BACKGROUND

The often severe problems of borderline personality disorder (BPD) are long-lasting and result in suffering for not only the individual with BPD but also his or her loved ones. Partners and other relatives of people with BPD often have very limited knowledge about the disorder and often exhibit significant distress about their loved one’s problems and suffering (Hoffman, Buteau, Hooley, Fruzzetti, & Bruce, 2003). About 75% of people with BPD engage in suicidal and nonsuicidal self-injury, and people with BPD typically have multiple co-occurring problems, including depression and anxiety disorders, substance abuse problems, eating disorders, post-traumatic stress disorder (PTSD), and an assortment of health and other problems (Zanarini, Frankenburg, Hennen, & Silk, 2004). This set of severe and chronic problems often is associated with emergency room visits, psychiatric hospitalization, problems at work (or disability), and chaos and conflict in relationships. It is easy to see the strain these problems can put on a partner and on a couple, in addition to the obvious suffering of the person with BPD.

There is some good news, however, despite the rather serious problems associated with BPD: Effective treatment for BPD is increasingly available. Dialectical behavior therapy (DBT), developed by Linehan (1993a, 1993b), has been shown consistently to improve significantly the safety and stability, and decrease the distress, of patients with severe difficulties across multiple randomized controlled trials in the United States and abroad (Robins & Chapman, 2006; Stoffers et al., 2012). In addition, two other treatments under development (mentalization therapy and schema-focused therapy) have shown promise in the treatment of people with BPD, (Bateman & Fonagy, 2006; 2009; Giesen-Bloo et al., 2006).

Unfortunately, the couple and family relationships of people with BPD have mostly been neglected. However, recent advancements involving adaptations and extensions of the principles and practices of DBT to couples and families have shown promise. In multiple studies, parents and partners of people with BPD who participated in a time-limited group program called Family Connections showed significant reductions in grief, depression, burden, and increases in mastery and empowerment, all of which were maintained at follow-up (Ekdahl et al., 2014; Hoffman et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007; Rajalin et al., 2009). Adding a DBT couple intervention to ongoing individual DBT has resulted in substantial individual and relationship improvements (Fruzzetti, 2014; Kirby & Baucom, 2007). A group of couples (with and without a partner with BPD or significant BPD features) who participated in a pilot
DBT couple therapy study showed significant improvements in relationship satisfaction and communication (decreased invalidating and increased validating responses), and individual partners reported lower individual distress and depression, all of which were maintained at follow-up (Fruzzetti et al., 2014).

This chapter explores many of the issues and challenges that confront therapists treating couples in which one partner (or both) has the characteristics of BPD, in particular, high levels of emotional reactivity or dysregulation, which can lead to conflict and emotional distance. Interestingly, partners in relationships that do not include a BPD member may also develop (usually temporarily) many of the core characteristics of BPD when in severely distressed relationships, albeit typically only in interactions within that relationship. Over time partners can become acutely sensitive and highly reactive to each other, and chaos and negative emotion flow in abundance. Thus, the treatment approach described in this chapter may be quite useful for many such “borderline couples” in which neither partner has BPD or any characteristics of BPD historically, but in which partners have developed patterns of high conflict or other destructive patterns of interaction (e.g., mutually destructive patterns, mutual avoidance patterns, or engage distance/demand withdraw patterns; Fruzzetti & Jacobson, 1990).

Details of the essential structure of treatment, targeting processes, skills, and treatment processes of DBT with couples will be described. DBT is an integrative treatment and is compatible with (and indeed includes) both behavioral and systems interventions (Fruzzetti, 2002), yet also includes some aspects of treatment that are quite uncommon, such as a focus on emotion regulation. The DBT approach will provide the core of the chapter, but many of the concepts, techniques and strategies may be incorporated into other approaches (e.g., Baucom, Epstein, Kirby, & LaTailade, Chapter 2; Christensen, Dimidjian, & Martell, Chapter 3; Gottman & Gottman, Chapter 5; and Gurman, Chapter 7, this volume).

**UNDERSTANDING BORDERLINE PERSONALITY DISORDER AND COUPLE INTERACTIONS**

It is important to understand the “transactional” model for the development and maintenance of BPD, and how BPD and related problems manifest in couple interactions. This is useful in understanding both couples who have a partner with diagnosed or diagnosable BPD and the larger population of distressed couples whose partners react strongly and quickly with high negative emotion (often referred to as “borderline couples”).

**BPD Basics**

BPD is characterized by high levels of emotional distress, sensitivity, reactivity, and impulsivity, including suicidality and self-harming behaviors, interpersonal difficulties, fears of abandonment, along with occasional transient paranoia and difficulties with experiencing “emptiness” or maintaining a consistent and independent sense of self. About 1-3% of the population technically meets full diagnostic criteria for BPD, but a much greater percentage has significant features that include high negative affectivity in a significantly distressed relationship.

The best evidence suggests that these kinds of difficulties develop in a complicated transaction between an individual with high emotional vulnerability (e.g., sensitivities, reactivity, and a slow return to emotional equilibrium) and invalidating responses from his or her social and family environment (Fruzzetti, Shenk, & Hoffman, 2005; Fruzzetti & Worrall, 2010). The essence of this model is that “emotion dysregulation,” the core problem of BPD, may also be the core problem of many entrenched distressed and negatively reactive couples.

As show in Figure 23.1, high negative emotional arousal results from a combination of the ongoing events in life plus vulnerability to negative emotion. These events are usually quite ordinary and occur throughout every day (e.g., getting a slightly less than desired reaction after saying “hello” to a neighbor, coworker, or family member; finding that one’s partner is not as interested in taking a walk or watching a film as one hoped), but they may also be more significant, less regular, and carry more impact (e.g.,
having a major argument with a partner, receiving a poor job review, or getting a parking or traffic ticket). When negative emotional arousal is sufficiently elevated, partners commonly focus increasingly on escape from this painful experience and focus less and less on effective problem solving, tolerating the experience, or constructive engagement (Fruzzetti & Jacobson, 1990). Dysfunctional behaviors, such as self-harm, substance abuse, and even aggression, develop as effective means of escaping aversive emotional arousal.

When partners’ emotional arousal becomes elevated, and they focus increasingly on escape from this painful arousal, their ability to express or describe their private experiences accurately (emotions, wants, thoughts) is limited. They are more likely to get stuck in a pattern of being judgmental, further fueling their arousal, and expressing a great deal of negativity rather than simply describing their initial or primary emotional responses and the situation that triggered them. Most often, they become judgmental, finding extreme fault (“wrong” or “bad”) with the other person or with themselves. When they are judgmental of themselves, shame ensues, typically followed by withdrawal. When they are judgmental of others, such as a partner or spouse, anger grows and typically leads to an attack (in tone, emotions, facial expression, and words) on the other person, although sometimes this also leads to withdrawal. Both of these scenarios [judgment \(\Rightarrow\) emotional arousal (shame or anger) \(\Rightarrow\) inaccurate expression (including demanding, criticizing, blaming, nagging, and withdrawing)] are common in distressed couples in general, and in “borderline” couples in particular (Fruzzetti, 2006).

Of course, the person under attack sees, hears, and feels the attack, and may have his or her own vulnerabilities, increased emotional arousal, and/or judgments. It is extremely difficult for him or her to notice that the attacker’s expression is not an accurate reflection of what started this progression of emotion dysregulation, which likely was a softer, more primary emotion (disappointment, longing, loneliness, or worry) or relationally reasonable desire such as wanting to spend more time together or to receive or to provide more closeness or support.

It is extremely important not to pathologize either partner, including the partner with BPD; rather, it is essential for the therapist and the partner (and others) without BPD to understand this disorder as a logical outcome of rather extreme but understandable transactional factors over time, including ordinary temperament factors and pervasive invalidation. Many people may become increasingly negatively reactive following consistent invalidating responses from others, and they may have had such experiences with boyfriends or girlfriends, family members, supervisors, or others.

Part of the problem in these transactions is that partners’ primary emotions are missed, and instead they express secondary emotions (Fruzzetti, 2006; Greenberg & Johnson, 1988, 1990). “Primary” emotions are typically universal, healthy responses to situations or stimuli. In contrast, “secondary” emotions may be learned escape reactions from primary emotions or indirect reactions that are mediated by judgments. For example, if Maria is looking forward to Roberto coming home for dinner, but he calls to say he has to work late and will not be home until after dinner, Maria’s primary emotion is almost certainly disappointment (she is not getting what she wants). However, if Maria becomes judgmental of Roberto (“He’s inconsiderate” or “What a jerk to abandon me like this”), then the energy of her disappointment quickly transforms into anger. Here, anger is a secondary emotion. Similarly, if Roberto has often been late and the partners have had many negative interactions around this, Maria may simply feel angry (no judgment is required; it is just a learned pattern from repeated similar experiences) when she learns he will be late again tonight. Again, the anger is a secondary emotion. In DBT with couples we emphasize the accurate expression of primary emotions, which are more easily connected to what just happened (and is similar in this way to emotionally focused couples therapy; Johnson, Chapter 4, this volume). Expressing secondary emotions rather than
primary emotions is an important part of dysregulated emotion, and inaccurate expression of emotion.

**Conflict Patterns**

Couples develop fairly consistent patterns of interacting in conflict situations. Although partner behaviors may vary somewhat in different situations, they often form predictable patterns. Here, “conflict” simply means situations of disagreement, such as when partners are unhappy with one another or do not like something the other has or has not done.

**Constructive Engagement Pattern**

This pattern is, of course, the goal. Here, partners bring up issues that bother them and express themselves in a non-attacking way that reflects an accurate description of what they feel, think, or want, including accurate expression of primary emotions. The other partner listens, brings curiosity, tries to understand, and communicates that understanding, even if he or she disagrees. With this beginning, many problems are solved, but even if they are not solved immediately, each person understands the other better and may be able to be more emotionally responsive (be more soothing or validating). Sometimes simply exploring the conflict can bring couples closer by increasing mutual understanding. But, to do this constructively, both partners must be aware of their emotions and wants, and be able to regulate their emotions effectively (Fruzzetti & Iverson, 2006).

**Mutual Avoidance and Withdrawal Pattern**

When one partner has a negative reaction to the other and starts to become more highly negatively emotionally aroused, the other partner reacts to this and starts to “spike” emotionally as well (typically into secondary emotions, often anger and sometimes fear). Each partner may be aware of the other’s accelerating negative arousal and potential to become dysregulated quickly, and may consequently avoid bringing up important issues altogether or avoid any interaction for a period. Of course, problems that cannot be discussed cannot be solved, so over time this pattern exacerbates the couple’s problems. Closeness and intimacy decrease even though arguments may be infrequent.

**Mutual Destructive Engagement Pattern**

In this pattern, partners express a great deal of anger (secondary emotion) and engage in mutual attacks. They become so emotionally aroused that they briefly fail to remember (or care) that the person they are attacking is the person they are in partnership with and love. Furthermore, arousal interferes with each partner’s ability to listen to and understand the other’s experience and point of view, which is already obfuscated by inaccurate expression, mostly in the form of anger and judgmental attacks. Both partners behave in a maladaptive manner (often hurtfully toward each other) and regret doing so later, when re-regulated. Importantly, this kind of interaction heightens partner vulnerability to negative emotional reactivity the next time a conflict situation arises.

**Engage ↔ Distance Pattern**

In what is sometimes called the “demand ↔ withdraw” pattern, as one partner moves toward the other, the other resists this increased engagement and may even seek more distance. One partner wants to discuss a topic, be together, and so forth, but the other does not want to do this, at least not at that moment. Often, the conflict is over something related to closeness in the relationship, such as being heard or spending more time together. Either the “engager” or the “distancer” can start out doing his or her part in either an effective, constructive way or in a more destructive way (aversive and avoidant, respectively), but eventually the pattern becomes aversive, resulting in more distance (attacking and withdrawing) between partners.

