CHAPTER 13

BORDERLINE PERSONALITY DISORDER

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The primary purpose of this chapter is to elucidate the role of therapy homework in the context of an empirically supported treatment for borderline personality disorder—Dialectical Behavior Therapy (DBT; Linehan, 1993a). Borderline personality disorder (BPD) is a disorder of emotion dysregulation, and patients who meet criteria for BPD often present with myriad life difficulties and comorbid disorders. According to the biosocial theory on which DBT is based, individuals with BPD have fundamental deficits in the skills necessary to regulate emotions, but they also have difficulties in a variety of other skill domains, including interpersonal skills, attention, distress tolerance, and self-management. Consequently, the acquisition and strengthening of behavioral skills is a fundamental goal of DBT. Along with behavioral skills training, generalization strategies, and other interventions in DBT, homework assignments constitute one of the means to achieve this goal. This chapter includes a description of BPD and Linehan’s biosocial theory, an overview of DBT, and a discussion of the role of homework in DBT in achieving treatment goals and prevention of relapse. In addition, we discuss some of the unique barriers to implementing homework assignments with BPD patients and DBT strategies used to overcome these barriers.

BIOSOCIAL THEORY OF BORDERLINE PERSONALITY DISORDER

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV; American Psychiatric Association, 1994) defined borderline personality disorder (BPD) as “...a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (p. 650). Defining features of BPD include efforts to avoid abandonment, unstable interpersonal relations, identity, and affect, impulsive, self-damaging behavior, suicidal and/or parasuicidal behavior, problems with anger, and paranoia or dissociation in response to major stressors (American Psychiatric Association, 1994).
According to Linehan’s (1993a) biosocial theory, BPD is a pervasive dysfunction of the emotion regulation system caused by the transaction of biology/temperament and environmental factors. The primary biological factor is emotion vulnerability, which consists of quick, strong, and long-lasting emotional reactions. The environmental factor consists of an invalidating rearing environment, characterized by a deficit in the environmental support necessary to help the emotionally vulnerable child learn how to regulate emotions. The invalidating environment punishes, ignores, dismisses, or trivializes the child’s emotional experience, in addition to oversimplifying the ease of problem solving. The invalidating environment also may involve abuse (physical, sexual, emotional), and may consist of caregivers who become emotionally dysregulated when their child experiences strong emotional arousal. In a systemic interplay, the child’s emotional temperament and the invalidating environment transact (mutually influence each other). Emotion vulnerability pulls for invalidating behavior when the caregivers are unable to regulate their own emotions; do not understand why the child is so upset; or lack the requisite skills to soothe, coach, or help the child manage overwhelming affect. Similarly, the invalidating environment amplifies emotion vulnerability, reinstating the very conditions that trigger invalidating behavior, and so on. Eventually, the child learns that emotions are frightening and is left bereft of the skills required to manage emotions, resulting in emotion dysregulation.

Emotion dysregulation broadly involves difficulty up or down-regulating emotional arousal, along with an inability to direct attention away from emotional stimuli. Many of the behavioral problems commonly seen among borderline individuals (e.g., substance abuse, suicide attempts, self-injurious behaviors, and eating disorders) result from emotional dysregulation, or function to regulate emotions. For instance, self-injury may be an outcome of the impaired problem-solving, cognition, or information processing associated with intense emotional arousal (Chapman, Gratz, & Brown, 2006), or a strategy to reduce unwanted or intolerable emotions. The biosocial theory of BPD takes a systemic view of emotions and emotion dysregulation. Emotions are considered full-system responses, encompassing environmental triggers for emotional arousal, cognition, perception and interpretations, physiological changes and brain activity, emotion-expressive tendencies, and actions; consequently, dysregulation in the emotional system leads to dysregulation in a variety of other areas.

Dialectical Behavior Therapy: Overview of the Treatment and the Research

DBT is an empirically supported cognitive-behavioral treatment for BPD. Initially developed to treat highly suicidal women, DBT evolved into a treatment for BPD, primarily due to the prevalence and severity of suicidal behaviors in individuals who meet criteria for. The first randomized controlled trial (RCT) was conducted by Linehan and colleagues (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994) and compared DBT with a control condition that consisted of treatment for BPD as it usually occurs in the community (treatment-as-usual, or TAU). The results indicated that patients in DBT had greater reductions in the frequency and medical risk of parasuicidal behavior, anger, and the use of emergency and inpatient treatment services.
along with a considerable advantage in terms of service costs. DBT patients also had greater increases in global and social adjustment (Linehan et al., 1991). Since this study was published, seven RCTs across four separate research groups have evaluated DBT or DBT-oriented treatments of BPD (Koons et al., 2001; Linehan et al., 1999, 2002, 2006; Turner, 2000; van den Bosch et al., 2002; Verheul et al., 2003). The outcome data indicate the superiority of DBT, when compared with TAU and other control conditions, particularly in the reduction of suicidal and self-injurious behaviors, as well as illicit drug use (Linehan et al., 1999, 2002). Following the criteria set forth by Chambless and Hollon (1998), DBT meets criteria for an efficacious and specific treatment, in that multiple studies from different sites and with different investigators have demonstrated the efficacy of DBT in comparison to several active control conditions.

DBT is a comprehensive, cognitive-behavioral treatment with theoretical roots in behavioral science, dialectical philosophy, and Zen practice. Most often associated with Marxist socioeconomic principles, dialectical philosophy posits that reality is constantly changing in response to tension that exists between polar opposites, most commonly referred to as "thesis" and "antithesis." Both thesis and antithesis are incomplete and insufficient on their own, but when synthesized, they form a more complete, coherent whole. The process of dialectics involves the emergence and synthesis of thesis and antithesis; the synthesis itself constitutes the next thesis, the contradictions inherent in which produce yet another antithesis, and so on.

