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Series Preface

Tony Rousmaniere and Alexandre Vaz

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as getting very emotional, hopeless, or skeptical about therapy. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role-plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 10 to 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

This book in the series is on dialectical behavior therapy (DBT), an integrative behavioral treatment used to treat individuals with severe emotional and behavioral dysregulation, such as borderline personality disorder. DBT training typically involves learning the theories that underlie the DBT model, observing expert practice, experiential exercises (e.g., role-playing), supervised clinical work, and participation on a DBT consultation team. Deliberate practice is intended as an additional piece designed to enhance DBT training. It is not intended to be the only delivery format through which DBT skills are acquired, nor is this book sufficient on its own for obtaining full proficiency in DBT. However, the practice of the skills set forth in this book provides trainees with the opportunity to translate their didactic learning of DBT to a simulated environment that mimics the clinical interaction, which can later be applied with actual clients. This book provides opportunities for trainees to experiment using DBT skills with a range of client presentations and clinical scenarios; to practice what they would say and how they would say it. We hope this book stimulates your interest and engagement in DBT and supports your ongoing development as DBT therapists in training!

CHAPTER 1

Introduction and Overview of Deliberate Practice and Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is an evidence-based psychotherapy typically used to treat individuals with severe emotional and behavioral dysregulation, such as borderline personality disorder (BPD). Learning DBT can be a daunting task. DBT is a comprehensive behavioral treatment that includes numerous therapeutic strategies and techniques that are dialectically balanced between accepting the client as they are within a context of trying to teach them how to change (i.e., use more effective coping strategies). As a principle-driven therapy, the effective delivery of DBT requires therapists to have a strong grasp of the foundational theories underlying the treatment. When paired with an individualized DBT case formulation based on frequent and thorough behavioral assessment, these principles serve as guidelines for the application of DBT strategies and techniques.

Adding to the treatment complexity is the client population for whom DBT was originally designed: severe, high-risk individuals with pervasive difficulties regulating emotion. Treating complex clients can be challenging, even for the most seasoned therapists. When clients are emotionally dysregulated or present with high-risk behaviors, therapists are especially vulnerable to becoming reactive (e.g., becoming overly accommodating or overly rigid in their practice). Therefore, a large part of DBT training and skill development involves learning how to flexibly respond to clients across a range of clinical scenarios.

This book is designed to facilitate the acquisition of foundational DBT skills. Through deliberate practice, these DBT skills will eventually become more fluid and natural and will help trainees respond effectively and flexibly in their work with complex clients. The exercises included in this book are aimed at developing DBT skills in response to a diverse set of clinical presentations and situations.

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Deliberate Practice in Dialectical Behavior Therapy, by T. Boritz, S. McMain, A. Vaz, and T. Rousmaniere

Overview of the Deliberate Practice Exercises

The main focus of the book is a series of exercises that have been thoroughly tested and modified based on feedback from trainees and DBT clinicians and trainers. The first 12 exercises each represent an essential DBT strategy or skill. The last two exercises are more comprehensive, consisting of an annotated DBT transcript and improvised mock therapy sessions that teach practitioners how to integrate all these skills into more expansive clinical scenarios. Table 1.1 presents the 12 skills that are covered in these exercises.

Throughout all the exercises, trainees work in pairs under the guidance of a supervisor and role-play as a client and a therapist, switching back and forth between the two roles. Each of the 12 skill-focused exercises consists of multiple client statements grouped by difficulty—beginner, intermediate, and advanced—that call for a specific skill. For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of it. The trainee playing the client then reads the statements, which portray a range of possible problems and emotional states typically seen in clients presenting for DBT. The trainee playing the therapist then responds in a way that demonstrates the specified DBT skill. Trainee therapists will have the option of practicing a response using the one supplied in the exercise or immediately improvising and supplying their own.

After each client statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–client–therapist) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment.

Trainees, in consultation with supervisors, can decide which skills they wish to work on and for how long. On the basis of our testing experience, we have found practice sessions last about 1 to 1.25 hours to receive maximum benefit. After this, trainees become saturated and need a break.

Ideally, learners will both gain confidence and achieve competence by practicing these exercises. Competence is defined here as the ability to perform a specific DBT strategy or skill in a manner that is flexible and responsive to the client. Skills have been chosen that are considered essential to DBT and that practitioners often find challenging to implement.