**THE TREATMENT MODEL**

The role of negative emotional arousal and dysregulation is clear in each of the problematic patterns we noted earlier, and helping partners regulate their emotions in response to each other is an ongoing treatment target. In DBT for couples, the larger treatment goals, of course, include reducing these negative patterns and creating more constructive interaction patterns. Regulating one’s own emotion is one key part of
these changes. To do this, the problems the couple has are arranged in a treatment target hierarchy, with more severe and destructive (and dangerous) behaviors treated before less severe ones. Interactions leading to the chosen treatment targets are examined to find the “links” in the chains of actions and reactions that send the interaction in the dysfunctional direction (Figure 23.2, discussed in detail later). At these junctures, the therapist helps partners both to understand (accept) and to problem-solve (change) various steps in these interactions, and to learn specific skills (e.g., emotion self-management, accurate expression, relationship mindfulness, validation) to alter destructive patterns. The therapist models this “dialectic” of synthesizing acceptance and change, providing both consistent acceptance and validation (e.g., acknowledging how problem behaviors and destructive reactions make sense, providing “cheerleading,” and supporting and validating attempts to engage more constructively), and a consistent push to change negative reactions and incorporate more skillful alternative responses into partners’ interactions (e.g., blocking dysfunctional responses, insisting on trying new and more skillful responses, pushing each partner to take responsibility for his or her part of the ongoing transaction).

Balancing acceptance and change interventions is also a cornerstone of integrative behavioral couple therapy (Jacobson & Christensen, 1996; Christensen et al., Chapter 3, this volume). However, the dialectical process is more central and explicit in DBT for both clients and therapists. For example, in DBT the client is explicitly taught both acceptance skills (e.g., mindfulness, relationship mindfulness) and change skills (e.g., emotion regulation, problem solving), while the therapist utilizes a broad repertoire of both acceptance and change interventions, as noted earlier. In addition, DBT with couples emphasizes the role of dysregulated emotions in the breakdown of communication and the escalation of conflict, and includes many interventions to help partners regulate emotion as a means (or mediator) to either acceptance or change.

This dialectic of acceptance and change is the primary dialectic in DBT (see Linehan, 1993a), and acting within a dialectical framework is essential for the DBT couple therapist. However, other dialectical tensions when working with couples, in addition to the tension between acceptance and change, are important in DBT. For example, two distressed partners always have quite different experiences, attributions, and perspectives. Each has validity, and the ability of the therapist to synthesize the perspectives of two partners and reduce their polarization is essential (Fruzzetti & Fruzzetti, 2003). Polarization is viewed as a normal process, and thus is welcomed. However, to move forward, de-polarization (synthesis) must also occur, and most of the skills and therapy strategies are designed to help partners polarize and de-polarize skillfully.

This form of therapy is very flexible. Some couples prefer a more structured approach, and for them the therapy can be presented as a semi-structured “skills training” class, heavy on psychoeducation and learning and practicing new skills. This kind of couple therapy can be offered in groups or individually, and therapists can teach the skills using handouts or a therapy guide (Fruzzetti, 2006), and couples learn the skills in a progressive fashion. In a group, there are typically two therapists, both to allow modeling of the management of multiple perspectives and to allow one therapist to help manage dysregulated individuals while the other continues with the agenda. In addition, while one therapist focuses on skill content, the other can attend to more idiosyncratic application of the skills with specific couples.

Other couples either prefer a more traditional and less-structured approach, or cannot stay regulated sufficiently to appreciate a structured approach or learn new skills that way. For them, treatment is offered traditionally (one couple, one therapist), taking the current “hot topic” and examining it via chain analysis, and teaching the needed skill in that moment. Over time, all the skills required are covered, and the partners receive considerable practice in changing the steps in their “dance” to be more constructive, including managing their own
emotions more successfully.

Regardless of format, learning both individual emotion self-management skills (e.g., mindfulness, emotion regulation, accurate expression) and more relationship-oriented skills (e.g., relationship mindfulness, validation, true acceptance of the other) are at the core of this approach. However, although different couples may demonstrate quite similar skills deficits and interaction patterns, they may present with different overt (content) problems. For example, some partners are safe and stable even after a nasty argument, whereas for others a particularly unpleasant fight might include violence, or one partner might get drunk afterwards, or might attempt suicide. For partners with BPD and the associated negative emotional reactivity they often experience, it is important to establish a treatment structure that matches the severity of the disorder present, thereby reducing the risk of dangerous behaviors and negative outcomes. We now turn our attention to creating an effective treatment structure, then go on to discuss the practical details of conducting the treatment: assessment, identifying change targets and arranging them in a hierarchy, teaching skills, and other treatment strategies.

**TREATMENT CONTEXT**

It is important to consider the severity of BPD (or any other individual problem or disorder) in structuring couple therapy. If one or both partners have severe individual problems, concurrent individual treatment may be required. There may be times when individual treatment should begin, and progress in self-management should be demonstrated clearly, before initiating conjoint sessions. Let us consider some guidelines for making these decisions.

**Concurrent Individual Treatment**

The circumstances that would require concurrent individual treatment can best be described as occurring when one or both partners have “out-of-control” behaviors that may be life-threatening. This includes being suicidal or having recently made a suicide attempt, recent nonsuicidal self-harm (e.g., cutting or burning), severe substance abuse, recent child abuse or neglect, or other severe and destructive impulsive behaviors. In all of these cases, if there were no individual therapist to address these problems, the severity of the individual partner’s difficulties would require the immediate and ongoing attention of the couple therapist, therefore precluding, or at least severely limiting, him or her from addressing couple issues.

Of course, one might argue from a systemic perspective that these individual, out-of-control behaviors might be directly related to couple problems and couple interactions. This may often also be true from a DBT perspective. However, couple therapy requires raising difficult issues that often include a good deal of emotional pain. If the partner does not have the requisite skills to manage his or her own behavior without engaging in severe and dangerous or extremely destructive acts, doing the couple work could be iatrogenic. In addition, from a dialectical perspective, although a partner’s behavior is always related to his or her social and environmental context and may have an important function vis-à-vis his or her partner, this must be assessed to be determined. Even when relationship problems or one partner’s behavior is functionally related (e.g., a relevant antecedent or consequence) to the other partner’s out-of-control behavior, DBT emphasizes each individual’s responsibility for his or her own behavioral self-control.

The problems of partner abuse and violence provide a good example of this dialectic. On the one hand, there is the valid argument that to treat the abuse or violence conjointly (and to conceptualize it systemically) implies that the abuse victim has at least partial responsibility for the abuse and bears partial responsibility for changing his or her own behavior to help the perpetrator cease the abuse. To avoid blaming the victim, this perspective typically requires that the perpetrator (typically a male in heterosexual couples) be treated first individually, and only then would the couple enter therapy together to work on couple problems. On the other hand, many have noted that it is common for both partners to conceptualize partner abuse systemically, at least implicitly, and they often
want to work on reducing the conflict that they conceptualize as precursor to the aggression and violence. Especially when the violence is “moderate” or less severe, some therapists argue that conjoint sessions are not only acceptable but also useful (see Chapter 14, this volume).

From a dialectical perspective, we frame the issue as safety. Because DBT maintains that individuals must be responsible for their own behavioral self-control, the targets at this stage of treatment are individual, and the treatment is typically delivered one on one. However, this is conceptualized and communicated to partners simply as the first stage of the overall couple therapy. Thus, the DBT couple therapist may refer the perpetrating partner for individual therapy and require significant progress in self-control prior to initiating conjoint sessions, or he or she may choose to treat the couple comprehensively, including the domestic abuse, but engage the abusing partner alone for however long it takes to establish safety and self-control. How the partner abuse is treated in DBT is beyond the scope of this chapter, but is discussed elsewhere (see Fruzzetti & Levensky, 2000). Similarly, being the victim of domestic abuse may require special attention and specialized treatment (Iverson, Shenk, & Fruzzetti, 2009).

**Coordinating Care with Other Treatment Providers**

In many cases one or both partners may be involved in individual psychotherapy of some kind, and both partners seem to be safe and stable enough for couple work. In these cases, it is important to make sure that the individual therapist is not working at cross-purposes to the couple therapy, and to hold a meeting (in person or by telephone) that includes both therapists and both partners, in which treatment goals and targets are clarified for each therapy component.

Many treatment modalities may virtually always be compatible with DBT for couples. Obviously, individual DBT would be completely compatible with couple DBT, and typically CBT would as well. In addition, psychoeducation programs designed for family members of someone with BPD, such as Family Connections (Hoffman et al., 2005, 2007), might augment DBT with couples, because so much information about BPD is provided and skills for managing emotionally intense and reactive situations are taught. However, some individual treatments could be incompatible with couple DBT, particularly in the way that emotions and emotion regulation are conceptualized and treated. Of course, such conflicting treatments should be avoided, to instead provide clients with coherent help.

**DBT with Couples May Be Comprehensive Treatment**

Finally, if the individual problems of a partner are not out of control (for example, neither partner engages in suicidal behavior, self-harm, or partner violence), then DBT with couples may be provided as a comprehensive treatment; that is, distressed couples are likely to include partners with a variety of problems, including depression, substance abuse, eating disorders, and anxiety disorders, and the association between individual distress and psychopathology, and relationship distress has been well documented (Fruzzetti, 1996; Fruzzetti & Worrall, 2010).

**ASSESSMENT, ORIENTING, AND COMMITTING TO THERAPY**

There are two primary goals of the initial assessment with couples: (1) identifying treatment targets, and (2) quantifying a baseline against which to measure progress. Of course, also collecting posttreatment assessment provides objective measures of outcome. In addition, daily or weekly (ongoing) assessment may be an important additional tool to help monitor progress, adjust treatment targets, and keep partners and the therapist focused and collaborating on the same treatment goals or targets. Let us briefly consider both types of assessment.

**Assessment during the Pre- and Posttreatment Phases**

As noted previously and described in more detail below, DBT with couples follows a treatment target hierarchy paralleling that of individual
DBT (Fruzzetti & Fruzzetti, 2003; Linehan, 1993a). Consequently, it is essential to assess for relevant problems at each point in the hierarchy. This may be accomplished by a combination of self-report questionnaires, both individual and conjoint interviews, and direct observation of partner behaviors (Fruzzetti & Jacobson, 1992).

**Questionnaires**

Many psychometrically sound questionnaires are available for use with couples. It is particularly important to assess important overall dimensions of both individual and relationship functioning. Utilizing a gross measure of couple satisfaction is important. Similarly, including standard measures of individual distress can be quite useful, along with measures of emotion regulation or dysregulation. Measures of conflict, including partner abuse, are quite important to include. Perhaps the most common and sound among these measures is Straus, Hamby, Boney-McCoy, and Sugarman’s (1996) Revised Conflict Tactics Scale (CTS2). The specific questionnaires used perhaps matter less than that they are psychometrically sound, have established norms, and are clear about the domain(s) being evaluated.

