CHAPTER 4

Assessing Therapy-Interfering Behavior

Every effective therapist knows that assessment is essential to create a useful and targeted treatment plan. The same is, of course, true when creating a plan to target TIB in our clients. Without thorough assessment and functional analysis, we can create the wrong plans and then have no impact on the TIB we are trying to reduce, or worse, we can accidentally increase them! This chapter is designed to help you understand the form and function of your clients' TIBs and to better position you to build a plan together to target them.

THERAPIST ASSUMPTIONS ABOUT THERAPY-INTERFERING BEHAVIOR

Before we jump to assessment, I want to acknowledge that TIBs can stir up a great deal of emotion in therapists. Because clients with BPD are exquisitely sensitive, therapists can be especially prone to assumptions about a given client's behavior. I know I have the thought "She is so sensitive and understands so much, she must know how frustrating this is for me." These assumptions increase the intensity of our emotions, so we need to pay attention to the content of the assumptions. A general theme throughout this chapter is

"We don't know what we don't know." Getting our own emotions in check is essential to effectively addressing TIB.

Let's start with a list of common ineffective assumptions therapists are prone to make about TIB:

1. *A given TIB is on purpose.* This is the most tempting assumption about TIB. I hear it frequently from non-DBT therapists referring their clients to our program. It is also an assumption I make *all the time* (see the "Lean on Your Team" section at the end of this chapter for more on helpful strategies). When we make this assumption, we often assume a deliberate action regarding a TIB, and that the client intentionally acted the way that they did for a specific reason. Common presumed goals of clients are that they want to hurt us, avoid a topic or therapeutic task, they intend to be "provocative," or they want to get attention.

Do some clients engage in TIB for these reasons? Of course. And it's not all the time and it doesn't make me a more effective therapist to assume so.

2. *The client* knows *they are doing a TIB.* When a client expresses a lot of direct anger or other "big" interpersonal displays (e.g., loud crying, slamming doors, shocked and/or exaggerated facial expressions), it can be hard to believe that some of these actions could be outside of their awareness. And yet they can be. We don't know what our clients don't know. Also, because many people in their environment (family members and often, past therapists) have been walking on eggshells around them (or simply leaving), we may be the first to give them direct feedback about a specific interpersonal behavior.

3. *The client* doesn't know *they are doing a TIB.* The same assumption can be detrimental in reverse. With clients who are quieter, more compliant, or more internalizing, we can slip into "caretaking therapist" mode and assume that all TIBs from a given client are unintentional and outside of their awareness. I have been surprised (and a little impressed!) more than once when one of my "quieter" clients confessed they had been changing the subject and/or avoiding a particular topic on purpose for quite some time.

Rather than rely on the above assumptions, I'd like to make very explicit some DBT assumptions that therapists should be making about TIB (summarized in Table 4.1):

1. *Every client and every therapist will engage in TIB.* You know this one already. TIB is a part of treatment. It's not you or your client being "bad." Accept it, embrace it.

2. *TIB is TIB.* Nothing more, nothing less. We have to address it and we have the tools to do so. We don't need to look for deeper meaning in a given TIB.

3. *We don't know what parts of TIB matter (intent, impact, goals) until we assess them.* TIB will matter in different ways with different clients. Assessment is our best friend.

Keeping these assumptions in mind, you're ready to dive in and work to assess your client's TIB.

FUNCTIONAL ANALYSIS: KNOW YOUR CLIENT

Our main tool when trying to understand a given instance of a TIB is to rely on *behavior chain analysis*, just as we do for all of the behavior we are targeting for change in DBT. We use this tool again and again across the course of treatment to gain a deeper understanding of the times TIB does what it does best: interferes with therapy. At the outset of our treatment, however, we have a great opportunity to learn about TIB and potential TIB before it interferes with our work. Thus, I have divided this chapter into an initial interview/discussion of TIB section, and then give several examples of behavior chains and mini-assessments to demonstrate

TABLE 4.1. TIB Assumptions for Therapists

1. Every client and every therapist will engage in TIB.
2. TIB is TIB.
3. We don't know what parts of TIB matter (intent, impact, goals) until we assess them.

how we learn more about TIB and its functions across the course of treatment.