When applied to the treatment of BPD, the most central tension or dialectic in DBT is that of acceptance and change (Chapman & Linehan, 2005; Linehan, 1993a; Robins & Chapman, 2004). DBT began as an application of well-grounded standard behavioral and cognitive therapy procedures that had garnered empirical support for other disorders (i.e., problem solving, skills training, exposure, contingency management). However, Linehan (1993a) quickly discovered that patients reacted negatively to a treatment focused purely on behavioral or cognitive change. Indeed, this treatment may have mirrored the message given by the invalidating environment that BPD patients would not be so "pathological" if they would just change their thinking and behavior. On the other hand, a purely acceptance-based approach may invalidate the seriousness of the clients' problems and the need to make changes. In a dialectical fashion, an emphasis on change (thesis) pulled for acceptance (antithesis), and an emphasis on acceptance pulled for change, resulting in a treatment that actively involves the synthesis of acceptance and change strategies.

THE FUNCTIONS AND MODES OF DBT

As a comprehensive treatment, DBT addresses five important functions: (a) improving motivation to change behavior and to work toward developing a life-worthliving; (b) increasing behavioral capabilities, particularly in terms of skills needed to regulate emotions, but also in the areas of interpersonal, distress tolerance, mindfulness, and general self-management skills; (c) ensuring that new skills and capabilities generalize to the patient's natural environment; (d) structuring the environment in a manner that leads to reinforcement for functional, life-enhancing behaviors and punishment or extinction of dysfunctional behaviors; and (e) enhancing the skill and motivation of therapists who treat BPD patients.
DBT is structured in a manner that addresses each of these functions. In its standard form, DBT consists of individual therapy, group skills training, phone consultations, a therapist consultation team, as well as ancillary treatments as needed (e.g., pharmacotherapy, case management). **Individual therapy** focuses on reducing dysfunctional behaviors and enhancing motivation to change. Individual therapy also includes several interventions designed to generalize behavioral skills to the patient's natural environment, most notably homework assignments, the use of an audiotape recording of each session listened to by patients between sessions, and coaching on the use of skillful behavior, both in session and via telephone or email consultation. Group-based **skills training** focuses on building and generalizing capabilities through the teaching and practice of skills designed to help BPD patients regulate emotions (emotion regulation skills); tolerate distress and manage crises without making the situation worse (distress tolerance skills); mindfully participate in the present moment and regulate attention (mindfulness skills); and skillfully navigate interpersonal relationships (interpersonal effectiveness skills). Finally, the **therapist consultation team** consists of a micro-level “community” of individuals who treat BPD patients (Chapman & Linehan, in press; Linehan, 1993a). The team essentially applies DBT interventions to therapists in order to provide the support, training, practice, and feedback required to enhance motivation and promote effective therapy. The goal of helping the BPD patient establish a life worth living binds together all of these modes of treatment.

**THE ROLE OF THERAPY HOMEWORK IN DBT**

Homework assignments in DBT serve several functions. Because DBT is based on the premise that patients with BPD have deficits in skills, one of the most important functions of homework is to facilitate the acquisition and strengthening of those skills. In both skills training and individual therapy, homework often is used to assess patients' skill levels, introduce patients to new skills, facilitate their practice of skills, and to provide an opportunity for the therapist to give feedback, coaching, reinforcement, and didactic information on the patient's use of skills in daily life.

Once skills are acquired, patients must be able to apply them with ease and expertise in a variety of contexts; consequently, another function of homework in DBT is to help the patient generalize treatment gains to his or her natural environment. According to Skinner, generalization occurs when “... the control acquired by a stimulus is shared by other stimuli with common properties” (Skinner, 1953, p. 134). Indeed, one of the most important functions of DBT is to ensure that the ability of the therapist and therapy team to elicit and reinforce effective behavior somehow transfers to the patient’s natural environment. Homework assignments allow the patient to try out new skills and determine whether they work outside of the therapy context. The therapist provides coaching and feedback to ensure that therapy leads to effective behavior in the patient’s day-to-day life.

Homework is used in DBT in a manner consistent with the empirical literature on efficacious treatments, and with the principles that apply to the effective learning and strengthening of behaviors. Most the skills taught in DBT came from behavioral treatments found to be efficacious with other populations, or from basic research in the areas of emotion, personality, and social psychology. For example, the skill of “opposite action” in the emotion regulation module involves reducing emotional sensitivity and intensity through exposure to an emotion-eliciting event and acting
in a manner opposite to the action tendency associated with the emotion. This skill is based historically on the principle of reciprocal inhibition (Wolpe, 1954) and draws from exposure therapy, a treatment that is efficacious in the treatment of anxiety disorders, such as post-traumatic stress disorder (Foaa & Kozak, 1986), obsessive-compulsive disorder (Franklin et al., 2000), and panic disorder (Barlow, 1988).

The content of homework assignments in DBT is geared toward ameliorating skill deficits considered central to the biosocial theory’s conceptualization of BPD patients (Linehan, 1993a,b). Homework assignments to enhance emotion regulation skills might involve assignments designed to reduce vulnerability to negative emotions; increase the likelihood of experiencing positive emotions; increase mindfulness and acceptance of emotions; and hone the ability to continue with goal-directed behavior despite fluctuating moods. To enhance distress tolerance skills, assignments aim to enhance the ability of patients to tolerate crises without worsening the situation, through distraction, self-soothing, awareness, and acceptance of reality. In the interpersonal effectiveness module, homework assignments focus on having clients practice clarifying their goals in interpersonal situations, figuring out how strongly to assert their wishes, and acting appropriately assertive, in a manner that enhances self-respect, goal attainment, and relationship functioning. Finally, mindfulness assignments are almost entirely experiential, with the goals of helping patients practice the skills of observing, describing, and participating effectively in the current moment, without judgment, and while focusing on one thing at a time.