**Video-recorded Conversation Samples**

Unfortunately, many couple therapists still believe that video-recording couples is something that only researchers can do. On the contrary, clinicians should include video routinely in their practice for a variety of reasons: (1) It provides more objective opportunities to quantify couple communication and, therefore, valid indices of progress and outcome; (2) videorecorded material also may be used therapeutically later on; (3) this may be the most useful way to receive consultation from colleagues about working with the couple; and (4) videorecorded interactions may have more external/ecological validity, because what couples actually do when left alone for a while may be quite different than what they do in front of the therapist, and what they report. For example, people with BPD typically have quite discrepant views from those of their family members about their own and their family members’ behavior (Hoffman, Buteau, & Fruzzetti, 2007). Thus, it may be important to observe whether these differing views reflect distortions or misunderstandings on the part of the partner with BPD, the other partner, or both, or whether they simply reflect normative but different experiences.

It may be useful to ask couples to engage in several different conversations to provide the therapist with a more varied and representative sample of how they interact across multiple domains. Topics might include satisfaction with emotional closeness and intimacy, time together, or recurring problems. Each partner should be allowed to bring up at least one relationship-relevant problem for discussion, with the couple left alone in the room with minimal distractions, and given the instruction to try to discuss and solve each problem. If recording is not possible, the couple can be observed as inconspicuously as possible by the therapist, who gives the couple minimal instructions, arranges the chairs so that partners are facing each other, and then sits quietly and unobtrusively to the side, out of direct visual sight lines, where he or she can observe the interactions and take notes.

These conversations can be “coded” formally with an established rating or coding system. However, it may be even more practical or useful for the therapist to be able to observe the conversations in “real time” (informal coding), perhaps with consultation from a colleague, to understand each partner’s experience in the couple transactions and to help identify treatment targets. Rating or coding the conversations has the added benefit of providing an objective measure of treatment outcome if similar conversations are recorded at the end of therapy.

**Interviews**

There are many standard parts to any couple interview, including DBT with couples. Although there is not sufficient space to detail all aspects of a standard couple interview here (see Fruzzetti & Jacobson, 1992), it is important that we note several targets of the interview process.

First, it is important to include separate interviews with the partners, along with interviews of partners together. The advantages of
including individual interviews (e.g., more accurate or complete information, establishing rapport with each person as an individual, as well as with them as a couple) seem clearly to outweigh the potential disadvantages (e.g., unbalancing the therapy by allying, or appearing to ally, with one partner more than the other; risking the disclosure of a “secret”). During the separate interviews, partners should have the opportunity to discuss both life and relationship successes and failures, and some of their individual history, particularly as it may affect treatment targets. This should include history of problems and treatment (including suicide attempts and other self-harm or substance abuse); previous or current infidelities; physical and sexual abuse histories; experience of conflict in the relationship, including aggression, coercion, and violence; commitment to therapy; and commitment to the relationship. Incongruities between partners’ verbal descriptions and their questionnaires, of course, must be clarified.

There also should be one or more conjoint interviews that include information about the couple’s relationship history, strengths and problems, and any matters pertaining to safety. However, the most important strategy here is to begin to conduct a “chain analysis” of specific problems or targets (Fruzzetti, 2006; Fruzzetti et al., 2007). This is described in more detail below.

**Orienting and Committing to Therapy**

Given the chaos that often runs through the lives of high-conflict, highly distressed, couples, there are many things in their lives that may interfere with successful engagement in couple therapy. Clearly specifying what the couple may expect from the therapist, and what the therapist expects from the couple, allows partners to make a well-informed choice about participation. Because couple DBT requires more active partner participation (e.g., daily self-monitoring, between-session practice of new skills, and commitment to what for many is a new conceptualization of their problems and interactions), a clear orientation to therapy is essential to receive meaningful commitments.

In addition to orienting partners to the steps involved in the treatment, the therapist may also assess problems that are likely to interfere with or even preclude collaborative engagement in therapy. Have they dropped out of therapy before? If so, why? What would make this situation different (or the same)? Can the therapist and couple collaboratively anticipate problems in the therapy and problem-solve them before they occur? Common problems include one or both partners conceptualizing the therapy as a means of “fixing” the spouse to improve the relationship, rather than taking a more reciprocal or transactional view of their difficulties; wanting the therapist also to function de facto as an individual therapist for one or both partners; perceiving therapy simply as a place to vent, rather than as a program for changing important problematic interactions (with bilateral responsibility for improvements); and preferring a “free-flowing” type of therapy, in which they can talk about whatever is on their minds as opposed to the flexible but still semistructured DBT approach, in which a specific treatment target (drawn from the treatment target hierarchy) informs each session’s agenda, and in which specific skills are learned and applied.

In particular, because DBT with couples is organized according to a hierarchy of targets, it may be useful at times to make an initial contract for just a few sessions to see whether the partners can engage meaningfully in the treatment. One or both partners may be quite reluctant to make an open-ended or long-term commitment to couple therapy, but they may be willing to commit for 6–10 sessions. We can take that commitment and work within the hierarchy to make as much progress as possible within the available time. If this initial commitment is unsuccessful, the couple may be willing to recommit later for additional sessions to work on additional targets, if needed.

Thus, the couple’s initial commitment to therapy may be relatively brief (6–10 sessions), or much longer (15–20 sessions or more). If partners make improvements, then they may be satisfied and stop therapy at the end of their agreement, or decide to renew their commitment to work on additional problems. Because
of the nature of the treatment target hierarchy, the most important problems always are addressed first, so the therapist need not be too concerned with the length of the initial commitment. The DBT therapist is typically willing to renew an agreement (or “contract”), for additional sessions, if the therapy is demonstrably working and partners are showing meaningful improvement.

Data from one study demonstrate that significant improvements can occur after relatively few sessions. For example, Fruzzetti et al. (2014) found overall significant improvements in relationship quality and decreased individual distress after six to eight sessions of a couples group program (2-hour sessions), with a sample that included partners with a range of dysregulation. With more severe BPD and greater couple distress, couple therapy may be expected to continue longer, perhaps as long as the BPD partner is in individual therapy (a year or more). However, sessions typically are held less frequently after the initial phase of couple therapy. After a period of weekly sessions, especially after some of the more severe and destructive behaviors have been curtailed, it may be possible for a couple to attend therapy on alternating weeks (or even less often), giving the partners more time to practice between sessions.

Part of the orientation to treatment also includes an orientation to what BPD is and how it develops and is maintained. Psychoeducation is important in part because the transactional model employed in DBT (Fig. 23.1) is nonblaming (it also may be considered developmental or systemic; Fruzzetti et al., 2005; Fruzzetti, Gunderson, & Hoffman, 2014) and “sets the stage” for the consistently nonblaming framework of the treatment. Utilizing a transactional model is also important because it promotes the understanding that both partners play important roles in the relationship and take an active role in therapy. Some partners of people with BPD see BPD as “the problem” and therapy as a way for the partner with BPD to get “fixed,” rather than as a bilateral or joint approach to relationship enhancement that is good for both individuals. This view is problematic from a DBT perspective and must be challenged early on in treatment to orient clients to the model and to obtain a meaningful commitment to therapy.

Psychoeducation may be provided early in treatment in one or two sessions or be spread out over many sessions as topics naturally come up over the course of therapy. Essential psychoeducation topics include (1) understanding the components (“symptoms”) of BPD, and how problems regulating emotion are the central features of the disorder; (2) understanding how BPD and emotion dysregulation overlap with other diagnoses, such as depression, anxiety, eating disorders, and even other personality disorders; (3) understanding BPD as chronic emotion dysregulation that results from complex transactions of individual vulnerabilities (temperament, emotional sensitivity, and reactivity) and invalidating social and family responses (see Figure 23.1; Fruzzetti et al., 2005; Linehan, 1993a); and (4) knowledge about the natural course of BPD, including the fact that BPD is treatable. Because knowledge about BPD is often limited and frequently is not accurate (Hoffman et al., 2003), it is also important to answer questions that partners might have and to disabuse them of their misconceptions about BPD.

In DBT, the therapist approaches commitment (both to treatment targets and to treatment itself) in a manner similar to how he or she approaches other targets; that is, the therapist must simultaneously assess strength of commitment and validate partner experiences (e.g., worries about commitment, disappointments about prior failures, hopes for improvement), and what is needed to strengthen commitment, targeting these behaviors for change. Therefore, the therapist demonstrates the dialectical balance of acceptance and change that clients will face throughout the therapy, which further helps partners assess their comfort with the approach and make a well-considered decision about their commitment.
Ongoing, Daily Assessment and Monitoring:
Diary Cards
To continue to work within a treatment target hierarchy, it is essential to know what the couple is doing day to day. Having each partner monitor his or her own behaviors (for example, actions, emotions, judgments, and skills) increases the accuracy of weekly assessment, minimizes guesswork about the most important target on which to focus, and provides a more accurate “snapshot” of the couple’s daily life than retrospective reporting, which is affected by memory decay or recency effects bias. Self-monitoring has the added benefit of bringing the work of therapy into partners’ daily lives, reminding them of the importance of their work as well as some of the specific skills they are learning, and possibly enhancing practice.

Ideally, partners monitor their key targets every day. This can be accomplished simply on a piece of paper, or the couple may utilize more advanced technology (e.g., smart phone apps, Web-based daily questions, or an e-mail to the therapist). A typical diary card for a nonviolent couple is shown in Figure 23.2. Diary cards are updated as targets change over time.

Note that each partner monitors only his or her own thoughts, urges, actions, emotions, and so on, and may record entries with words, numerical ratings, or even plus and minus signs. Some partners may enjoy keeping track of many different things (a kind of semi-structured journal or diary), whereas others may prefer only to record the most important, current targets. The therapist may think of the diary card in the same way that a dentist utilizes an X-ray: it provides important information about what to treat right now, and what needs immediate attention in the context of a larger, overall treatment plan.

CHAIN ANALYSIS AND SOLUTION GENERATION
Conducting efficient chain analyses is one of the core activities of a DBT couple therapist, and at least one chain analysis (or part of a chain) is conducted in nearly every session. Chains provide the structure for sessions. This method of assessment is also an intervention in a variety of ways: The therapist not only identifies key points to change along the “chain” of behaviors (such as emotional reactions, overt actions, judgments, appraisals, or verbalizations) that resulted in dysfunctional or problem behavior (for example, screaming at or invalidating the other partner, suicidal urges, drinking, or other problems associated with emotion dysregulation), but also uses the chain as a means to understand, accept, and validate one or both partners and their experiences, to model validation, and as opportunities to elicit and coach one or both partners in accurate expression, validation, or other skillful actions. Thus, a chain analysis provides the opportunity for both acceptance and change.

In reality, the therapist actually conducts a “double chain,” and thus explores in detail the transaction between partners that includes each partner’s “chain” or steps toward the problem, and how each affects the other. These steps or links are both private, shown as open links in Figure 23.2 and that include thoughts and emotions, and public behaviors, those shown with a pattern filling in the link, such as facial expressions, talking, or taking action. The steps in conducting a chain analysis are actually rather straightforward, yet illuminate a great deal about the transaction between one partner’s overt behavior and the other’s dysregulated emotion (and vice-versa), help both partners (and the therapist) understand the psychological processes that led to becoming dysregulated, and thus identify specific targets to replace with new emotional or relationship skills. The steps in conducting a chain analysis include (see Figure 23.2):

1. After going over the diary cards partners completed since the last session, the therapist (in collaboration with the couple) selects a clear problem or target that has occurred since the last session (the most severe problem that has occurred in the target hierarchy).

