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Contains Video [1]

Orienting Clients to Telephone Coaching in Dialectical Behavior Therapy

Denise D. Ben-Porath, *John Carroll University*

Considerable attention in the literature has been devoted to individual therapy and group skills training in dialectical behavior therapy. However, there is a relative dearth of information on telephone coaching in DBT. While several authors have addressed important issues in DBT, including studies on efficacy and therapeutic considerations, what is glaringly absent from the literature is a basic overview of how to orient new clients to DBT phone coaching. The goal of the current paper is to highlight the following six important areas and their role in orientation to DBT phone coaching: (a) orientation to the three functions of DBT telephone coaching; (b) orientation to the rationale of the 24-hour rule; (c) orientation to the logistics of contacting their therapist after hours; (d) orientation to observing the therapist's personal limits; (e) orientation to the purpose of phone holidays; and (f) orientation to the practice of using skills prior to calling. A video is provided to further elucidate how to orient clients to DBT telephone coaching.

Dialectical Behavior Therapy (DBT) is one of the few treatment approaches that has been shown to be effective at reducing nonsuicidal self-injurious behaviors in a borderline population. To date, considerable research has demonstrated that DBT is an efficacious treatment for borderline personality disorder (BPD; Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006; Linehan, Heard, & Armstrong, 1993; Linehan, Kanter, & Comtois, 1999). Indeed, the American Psychological Association of Clinical Psychology (Division 12) has listed DBT as one of four empirically supported treatments (ESTs) for BPD and the only EST that has "strong" research support (Society of Clinical Psychology, Division 12, 2013). DBT is based on Linehan's (1993) biosocial model, which posits that BPD stems from an individual's inability to effectively modulate negative affect coupled with an environment that consistently provides invalidating messages. In DBT, four treatment modalities work in concert to provide validation to the client while also teaching the client more adaptive ways to regulate affect.

The four treatment modalities employed in standard DBT include individual therapy, group skills training, DBT consultation team, and DBT telephone coaching. The first treatment modality, individual therapy, serves as the core of treatment. The individual therapist validates the emotional pain of the client, yet also actively pushes the client to replace maladaptive behaviors with more skillful, adaptive behaviors. In the second treatment modality, clients learn from skills trainers, in a didactic group format, DBT skills designed to increase mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. The individual therapist reinforces the acquisition and strengthening of these skills during individual sessions. The central goals of the third treatment modality, consultation team, are to support the therapist to minimize burnout and to help maintain fidelity to the DBT treatment model. In team consultation, clinicians hold the dialectic of validating the therapist while simultaneously pushing the therapist and the team to problem solve and search for solutions that will be therapeutic for the client and the therapist. The fourth treatment modality, and perhaps the most radical departure from other approaches used to treat BPD, is the use of telephone coaching as a standard operating procedure in DBT.

Telephone coaching assists therapists in balancing the dialectic of providing additional contact to clients during crisis periods while simultaneously extinguishing passive, dependent behaviors and reinforcing active, competent skill use (Linehan, 1993). All clients enrolled in DBT are given access to their therapists between sessions and after hours to assist in the generalization of skills taught in the group skills training sessions (Linehan).

While considerable attention in the literature has been devoted to DBT individual therapy and group skills training,

[1] Video patients/clients are portrayed by actors.

Keywords: dialectical behavior therapy; telephone coaching; orientation

Continuing Education Quiz located on p. 534

only eight papers have been published on telephone coaching (Ben-Porath, 2010; Ben-Porath, 2004; Ben-Porath & Koons, 2005; Koons, 2011; Limbrunner, Ben-Porath, & Wisniewski, 2011; Linehan, 2011; Manning, 2011; Wisniewski & Ben-Porath, 2005). Koons (2011) has described the important role the DBT consultation team plays in maintaining fidelity to phone coaching and preventing burnout in the therapist. Steinberg, Steinberg, and Miller (2011) have described important and critical issues related to DBT telephone coaching when working with adolescents and families. Wisniewski and Ben-Porath (2005) have adapted the DBT telephone coaching model for BPD to patients with eating disorders. However, what is glaringly absent from the literature is a basic overview of how to orient new clients to DBT phone coaching. Indeed, Manning (2011) identified failure to orient DBT clients to phone coaching as one of the most common errors clinicians make when implementing DBT telephone consultation. Given that phone coaching is not a standard operating procedure in most therapies, it is important to address this area as many clinicians are unsure how phone coaching differs from intersession crisis-oriented contact. Thus, the goal of this paper is to highlight the functions of phone coaching in DBT and describe how to orient clients to phone coaching who are new to DBT.