Initial Interview

Start with a broader conversation about the client's understanding of their potential TIB. Members of my team ask some or all of the questions in Worksheet 4.1 (located at the end of this chapter) when trying to gain an understanding of a new client's behaviors that could get in the way of DBT. The advantages of having this conversation early, when you are orienting to the overall concept of TIB, cannot be overstated. Strike while you're likable!

Follow Worksheet 4.1 to ask about many areas that are rife with potential for TIB. This information will aid you in getting your client's commitment to work on the specific challenges you and your client are likely to have throughout their time in DBT. The discussion can then lead to a skills plan for monitoring and managing TIB that you and your client can collaborate on together.

As you can see from the worksheet, this is not a semistructured diagnostic interview. These questions are designed to be a springboard to discussion. Some of them will prompt contemplation of interpersonal dynamics that your client likely hasn't pondered before. Others will be validating to the client, in that you are likely asking about concerns or worries they have about this new therapeutic relationship, but may be too nervous to bring up. Either way, you will gain a lot of information that will make your job easier in the future.

Let's take an example of a cisgender teenage boy starting DBT. We demonstrate a potential conversation from the "Goals" section of the assessment worksheet.

> Therapist: So, it sounds like you have a lot of goals, both around your friendships and your schoolwork. That's great. What do you think will get in the way of our therapy?
>
> Client: Hmm. Well, I like therapy. I'm usually up for talking about things. But it's hard for me to be motivated.
>
> Therapist: That makes a lot of sense, depression definitely saps

motivation from us. Tell me a little more about what you mean.

Client: I don't know—Ben, my old therapist, said I would participate a lot in session, but then I had a hard time doing any of the things we talked about.

Therapist: Oh yeah, he mentioned that to me, too. Do you think that's true?

Client: Yeah, probably.

Therapist: OK, so we are definitely going to have to make sure we really plan for homework you need to do outside of session. There can be lots of reasons that it's hard to follow through. Are you a person who likes to do things on your own? Is it hard for you to follow rules and/or take advice?

Client: Actually, yeah. I mean, obviously, I want your help, that's why I'm here—and Ben thought it would be helpful, too. But in general, like, if someone tells me to do something, I kinda want to do it less. I like feeling like I can solve my own problems.

Therapist: OK, that's super helpful to know. I think there's sort of a stereotype about that being true of teens in general, but a lot of people have a certain amount of that—it's actually a personality trait called "reactance." It basically means once you've been told to do something, you're less likely to do it.

Client: Yeah, that's totally me.

Therapist: OK, so we will keep an eye on that, too. I need to know you're not bullshitting me, you know? If we make a plan together in session, we will have to discuss if you're likely to follow it or not. So, in general, how willing are you to do what I say—assuming my advice is considered and informed—in pursuit of your goals?

Client: It's not that I'm not willing, but it is something that's hard for me.

Therapist: I'm so glad we talked about this; that's really helpful for me to know.

How I use this information varies with the client and their goals. Asking about it early with this client gives me the chance to offer a nonpejorative, normalizing take on his behavior ("some people are high on reactance") and then he and I can address it as we go, rather than me becoming another adult who is disappointed that he's not following through. If we anticipate that TIB, we can work on it together more effectively. It's also less of a disappointment to both of us when TIB occurs: "Oh no, something must be wrong with the treatment or our therapeutic relationship if this is happening." Rather than being surprised or upset, we have the DBT framework and treatment hierarchy offering us scaffolding, as if to say, "We knew this was coming. This is what we prepared for, what can we try next?"

Further Assessment: Behavior Chains

Once you have the general picture of your client's self-reported past TIBs (as well as therapy-promoting behaviors), you'll often need to get a little more information about what is behaviorally maintaining these TIBs. You will use all of your DBT assessment tools in the process: questions and the interview, of course, building a case conceptualization and understanding the transactional model of how your client's behaviors affect their environment and vice versa. Just as you will use chain after chain to help understand LTBs, you will do the same for TIB. This often includes chains on what was maintaining those behaviors in previous therapeutic relationships and what still may be maintaining them in their personal relationships.