2. Partners identify one specific instance of this problem, or episode (a specific day, time, and place).

3. Partners identify the beginning, or trigger, for the episode, which is the event or situation
that started the “chain.”
4. The therapist helps partners “walk through” the chain, with each partner identifying what he or she was feeling, thinking, and doing at each step along the way. Each partner reports his or her private experiences before and after something was said or done by either partner. The public links are identified with descriptive, non-blaming, language. The therapist blocks negative escalation or unskillful behaviors, and helps each partner practice the next step skillfully.
5. Partners attempt to identify what happened so quickly in that moment that one or both of them got dysregulated, and/or reacted unskillfully.
6. The therapist validates the valid thoughts, wants, and emotional responses along the way, modeling skillful alternatives for the clients and cheerleading their new steps (Linehan, 1997).
7. The therapist helps each partner to express his or her own experiences accurately, and to understand and validate the other’s experience (emotion, wants or desires) in the ways those experiences are valid. The chain reveals and highlights how these experiences and actions were valid in some way, in that moment, even though they ultimately were destructive.
8. The therapist urges each partner to identify at least one skillful alternative that he or she could do the next time the couple is in a similar situation, instead of whatever he or she did this time.
9. Partners practice these new skills in the session, sometimes many times.
10. Each partner commits to practice whatever solutions are generated in preparation for the next similar situation, and the therapist helps them anticipate what might get in the way, and how to practice despite difficulties and barriers.

The double chain allows each partner to begin to understand the other’s private experiences, the thoughts, assumptions, and emotional reactions that led to each one’s public reactions. These experiences are typically quite new, as each partner had been generally unaware of the motivation of the other. Each partner works on managing his or her own emotion, increasing accurate expression, and letting go of judgments, while also bringing more open and mindful attention to the other, and increasing a variety of validating responses.

Thus, the analysis flows easily into solutions and results in identifying skills to learn and practice in-session and then between sessions, with possible reenactment the following session, using the new skills to change the sequence of the old chain. Of course, the “change” required along the chain may be as varied as “acceptance” of one’s own emotion or the partner’s emotion, acceptance of other behaviors, changes in one’s own behavior (e.g., accurately identifying or expressing a primary emotion, regulating an emotion, engaging the partner more constructively, validating), or other skillful alternatives. When enough old “chains” are altered, and replaced with new, skillful sequences, the recurrent interaction pattern will have been rechoreographed. Thus, a chain analysis is both the key intervention tool and the primary assessment tool, utilizing all of the other interventions common to this treatment along the way.

SESSION MANAGEMENT AND OTHER TREATMENT STRATEGIES
Several additional treatment strategies employed in DBT with couples are typically used throughout the treatment process, in every phase and type of session, so they constitute important components of the therapist’s repertoire.

**Therapist Mindfulness**
In part because mindfulness and relationship mindfulness are core skills for clients, it is also important for therapists to adopt a mindful, nonjudgmental stance and actively practice from this perspective. This is important in part because many people respond to partners who display extreme reactivity in invalidating ways, and this only exacerbates their difficulties. In addition, maintaining a nonjudgmental perspective promotes collaboration with both partners,
and models acceptance (personifying the treatment, in a sense). Having an effective consultation team (discussed below) facilitates achieving and maintaining a mindful approach, because colleagues are also committed to understanding and accepting, rather than blaming, clients for their difficulties.

In addition, clients with BPD and related problems sometimes engage in extreme behavior that can frustrate their therapists (as well as their partners), even pushing them to react countertherapeutically. Suicide attempts, nonsuicidal self-injury, substance abuse, extreme expressions of anger or shame, and other impulsive behaviors can be taxing. By consistently practicing mindfulness, the therapist is able to focus on assessing, understanding, and validating (the valid parts) rather than distancing, criticizing, blaming, or threatening when challenging situations come along. Therapist mindfulness helps the therapist like the partners and communicate this acceptance genuinely, which itself helps to regulate dysregulated partners. Thus, therapist mindfulness is the first step in effective session management with dysregulated couples.

When faced with particularly challenging behaviors during a session, the therapist may find it helpful to: (1) Observe the judgments he or she is having about the partner, for example, “I notice that the word “manipulative” is coming up…I am being judgmental”; (2) Practice observing and describing the situation instead: “This partner is expressing anger and it is making me feel anxious…what is his or her primary emotion? Probably he or she is feeling disempowered…sad, anxious, a bit humiliated…and has few skills to express this effectively”; (3) Put the “problem behavior into the transactional model: “based on what I know about this person’s history of invalidation and dysregulation, this makes sense”; (4) Use this empathy right now, helping both partners to move forward. This might include, a) interrupting the escalation; b) directing attention of the partner back to his or her primary emotion; c) modeling validating these primary emotion (perhaps including “speaking on behalf of the partner,” described later); d) identifying skills the partner can do differently when this sequence occurs again, and finally, e) getting both partners to practice this sequence and get a commitment to continue practicing outside the session. All of these things can be done dialectically, with a combination of warmth, soothing, validation, blocking, cajoling, and irreverence.

Mindfulness leads to understanding and acceptance, then to validation, which helps the therapist to deescalate mutual negative emotional arousal. This deescalation in turn promotes effective therapeutic interventions and minimizes dropouts and treatment failures.

Perhaps most important, mindfulness leads to descriptive, rather than interpretative or judgmental, thinking. The therapist, when faced with an escalating couple, can simply think out loud, describing what he or she has just observed, and reorienting the partners back to their own goals, which typically include kindness and understanding of the other, as well as being understood, supported, and validated. For example, as a couple begins to escalate into mutual blaming, the therapist might say (at first, loudly), “Wow! I really can see how painful this is, and how fast your relationship goes down the toilet. Let’s go back a couple of sentences. (Now, quieter, with warmth, turning toward one partner) I noticed you seemed sad a few seconds ago, at least I think that’s what I saw. But what you said was more blaming and critical (this validates both partners, helping to soothe their frayed emotions). Can you tell him (or her) what you were sad about?” The therapist can then block any escalation by either partner, and guide the other partner to listen and focus just on this one small statement, and perhaps “see” the sadness rather than the attack, and respond accordingly. Notice that therapist mindfulness is the first step in helping partners be mindful of their own experiences, especially their closely-held desires for a better relationship, and also mindful of their partners’ softer, more primary emotions and desires.

**Skills Generalization**

As described earlier, there are many skills for partners to learn in this approach, and framing
treatment targets as skill building further contributes to a non-blaming, supportive treatment context. Skill training is always done in session. Unfortunately, at least in some ways, clients’ arousal in session is often much lower than it is in difficult situations in vivo. Thus, being able to transfer (i.e., generalize) the skills learned in therapy to difficult situations at home requires direct and sustained efforts.

Fortunately, after completing several detailed chain analyses, the therapist is likely to have a good sense of the situations (both the interpersonal context and the level of emotional arousal present) in which skills are needed. Thus, the therapist may engage in many different types of rehearsal with one or both clients in anticipation of difficult situations at home. Similarly, the therapist may assign homework for partners to continue to practice or rehearse at home, but under slightly lower arousal conditions, thereby enabling partners to become more and more skillful and better able to use the new, more skillful approach, even when the conversation or situation feels provocative.

In addition, the therapist may make him- or herself available by telephone between sessions for quick (e.g., 5-minute) “coaching” calls. In these kinds of phone calls, the therapist may remind the partner (or both partners in a three-way call) what he or she has been practicing and is committed to doing differently, and may offer support and “cheerleading.”

Dialectical Strategies

Although many parts of the treatment include one or more dialectical elements, there are additional ways the therapist can provide the treatment dialectically (Fruzzetti & Fruzzetti, 2009). For example, the therapist can practice thinking dialectically. This might involve noticing every time he or she is pushing for change, and balancing that by offering acceptance as an equally acceptable goal (and vice versa). The therapist can model “both–and” rather than “either–or” thinking (e.g., “Both George and Martha have legitimate points in different ways” rather than “Either it happened the way he says or the way she says”). And, when stuck, by asking “What are we missing?” the therapist can look for imbalances or polarizations (transforming acceptance vs. change, intimacy vs. autonomy, emotion vs. rationality, pros vs. cons, into both–and rather than either–or perspectives) and try to depolarize and synthesize both partners into a more useful stance.

In addition, the therapist can vary his or her communication style, demonstrating at times a warm, supportive, accepting, and/or reverent approach, and at other times a more confrontive, matter-of-fact, change-oriented, and/or irreverent approach (Linehan, 1993a). Of course, when using irreverence it is essential that the therapist like the partner(s), understand how difficult change is, and not have any judgments about them. Playful irreverence can not only be an effective blocking strategy, but has the added benefit of energizing the therapist in difficult situations.

Of course, irreverence can be tricky, and could be misinterpreted negatively, in particular when a partner is dysregulated. However, in DBT the therapist treats partners like equal, competent human beings and does not shy away from playfulness or from blocking dysfunction via confrontation or other means. For this to be successful, irreverence must originate from an empathic understanding of how “stuck” the partner is, with the therapist able to imagine the chain (both in the present, and historically) that led him or her to act in the present destructive way. Simply put, the therapist must find ways to like the client, and express irreverence from this perspective. Then, it is far less likely that the partner will feel offended or react in other negative ways. Moreover, if the partner does misunderstand the therapist’s intentions, the therapist can quickly move to a more warm, radically genuine style and clarify: “Oh, my, I see how you might take it that way, so let me explain what I meant more clearly... (followed by a brief description of what he or she was trying to accomplish with the irreverence).” Missteps can always be repaired.

In DBT it is desirable to move quickly between a more accepting communication style (warmth, genuineness, validation) and more irreverent communication (matter-of-fact, even
playful or humorous ways of describing, and blocking, dysfunction). It is assumed that a good therapeutic relationship is built out of this broad set of styles, rather than needing to wait until a strong alliance is present in order to block or confront dysfunction. People with BPD have had many experiences being misunderstood, disliked, blamed, judged, avoided and pathologized. Consequently, in DBT, it is important not to be afraid of or deterred by ordinary dysfunction, and instead to validate “big” and also to block, confront, push for change in a big way.

The use of metaphors and stories is also an important dialectical strategy. The benefits include: (1) they pull partners’ attention in the visuals of the metaphor or story, thus out of their pattern of escalating emotion and judgments; (2) it is relatively easy for the therapist to capture the essence of both the change needed in the moment and what is valid that makes change difficult; and (3) although it is typically easy for partners to understand their “roles” in the metaphor, this approach elicits less defensiveness. Therapists can generate stories and metaphors spontaneously in the session, or consult with treatment team members to prepare appropriate metaphors for the particular “stuck” situations that the therapist frequently encounters.

Blocking
Sessions with reactive partners can sometimes be a challenge to manage effectively. Consequently, being able to utilize the dialectical strategies just described in the service of managing the session is important. For example, the therapist must be able to block partners from escalation of emotion when needed, while continuing to validate why that escalation urge makes sense. Similarly, the therapist must be able to invalidate the invalid actions partners take, while simultaneously finding other aspects of the same behavior to validate. For example, one partner may perceive that the other is lying or exaggerating to make him or her feel bad or look bad to the therapist, and may loudly and destructively express a lot of anger about this. The other partner may simply be describing his or her beliefs, perhaps in an unmindful and selectively descriptive way (but without lying or intentionally trying to distort the story). Blocking interrupts destructive, overlearned patterns and provides the opportunity for new, skillful, behaviors to emerge and “work” in the session. Blocking can be delivered in a warm and gentle way, playfully, or in a rather confrontive manner. For example, the statement “It is hard to see the worry and the love when anger comes out and you attack,” depending on tone and therapist affect, could be employed in a variety of ways to stop escalation in the session.