**Types of Homework Assignments in DBT**

There are essentially four types of homework assignments in DBT: (a) discrete homework assignments, (b) self-monitoring homework assignments, (c) skills practice assignments, and (d) conditional homework assignments. Discrete homework assignments involve the explicit assignment of a discrete task, sometimes for a specified period (e.g., practice eating mindfully three times a week for the next week). This type of assignment is a regular component of the skills training group, and occurs less frequently in individual therapy.

In skills training, there is a formalized system of homework handouts and assignments designed to help patients learn and practice new behavioral skills. Each of the four primary skill modules has a set of homework sheets, and typically, patients are asked to complete one or more of the homework sheets each week. For instance, in the emotion regulation skills module, some of the homework sheets involve sections on which the patients note which emotions they had over the past week, the prompting events or triggers of the emotions, their bodily sensations of emotion, the action urges associated with the emotions, and their behaviors. This particular assignment is designed to help patients increase their awareness of emotions, the factors that prompt them, and the action urges and behaviors associated with them. Patients fill out their homework sheets, and each week the first half of the skills training session focuses on homework review. Skills trainers and patients enter into a dialogue about which skills were practiced and difficulties understanding or implementing new skills. Skills trainers use a variety of behavioral strategies to strengthen skill acquisition and homework completion, including shaping, positive reinforcement, didactics on particular skills, and coaching on the effective use of skills. Often, discrete homework assignments are used to consolidate the learning of a particular skill, provide a structured opportunity
to try these skills, and to increase the likelihood that the skill behavior will be in the patient's behavioral repertoire to draw upon when needed.

A second type of homework assignment in DBT is the self-monitoring homework assignment. Self-monitoring assignments involve having patients monitor various behaviors on an ongoing basis, typically daily. In skills training, patients are asked to track the practice of each skill across all skill modules on a self-monitoring form called the diary card. Each week, the patients circle which skills they practiced on each day of the week. They also note the extent to which they tried to use skills and how helpful the skills were, using a scale that ranges from 0 (did not try skills) to 7 (skills were executed automatically and were helpful). Ultimately, the goal is to shape the patients toward increasing ease of skill use, such that they eventually use the skills as automatically as shifting gears while driving a car.

Similar to the skills group, a self-monitoring assignment in individual DBT involves filling out a self-monitoring diary card on an ongoing basis. In individual therapy, the patient keeps track of a variety of behaviors, most typically including the following: (a) emotional and physical misery, (b) urges to engage in self-injury, suicidal, or drug use behavior, (c) drug and alcohol use, (d) prescription drug use and misuse, (e) lying, (f) self-reinforcement for functional behaviors, among other behavioral targets that are ideographically determined to be relevant behavioral targets for the patient.

In individual therapy, this self-monitoring homework assignment is integral to the organization of session time. The therapist uses the information provided on the diary card to organize the session according to the most important treatment targets, following a standard hierarchy of targets. At the top of the hierarchy is life-threatening behavior, including suicidal crisis behavior, suicide attempts, ideation, and urges, as well as non-suicidal but deliberate self-injury and other potentially life-threatening behaviors. The next item on the hierarchy is therapy-interfering behavior, such as missing sessions, lying, aggressive behavior toward the therapist, lack of engagement or commitment to therapy, or lack of compliance with homework in either skills training or individual therapy. Next are the quality-of-life interfering behaviors, (i.e. any behavior that directly hinders the effective implementation of treatment) including problems associated with DSM-IV Axis I disorders, problems in living (finances, housing, etc.), or other difficulties that threaten quality of life. The last two items on the hierarchy include behavioral skills, and secondary behavioral targets, or "dialectical dilemmas" (discussed later in this chapter). Essential to individual therapy, this ongoing self-monitoring assignment is the primary "source of data" on the high priority targets of treatment, as well as the primary tool used to organize the focus of each session.

There is some evidence that the daily monitoring of behaviors may have therapeutic benefits that extend beyond the purposes noted above. For instance, some studies have indicated that there is very little concordance between reports on behaviors that are tracked weekly and reports on behaviors that are tracked on a daily basis (Smith et al., 1999), suggesting that daily self-monitoring may increase the accuracy of the clinical information on which the therapist bases his or her interventions. In addition, the findings of one of our studies suggested that time spent monitoring a target behavior may enhance recall of behavior that occurs between sessions. In a randomized clinical trial that evaluated the efficacy of DBT in comparison to a control treatment for women who met criteria for opioid dependence and BPD, participants in the DBT condition evidenced a strong association between their reports of drug use and the data on drug use collected via urinalysis ($r = 0.72, p < 0.02$). In the control
condition, which did not involve daily self-monitoring, this correlation was very small ($r = 0.02$), and non-significant (Linehan et al., 2002). Indeed, some researchers have suggested that improvement in the specificity of patients’ autobiographical memory may underlie some of the treatment effects of DBT (see Lynch et al., 2006, for a detailed discussion of the mechanisms of change in DBT).