TABLE 1.1. The 12 Dialectical Behavior Therapy Skills Presented in the Deliberate Practice Exercises

Beginner Skills	Intermediate Skills	Advanced Skills
1. Establishing a session agenda 2. Validation 3. Reinforcing adaptive behaviors 4. Problem assessment	5. Eliciting a commitment 6. Inviting the client to engage in problem solving 7. Skills training 8. Modifying cognitions 9. Informal exposure to emotions	10. Coaching clients in distress 11. Promoting dialectical thinking through both–and statements 12. Responding to suicidal ideation

The skills identified in this book are not comprehensive in the sense of representing all one needs to learn to become a competent DBT clinician. Some will present particular challenges for trainees. A short history of DBT and a brief description of the deliberate practice methodology is provided to explain how we have arrived at the union between them.

The Goals of This Book

The primary goal of this book is to help trainees acquire and develop core DBT skills. Therefore, the expression of that skill or competency may look somewhat different across clients or even within a session with the same client.

The DBT deliberate practice exercises are designed to achieve the following:

1. Help learners develop the ability to apply the skills in a range of clinical situations.
2. Move the DBT strategies and skills into procedural memory (Squire, 2004) so that learners can access them even when they are overwhelmed, stressed, or discouraged.
3. Provide learners with an opportunity to practice the DBT strategy or skill using a style and language that is congruent with who they are.
4. Provide the opportunity to use the DBT strategy or skill in response to varying client statements and affect. This is designed to build confidence to adopt skills in a broad range of circumstances within different client contexts.
5. Provide DBT learners with many opportunities to fail and then correct their failed response based on feedback. This helps build confidence and persistence.

Finally, this book aims to help trainees discover their own personal learning style so that they can continue their professional development long after their formal training is concluded.

Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs. It assumes the following:

1. The trainer is knowledgeable about and competent in DBT.
2. The trainer can provide good demonstrations of how to use DBT strategies and skills across a range of therapeutic situations, via role-play and/or video. Or the trainer has access to examples of DBT being demonstrated through the many psychotherapy video examples available (see McMain & Wiebe, 2013; Tullos et al., 2014; Yalom et al., 2013).
3. The trainer can provide feedback to students regarding how to craft or improve their application of DBT strategies and skills.
4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and rationale of DBT and each particular strategy and skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

The exercises covered in this book were piloted in 15 training sites from across four continents (North America, Europe, Asia, and Oceania). The book is designed for trainers and trainees from different cultural backgrounds worldwide.

This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing the adjusting of the difficulty to precisely target the needs of each individual learner. The term "trainee" in this book is used broadly, referring to anyone in the field of professional mental health who is endeavoring to acquire skills in the DBT. For further guidance on how to improve multicultural deliberate practice skills, see the forthcoming book *Deliberate Practice in Multicultural Therapy* (Harris et al., 2022).

Deliberate Practice in Psychotherapy Training

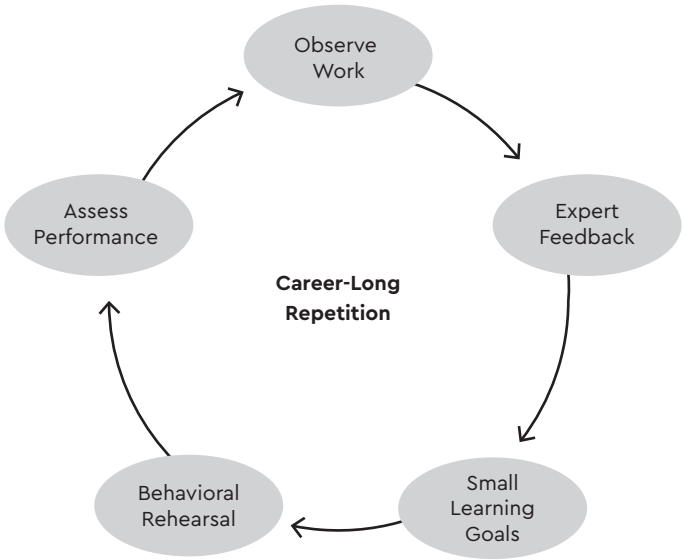
How does one become an expert in their professional field? What is trainable, and what is simply beyond our reach due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture of awe, admiration, and even confusion surround people such as Mozart, da Vinci, or more contemporary top performers such as basketball legend Michael Jordan and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of time spent on a particular type of training is a key factor in developing expertise in virtually all domains (Ericsson & Pool, 2016). *Deliberate practice* is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process deliberate practice, a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book, *Outliers*, although the actual number of hours required for expertise varies by field and by individual (Ericsson & Pool, 2016). This, however, perpetuated two misunderstandings. The first is that this is the number of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required.