Revolving Door Strategy
Sometimes the therapist may need to separate the partners (briefly, or perhaps even for the rest of the session), for a variety of reasons. For example, one or both partners may become too aroused about a particular topic to participate effectively. In these circumstances, separating partners for part of a session or even for several sessions, so that they spend individual time with therapist, may be useful. When arousal is too high, people feel out of control, and their ability to remember or learn new things is reduced. Thus, it may be counterproductive to try to “push through” when arousal has risen to a particular level. Partners are always oriented at the beginning of therapy to this intervention strategy; the therapist explains honestly that people often need to practice new things in easier, controlled settings in order to develop mastery (such as learning to swim in a swimming pool, not in the ocean during a hurricane). This preempts partners from feeling humiliated when the therapist invokes the revolving door, and also from using it to criticize the other at a later time. The revolving door is thus framed as a very positive, skill-building opportunity and routine part of treatment, and a strategy that is consistent with the partners’ stated goals of self-management and increased responsiveness to each other. Partners can trust the process (reducing suspicion and fears of being criticized behind their backs) because, of course, the therapist never says anything judgmental about the absent partner, always blocks judgments of the absent partner, and continues to help each
partner to be more descriptive about the other, even while validating the present partner’s experience. Thus, no secrets are kept or separate alliances forged in the absence of either partner: The therapist is always working on behalf of both partners and their relationship. Situations to use the revolving door include:

1. One or both partners’ affect is too high to be useful, the usual “traffic control” strategies are not working, and each partner is at that moment a trigger for the other’s escalating arousal. Partners do not benefit from “practicing” their dysfunctional patterns in the session. The therapist might say, “Stop. You don’t need to practice this here…I think you both are pretty good at this already (smiling painfully but empathically). Let’s try something different here. How about each of you takes a turn alone here with me to work on your own part, while the other gets a break in the waiting area? Then we’ll come back together. Who wants to go first?”

2. One partner, who is trying and practicing new approaches to the couple interaction but is not yet very skillful, is talking about the other partner in rather negative ways; in this situation, the criticized partner is spared the bludgeoning, and the practicing partner is spared being “reined in” publicly by the therapist (which could be experienced as embarrassing).

3. Sometimes the therapist wants to push a client very hard to change something but not humiliate him or her in front of the partner or give the other partner “ammunition” with which to criticize later. For example, the therapist can say something like, “Wow, you really were attacking him (or her) back there (before the partner left the room)” much more clearly and forcefully while the other partner is not present, perhaps going on to, “Were you aware of this? What triggered you?” And, he or she can really push this partner to understand the impact of his or her attack, albeit in a constructive and accepting way, in order to increase commitment to reducing attacks and commitment to practicing alternative skills.

4. Conversely, the therapist may want to validate one partner’s experiences quite strongly (e.g., sadness, fear, hopelessness, frustration, or disempowerment following an episode of individual dysfunction, such as self-harm by the partner), without eliciting further shame or defensiveness on the part of the other partner.

When the new skills are learned, and partners have regulated their emotions, they can be reunited for joint practice in the session.

**Speaking for the Partner (While Making Him or Her Look Good)**

There are many opportunities in conjoint sessions to help partners express themselves more accurately, and to validate the other partner. At times, one partner can be in a lot of emotional pain while the other partner has few skills to soothe or validate. In these situations it is easy for therapists to jump in and soothe and validate, and failing to do so may run the risk of escalating dysregulation. Unfortunately, therapist validation and soothing can have the undesirable side-effect of making the other partner look incompetent or unmotivated (therapists are typically good at soothing and validation), and can result in increased distance even if the therapist helps one person to regulate his or her emotions. The point of the therapy is not for the therapist to validate the partners and build a strong relationship or alliance, but to help the couple rebuild their relationship by using these skills themselves.

Fortunately, there is a way for the therapist to move the session forward, help both partners increase their skill, and do this without making either partner look bad. The key is for the therapist occasionally to “speak for the partner.” For example, if one partner is feeling very sad (primary emotion) but is expressing only anger (secondary emotion), and the other does not seem to understand and is not yet able to respond in a very validating way, the therapist might say: “Of course, it’s hard to tell your partner how sad you feel...(then, turning toward the other) ...now that she has told you how sad she is, of course you want to be supportive, you want to validate. (Turning
toward the first) of course, he really understands this, it makes perfect sense.” Later, of course, the therapist will elicit and support more validating statements (or accurate expression) from partners directly, as they learn the skills and manage their emotions more effectively.

This kind of activity models the skills that partners need (accurate expression and validation), but gives partners some credit for doing it even though they have not yet said anything. Surprisingly, as long as the partners do not contradict these statements, they easily end up “owning” the words, and the larger impact is salutary. The therapist can then ask them to start over, slowly, and do it again, the next time coaching each partner on his or her own skillful expression. The result is that partners stay emotionally regulated, and neither is humiliated in front of the other for not being able, or willing, to be skillful in the beginning.

**Team Consultation**

It should be clear by now that a great deal of “balancing” work is done with highly reactive partners. It may be impossible to do what is needed, staying emotionally balanced and non-judgmental, in isolation. A treatment team in DBT is essential both to help therapists continue to improve their own skills and to apply skills effectively in often difficult (and sometimes novel) situations, and to help provide emotional support to reduce stress and burnout (Fruzzetti, Waltz, & Linehan, 1997). When working with couples with a BPD member or similar problems, a treatment or consultation team should meet between sessions. In these meetings, therapists accept a dialectical approach and commit to practicing mindfully, both with clients and with each other. Thus, in this emotionally supportive environment, each therapist can seek consultation, learning how to improve his or her therapeutic repertoire, while simultaneously receiving support and validation, getting help to stay balanced and like both partners, and allaying stress and burnout.

**TREATMENT TARGET HIERARCHY**

Treatment targets are organized hierarchically according to the severity of the behavior in question. This hierarchy is a cornerstone of both individual and couple DBT (Fruzzetti & Fruzzetti, 2003; Linehan, 1993a). The treatment target hierarchy posits that more severe and problematic behaviors must be resolved and brought under control before less severe behaviors can be addressed. Because the overall goal is to help clients establish a satisfying life together, including couple or other family relationships that are supportive, validating, and satisfying, the treatment target hierarchy identifies targets depending upon how much they interfere with (1) safety, (2) active and collaborative participation in treatment, (3) basic individual and relationship/family stability, (4) emotional satisfaction (and regulation), (5) a validating relationship, (6) resolution of conflicts, and (7) emotional closeness and intimacy. Constructing the hierarchy also includes building in basic self-management skills first; more complicated skills that require a solid foundation come later on in therapy.

For example, if a couple’s list of presenting complaints includes conflicts about money, child-rearing issues, recent partner abuse and violence, and conflicts around sex and emotional distance, then violence is addressed and resolved initially (as described earlier), prior to addressing any other issues. Once the violence in the relationship is stopped, then the other, less severe issues presented by the couple are addressed, with the more severe conflicts in the treatment target hierarchy addressed first. The following identifies the general kinds of targets and the order in which they are addressed, in couple DBT.

**Increase Safety**

As discussed previously, a violent partner may need to be referred for individual treatment if there has been recent violence or the threat of violence. Furthermore, when domestic violence has occurred or is a risk factor, the therapist needs to take additional steps to ensure client safety (Fruzzetti & Jacobson, 1992; Fruzzetti & Levensky, 2000). It may be necessary to develop a safety plan if one client needs to escape a threatening interaction with his or her partner.
This may include, for example, having a set of spare keys, hidden cash, a prepacked suitcase, or other preparations, in case the client needs to move quickly to a safe environment.

In addition to addressing domestic violence to improve safety, both suicidal and nonsuicidal self-injury may be present in one (or both) partners in couples with BPD. Sometimes it becomes clear that a partner is positively reinforcing self-harm, often with increased positive attention, warmth, or soothing. Thus, it may be necessary to target moving the partner’s reinforcing behaviors. In practice, the target would be to urge the non-self-harming partner to provide warmth, attention, and soothing on a regular basis to the partner who self-harms, no longer providing the differential positive reinforcers that follow self-harm. Similarly, one partner may be quite critical and hostile toward the other, reducing this negativity only when the partner becomes acutely distressed, suicidal, or engages in self-harm or other dysfunctional behaviors. In such cases, the partner’s reduced aversive behaviors may actually negatively reinforce the self-harm or other problem behaviors (i.e., the self-harm functions to reduce the partner’s aversive responses). In these cases, the therapist would target removing the negative or aversive responses altogether, or at least reducing them significantly.

For example, Jillian typically describes her husband Kevin as distant and disconnected, as Kevin often prefers to play softball or golf, or to go bowling with his friends or watch sports at a local bar, than spend time with her. She reports that when she tries to be close to Kevin and spend time with him at home he often retreats to the TV to watch the sports channel. She worries that he is burned out on her “neediness” (on his chain he reports feeling stuck and overwhelmed when she is despondent, and in fact he does withdraw). This leaves Jillian feeling unloved and lonely, which often escalates into other intense, negative emotions (e.g., fear, self-loathing/shame, hopelessness, and more despondency) and leads to self-injurious thoughts, urges, or actions. When Jillian begins to engage in these dysfunctional behaviors,

Kevin remembers that he loves Jillian and becomes more attentive and involved, in fact providing some of the warmth and attention that Jillian had craved. The attention Kevin gives to Jillian during these dysfunctional episodes reinforces her self-harm. However, were he to simply remove that warmth, Jillian would be left with none at all. Consequently, the target is to have Kevin spend time with Jillian on a regular basis (“move” the reinforcers), so that she is not dependent on suicidality or urges to self-harm in order to receive Kevin’s love, care and attention. For example, Kevin may agree to spend 45 minutes with Jillian on most days, and to keep his attention (and warmth) focused on her during that time. Jillian might agree that when she begins to have self-injurious thoughts, she will not turn to Kevin for support, but will instead use self-management techniques she has learned from therapy or call others for support (e.g., friends or her individual therapist), thus not putting Kevin in the position of reinforcing her self-harm.

Alternatively, James sometimes becomes extremely judgmental, angry, and critical of Liza, to the point that he screams at her and tells her many things that are “wrong” with her. After a dose of James berating her, Liza often becomes “stuck” in his criticism, feels very ashamed and worthless, abandoned, hopeless, and becomes increasingly suicidal. James can see the shift in her and typically stops his criticism, gets quite scared, and may even apologize for his mean and invalidating behavior. Thus, his intense criticism elicits her negative emotion (primarily shame and hopelessness), and by stopping his criticism only after Liza becomes suicidal, James is, in fact, negatively reinforcing her suicidality. Here, the target would be get James to stop expressing his dislikes with such negative intensity (“remove” the negative reinforcer), thereby reducing Liza’s suicidal behavior and potential.

Both of these scenarios require a good deal of in-session work and practice before being put into effect in partners’ daily lives. These are very new ways to engage in their interactions, and both partners need to use excellent self-management skills in order to sustain these
new behaviors. For example, if Kevin or James seem even slightly sarcastic, their otherwise changed behaviors are unlikely to have an impact on their partners. The hint of sarcasm, given their sensitivities resulting from their longstanding patterns, would override any other changes. Similarly in these examples, if Jillian or Liza are even a bit judgmental or critical (or embarrassed) when their partners begin to change their parts of these dysfunctional transactions, it will punish their new behaviors and they quickly will revert back to old patterns. Anticipating what each new step that each partner makes, along with what reactions they will elicit, and walking these through slowly, and repeatedly, is essential in the ultimate success of this approach. Thus, partners need to understand the mechanics of their transactions and engage in changes authentically, first succeeding in-session, then transferring these new patterns to their daily lives.