The third type of homework assignment involves skills practice assignments that encourage the continual practice of skills. This type of homework assignment is designed primarily to strengthen skills, with the ultimate goal of helping the patient develop skills that are so over-learned that they are emitted effortlessly in every situation in which they are needed, particularly in crises. Indeed, learning and strengthening skills requires time and repeated practice under conditions that support new learning. Patients with BPD often present with stormy lives characterized by chaos, overwhelming stressors, and repeated crises; thus, it is particularly important for them to practice skills during the periods of calm that occur between crises. Because patients with BPD experience quick, strong, and long-lasting emotional responses and have difficulty regulating their emotions, attempting to learn new skills can become untenable in the midst of a crisis. Indeed, some studies have indicated that cognition and information processing are disrupted and tend to narrow under conditions of intense emotional arousal, resulting in difficulties with effortful cognitive processes and problem solving (Gellatly & Meyer, 1992). Essentially, learning a new skill in a time of crisis is akin to running marathons while having pneumonia, or learning a Bach toccata with a pinched nerve in the back. Therefore, the goal of ongoing practice homework assignments is to help the patient become such an expert in new skillful behavior that he or she can effectively handle even the most challenging situation.

Lastly, the fourth type of homework assignment is the conditional type. This type of homework assignment most commonly occurs in individual therapy. In fact, aside from the self-monitoring assignments, individual therapists tend to use conditional homework assignments much more often than other types of homework assignments. DBT is a principle-driven treatment that requires the flexible application of treatment interventions in a manner that most effectively targets each patient’s problems. Using the self-monitoring diary card, the patient comes into each session with a list of potential behaviors on which to focus. The therapist typically spends the most time on high priority behaviors, and the approach follows a problem-solving model. After highlighting high-priority behaviors (i.e., “Oh, I see that you cut yourself on Thursday”), a detailed chain analysis is conducted. The chain analysis consists of a detailed discussion of the events surrounding a single instance of dysfunctional behavior, with the goal of determining, in minute detail, the events that set up conditions for the behavior to occur (vulnerability factors or establishing operations), the prompting events or triggers for the behavior, and the consequences of the behavior. Either after or during the chain analysis, the therapist and patient generate solutions (often involving the use of specific skills) that will make the behavior less likely to occur under similar conditions in the future, or that solve the ongoing problems that led to the behavior in the first place. These solutions are agreed upon, and the patient may be given a conditional homework assignment that involves implementing the solutions the next time a similar situation is encountered.

For example, one of the authors of this chapter had a patient who struggled with intense, episodic suicidal ideation, most commonly in response to feeling overwhelmed with stressors related to work demands and familial conflict. This patient
believed that suicide would provide an escape from emotional pain. After a detailed chain analysis, the therapist generated a solution that involved having the patient ask herself, “What do I want right now? Do I want to be dead, or do I want to escape or find peace?” As it turned out, the patient actually wanted peace, but could not think of any way to attain it other than suicide. The homework assignment was for the patient to use specific self-statements (“I don’t want to be dead. I just want peace. What skills can I use now to get peace?”) whenever she had suicidal ideation. This is an example of a conditional homework assignment, because (a) it was assigned in response (contingent on) to the occurrence of a problem behavior (suicidal ideation), and (b) the instruction was for the patient to use the strategy in a manner contingent on the occurrence of suicidal ideation.

Other conditional homework assignments involve the application of if–then rules for the patient. For instance, the client may be encouraged to use crisis survival or distress tolerance skills whenever he or she is in a crisis. Another example might involve the use of a chain analysis by the client. Sometimes, clients are instructed to complete a chain analysis form after the occurrence of a specific type of behavior, such as a self-injury act. In sum, DBT includes many types of homework assignments that involve having the patient engage in new behaviors outside the therapy room, but only a fraction of this work fits traditional model of discrete homework assignments.

**Homework and Relapse Prevention**

In DBT, homework plays a key role in preventing the relapse of dysfunctional behaviors. Indeed, as a skills-training approach, homework in DBT aims to hone the very skills that patients need to enhance quality of life and prevent the relapse of behaviors that threaten quality of life. In addition, homework can be used specifically to reduce the likelihood that certain behaviors will occur again in the future. For instance, when a crisis has occurred, the therapist often uses conditional homework assignments to help the patient find a way to reduce the likelihood that a similar crisis will recur. For instance, the therapist might urge the patient to engage in imaginal rehearsal of effective coping behaviors that he or she could use next time a similar situation arises. If people in his or her natural environment reinforce the patient's crisis behaviors, the therapist might assign the patient the task of restructuring the environment to prevent the reinforcement of crisis behaviors. For example, one of the authors of this chapter had a patient who frequently engaged in rage behavior at her parents’ home (throwing things, breaking things, yelling, screaming). Over time, it became apparent that the parents often became very solicitous, warm, and soothing after the rage attacks (possibly, reinforcing rage behavior). In order to prevent the relapse of rage behavior, the therapist assigned the patient the task of educating her parents on reinforcement and asking them to stop being warm and supportive when she has “rage attacks.”

Relapse prevention fundamentally is a task that involves enhancing the generalization of treatment gains, and homework in DBT can enhance generalization in several ways. For instance, homework assignments may facilitate generalization by bringing the therapist into the patient’s natural environment. The therapy setting often constitutes a context in which dysfunctional behaviors are extinguished (Lynch et al., 2006) and effective behaviors are reinforced. Research on extinction has indicated that the re-emergence of extinguished responses (e.g., the relapse of cutting or drug use) may
occur in new settings or at times in the future, because people essentially fail to retrieve the memory that the behavior has extinguished [the memory of extinction (Bouton, 1993; Bouton & Brooks, 1993)]. Homework assignments therefore may constitute extinction “reminders” (essentially, reminders of therapy) that reduce the re-emergence of dysfunctional behavior in settings outside the therapy room. Similarly, the mere existence of homework assignments may bring the therapist to the patient’s natural environment, serving as a reminder of effective behaviors learned in treatment.

COMMON BARRIERS TO THE EFFECTIVE USE OF HOMEWORK WITH BPD PATIENTS

There are several barriers to the effective use of homework with BPD patients. Many of the barriers are similar to those encountered with other clinical populations, such as a mismatch between the homework assignment and the treatment targets, unclear instructions on the homework assignment, poor motivation, and difficulty remembering or executing homework assignments. For the following section, we focus on barriers that we have found to be unique to BPD patients, and that are consistent with the biosocial theory underlying DBT. These barriers include emotion dysregulation, dialectical dilemmas, and motivational problems.

