she will be "annoying" or "a burden" if she expresses herself in those moments and that she fears he will want to leave her if she does. Ian replied,

> *It's honestly more of a burden to me when you don't tell me what's going on. I give you full permission to be annoying. Please be annoying. It's way more annoying when you shutdown.*

Jane laughed and committed to doing her best in future. I reminded her that doing so is difficult and that we had planned to ask for Ian's patience as she works to increase her expressiveness. Jane said, "Oh yeah, that too," and we all laughed together.

CONCLUSION

In sum, the emphases in the Commentaries by Galen et al. and by Ruork on the roles of "countertransference" dynamics and "secondary targets" in Jane's therapy were very helpful to me as perspectives in re-analyzing the process of my therapy with Jane. Specifically, these emphases guided me in reconstructing a crucial theme in the therapy. This theme centered around a long process with four steps: (a) my becoming more aware of and expressing my

countertransferential feelings towards Jane, which in turn (b) promoted discussion that enhanced my understanding, acceptance, and empathy towards Jane's problems, which (c) facilitated my helping Jane to overcome her resistance to expressing her feelings towards her partner, which in turn (d) created conditions for one of the powerful change agents in helping Jane—namely, the next-to-final session in which Jane's partner Ian attended and participated, ideally modeling direct communication.

It should be noted that before I saw the Commentaries, I had made three previous passes through the therapy process of Jane's case: first, as I was directly experiencing the therapy as it was being conducted; second, as I was supervised and received feedback from my DBT consultation team in reflecting on the therapy as it was proceeding; and third, as I was writing up the whole case study of Jane's therapy for my dissertation (a revised version of which is the present published case study [Marks, 2022]). Each of these three passes provided important cumulative learning and understanding of Jane's therapy.

However, as discussed above, there was distinctive additional learning for me that was facilitated by the Galen et al. and Ruork Commentaries. Importantly, the theme these authors helped me to see had in fact been *hiding* in the case study that I had written. It seems to me that this is one type of validation of the importance of writing up in detail systematic case studies with extensive amounts of descriptive clinical data. While such reports do contain their own interpretations of these data, the setting forth of the extensive amount of such data itself provides material for new, alternative interpretations of dramatic value.

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