**Reduce Invalidation**

Once safety has been established in the relationship, the next target is to decrease the invalidating behaviors of one or both partners. “Invalidating” behaviors convey judgments (e.g., right vs. wrong, self-righteousness) and assert that valid thoughts, feelings, or desires are instead wrong, illegitimate, or otherwise invalid, or they are used to criticize or express contempt for the other person (Fruzzetti & Iverson, 2004; Fruzzetti et al., 2007). This step involves identifying the most corrosive invalidating responses, those that are most responsible for hurt feelings, further negative responses (negative escalation), and destructive conflict.

Reducing invalidating responses requires a committed focus on a number of secondary targets; that is, the partner first has to be willing to give up his or her “self-righteousness” and to “step down” in a conflict situation, in part because it is more important to be effective in the relationship than to be “right.” Once the partner is willing to engage differently, he or she still has to recognize when emotions are rising and conflict is intensifying, and to use some alternative skill instead of criticizing and invalidating the other partner (regardless of the legitimacy of the criticism). These alternative skills include learning mindfulness and being able to focus on long term-goals (e.g., having an improved relationship and enhanced self-respect) rather than noticing and acting on only short-term goals (e.g., impulses to say something invalidating that might allow the partner to feel self-righteous). In reality, this is another self-control or self-management target, similar to those noted above, albeit with behaviors that are less dangerous (invalidating verbal responses) and not directly tied to safety issues.

**Relationship Reactivation: Increase Time Together, and “Being Together” When Together**

Often couples have so many aversive interactions that they become increasingly distant, resulting in decreased and limited time together. As partners argue more, they avoid each other more, and even the positive and neutral things in their relationship fall away. In short, each has become an aversive stimulus for the other, and avoidance is reinforced (as it is in any “escape paradigm”). Because of this decrease in positive interactions, the proportion of all of their time together that is negative increases greatly. Thus, relationship reactivation is an important treatment target.

It is important for couples to share time and experiences together without anything aversive occurring. These experiences should be mutually satisfying to both partners overall, eventually. Illustrative activities include spending time with friends and/or family, joint participation in recreational activities, sharing intellectual pursuits and spiritual experiences, or simply sitting in the same room in the evening while engaging in various (even separate) activities. It is important for the couple to include a variety of activities, and not to focus too much on talking, especially on “hot” or recurrent problem topics. Many couples have significant differences in both verbal skills and comfort with intense or extended verbal interactions. In this approach, the talking comes later, after safety has been established, negative interactions have been reduced, and positive time together has been restored.

Part of what makes closeness grow is a
sense of “we-ness" in a couple, the idea that one is part of something bigger, the couple, and has both an individual identity and a couple identity. One way to increase this sense of being in the relationship is by increasing mindfulness of the other person, or “relationship mindfulness.” Partners using this skill do not even necessarily have to spend more time physically with each other to engage in relationship reactivation. It may be sufficient simply to increase awareness of themselves as a couple in situations in which they are connected in some way (e.g., they both may be in the kitchen, but doing different things). Simply being more aware of each other may enhance their “we-ness” and provide moments of positive emotions in the relationship.

**Increase Accurate Expression and Validation**

Many people with BPD have difficulty accurately identifying and labeling their emotions, which leads to inaccurate expression of the emotions they are feeling, ultimately resulting in partner invalidation (Fruzzetti et al., 2005). Partners with BPD (and other very distressed partners) often initially express more judgments and secondary emotions, such as anger and shame, instead of more accurate and descriptive primary emotions, such as disappointment, loneliness, or fear. When a client expresses judgments and secondary emotions, the partner may have a difficult time understanding and may more often respond in an invalidating way that leads the interaction into an escalating argument between them (see Figure 23.1). To express emotions accurately, one must possess the skills necessary to identify primary emotions, understand how those emotions are linked to whatever just happened, and also be in a supportive and validating social environment that encourages and reinforces accurate and effective emotional expression. Therefore, some treatment targets during this phase in therapy include developing the skills to be aware of one’s own emotions and to express them in a descriptive way, as well as to become increasingly aware of one’s partner’s emotions and become more validating.

For example, rather than saying, “You’re such a jerk. I can’t believe you forgot my mother’s birthday dinner is tonight, after I just reminded you yesterday. What the hell is wrong with you!” it would be more effective and accurate (and would likely make one feel more vulnerable) to say, “My feelings are hurt and I’m really disappointed that you forgot her birthday dinner.” The latter is a more accurate expression of legitimate feelings, whereas the former is filled with judgments (“jerk”) and secondary emotions (anger) that are likely to leave one’s partner feeling attacked. Moreover, it is almost impossible to validate the other’s disappointment when one is under attack, so the critical partner’s emotions are very likely to be invalidated, further escalating the conflict.

The focus of this step in teasing out primary emotions overlaps considerably with the work of Greenberg and Johnson (1988; Johnson, Chapter 4, this volume). However, from the DBT perspective, the reciprocal roles of inaccurate expression (including secondary emotions) and invalidation (especially of primary emotions) are posited as the central features in the maintenance of chronic emotional dysregulation and BPD. Consequently, from this view, multiple skills are required to help regulate partners and turn the dysfunctional transaction (inaccurate expression ← invalidation) around, and into a more stable and constructive transaction (accurate expression ← validation). These skills are a centerpiece of the DBT approach (see below). In addition, extreme partner behaviors such as suicide attempts or self-harm are contraindicated in emotionally focused couple therapy (Greenberg & Johnson, 1988) but commonly encountered and addressed in DBT with couples, as noted earlier.

**Manage Conflict**

“Problem solving” refers to issues in the relationship that can be addressed, resolved, and “forgotten,” at least for a while. “Problem management” refers to how to handle problems that cannot quickly be solved but instead require continued attention, mutual understanding, and validation. At this point in therapy, couples should have established safety and stability in their relationship through self-management
skills, decreased invalidating conflict cycles, increased time together, and increased accurate emotional expression and validation cycles. Because of these changes in the relationship, partners should be less reactive and better able to discuss sensitive problem issues in their relationship. Problem management includes defining the problem, analyzing the problem, and looking at acceptance as an alternative to change. Defining the problem is necessary for resolving couple problems, because often partners in conflict may be fighting over the same issue or over two separate but related issues.

Many times partners in severely distressed relationships engage in interaction patterns that impede effective communication. Because partners often engage in negative patterns or engage↔distance patterns, changing these interaction patterns is an important target that aids in effective problem management. Consequently, the double chain is used to identify the steps partners take, and how each affects the other. Missteps along the chain are typically easy to identify, and partners can collaborate on what each person could do differently to "re-choreograph their dance." Couple mindfulness skills (see below) can help partners slow down in their interactions and refocus on their long-term relationship goals (rather than on being right, winning the argument, or escaping from conflict). Accurate expression (no judgments), relationship mindfulness and validation come together to build understanding and trust, and soothe painful reactions. Radical acceptance and emotion regulation skills can help further to decrease individual reactivity and increase accurate descriptive expression of emotion. Improving such skills helps couples to discuss sensitive topics in effective, intimacy-enhancing ways.

**Increase Closeness and Intimacy**

At this point, clients have learned how to communicate more effectively and deal with daily life problems, but often they still struggle with isolation and a lack of intimacy. Often the next logical treatment target is for clients to enhance the amount of closeness and intimacy in their relationship, but not at the expense of also maintaining autonomy. Thus, this last target involves finding a balance, or a synthesis, of the tensions between intimacy and autonomy (Fruzzetti, 2006).

Many clients with BPD report fears that increasing individuality will not only be painful but also decrease the overall current level of intimacy in their relationships. At the same time, partners of some individuals with BPD express feelings of being overwhelmed by the attachment needs of their partners, often leading to feelings that their own independence is being threatened or severely limited. Previously, sharing activities together was addressed as a way to reactivate the relationship. But in addition to spending time together, it can also be highly beneficial to balance time together with time alone, to synthesize autonomy and intimacy. Engaging in independent activities can lead to three positive outcomes for the relationship: (1) An energized and satisfied partner is much more pleasurable to be around and also has more energy to give to the other partner and the relationship; (2) nonshared activities allow each partner to share verbally and discuss those activities with the other; and (3) partners feel less stress and obligation to confine their interests only to shared activities, resulting in a greater appreciation for the variety of both partners’ interests. Intimacy can be used to support autonomy, and autonomy can infuse the relationship with novelty and excitement that contribute more to sharing and result in enhanced closeness.

Thus, as partners begin to establish their autonomy, it is important for them also to encourage emotional intimacy with one another. To maintain both autonomy and intimacy, it is important for couples to do three things: (1) maintain a balance between time apart and time together; (2) support one another in independent activities; and (3) discuss and support each other’s time apart.

Once couples have learned all these skills, the next step is generalization of these skills effectively to maintain a healthy, stable relationship outside therapy. Couples may choose to take a temporary break from therapy to monitor
their relationship on their own. During this break, couples often find it helpful to make note of situations in which they found it difficult to use their skills or to behave effectively. When the partners return to therapy, they can discuss these difficult situations and possible solutions. The partners can then take another break from therapy to try their skills on their own.

As clients learn to implement skills such as emotion regulation, radical acceptance, accurate expression, and validation, they strengthen not only their individual autonomy but also their couple intimacy, because they are learning to work collaboratively to communicate more effectively and to understand one another.

**COUPLE SKILLS**

Most partners, minutes or hours after an argument in which they behaved badly, recognize that their responses were not only ineffective and hurtful, but also, paradoxically, resulted in getting less of what they wanted (e.g., wanting more but getting less closeness and understanding, support, collaboration, and a better relationship). The reality is that, on the one hand, partners often already know what they need to do to be effective. On the other hand, they often do not have the skills to manage their emotional arousal and get themselves to do what is needed to become more relationally effective. Many partners know at least a little about clear expression and active listening (or similar skills and constructs) but are not able to use these more skillful alternatives, especially when their negative emotional arousal is at a painful level.

For these reasons, couple DBT focuses more attention on the skills needed to regulate emotions, to increase awareness of genuine or heartfelt goals (e.g., having a better relationship) even when the urge to be nasty is present, and to match the form and function of communication, so that expression is more accurate, making it easier for partners to understand and validate each other. This approach focuses on creating a variety of effective ways to validate the inherently valid things that partners express.

There is a lot of flexibility in how these skills are taught, as mentioned earlier. Skills may be taught formally, in a more classroom-oriented environment in groups, or while doing chain analyses, if the therapist identifies one or more skills that are lacking and would result in a less destructive transaction. In this section, we highlight the main skills taught in DBT for couples.

**Mindfulness and Relationship Mindfulness**

In DBT, mindfulness and relationship mindfulness are the first skills couples are taught (Fruzzetti, 2006; Linehan, 1993b). These are considered the “core” skills in DBT, as mindfulness of one’s own experience, the partner, and relationship are required before other skills can be used. For example, before partners can manage their emotions, they must be aware that their arousal is escalating, and aware of their long-term goals. Similarly, before one can validate another, one must be aware of the other’s experience and the legitimacy of that experience. Mindfulness in general includes being able to focus attention and awareness, and to be aware in a descriptive (rather than judgmental, or “right–wrong”) way.

Being mindful of one’s partner includes simply becoming aware of him or her, and noticing and describing him or her physically, along with whatever behaviors and feelings, thoughts, and attitudes that can be observed (or are disclosed) rather than inferred. Being mindful of one’s partner includes not attaching judgments or other interpretations to the things one notices and describes. Often, a partner may start to notice the behavior of the other (“She’s talking on the phone with her sister and not paying attention to me”), describe how he or she feels (“I feel disappointed, and a bit lonely”), then immediately attach a judgment to what he or she noticed and described (e.g., “She’s selfish and insensitive” or “He doesn’t really care about me”) that then transforms the energy from the primary emotion to a secondary emotion (“I’m angry”). The result may be an inaccurate expression (e.g., withdrawal in a huff, which does not accurately express loneliness) or an attack (resulting immediately in less warmth and soothing attention). Partners often automatically and unknowingly jump to judgments about
Mindfulness skills allow partners to become more aware of a present situation and their genuine emotions and desires in that situation, and simply to notice and describe (more accurate expressions) rather than to become judgmental and ineffective, to reduce reactivity.