EMOTION DYSREGULATION

According to the biosocial theory of BPD, many of the behavioral problems of BPD patients are caused by a fundamental deficit in the ability to regulate emotions, combined with a susceptibility to quick, intense, and long-lasting emotions. Indeed, individuals with BPD have considerable difficulty with many of the tasks involved in regulating emotions, such as modulating physiological arousal, diverting attention from emotional stimuli, inhibiting impulsive behavior, and organizing behavior to achieve external, non-mood dependent goals [see Gottman and Levenson (1986), for a review of the key tasks involved with emotion regulation]. In turn, the therapist may view and target many of the barriers to the successful use of homework in DBT as emotion-regulation problems. In this way, problems with the completion of homework assignments are conceptualized in a similar manner as other behavioral problems, and in many cases, represent a microcosm of the myriad life difficulties experienced by BPD patients.

There are several problems related to emotion dysregulation that may interfere with the successful implementation of homework assignments in DBT. The patient may have difficulty completing homework assignments primarily because of deficits in the skills necessary to regulate intense emotional arousal. Indeed, intense, dysregulated arousal can make it exceedingly difficult to pay attention, process information, and remember the point of any given homework assignment. Patients also often report that they were overwhelmed with other tasks and stressors and could not manage “one more thing.” Other patients may have difficulty with completing a homework assignment (particularly, the self-monitoring type of assignment), because it forces them to look inward and think about their problems. In many cases, these patients may experience shame when they attend to their life difficulties; avoiding homework is a way to avoid shame. An additional problem may emerge when the patient attempts
to complete a homework assignment under conditions of high emotional arousal. Indeed, patients often report that they tried to complete their homework but were "too upset" to do it.

BPD patients often engage in mood-dependent behavior and have difficulty inhibiting this behavior in the service of long-term goals. They experience intense and often-changing moods that prompt urges to engage in a variety of behaviors. For instance, the most common urge associated with anxiety is to escape or avoid the anxiety-provoking situation. The action urges associated with shame compel people to hide those aspects of themselves or their behavior of which they are ashamed. At least at the beginning of treatment, BPD patients often have difficulty inhibiting the action urges associated with a variety of emotions. Homework often requires that patients inhibit mood-dependent behavior in the service of long-term goals (e.g., to learn a new skill); thus, BPD patients who have difficulty inhibiting mood-dependent behavior also tend to struggle with homework.

**Dialectical Dilemmas**

Consistent with the dialectical philosophy underlying DBT, some of the barriers to the successful implementation of homework in DBT involve failures to synthesize dialectical tensions. While developing DBT, Linehan (1993a) identified several distinct patterns of phenomena that appeared to be interfering with applying behavioral therapy techniques with BPD patients. Linehan classified these into three "dialectical dilemmas," (a) emotion vulnerability vs. self-invalidation, (b) active passivity vs. apparent competence, and (c) unrelenting crises vs. inhibited grieving. Reflecting the patient's dysregulated emotional system, these patterns typically involve vacillation between extreme poles of thought and action, without integration or synthesis. Thesis and antithesis move back and forth as if on a "teeter-totter," never forming an integrated whole or moving toward a synthesis representing more effective behavioral patterns.

The first dialectical dilemma involves vacillation between extreme emotion vulnerability and self-invalidation. Emotional vulnerability in this context refers to the experience of vulnerability by the patient. Essentially, the patient experiences him/herself as fragile, crazy, intensely vulnerable, and as being completely controlled by the environment. The patient may believe that it is impossible to do what the therapist expects and may feel angry at the therapist for assigning homework, because the therapist expects too much. Alternatively, clients sometimes feel angry when the homework assignment is perceived as "too simple to solve problems of this magnitude." On the other pole of the dialectic, self-invalidation involves invalidation of the individual's own affective experiences, looking to others for accurate reflections of reality, oversimplifying the ease of solving life's problems, and inhibition of emotional experiences and expression. In this case, the patient may underestimate the difficulty of the homework task and then actively engage in self-punishment, criticism, or invalidation when he or she encounters difficulty completing the task.

Another dialectical behavior pattern involves the dialectic of active passivity versus apparent competence. At times, the individual demonstrates the competency to effectively solve problems with very little help, but in other contexts, appears to completely lack this same competency. The patient who exhibits apparent competence often appears to have competencies and capabilities that actually are not present; thus, the therapist may unknowingly assign homework tasks that are overly difficult.
resulting in failure experiences for the patient. The therapist also might assume that the patient is capable of completing the task but is not motivated or working hard enough. In this case, the therapist may fail to notice or address skill deficits that are interfering with the completion of homework assignments.

At the other side of the dialectic is active passivity, where the BPD patient approaches problems passively and helplessly, and enlists individuals in his or her environment to come up with solutions to life problems. In this case, the therapist may underestimate the patient's capabilities and avoid assigning homework, do all the "therapy work" for the patient, or assign overly easy tasks that have little impact on therapeutic progress.

Finally, the third dialectical behavior pattern involves unrelenting crisis versus inhibited grieving. Unrelenting crisis refers to the clinical observation that the lives of BPD patients often involve constant turmoil, stress, and disaster. These factors can undermine homework practice in several ways. For instance, patient and therapist may be caught in a cycle of constantly managing crises and "putting out fires" that allows little room to focus on the strengthening of skills. Indeed, this is partly why the DBT skills group (with its focus on building skills) occurs separately from the individual therapy sessions. Unrelenting crisis also may involve a chaotic interpersonal environment, consisting of individuals who essentially punish skillful behavior. For instance, the authors of this chapter have had patients who go out to their home environments to practice a new interpersonal skill, only to be told, "That psychology mumbo jumbo won't work on me!" When the patient's natural environment punishes newly learned behaviors or fails to reinforce therapeutic progress, homework can be extremely challenging.