The second misunderstanding is that engagement in 10,000 hours of work performance will lead one to become an expert in that domain. This misunderstanding holds considerable significance for the field of psychotherapy, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). Research suggests that the amount of experience alone does not predict therapist

FIGURE 1.1. Cycle of Deliberate Practice



Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (https://doi.org/10.1037/0000227-000). Copyright 2021 by the American Psychological Association.

effectiveness (Goldberg et al., 2016). It may be that the *quality* of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have recently called for deliberate practice to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between psychotherapy and other professional fields, like sports or music, because by comparison psychotherapy is so complex and free form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction is coconstructed among band members. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) listed 18 skill areas that students must master, each of which has multiple discrete skills including tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005, p. 112).

The main idea that we stress here is that we want deliberate practice to help therapists learning DBT to feel comfortable bringing their unique personalities and styles into their practice. The idea is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel

right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, it should enhance it. We recognize and celebrate that psychotherapy is an ever-shifting encounter and by no means want it to become or feel formulaic. Competent DBT therapists are able to use DBT skills adeptly while ensuring responsiveness to the individual client and their context. The core DBT responses provided are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you. We encourage flexible and improvisational play!

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to the real-world experiences, so that they mimic that they provoke similar reactions. This facilitates *state-dependent learning*, in which professionals acquire skills in the same psychological environment where they will have to perform the skills (Fisher & Craik, 1977). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. For the psychotherapy training exercises in this book, the "simulators" are typical client statements that might be presented in the course of therapy sessions and call upon the use of the particular skill.

Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and often acquired relatively quickly. In contrast, procedural learning is implicit in memory and "usually requires *repetition of an activity*, and associated learning is demonstrated through *improved task performance*" (Koziol & Budding, 2012, pp. 2694, emphasis added). *Procedural knowledge* is what a person can perform, especially under stress (Squire, 2004). There can be a wide difference between their declarative and procedural knowledge. For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing it with a professional ability. Likewise, most dance, music, or theater critics have a very high ability to write about their subjects but would be flummoxed if asked to perform them.

In DBT training, the gap between declarative and procedural knowledge appears when a trainee or therapist can recognize and appreciate—for example, the need for a validating response that helps the client feel understood when emotionally aroused but has trouble providing effective validation with real clients even when they want to in a given moment. **The sweet spot for deliberate practice is the gap between declarative and procedural knowledge.** In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once skills are learned, with the help of deliberate practice, we work toward the development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can pull on when necessary.

Let us turn to a little theoretical background on DBT to help contextualize the skills of the book and how they fit into the greater training model.

DBT: Theoretical Overview

The theoretical foundation of DBT integrates learning theory, Zen Buddhism, and dialectical philosophy. *Learning theory* states that all behavior is learned and that behavioral change occurs via the principles of learning. This is addressed through the DBT change strategies, which include an emphasis on problem solving. *Zen Buddhism* contends that suffering increases with attachment to things being a particular way and decreases with the acceptance of reality and its limitations. This is addressed through the DBT acceptance strategies, which include an emphasis on validation. At the core of treatment is *dialectical philosophy*, which emphasizes the value of searching for and finding syntheses between natural tensions to bring about change. In DBT, the central dialectic involves striking a balance between change and acceptance; clients are encouraged, on one hand, to acknowledge and accept emotional experience and, on the other, to use a variety of strategies and skills to bring about behavioral change.

DBT conceptualizes pervasive emotion dysregulation as the core dysfunction underlying BPD and other clinical disorders associated with severe emotion dysregulation problems (e.g., substance use, eating disorders). *Emotion dysregulation* refers to difficulty effectively modulating and expressing emotion across a range of contexts. In its extreme form, such as in the case of BPD, emotion dysregulation is pervasive, occurring with frequency and intensity across many contexts. From a DBT perspective, dysfunction across multiple domains of functioning (cognitive, behavioral, interpersonal, self/identity) is an inevitable consequence of dysregulated emotions, or maladaptive attempts to cope with intense and distressing emotion (Linehan, 1993a, 1993b).