Noticing and describing are open responses that lead to a desire to know more about the partner and understand him or her better, and result in increased curiosity; in contrast, judging is a closed response that is full of assumptions; no more information is sought or processed, because the individual has already reached a “final judgment.” Although being judgmental is a form of thinking, mindfulness provides a different approach to dealing with judgments than might be found in traditional cognitive therapy. In a mindful approach, the partner’s target is always first to be aware of a judgment, then to turn attention to noticing and describing more objective reality, both the thing being judged (e.g., the other partner, what he or she did) and one’s own experience (e.g., sensations, emotions, desires). The consequence is that emotional arousal does not rise to dysregulated levels. A mindful approach does not include challenging negative thoughts or judgments per se, or changing thoughts according to rational rules, but simply letting go of the judgments and returning to descriptive reality, with increased awareness.

Mindfulness comprises three “whats” (what to do to be mindful) and three “hows” (how to do it), developed by Linehan (1993b), who adapted mindfulness as taught by Thich Nhat Hanh (1975) into psychological and attention skills. With couples, the “whats” include (1) notice/observe—just notice, become aware of, observe your own experience or that of the other person, or how our behaviors are linked; (2) describe—attach words to the experience; and (3) participate—let go of self-consciousness or self-talk (including worry thoughts) and simply engage in the experience or activity. The “hows” include (1) be nonjudgmental—let go of ideas of “shoulds” and “rights” and “wrongs”; (2) act one-mindfully—focus on only one thing at a time, in the present moment, such as one’s own experience or that of the partner, and so forth; and (3) act effectively—remember that this is someone you love.

Relationship mindfulness is a key skill in couple DBT. In addition to letting go of judgments and being emotionally present, relationship mindfulness also focuses on the clients “being ‘together’ when they are together” (Fruzzetti, 2006, p. 39). There are three ways for couples to be together:

1. Passively together: Partners are physically present, but not interacting or really aware of one another. Attention is focused on the individual tasks in which each partner is engaged, and his or her benign presence.

2. Actively together: Partners are engaged in an activity together, such as watching a movie or taking a walk. Attention is focused primarily on the activity, but partners are minimally aware of each other, and may increase their awareness of each other without sacrificing the activity.

3. Interactively together: Regardless of other activities going on, partners’ attention is focused primarily on each other. Both partners feel that they are engaging in an activity together and intimately sharing an experience. Relationship mindfulness allows partners to be more aware of each other, regardless of the activity or how much verbal communication is exchanged. Partners are encouraged to notice when they are passively together and to try to become more actively together, and to notice when they are actively together and try to become more interactively together. Mindfulness and relationship mindfulness are taught and emphasized throughout the therapy, beginning with practice in the session and then quickly generalized to (hopefully) daily practice outside the session. It is important to note that mindfulness in DBT does not require any kind of formal practice or meditation. Rather, mindfulness is any activity that one engages in on purpose, in the present moment, without judgments. Thus, partners can practice eating breakfast or driving mindfully, or listening mindfully, or simply noticing the other partner in a descriptive way.
**Emotion Self-Management**

Partners in distressed relationships must manage their own emotional arousal if they are to change dysfunctional patterns of interaction successfully. To increase self-control, clients must be committed to this target (being “effective” rather than being “right”). To be able to control their emotions in highly arousing situations, clients must commit to practicing emotional self-management and emotional self-regulation before they find themselves in such highly arousing situations. Practicing the management of emotions enhances these capabilities, so that they may eventually feel “automatic.”

At times, a person may feel justified in responding to his or her partner in a critical or invalidating way, because he or she “deserved it.” However, behaving in this way does not improve the conflict situation; rather, it leads to greater overall distress in the relationship. If both partners are mindful of the relationship, they will see that they are engaging in harmful and invalidating behaviors, and that unless one of them decides to step back and break this cycle, it will continue. It is important for partners to use mindfulness to remind themselves that they love and cherish each other and their relationship, and that invalidating behaviors do not help their relationship. A person may feel that he or she surrenders by “giving in” and letting the partner attack him or her and not attacking back. However, partners must increasingly realize that engaging in an invalidating conflict is a “lose–lose” situation. They lose control of their own emotions while simultaneously hurting their partners, doing more damage to the relationship, and getting less and less of what they want. By stopping the cycle, partners enter into a “win–win” situation by maintaining their own self-control and self-respect, and not damaging their partners or their relationships. It is much harder for clients to stop the cycle and to think mindfully about being effective in difficult situations than simply to react to the situation without thinking about the effects of their behavior. This is why partners need to be fully committed to managing their emotions and stopping the process of invalidation early in the chain of a potentially damaging situation, and why repeated in-session rehearsal is essential.

To decrease the likelihood of getting in a damaging argument, partners need to anticipate their impulsiveness by identifying potential triggers and rehearsing how they will respond to them. By anticipating potential destructive triggers, partners can be better prepared to handle them effectively by down-regulating their emotional arousal. Rehearsal allows for some exposure-based reductions in reactivity to those triggering situations. One strategy for achieving this is for the partner to distract him- or herself from the situation until arousal decreases, by going for a walk, saying a short prayer or a calming verse, doing slow, deep breathing or something soothing, such as listening to music or taking a bath. However, keep in mind that sometimes one partner has the fear that the other is abandoning him or her when the other takes time away, even for a few moments. In fact, many partners take time away intentionally, to hurt the other. Consequently, it is important to walk through these steps together. Typically, it is very helpful for the partner who is taking time away to specify: (1) that he or she is taking a moment (or however long); (2) doing so to self-manage, to be a better partner; and (3) specify when he or she will return, and the desire to continue the conversation albeit in a more constructive way. Note that each person is responsible for taking a “time out” as needed, and not suggesting that the other should do so.

Once partners identify possible triggers, and possible ways to handle their reactions to those triggers, they can mentally rehearse, as well as rehearse in-session, and prepare for times when those difficult situations arise. Another strategy in situations of emotional and conflict escalation is to remember the question, “Will responding this way get me what I really want in the world, a close and loving relationship?” Many other skills may be utilized to change overlearned, automatic, negative responses (Fruzzetti, 2006; Linehan, 1993b).

Not only is it important for couples to be committed to effective practice and to antici-
mate their triggers and impulses, but it is also important to learn to manage destructive urges. To control destructive urges, partners can visualize the expected negative outcomes that are likely to occur if they act on their urges. By thinking about possible negative outcomes, partners learn to balance the short-term outcomes (acting on urges may make them feel better initially) with the long-term outcomes (acting on urges will most likely lead to long-term damage). Partners can also learn simply to notice the urge without acting on it. Urges subside over time, and this reduction can be facilitated by simply “noticing” the urges. Doing this can make acting on the urge seem less desirable. If, however, the urge does not subside by simply noticing it, the partner has given him- or herself the choice to act rather than to react automatically, and can employ other skills to manage the urge and return to a constructive stance. Couples can also recall and visualize the positive outcomes of “riding out the urge.” Unlike the previously discussed strategy that uses partners’ desires to avoid negative situations as a motivation, this method helps partners use their desire to achieve positive outcomes as a motivation to regulate themselves more effectively.

**Accurate Expression**

To increase understanding and validation, partners are taught how to express their emotions accurately. To express him- or herself accurately, a partner must know what he or she wants, feels, thinks, and so forth. Partners are taught to use mindfulness to identify what they want, feel, and think. Mindfulness can help partners realize that they are unsure of what they want or that they simply need more time to identify their goals.

Partners typically express emotions inaccurately in one of two ways. The first ways is to express secondary emotions instead of primary emotions, as discussed earlier. Expressing secondary emotions usually leads to misunderstanding and invalidation (see Figure 23.1).

For example, Tracey decided she wanted to take Tim out for a date on their 1-year anniversary. She asked him to be home by 6:00 P.M. to make their dinner reservation, and he agreed. However, on the way home, Tim got stuck in snarled traffic and had accidentally left his cell phone at the office. While Tracey was waiting at home for him, she became very worried, wondering where Tim was. After an hour, she assumed that Tim had forgotten about their date and had gone to the gym after work instead—something that he did regularly. She decided that was probably why he was not at the office and not answering his cell phone. By the time Tim arrived home at 7:15, Tracey was very angry. When he walked in the house, excited to see her and feeling bad he was late for their dinner, Tracey met him with a grimace and a biting remark about him being “selfish” and that she “can’t count on him for anything.” Tim then became defensive and the argument escalated from there. However, if Tracey had simply noticed and described the situation, without attaching judgments, she could have more effectively and accurately expressed to Tim that she had been very worried and concerned because he was not home when he said he would be, and disappointed that they had missed their date, or at the very least would be late and have less time together. Tim then could have validated her disappointment and been able to soothe her, along with explaining what had actually happened. They probably would have gone on their date, just a bit later, and had a pleasant time.

Another way partners inaccurately express their emotions is by undervaluing or understating the importance of a topic or event due to self-invalidation (e.g., “this shouldn’t bother me”). In these situations the partner may be unable to understand the significance of the event or topic, and thus is unlikely to respond accordingly. On the other hand, people sometimes overvalue or overstate the importance of matters out of fear that otherwise their partners will not take their desires seriously. However, when a person presents too many issues as being of maximum importance it is difficult for the partner to discriminate what really is relatively more important to that person.

It is also important for clients to learn how
to match their goals with an effective strategy to help them accurately express emotions. If the goal is to “sort out feelings,” the strategy would be to describe both the situation and reactions to it. If the goal is to communicate, the strategy would be to use mindfulness to describe emotions, wants, and opinions. If the goal is to get the other person to change, the strategy would be to describe the situation or problem mindfully, to express clearly what one desires, and to work collaboratively on a solution to support and encourage each other. If the goal is to support the partner, one should validate him or her on multiple levels. Finally, if the goal is to correct an injustice, the goal would be to describe the situation, the emotions surrounding the situation, then negotiate possible solutions. All of these skills and strategies aid accurate expression, which in turn allows partners to validate each other’s emotions and experiences.

**Validation**

“Validation” is identifying and clearly communicating one’s understanding and acceptance of another’s feeling, thoughts, behavior, or experiences. Validation is not appeasement, advice, or agreement. It simply conveys that one accepts and understands the experiences of the partner. Validation helps couples to increase accurate emotional expression, to build trust, to reduce negative emotional arousal, and to make difficult situations and discussions tolerable. There are several different ways to validate a partner verbally (Fruzzetti, 2006; Fruzzetti & Iverson, 2006; Fruzzetti et al., 2007): (1) simply paying attention and actively listening (relationship mindfulness, therefore, is also often validating); (2) acknowledging the other’s feelings or desires descriptively (nonjudgmentally); (3) being genuinely curious and asking questions about the partner’s perspective or experience to seek clarification; (4) understanding mistakes and problems narrowly, in the context of the partner’s life given his or her history and experiences (i.e., we are defined by a good deal more than our mistakes); (5) normalizing the partner’s experience, trying to understand how his or her feelings or desires make perfect sense (i.e., “Wouldn’t almost anyone feel that way in that situation?”); (6) being genuine by treating the partner as an equal, with respect and care (not as fragile, nor as incompetent or unworthy); and (7) self-disclosing one’s own vulnerability to match the other’s vulnerability.