At the other end of the dialectic, BPD patients often avoid or inhibit the experience and expression of painful emotions in response to stressful life events (inhibited grieving). Most notably, BPD patients may inhibit the natural grieving response to a life filled with tragedy and crisis. Inhibited grieving also broadly involves experiential avoidance, or attempts to avoid, escape, or suppress unwanted emotions, thoughts, or physical sensations (Hayes et al., 1996). With patients who tend to avoid their problems, assigning homework that encourages them to focus on and tackle their problems head-on can be a daunting task.

Motivational Problems

Although motivational problems may underlie problems with homework in many clinical populations, DBT conceptualizes motivation from a behavioral perspective, essentially proposing that sufficient motivation to change is present when the contingencies of reinforcement support behavior change. However, BPD is a disorder of emotion dysregulation, in which motivation to change behavior often waxes and wanes in response to changing moods or emotions. Indeed, for patients who repeatedly self-injure, attempt suicide, and are in toxic interpersonal environments characterized by abuse, behavior change can be as painful as trying to scale a mountain of hot coal with one's bare hands and feet. Under these conditions, it is exceptionally difficult to maintain a consistent motivation to change. Indeed, we have often found that consistent low or unstable motivation to complete homework assignments is caused or exacerbated by many of the factors discussed above (i.e., emotion dysregulation, dialectical dilemmas, lack of reinforcement for new behavior).
STRATEGIES TO OVERCOME BARRIERS TO EFFECTIVE HOMEWORK IN DBT

In DBT, problems with homework often fall into the category of therapy interfering behaviors and are managed in a manner that is similar to other behavioral targets. For most behavioral targets in DBT, the chain analysis serves as the springboard from which the therapist implements a variety of treatment interventions. As discussed previously, the chain analysis in DBT is a method used to evaluate, in minute detail, the circumstances surrounding a particular problem behavior. The chain analysis primarily occurs in individual DBT, although at times, group skills trainers may conduct brief chain analyses of problems in completing homework. When a patient does not complete a homework assignment, the therapist often conducts a chain analysis to determine what has interfered with the completion of homework. The therapist works to help the patient clearly define the problem that led to difficulty with homework, fluidly moving back and forth between assessment of problems and interventions to solve these problems. Because the chain analysis is primarily a change-based strategy, it often is important for the therapist to weave acceptance-based strategies in order to facilitate the patient’s engagement in the process, and to enhance the patient’s amenability and motivation to change. For instance, in many cases, therapy-interfering behavior is perfectly understandable, given the presence of emotion dysregulation, chaotic interpersonal environments, and other factors; thus, the therapist may use validation strategies to convey that dysfunctional behavior is understandable; at the same time, it must change [see Linehan (1997) and Koerner & Linehan (2003) for a detailed discussion of validation in DBT].

A clear and detailed assessment of the problems that led to difficulties with homework can point the therapist and patient in the direction of useful solutions. Chain analysis is not always conducted when a patient has problems with homework; however, at the very least, it is important for the therapist to ask useful questions that facilitate effective problem solving. The therapist may inquire whether the patient took in or encoded information about the assignment in the first place (e.g., Did the patient hear the assignment? Was the patient paying attention while homework was being assigned?). Another question a therapist might ask is whether the assignment was encoded but somehow not retrieved at the appropriate time (e.g., Did the thought of doing the homework ever enter the patient’s mind in between sessions?). In addition, the therapist might inquire as to whether the patient knew how to do the assignment, was able to find and understand the instructions, or whether there were obstacles to doing the homework (e.g., emotions dysregulation, willfulness, lethargy, other people). A critical point here is that BPD patients often feel ashamed and expect to be judged for not completing assigned tasks. It is essential for the therapist to approach homework difficulties in a non-judgmental manner, as problems to be solved.

Based on an assessment of what got in the way of completing the homework, the therapist might use a variety of strategies to help the patient. If the problem appears to be one of emotion dysregulation, the therapist might help the patient practice regulating emotions in session, reduce factors that create vulnerability to overwhelming emotions (e.g., insomnia, mismanagement of physical illness), or conduct exposure interventions to reduce the patient’s sensitivity to emotional stimuli. If the problem is related to dialectical dilemmas, the therapist would help the patient find some way to synthesize these behavioral patterns. For instance, if the phenomenon of apparent
competence led the therapist to give an overly difficult homework assignment, the therapist might help the patient more accurately express his or her capabilities. Indeed, if the problem is that unrelenting crises got in the way of the homework, the therapist might help the patient reduce chaos or crises, or if this is not possible, intervene directly in the environment on behalf of the patient.

In addition, several other strategies may be helpful, depending on the reason for homework difficulties. For instance, the therapist and patient may use contingency management strategies, by setting up a system of reinforcement for homework completion. The therapist also may manage contingencies in the therapeutic relationship, by expressing mild disappointment when homework is not completed, and praise and enthusiasm when it is completed. If the problem was one of low motivation, the therapist might use a variety of strategies geared toward enhancing the patient’s commitment. For instance, the therapist might “sell commitment” by connecting the homework assignment with the patient’s goals (e.g., “This skill is going to help you attain a life worth living!”); work with the patient to devise the pros and cons of completing homework. Even when motivation is not the problem interfering with homework, the therapist often seeks a renewed commitment to do the homework, and follows this up with troubleshooting aimed at coming up with back-up plans to circumvent additional barriers to completing the agreed upon assignment.