DBT's *biosocial theory* posits that pervasive emotion dysregulation results from a transaction between an individual's biological predisposition toward emotional vulnerability and an invalidating environment that minimizes, ignores, or punishes emotion expression and communicates to a person that their understanding of events and internal experiences is wrong. Over time, this transaction leads to problems with emotion regulation, including difficulties understanding, labeling, tolerating, and modulating emotional responses; effectively communicating emotional needs; and effectively solving the problems contributing to emotional distress (Linehan, 1993a, 1993b). Problematic behaviors, including extreme behaviors such as self-harm, suicide attempts, and substance use, are seen as attempts to regulate emotion, or as the result of failed attempts to regulate emotion. Over time, these behaviors become reinforced as avoidance or escape behaviors from aversive emotional states.

While learning any new therapy approach can be a daunting task, even for the brightest of students, it can be especially challenging for trainees learning DBT because the therapy typically involves treating clients who are highly sensitive, reactive, and impulsive. We have found this to be a little like learning under fire as our clients can be unpredictable, and, more importantly, high risk behaviors can arise quickly. DBT trainees are often required to adapt quickly to challenging clinical situations. This requires an ability to simultaneously modulate one's own emotional reactions while fluidly employing a range of diverse treatment skills and techniques to appropriately respond to the client and clinical context. DBT addresses these challenges by articulating a set of principles therapists use to guide clinical decision making. These principles are designed to enhance therapist effectiveness and adherence to the treatment

model while remaining flexible and responsive to the client. DBT therapists flexibly apply treatment principles within a highly structured and comprehensive treatment program, typically delivered via four modes of intervention: individual therapy, skills training group, between-session phone coaching, and a consultation team for therapists.

In DBT, all treatment strategies directly or indirectly aim to decrease emotion dysregulation and associated maladaptive responses, and to enhance emotion regulation and adaptive responses. Treatment strategies in DBT are dialectically balanced between accepting the client as they are within a context of trying to teach them how to change (i.e., use more effective coping strategies). Key DBT strategies include (a) acceptance strategies focused on the adoption of a nonjudgmental therapeutic stance and the use of validation (i.e., explicit communications about what makes sense about a client's responses), (b) change strategies focused on problem assessment and problem solving, and (c) dialectical strategies focused on balancing acceptance and change-focused strategies to address polarization and promote synthesis between opposing positions. Most of the DBT skills embody a dialectical approach; this is reflected in the skills criteria for the exercises in this book, most of which include both acceptance- and change-focused responses.

The Role of Deliberate Practice in DBT Training

Returning to the metaphor described earlier in this chapter, the practice of DBT—like deliberate practice more broadly—has a lot in common with playing jazz. Similar to jazz musicians, it is important for DBT therapists to be able to improvise and respond in an agile and creative manner to rapidly evolving and sometimes unpredictable contexts. Developing competence as a DBT therapist requires foundational knowledge in DBT theory and a solid understanding of the principles underlying the treatment strategies, as these form the basis on which a clinical decision to intervene one way or another is made.

Similar to other therapies, beginning training in DBT typically starts with didactic learning, such as through reading treatment manuals and attending seminars and workshops to develop a foundational theoretical understanding of the DBT model. As training progresses, trainees begin practicing DBT with actual clients and focus shifts to skill development both in the delivery of DBT techniques and in case formulation, and feedback is provided via supervision or consultations as well as through direct observation of therapy sessions. At all stages of training, there is a strong emphasis on experiential practice. For example, trainees are expected to participate in role-plays, practice DBT skills themselves, engage in mindfulness practice, and complete homework exercises.