I am aware that many therapists skip doing chains on TIB. It's generally not life-threatening, and we often either run out of time or minimize the importance of chains to our care until our client is on the precipice of dropping out. Let this paragraph be your reminder to do lots of TIB chains. For more on chains, see Shireen Rizvi's (2019) excellent book in this series, *Chain Analysis in Dialectical Behavior Therapy*.

Below is an example chain on a very common TIB: not calling for skills coaching at a time when it would have been effective to do so. Let's also assume that our client, Michele, has only been in full-program DBT for about a month.

Therapist: [Transitioning from chain on SI] Michele, I'm so glad you were able to get through Tuesday evening without acting on your suicidal thoughts. That's huge. And it sounds like it was a really hard night, yeah?

Client: Yeah. I was sort of barely hanging on.

Therapist: Yeah, I picture you literally hanging off a branch, like one of the kitten posters. Holding on supertight, like "white-knuckling" it, is that accurate?

Client: (*laughs*) Totally. That's exactly what it was like.

Therapist: OK, then I want to spend a few minutes on that, because I hope across the course of DBT we can give you a few tools so it doesn't feel so precarious to get through days and nights like that. Even though, as I said, I think it was very impressive that you did.

Client: I mean, I know I should have used some skills, but I really didn't know which ones to use . . .

Therapist: Yeah, I wouldn't really expect you, 1 month into DBT, to know all the skills. There's a reason this program lasts a year!

Client: OK, well I'm not sure what else I could do.

Therapist: Right, so I have an idea (*pantomimes holding a phone*).

Client: Oh, right. Phone coaching.

Therapist: Ding ding ding! Correct. And my guess is you had some good reasons for not calling. So, even though we just finished our chain on your ideation, I'd like to do a quick behavior chain on why you didn't call. Sometimes we also call that a "missing links analysis."

Client: I just forgot about it. It's not that deep.

Therapist: OK. Well, I'd still like to spend a little time learning more about why. Let's say 5 minutes, tops?

Client: OK, but it better be only 5 minutes. I didn't even want to talk about the suicidal thoughts and now we have to talk about this, too, and I have other stuff I need to talk about. I'll just call you next time.

Therapist: Five minutes, I promise. First, have you ever thought about calling for coaching, since the first time you did it 3 weeks ago? Like, does the thought enter your mind occasionally?

Client: Yeah, it does. I even thought about it earlier that day, I'm pretty sure. Just not when things were really bad.

Therapist: Great! So, it's not an issue of getting it into your short-term memory. When did you think about calling me earlier that day?

Client: Just when Andy wasn't calling me back. I was feeling super anxious and I thought maybe I should check in or think of some skills to calm my body down a little bit. But then I got lunch and I got distracted and I felt a little better.

Therapist: Well, that's huge. I love that. It's early in the chain that led you to SI—as we discovered earlier—and seems like a great time to call. Did anything else keep you from calling then, other than the fact that you needed it a little less after lunch?

Client: I mean, I guess it seemed sort of silly. Like people don't call people all the time. I didn't want to bother you for something small.

Therapist: Ah, so I hear a little self-invalidation there—"it's silly"—as well as a worry about my time. Is that accurate?

Client: Yeah. I mean, it's easy to say I don't want to bother you, but it's mostly the first one, it feels dumb.

Therapist: OK, I hear another judgment there. What's the emotion when you think, "it's dumb."

Client: It's like "you can't even handle not being texted?"

Therapist: So you have some thoughts judging yourself. Sounds like maybe some embarrassment, or shame?

Client: Yeah, like, I'm 25, I should have this figured out.

Therapist: Oof, more judgments!

Client: Yeah . . .

Therapist: OK, so for us to get you to use coaching, we are going to have to work on some of those.