RESEARCH ON HOMEWORK IN DBT

To date, two studies have addressed homework in DBT. Lindenboim et al. (2005) found that suicidal BPD participants in a year-long standard DBT treatment, on average, practiced at least one skill on more than 60% of the days in treatment. Summing over the 19 skills represented, sample mean for the treatment year was upwards of 4 skills practiced a day. Miller et al. (2000) examined client perceptions of the usefulness of the DBT skills as part of a quasi-experimental treatment study of DBT with suicidal adolescents with BPD features. On a 5-point scale ranging from (1) not at all helpful to (5) extremely helpful, mean client ratings of the 19 specific skills ranged from 3.00 to 4.27 indicating moderate to high overall perceived utility and acceptability of DBT skills in that sample. Although this second study was not directly focused on homework implementation, the finding that patients tended to experience homework assignments as acceptable and useful indirectly supported the use of homework in DBT.

CASE ILLUSTRATIONS

The following section involves two case examples designed to illustrate the role of homework assignments in DBT. Each case example consists of a description and DBT-based conceptualization of the case, followed by a discussion of the types of homework assignments used in treatment, the barriers to successful implementation of homework, and strategies used to overcome these barriers.

CASE EXAMPLE I

Case Description and Conceptualization

Tory was a 28-year-old single Caucasian female referred for treatment following hospitalization for a suicide attempt. She reported a history of sexual and physical
abuse by her father and, at the time of intake, she met criteria for BPD, PTSD, Bulimia Nervosa, and Social Phobia. Tory had attempted suicide on three occasions in her life (mainly via overdosing) and cut herself about twice a week, without suicidal intent. In addition, Tory reported several impulsive, mood-driven behaviors, including binge-eating and excessive drinking. She also reported emotion dysregulation, consisting of periodic, intense mood changes, difficulty regulating her emotions, and problems with excessive and inappropriate shame. Tory also noted that she often had difficulty thinking or believed that others were watching or scrutinizing her, particularly when she was very anxious. Finally, Tory reported that she often felt as if she were an empty “void.”

Homework Assignments

Tory entered standard DBT treatment, consisting of individual therapy, skills training, and phone consultation as needed. Individual therapy targeted reducing or stopping self-harm behavior, suicidal ideation, and disordered eating. Homework assignments consisted of self-monitoring via the DBT diary card, completing chain-analysis worksheets whenever she engaged in cutting or binge eating behaviors, as well as tasks that exposed her to avoided social cues. All of the patients in Tory’s skills group were suicidal women with BPD. Homework in group largely followed Linehan’s manual (1993b), and included worksheets and exercises in all four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Many of the homework assignments were of the discrete type, which typically accompany each individual skill module, but the group leaders also worked with Tory to develop individualized skills practice homework assignments that were tailored to her problems. These assignments consisted of building mastery experiences, acting in a manner opposite to the action urges associated with shame and anxiety (“opposite action”), and assignments designed to reduce perfectionism.

Barriers to Homework Implementation

The primary barriers to homework with Tory included emotion dysregulation and the dialectical dilemma of emotion vulnerability versus self-invalidation. Tory was very courteous and pleasant but appeared anxious and uncomfortable in the group. Tory’s group cohort had developed a culture of dedication, hard work, and homework completion; however, it quickly became evident that Tory was struggling in the group, both in the didactic portion and in the homework practice. In terms of emotion dysregulation, Tory appeared flustered and anxious especially during the homework review, a portion of the group time during which the group leaders focus on one patient at a time and discuss homework. When she became anxious, and she usually said whatever was necessary to get the attention of the group away from her as quickly as possible. Consequently, it was difficult for the group leaders to provide her with the time, attention, and feedback she needed to benefit from the homework assignments. In terms of the dialectical dilemma of emotion vulnerability versus self-invalidation, Tory often reported extreme emotional instability and attributed her difficulty completing homework to problems that were beyond her control. (e.g., being too emotional). On the other end of the polarity, Tory would invalidate her own experience, by downplaying and oversimplifying challenges in her life and the difficulty of the material (e.g., stating “I am too dumb”).
Strategies Used to Overcome Barriers

The skills training and individual therapists used several strategies to overcome these barriers to effective homework implementation with Tory. First, in order to help Tory reduce her level of anxiety about being the focus of attention in group, the skills trainers encourage her to practice relaxation and mindfulness exercises during group. The individual therapist worked with Tory to expose her to anxiety provoking social cues, which subsequently led to a reduction in her anxiety during group. Although Tory continued to struggle with some homework assignments, once her anxiety and avoidance behavior had reduced, it was much easier for the therapists assess these difficulties and help her find solutions to overcome them. To reduce self-invalidation, the therapists highlighted her use of unrealistic self-expectations (perfectionism) and judgments and actively encouraged her to reframe and re-phrase these self-statements. The therapists also modeled ways to do this, by using validation strategies to convey understanding of how difficult the homework assignments were, as well as self-disclosure of their own struggles in trying to practice the skills. Finally, earlier in treatment, the therapists worked on stimulus controls strategies to help Tory avoid situations in which she was likely to experience shame (the most frequent precipitant for the binge episodes); however, later on, Tory began to implement homework that involved exposure to shame-eliciting situations, along with response prevention.

CASE EXAMPLE II

Case Description and Conceptualization

Wendi was a 38-year-old divorced Caucasian woman, unemployed, who came to treatment following a recent suicide attempt prompted by a relationship break-up. She met criteria for BPD, as well as severe recurrent Major Depressive Disorder, Panic Disorder, and alcohol abuse. She demonstrated emotion dysregulation, in that she had considerable difficulty with intense shame, as well as a pattern of intense, widely fluctuating moods. She also had considerable difficulty establishing a sense of identity and setting life goals. For instance, she reported a pattern of changing jobs, careers, and religious orientations, along with confusion about who she is as a person. Wendy had a history of recurrent suicide attempts and considerable difficulty regulating impulsive behavior when she was emotionally aroused. Finally, Wendi also reported the tendency to dissociate whenever she was overwhelmed by stressors at work, school, or in her relationship with her ex-partner.