Neither this book nor the deliberate practice method in general is intended to be sufficient for obtaining competence in DBT on its own. The skills included in this book are ideally embedded in a practicum course (see the sample syllabus in Appendix C). Trainees should have prior or parallel exposure to DBT theory and application in dedicated coursework and readings. In line with what we said earlier in this chapter, this loosely reflects the distinction between declarative and procedural knowledge. The DBT deliberate practice methods outlined in this book are not intended to be a primary source of declarative knowledge or to replace or replicate work with actual clients or training cases and case-based supervision (e.g., with review of actual session audio or video). Nevertheless, we envision this book as being useful for DBT training and professional development at all levels. Deliberate practice methods can play a complementary

role in DBT training, in the service of augmenting core readings and work performance with real clients. With this in mind, in Appendix C, we recommend resources that provide more information about DBT principles, skills, and training for trainees at all stages of development. Deliberate practice methods provide the first opportunity for a trainee to translate their didactic learning of DBT to a simulated environment that mimics the clinical interaction, which can later be applied with actual clients.

DBT Skills in Deliberate Practice

We have thus far provided a brief introduction to DBT and highlighted how deliberate practice methods are particularly well-suited to the DBT paradigm. In the following sections, we describe the categorization of different DBT skills and outline the skills that will be the focus of the deliberate practice exercises in this book. In addition, we address the importance of the therapeutic relationship in DBT.

Categorizing DBT Skills

We endeavored to distinguish among (a) beginner foundational/structural DBT skills, (b) intermediate-level DBT strategies, and (c) advanced DBT strategies. With this in mind, we considered (a) establishing a session agenda, (b) validation, (c) reinforcing adaptive behavior, and (d) problem assessment to be foundational/structural skills. In turn, we considered (a) eliciting a commitment, (b) inviting the client to engage in problem solving, (c) modifying cognitions, (d) informal emotional exposure, and (e) skills training to be intermediate DBT skills. Finally, we considered (a) promoting dialectical thinking through both–and statements, (b) coaching clients in distress, and (c) responding to suicidal ideation to be advanced DBT strategies.

The DBT Skills Presented in Exercises 1 Through 12

The exercises in this text use a developmentally informed pedagogy in which more advanced skills build on less advanced skills, as indicated in Table 1.1. The beginner level exercises consist of the most basic DBT skills used in most sessions. Establishing a session agenda (Exercise 1) is an essential element for structuring therapy time and prioritizing a session focus. Problems are prioritized according to the degree to which they impede the client's quality of life: Therapy tasks focused on life-threatening behavior take precedence over behaviors that interfere with the therapy itself, which take precedence over other maladaptive behaviors that are interfering with the client's well-being. Validation (Exercise 2) is a core acceptance strategy that communicates to a client that their responses make sense and are understandable in some way. Validation also involves a nonjudgmental therapeutic stance in which the therapist engages with the client in a genuine and authentic manner, treating the client as equal and capable and with respect. Reinforcement of adaptive behaviors (Exercise 3) is used to strengthen adaptive behaviors, including gradual approximations toward behaviors the client is trying to increase. Problem assessment (Exercise 4) is a core change strategy that focuses on understanding the functional relationship between a behavior and its antecedents and consequences.

The first of the intermediate exercises focuses on eliciting a commitment (Exercise 5), which occurs when a therapist seeks explicit agreement from the client to work on mutually determined goals or engage in specific therapy tasks. Problem solving (Exercise 6)

involves helping the client identify maladaptive responses or problem behaviors with more skillful and effective responses. Problem solving includes generating, evaluating, and implementing solutions for identified problems. One of these solutions may be skills training (Exercise 7), which is used when the client has a deficit of coping skills and therefore needs support from the therapist to acquire and practice specific effective behaviors. Another solution involves modifying cognitions (Exercise 8) to help the client enhance their ability to observe and identify maladaptive thinking and its impacts, and then to work towards changing or replacing cognitive errors or biases with more adaptive and dialectical thinking. Informal emotional exposure (Exercise 9) is a solution used to address emotional avoidance. Informal exposure involves helping clients understand the principles of exposure and the adaptive function of emotions, focusing the client on their emotions in the here and now, and encouraging them to experience their emotions without escape or avoidance.

The advanced exercises are placed at the end because they require a deeper understanding of DBT theory and principles and involve more complex skills for managing higher risk client behaviors. All the skills in the advanced section build on the earlier skills. Coaching clients in distress (Exercise 10) involves assisting clients in crisis or moments of extreme emotional distress to effectively use skills to down regulate intense emotion. Promoting dialectical thinking through both–and statements (Exercise 11) weaves together validation and change strategies to help clients shift polarized or extreme responses to more balanced, effective responses. Finally, responding to suicidal ideations (Exercise 12) involves assessing and highlighting the emotional problem driving the client's thoughts of escape or avoidance and helping the client consider more effective ways to solve the emotional problem driving their suicidal thoughts.