There also are ways to validate one’s partner nonverbally, for example, by (1) responding to the partner in a way that takes him or her seriously (e.g., if one partner wants company, the other may join him or her in an activity to validate this desire); and (2) providing support and nurturance, asking oneself, “How would I want to be treated in this situation?” By using mindfulness, relationship mindfulness, accurate expression, and validation skills, the couple is likely to experience enhanced satisfaction and likely reduce much potential conflict. In addition, these skills make it possible for partners to engage in problem solving and problem management.

**Problem Management Skills**

Now that couples have learned skills to communicate effectively, it is important for them to learn skills to manage difficult problems that are not easily resolved. When change seems to be a feasible option, several skills are involved in negotiating solutions. These steps include (1) focusing on one conflict at a time; (2) brainstorming possible solutions; (3) negotiating an agreement; (4) committing to an agreement; and (5) reevaluating the effectiveness of the agreement and modifying it as needed. Although these steps are similar to those found in more traditional behavioral approaches (e.g., Jacobson & Margolin, 1979), they rest on the foundation of accurate expression and validation. And, generation of a solution per se is not the goal; rather, the goal is an improved relationship marked by closeness and understanding.

Thus, accepting the existence of a problem and recognizing that it may, at least temporarily, be intractable can be as valuable an outcome as resolving the problem. For problems for which there are no obvious immediate solutions, partners may focus on accepting their situations for now. This acceptance, is referred to as “radical acceptance” and described in more detail later, involves not trying to change the other
partner’s behavior right now, tolerating one’s own disappointment (including letting go of judgments and anger), and accepting the fact that the problem behavior may continue to be bothersome. This combination of acceptance and change skills helps partners work together to reach mutually satisfying decisions about how to handle problem situations. By approaching the situation skillfully, the conflict resolution process, which previously might have been emotionally volatile and difficult, can now be managed in an effective manner in which both partners communicate clearly, validate one another, and work together to solve a problem (or accept it as not currently solvable). Such improved processes ultimately play a large role in increasing closeness and intimacy between the partners.

This approach overlaps somewhat, as noted earlier, with that of integrative behavioral couple therapy (Christensen et al, this volume; Jacobson & Christensen, 1996). However, the DBT approach differs in its greater focus on emotion and emotion regulation, explicit teaching and use of both acceptance and change skills, dialectical style of the therapist (warm and validating, and irreverent and confrontive), and overall dialectical approach to the process of change.

**Closeness and Intimacy**

Clearly, spending mindful time together; being able to express emotions, desires, and thoughts accurately; and being validated help to foster closeness. However, when couples have encountered an excess of escalating conflict in their relationship they also have been hurt emotionally and are still sensitive to distancing and emotional separation. Effective conflict resolution can serve to bring partners closer together, but some problems just cannot be solved, or at least not at the moment. Thus, radical acceptance of undesirable situations or behaviors can not only be a solution to unsolvable conflict but also bring partners together.

Being able neither to solve nor to accept problems leads to frustration, bitterness, blame, judgments, and increased distance. If one partner will not, or cannot, accept a partner’s behavior or a relationship situation that is not likely to change, the relationship will most likely continue to be plagued by frustration and unhappiness. In situations in which problem behaviors are likely to be maintained, it can be helpful for clients to attempt to accept the behavior, at least for a time.

However, it is important to emphasize that some problems are never the focus of radical acceptance. For example, behaviors that are aggressive or coercive, or otherwise threaten safety or basic self-worth (of either partner) are always targets for change (reduction or elimination). Moreover, it is up to each partner to determine whether to continue to focus on acceptance, or go back to working for change, and at each step the therapist revisits this choice. Even if one partner’s behavior seems trivial to him or her (and this partner wants the other to accept it), the other must decide, within his or her own wisdom (that is, not spitefully) whether to focus on acceptance.

When acceptance is a goal, the first step is for one partner to stop putting energy into the attempt to change the other partner to get what he or she wants, because these efforts have not worked. These types of behaviors include nagging, complaining, negative looks, and so possibly even desperate and aversive demands for change. If the partner can successfully curtail these change-seeking behaviors for a period of time, it is likely that he or she will experience some disappointment simply because the situation is not what he or she wants.

To keep from getting stuck in disappointment, it is necessary for the partner to validate the disappointment (it makes sense to be disappointed when one does not get what one wants) and to soothe the pain. The partner needs to treat him- or herself kindly, often in ways similar to how he or she would treat others going through a sad or disappointing time, and then become active in the relationship again. Becoming active helps to distract the partner from his or her negative emotional experience and also helps to create more positive experiences.

Another approach to help clients learn to
tolerate and accept one another involves having both partners keep a log of their attitudes and emotions after they “tolerate” a problem behavior. As partners begin learning to accept problem behaviors, they most likely continue to experience frustration toward each other. Each time a partner “tolerates” a problem behavior by not engaging in change-oriented behavior, that partner keeps a log of how he or she feels after the encounter, and how long these feelings of frustration lasted. This exercise helps partners to see how much time and energy their desire to change is costing them, and how little it works. It can help them to see more accurately the effort they expend thinking about the problem behavior, perhaps along with an enhanced awareness of other, more satisfying aspects of their lives that they are missing. The log helps partners weigh the costs and benefits of their habitual ways of trying to change each other.

The focus with tracking these behaviors and reactions is for partners to begin to understand how much misery has resulted from an exclusive focus on change. Frequently, the attempts to change the partner can cause more damage to the relationship than the initial partner behavior. Thus, the point is not to track “mistakes” the partner makes (in fact, the complaining partner is already acutely aware of these, often to the exclusion of many other things), but rather to become aware of the negative impact of the negative judgments, reactions, expectations, and interpretations that he or she makes about the partner’s “mistakes.” As noted, if in the process of being mindful of these processes the partner prefers to go back to focusing on change, the therapist will support that effort, if feasible. However, if the balance suggests working on acceptance, effort will turn there.

As partners strive to accept one another’s difficult behaviors, a few techniques can help them to engage more fully in life and accept one another. Recategorizing the partner’s problem behavior (understanding it in the context of the partner’s life) may help a client to see the problem behavior in a different, more beneficial way. Focusing on the “bigger picture,” and on what they like about each other, and other aspects of his or her behavior that have been missed or neglected may help partners accept, understand (and occasionally even appreciate) the problem behavior.

Couples can also benefit when each partner finds other legitimate, equally valid meanings for the other’s behavior. This strategy is similar in some ways to “reframing” a problem but involves considerable mindful attention to the reframe. By carefully looking at each other’s lives, histories, and experiences, partners are better able to understand why they act the way they do. This approach is very similar to finding things to validate about the partner and his or her behaviors. Although partners may not like certain behaviors, if they are better able to understand why they occur, then it is easier to accept them.

For example, one partner coming home late from work (or other repeated behaviors that bothers the other, such as leaving dirty clothes on the floor, driving in the “wrong” gear or not cleaning the kitchen to the other’s satisfaction) may be the topic of regular arguments, even following successful acquisition of many emotional and relationship skills. The one partner has tried, at various stages, warm engagement, bitter complaining, or nagging to try to get the other partner to come home “on time.” But, none of these strategies have worked very well. The steps of radical acceptance would be as follows: (1) Behavioral tolerance would be a period during which the partner would stop nagging or complaining; (2) Mindfulness of the pattern would lead the partner to realize that he or she was feeling bitter and angry for 30 to 60 minutes several times each week (or more often), and during this time the partners would likely avoid each other (at best); (3) Recategorization would push the partner to look for what she or he had been missing while focusing on the “problem” of the other partner coming home late. For example, the partner might be a reliable contributor to the family finances, or might be doing things that he or she enjoys (and could be in a good mood following those activities). Moreover, the partner does
come home, has not divorced, and is still alive. These last things are important to notice. Although not intended at all to invalidate the partner’s preference for the other person to come home earlier, they provide a different context, or more balanced “meaning” to the lateness. These are all parts of reality that always have been present, but often are missed when the partner focuses almost exclusively on the undesirable behavior. The partner who is habitually late also has a number of other characteristics and behaviors that are important, desirable and meaningful. Broadening one’s attention to these other aspects of reality (the larger context) can be a powerful exercise as partners find that the parts of reality being previously left out of their attention are not trivial. Sometimes, this can help the first partner find balance: “Yes, I would prefer that s/he come home earlier on these occasions, but I also see that the reason I want this is because I love my partner…and noticing that s/he does come home is satisfying, and reduces the disappointment that it’s later than I’d like.” When these skills are practiced, a possible chronic negative interaction can be changed into opportunities to increase intimacy and closeness, and these negative emotions can experienced as brief waves instead of long lasting storms.

Often, couples in distressed relationships experience increased amounts of misunderstanding and become judgmental, and can “lose the forest for the trees.” To increase intimacy and mutual acceptance, partners can benefit from “minding the gaps” in their relationship and in their closeness, in addition to recontextualizing conflict. When partners experience chronic conflict topics and gaps in the understanding of one another, faulty assumptions and judgments often follow, leading to dysregulated emotions and further distance. If partners can learn slow down, and not to reach conclusions too quickly, not to make judgments about each other, but instead to manage their own attention and emotion, they can be curious, interested, or confused instead of angry and attacking. These skills are good for partners individually as well as for their relationship, leading to increased individual well-being and more support, understanding, and closeness in their relationships.

**CONCLUSIONS**

This chapter has provided an overview of some of the problems of couples in which at least one partner has BPD or related difficulties, with a focus on emotion dysregulation and how it can make couple therapy challenging, but also how these difficulties are common to many other distressed couples. By providing a conceptualization that leads to compassion and understanding, the therapist may be able to communicate this acceptance and understanding by blocking dysfunction, creating opportunities for new skills to emerge, validating directly, coaching accurate expression and validation, and balancing acceptance with efforts to help partners change in important ways. The treatment target hierarchy was detailed, as were the skills and strategies needed to help partners regulate their emotions, reduce their destructive behaviors, express themselves more accurately, validate each other, focus on closeness, and thus generate more peace and intimacy in their relationship.

**SUGGESTIONS FOR FURTHER STUDY**


REFERENCES


Christensen, A., Dimidjian, S., & Martell, C., Chapter 3.


Gottman, J. M., & Gottman, J., Chapter 5.


Gurman, A. S., Chapter 7.


Figure 23.1 Transactional Model

Emotion Vulnerabilities

Pervasive History of Invalidating Responses

Event

Judgments

Heightened Emotional Arousal
(primary & secondary emotions, toward emotion dysregulation)

Dysregulated Emotion & Inaccurate Expression

Invalidating Responses
(from partner)

Partner Vulnerabilities

Partner Emotional Arousal

Partner Judgments
Figure 23.2 Double Chain

- Individual’s history, especially with partner
- Thoughts & emotions
- Verbal/public behaviors
- Judgments & secondary emotions
- Hurt feelings, further dysregulation
- Negative Outcome – Attacking or Withdrawing

Situation/Event

Individual’s history, especially with partner
### Figure 23.3 Sample Diary Card

<table>
<thead>
<tr>
<th>Day/Date</th>
<th>Accurate expression (+ or -)</th>
<th>Level 2 Validation (how many times)</th>
<th>Quality of time together (+10 to -10)</th>
<th>Practiced relationship mindfulness (Y/N)</th>
<th>Satisfaction (+10 to -10)</th>
<th>Note primary emotions and rate intensity (1 to 10)</th>
<th>Describe important situations &amp; skills used, or, ineffective behaviors or responses</th>
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