Homework Assignments

As with Tory, Wendy received standard DBT, including skills training, individual therapy, and as-needed telephone consultation. The first few weeks of treatment involved obtaining and strengthening a commitment to stop all suicidal behaviors. Many of the homework assignments during this period were of the conditional type. For instance, Wendi’s individual therapist taught her some of the distress tolerance skills and instructed her to use these strategies whenever she experienced the urge to harm herself. Wendi had notable success with these strategies, and had stopped all overt suicidal behavior within the first few weeks of treatment. The individual
therapist also worked with Wendi to develop a treatment plan focused on increasing her ability to regulate emotions, reducing the occurrence of distressing situations or crises, and adding some structure and pleasant activity to her life. In addition, Wendi received discrete and ongoing skills practice homework assignments during skills training, in order to enhance her skills acquisition.

Barriers to Homework Implementation

The first barrier to homework completion was related to the problem of emotion vulnerability. Wendi had established rapport very quickly with her individual therapist, but found the skills trainers to be "difficult." She regularly complained to her primary therapist that the "skills trainers push her too much," that "they don't understand what she's going through" and that she "can't do all these skills." Wendi often did not fill out the skills or the behavioral targets on the diary card, and did not practice her skills in a consistent manner. Perhaps due in part to these difficulties with homework, Wendi did not appear to be benefiting from treatment, after her initial drop in suicidal behavior. In fact, she frequently communicated to her individual therapist that treatment was "not helping."

Strategies to Overcome Barriers

Initially, the individual therapist made use of chain analyses and contingency management strategies to help Wendi complete and benefit from her homework. When Wendi came to session without her homework done, the individual therapist would have her fill out her self-monitoring diary card in session, without extending the session length. Essentially, Wendi had to complete her homework before arriving in order to have a normal-length session. The therapist also used chain analyses to determine what seemed to be getting in the way of homework completion. Based on these analyses, the therapist reduced the number and difficulty of the homework assignments; reinforced small steps toward more skillful behavior (i.e., shaping), coached Wendi on using stimulus control strategies to help her remember her homework assignments, and used heavy doses of "cheerleading", communicating faith in Wendi's ability to complete the homework assignments.

Despite these interventions, Wendi did not seem to be improving in treatment, and by her account, was not practicing skills or completing her homework consistently. In fact, during one session, Wendi stated that "the skills were not all that helpful, and all the therapist ever has to offer are skills, or for her to do x or to do y," and that she thinks she needs something different. The therapist highlighted the pattern that Wendi seems to need and wants help, but that she is not putting effort into therapy, and is consistently telling the therapist that treatment is not working. Using the dialectical strategy of extending the seriousness or implication of Wendi's communications, the therapist suggested to Wendi that they consider the possibility that the therapy is not working, and that a different therapist might be more helpful. The therapist emphatically stated that she would consider it unethical to knowingly conduct ineffective therapy. As it turns out, this was the "magic" intervention for Wendi. She completely changed her demeanor. She told the therapist that therapy has been helpful (even skills training) and that she has been doing more work than she has been reporting, primarily because she was terrified of communicating that she
was getting better. As it turns out, Wendi was afraid that, if people believed she was improving, they would stop helping her and increase her expectations of her. The therapist validated her fear, (based on a long history of these kinds of experiences) and came up with a solution to this problem that involved changing the contingencies of treatment. The solution was to agree that Wendi could continue to see her therapist as long as she was improving in therapy. Subsequently, Wendi’s progress improved, as did the accuracy of her reports about her progress, and she consistently completed her homework assignments.

SUMMARY

DBT is a comprehensive, multi-modal cognitive behavioral treatment that is firmly embedded in a dialectical philosophy. The biosocial theory of BPD posits that patients with BPD suffer from a fundamental dysfunction of the emotion regulation system, characterized by both motivational and skill deficits. Several different types of homework assignments are used in DBT to ameliorate skills deficits and facilitate the targeting of behavior by the therapist. Some of the homework assignments are instrumental to the process of targeting and working toward high priority goals (e.g., self-monitoring DBT diary cards), while other homework assignments are more directly focused on having the patient hone particular skills (e.g., skills practice assignments). Homework in DBT is used in a variety of ways to enhance skill acquisition, strengthening, and generalization among BPD patients.

In many ways, DBT was built from the “bottom up” to address problems with implementing standard therapy procedures with multi-problem patients. Along these lines, therapy with BPD patients often involves many barriers to homework implementation. Much of the focus of individual therapy in DBT is geared toward preventing or ameliorating problems that serve as barriers to developing a life worth living, through the synthesis of acceptance and change strategies. Barriers to homework implementation are treated as therapy-interfering behaviors, and the therapist tackles these problems in a similar manner as other behavioral difficulties, based firmly in a DBT case conceptualization, behavioral principles, and common therapeutic sense. The underlying assumption is that the most caring thing a therapist can do is to help patients change in ways that bring them closer to their own ultimate goals. In terms of research on homework, some encouraging evidence supports the acceptability of homework in DBT. In addition, contrary to clinical lore, evidence suggests that suicidal BPD patients do, indeed, practice their skills and do their homework. We hope that this chapter provides guidance on the important role of homework in DBT that will encourage clinicians to use this therapeutic tool in a manner that enhances the lives of BPD patients.

REFERENCES