In this example, you can see that the chain started off in a pretty basic place ("Did you remember to call me or not?") and then went to a much more emotional place, likely related to other parts of the client's goals (self-judgment and shame). The client did not want to do this chain ("It better be only 5 minutes"), but the therapist kept it on the agenda as required nonetheless. This might have been valuable blocking of an avoidance behavior (not wanting to discuss shame), or simply a case of the client prioritizing another goal. We don't know that yet but the therapist did get Michele to provide some valuable information that may increase the likelihood that she will call in the future.

Other Factors to Address

In the following section, I discuss other factors about the client and their history that may have an impact on their TIBs. Sometimes we assess these directly through questions and other times this information is revealed through chains. When and how you address the topics below is dependent on your treatment hierarchy, your case conceptualization, and how interfering a given behavior is at a given time in treatment. These factors include cultural context, the client's personal learning history, and how to assess new TIB as it appears.

Cultural Context

Most broadly, you want to take your client's overall context into account. You assessed this somewhat in your initial interview but you need to keep attending to it throughout treatment. What is your client's personal history? If they are an individual who is minoritized in one or more ways by the dominant culture where you both reside, how can the two of you work to help them feel less minoritized in the context of your relationship and DBT? Given that systems of oppression (e.g., racism, transphobia, and ableism, just to name a few) form a backdrop of potential invalidation, how can you work to undo that to the best of your abilities in this relationship? In what ways can these factors lead to TIB in you, the client, or both?

For example, clients in North America who are Black, Indigenous, or other people of color often have cultural mistrust, or "healthy cultural paranoia" (Whaley, 2004). This is a distrust of white society, given the threats and experiences of discrimination and racism. Cultural mistrust often leads clients of color to have a harder time being open and honest with a white therapist. This is totally reasonable given the client's and/or their family's previous experiences. Unfortunately, this can also be a TIB—lack of trust, though warranted (and *not* the fault of the minoritized client!), can impede a client's progress. If only a white therapist is available, it is incumbent upon that white therapist to work extra hard to find what therapy-promoting behaviors they can do to increase their client's level of trust and comfort with them over time. The white therapist who does not engage in this work would also be therapy interfering.

TIB Tip

It is always the job of the therapist to work to increase a client's comfort with you and gain their trust over time. The therapist has to figure out what is therapy promoting for the client in front of them.

Personal Learning History

What does your client find reinforcing? What do they want to avoid more than anything? You will find some of this out by asking, but mostly it's revealed through behavior chains. Over time, you will assess and discover:

- What are the current contingencies in your client's life that maintain TIBs?
- What are the risks of giving up the TIB?
- How can you reinforce the client in the moment for not giving into TIB urges?

For example, let's say you have a client who struggles with perfectionism. For most DBT cases, this would be under quality-of-life–interfering behaviors on our hierarchy. However, sometimes

perfectionism can lead to TIB—if the client brings in their homework or diary card only when it's "perfect" (whatever that means)—which can result in occasionally (or frequently) having no diary cards and no homework at session, an all-or-none (and very undialectical) outcome. You would need to then go through the questions above to see what specific factors are interfering with bringing in "imperfect" homework. If you jump straight to exposure as an intervention, you may be missing other reinforcers that are maintaining this behavior. It is crucial that you assess the behavior thoroughly to get the homework to the session.

How to Assess New TIB as It Appears

We will not know all of our client's TIBs at the outset of treatment. New ones show up for all kinds of reasons as we progress in treatment. We have to do targeted behavioral analysis of new TIBs as they occur, or we risk leaning back on those ineffective assumptions from the beginning of this chapter. We need to know whether the behavior is automatic (a conditioned response [CR], or an unconditioned response [UCR]). Is it an overlearned operant behavior with a strong history of having been reinforced? We can ask ourselves the questions in Table 4.2 about a given behavior and do chains and behavioral experiments to answer these questions.

First, is it a skill deficit? Does the client even know how to perform the desired behavior? If they do, we can examine other things that may be maintaining the TIB. If the TIB was previously reinforced, what might the original function have been? Is that function still valid for the client? Or has it become problematic, relative to their current goals?