A Note About Managing Self-Harm and Suicidal Behaviors in DBT

DBT was originally developed as a treatment for people at chronic risk of suicide (Linehan, 1993a, 1993b) and has been most extensively applied with adults with borderline personality disorder engaging in self-harm and suicidal behaviors (Cristea et al., 2017; Stoffers et al., 2012; Storebø et al., 2020). Although a growing literature has now established DBT's efficacy for a wide range of problems, many clients referred for DBT engage in extreme behaviors associated with emotion dysregulation, including suicidal thoughts, gestures, and actions. For this reason, we have provided client statements referencing self-harm and suicidal ideation across all exercises that can help DBT learners develop skills for responding more effectively when presented with these issues in a therapy session.

It is important to note that these exercises alone are insufficient for competently responding to and managing suicide risk. How a therapist responds to any single instance of a self-harm and suicidal behavior should always be guided by and informed by the client's risk history, their current context and situation, a personalized case formulation that includes an understanding of the function of self-harm and suicidal behaviors for the client, and the therapeutic relationship. **At all stages of training, supervision and consultation should be sought when determining how best to respond and intervene if your client expresses suicidal ideation or discloses self-harm or suicidal behavior.**

For additional resources on managing suicide risk in DBT, supervisors and learners may wish to familiarize themselves with the Linehan risk assessment and management protocol (LRAMP; Linehan, 2016). The LRAMP is an empirically supported framework that is commonly used in DBT for assessing, managing, and documenting suicide risk. It

also provides a guide to support clinical decision-making as therapists consider various options for intervening with suicidal clients.

The Therapeutic Relationship in DBT

A strong therapeutic relationship is central to DBT and is the primary vehicle for engaging clients in treatment and increasing motivation and willingness to change (Linehan, 1993a, 1993b). DBT therapists strive to engage with their clients with warmth, compassion, and acceptance. Additionally, DBT therapists are encouraged to be fully present to the client and the unfolding therapy process, including being awake to subtle shifts in the client in-session or in the therapist's own reactions or behaviors toward the client. Adopting an open, curious, and nonjudgmental stance can help therapists remain balanced and less reactive in the face of challenging situations. This promotes trust in the relationship and engagement in therapy, which in turn allows the client to be open to emotional experiencing and expression as well as new learning experiences and problem solving. These qualities are conveyed both verbally (e.g., through the use of validation) and also through nonverbal and paralinguistic cues, such as vocal quality, tone, and posture. For further discussion of the therapeutic relationship in DBT, learners may wish to review additional writing, such as Bedics et al. (2012a, 2012b, 2015), Boritz et al. (in press), Rizvi (2011), and Shearin and Linehan (1992).

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions upfront overwhelmed trainers and trainees, and they skipped past them as a result. Therefore, we kept these instructions as brief and simple as possible to focus only on the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most out of deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 12 skill-focused exercises, which are ordered based on their difficulty: beginner, intermediate, and advanced (see Table 1.1). They each contain a brief overview of the exercise, example client–therapist interactions to help guide trainees, step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. The client statements and sample therapist responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately so that the trainee playing the therapist has more freedom to improvise responses without being influenced by the sample responses, which should only be turned to if the trainee has difficulty improvising their own responses. The last two exercises in Part II provide opportunities to practice the 12 skills within simulated psychotherapy sessions. Exercise 13 provides a sample psychotherapy session transcript in which the DBT skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual therapy session. DBT trainees are invited to run through the sample transcript with one playing the therapist and the other playing the client to get a feel for how a session might

unfold. Exercise 14 provides suggestions for undertaking mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used to during a training session's final evaluation to process the trainees' experiences, but its primary purpose is to provide trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents a sample syllabus demonstrating how the 12 deliberate practice exercises and other support material can be integrated into a more comprehensive DBT training course. Instructors may choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Clinician and Practitioner Resources" tab at https://www.apa.org/pubs/books/deliberate-practice-dialectical-behavior-therapy.