How to Orient Clients to DBT Telephone Coaching

Research demonstrates that when individuals are informed of goals and expectations in treatment, compliance in therapy increases. For example, Yeomans et al. (1994) have demonstrated that when clients are informed of their expectations and responsibilities in treatment, premature termination decreases and compliance to treatment increases. In spite of this, many clinicians fail to orient their clients to treatment. For example, Kamin and Caughlan (1963) interviewed former clients about their experience in treatment and found that almost 75% had no clear understanding of their role or the role of the therapist.

Thus, informing clients of the rationale and the functions of telephone coaching in DBT is an important part of orienting clients to DBT treatment. As seen in the video, clients are informed in the orientation session that after-hours telephone coaching is offered for three important reasons: (a) to decrease suicidal and nonsuicidal self-injurious behaviors, (b) to assist in generalizing the skills taught in treatment to everyday life, and (c) to provide an opportunity to make a repair in the therapy relationship if warranted (Linehan, 1993).

Orient Client to the First Function in DBT Phone Coaching

When working with suicidal clients or nonsuicidal self-injurious clients, an important goal is to reduce the risk of a completed suicide while not simultaneously reinforcing future suicide behaviors (Linehan, 1993). This can be a delicate walk as the very intervention that is at times required to prevent suicide (e.g., hospitalization, additional therapy contact, etc.) can also serve to perpetuate suicidal behaviors. Thus, it becomes critical to properly orient DBT clients to the first function of telephone coaching: decreasing suicidal behaviors.

Many individuals with BPD have previously been reinforced for nonsuicidal self-injurious/suicidal behaviors or have found that the only way in which their needs are met is through escalation and crisis-oriented behaviors. Thus, some individuals with BPD have learned to use nonsuicidal self-injurious/suicidal behaviors as a method to communicate distress, while other clients become so dysregulated it becomes a habitual problem-solving response. For these reasons, teaching clients new and appropriate ways to ask for help is critical.

When orienting clients to the first function of telephone coaching in DBT the therapist must emphatically state to the client that they call *before* engaging in a nonsuicidal self-injurious act (Linehan, 1993). This changes the timing of the reinforcement so that the reinforcer (e.g., therapist time and attention) is no longer provided *after* nonsuicidal self-injury or suicidal behaviors but rather is provided *prior* to nonsuicidal self-injury/suicidal behaviors, thereby rewarding and teaching the client to "catch" nonsuicidal self-injurious and/or suicidal urges. Sometimes clinicians are working with individuals with BPD who may not engage in nonsuicidal self-injury, but rather use suicidal thoughts, urges, and/or threats as communication or problem-solving attempts. If a client does not self-injure but instead becomes suicidal, the therapist then instructs the client that they must call during the ascending arm of the suicidal crisis rather than waiting until the crisis reaches its peak or during the descending arm of the crisis. This can be difficult territory to navigate and misunderstandings between client and clinician are common here. Clients, understandably, feel that they have been instructed to call their therapist when they are distressed and at risk for suicide. While this is obviously true, the key point to be made to the client is that they must call at a time when they are able to receive feedback and benefit from skills coaching. Otherwise, there is very little the therapist can do to be of assistance but call 911. Orienting the client to call prior to escalation of suicidal impulses and nonsuicidal self-injurious acts is an important step in shaping future skillful, effective behaviors.

Baddeley (2007) has stated that when emotional arousal becomes too high, no new learning can occur. Thus, as emotional arousal increases, the ability to take in, profit from, and effectively use feedback decreases. When orienting clients to DBT, it is important to also explain that most people are unable to effectively take in and use