TABLE 4.2. Questions a Therapist Might Ask about a TIB

- Is it a skill deficit?
- What was its original function?
- Is the function of the TIB still valid?
- How is the client affected by the TIB?
- How is the therapist affected by the TIB?

If it is not problematic for the client in other contexts, how does the client's behavior affect you, the therapist? What can you do to react differently, tolerate it, or find the valid piece and validate it? Sometimes the best thing to do with a TIB that affects only the therapist is learn to let it go (more on this in Chapter 5).

Let's take the behavior of not saying hello or greeting the therapist in the waiting room as an example. Depending on the client, this could serve many different functions. For one client, it may indeed be a skills deficit, and very important to their goals that they learn to make an initial connection with another person—we may need to target it early, and our relationship can serve as practice. For another, looking down and not addressing elders may be part of their cultural practices. For another still, they may have been punished for being friendly and may be fearful of doing so. A fourth client may have learned the skill, but anxiety is getting in the way of using it, and not just with the therapist—it is blocking them from making friendships, a top life-worth-living goal for them. Because of this, the therapist would want to address this as soon as possible—not because it is upsetting to the therapist but because it is relevant to the client's goals. A final client might just be a teenager who doesn't want to be there—greeting the therapist may not be important to them. Only by doing this analysis are we able to decide what mode of intervention (if any) to use for a given TIB.

QUICK AND ONGOING THERAPY-INTERFERING BEHAVIOR ASSESSMENTS

In this section I provide two short examples of discussing TIBs with clients. Addressing TIB compassionately and in a nonblaming, nonthreatening way helps to make sure you are targeting TIB adequately without letting it take over your whole appointment. In a given session, you are, of course, addressing higher-order targets like self-harm and suicidal thinking first. In order to keep your client engaged, you also want to make sure to budget enough time to address quality-of-life goals that are time sensitive and/or very important to them. I hope the following tiny examples give you

ideas for how quickly you can assess/label a TIB and still get to everything else you need to do in your session.

Therapy-Interfering Behavior and Goals

Of course, questions about potential TIB are tied up with questions about goals and reasons for being interested in DBT in the first place. The use of commitment strategies can be very helpful in linking TIB back to the reasons the client is coming to you in the first place. Let's take a client whose main life-worth-living goals are centered on developing deeper friendships and eventually finding a romantic partner:

Therapist: Thanks so much for telling me that you tend to get angry and defensive when you are feeling ashamed. That's really important for me to understand. My guess is we will have to talk about some things that make you feel embarrassed or ashamed in order to help you feel ready to date again. Do you think that's true?

Client: I don't like it . . . *at all* . . . and yes, that's probably true.

Therapist: Well, luckily, I'm not expecting you to like it. Shame is an emotion that's really hard for many people to tolerate. I'm actually optimistic that DBT has many tools that can help you manage it. Unfortunately, I can't teach them to you all at once, so there will be some instances where I need you to tolerate shame during our sessions. What can we do to work together if you start to get angry and defensive, though? I want to make sure you and I stay on the same team, working toward getting you those close relationships you want to have.

Client: Well, sometimes I don't realize I'm doing it. Like, I'm so used to slipping into the anger I don't notice it at first.

Therapist: Oh, that's super helpful. How do you think you would respond if I pointed out some early anger signs, like you are clenching your fists, for example?

Client: I mean, it might make me mad.

Therapist: OK, what do you think I could do instead?

Client: Sometimes, just telling me to slow down works. Like, "Annie, slow down for a second."

Therapist: Oh, I like that. I can definitely do that. Then you think after a minute or two I can ask some other questions about emotions?

Client: Totally.

In this way, the therapist both reminds the client of her goals (close relationships) and reminds her of the overall treatment contract (client and therapist are on the same team and working together toward the client's goals). The therapist then invites the client to help problem solve regarding her TIB—this is something she and the therapist will work on together, not something the client needs to just "stop."

DBT Compared to Previous Therapy

Some of our clients' previous experiences in therapy have been warm, kind, and loving—but have not helped them reach their goals. This is usually the result of a therapist TIB of being too focused on acceptance and not enough on change (for this particular client):

Client: Well, my best previous therapist was Cheryl. She was so sweet and so validating—she really got me. She understood what I was saying and she let me know it. I also really liked that she let me talk about whatever I wanted to talk about that day.

Therapist: That sounds really comforting. I'm glad you had that positive relationship with Cheryl, as that shows me you can form a close bond with a therapist. I'm also glad that you are telling me about this now, because I think there are some ways that I can be like Cheryl and some where I can't.

Client: (*suspicious tone*) What do you mean?

Therapist: I'm going to work really hard to be as validating as possible and to really let you know I hear where you're coming from.

Client: Good . . .

Therapist: And, at the same time, I'm afraid I can't *only* do that. You've said you're coming to me because you really want to go back to school and the cutting and your hospitalizations are getting in the way, right?

Client: Yes, that's true.

Therapist: So, I just want you to be prepared that I'm going to make us set an agenda and stick to it, so we can work toward your goals in every session. Also, there will probably be times when I'm not validating enough for you, because I'm trying to encourage some change. You can always give me feedback if I'm pushing too much change and we can work on it together. Deal?

Even "good" things about previous treatment can give us the opportunity to discuss how DBT may be different for our clients. Those differences may be jarring and can be a perfect breeding ground for TIB if we don't discuss it in advance. We model dialectics by not making false promises ("I'll be just as validating as Cheryl") while also explaining our reasoning ("You are here to change and I will help you").

LEAN ON YOUR TEAM

TIB targeting is slippery and often emotional. The focus can move off of TIBs quickly: Sometimes we are working to resolve a TIB that seems to be the most important thing on our hierarchy, and then a new LTB or even a different TIB can knock it several spots down our priority list. We can collaborate with a client to address a specific TIB and it can come back in a different form or in a different context. For example, I had a client who often called her best friend when she wanted to self-harm instead of calling me. The friend was accidentally reinforcing self-harm, which wasn't helping the client reach her goals, and it was directly stopping her from getting skills in the moment. Over several sessions, my client oriented this friend to help her call me instead and was able to go several weeks during

which she used coaching appropriately and did not call her friend during a crisis. About a month later, when I had just gotten comfortable that she was using coaching as intended and not building her relationships to reinforce her LTB, she started to call a new romantic interest when she wanted to self-harm. This makes sense given her history: This type of "bonding" with new people had been heavily reinforced in the past. I am also human, however, and I had all kinds of unhelpful thoughts like "I thought we were *done* with this!" that would *not* have led me to address this behavior very effectively. This is when I need my team—for these moments of confusion and frustration in my work against TIB in myself and my client.

Our teams are essential support systems that help us refocus and understand our client's TIB. In just the last 2 weeks, my team has helped me address TIB by:

- Helping me develop more empathy for my client or their family.
- Checking my assumptions.
- Pointing out what I'm leaving out.
- Leading me to additional assessment questions or behavioral experiments.

TIB Tip

Having a challenging time with a troubling TIB? Don't go it alone! Your team is there to help you understand your limits and make a plan.

As with everything in DBT, you don't have to go it alone. Our consultation teams are our most important resource for keeping ourselves regulated while we address TIB in all its forms. Your team members can point out the other side, help you reregulate, and come up with new and innovative ways to address a TIB that is hanging on too long (either on your part or on the client's part). They can also help us understand where our personal limits are and why a particular TIB might be especially vexing to us (when it is not to someone else).

Assessing TIBs in DBT is an ongoing process. While we can gather a lot of information at the start of treatment, new TIBs, both our own and our client's, will pop up along the way, and some of them will still surprise us. Our evolving case conceptualization and ongoing behavior chains will give us the information we need to target them and keep our clients moving forward toward their life worth living. Now let's travel onward to Chapter 5, where we can discuss when and how to label TIBs effectively (and when not to).