Pragmatic Case Studies in Psychotherapy, doi: http://dx.doi.org/10.14713/pcsp.v10i1.1845
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

Commentary on The Case of "Sonia": Psychotherapy With a Complex, Difficult Patient Grounded in the Integrated Psychotherapy Model of Héctor Fernández–Álvarez

The Case of "Sonia" Through the Lens of Dialectical Behavior Therapy

SARA GEISSER [a,b] **AND SHIREEN L. RIZVI** [a]

[a] Graduate School of Applied and Professional Psychology, Rutgers—The State University of New Jersey

[b] Correspondence regarding this article should be addressed to Sara Geisser, PsyM, Graduate School of Applied and Professional Psychology, Rutgers—The State University of New Jersey, 152 Frelinghuysen Road, Piscataway, NJ. 08854
Email: sara.geisser@gmail.com

ABSTRACT

Scherb (2014) describes the case of Sonia, a 44-year-old woman with severe and complex presentation of borderline personality disorder, along with diagnoses of bipolar disorder, trichotillomania, borderline intellectual functioning, and obesity. At the end of 10 years of therapy with decreasing frequency, Sonia has made a dramatic recovery from almost all of her presenting symptoms. Scherb's therapeutic approach was based on Fernández-Álvarez's Integrative Psychotherapy Model, which incorporates behavioral, cognitive, and emotional components. In this commentary we look at Sonia's psychopathology and treatment through the lens of Dialectical Behavior Therapy, a highly developed treatment model that has shown impressive success in treating individuals with borderline personality disorder and that also combines behavioral, cognitive, and emotional components. A comparison of a DBT approach to Sonia's case with the approach Scherb actually employed reveals many similarities in proposed treatment strategies, as well as differences in the format and delivery of treatment.

Key words: borderline personality disorder; Dialectical Behavior Therapy; case formulation; case study; clinical case study

Elena Scherb (2014) describes the case of Sonia, a clinically complex client she treated over the course of ten years at the AIGLE center in Buenos Aires, Argentina. Sonia participated in a longitudinal research study run by Scherb designed to treat severe and multi-problem clients with a history of hospitalization utilizing Héctor Fernández-Álvarez's (1992, 2001) Integrated Psychotherapy Model. Sonia entered the treatment as a 45-year-old morbidly obese woman who had problems managing her financial situation and her 18-year old mentally retarded son's care. Her family paid for Sonia's apartment and her son's care and, while they supported her financially, Sonia's relationship with her parents was marked by periods of conflict and fighting followed by efforts to take over Sonia's responsibilities and at times hospitalize her. Scherb's guiding model throughout treatment was the Integrated Psychotherapy Model, a model promoting change through addressing dysfunctional schemas through a bio-psycho-social perspective. Scherb and Sonia's agreed-upon treatment plan included individual therapy, family therapy, intensive case management and therapeutic coaching, and medication management, all

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

occurring in different settings to help Sonia practice new behaviors in relevant settings such as her work place and her parent's house. Over the course of treatment, Scherb and Sonia focused on restructuring Sonia's beliefs about herself and her relationships with others, especially her family, and made great progress in developing interpersonal skills and self-management skills.

Scherb's conceptualization of Sonia's case called for specific cognitive, behavioral, and systemic interventions designed to address Sonia's dysfunctional schemas. In this paper, we provide an alternative perspective to conceptualizing Sonia's treatment. Using Dialectical Behavior Therapy (DBT; Linehan, 1993a, 1993b) we aim to identify problematic behavioral patterns that underlie Sonia's difficulties in functioning and systematically target these patterns according to a hierarchy prioritizing behaviors that threaten Sonia's life, treatment, and quality of life. In this alternative case conceptualization, DBT will be used as the framework in conceptualizing Sonia's presenting problems, and the DBT structure and treatment strategies will inform the development of Sonia's DBT treatment plan.

DBT was originally developed by Marsha Linehan to treat women with suicidal behaviors and BPD. Since its first implementation, DBT has gained strong empirical support from randomized clinical trials (Lynch, Trost, Salsman, & Linehan, 2007). DBT has been found to significantly reduce suicidal and self-injurious behaviors, decrease psychiatric hospitalizations, decrease depression, and decrease dropout rates among participants as compared with control groups (Linehan, Armstrong, Suarez, et al. 1991; Linehan, Comtois, Murray, et al., 2006; Linehan, Heard, & Armstrong, 1993; Lynch et al., 2007). More recently, DBT has been effectively applied to other diagnoses like substance dependence and eating disorders as well as various treatment settings (Lynch et al., 2007).

DBT CASE FORMULATION

A strong case formulation in DBT in essential to inform the direction of treatment (Koerner, 2007). After a thorough assessment of the client's presenting problems and psychological history, the first step in formulating a case is determining the client's current level of disorder which informs his or her stage of treatment (Linehan, 1993a). The different stages of treatment determine which behaviors are targeted in treatment. Linehan has described five different stages of treatment that progress from a "pretreatment stage" to Stage 4. In these stages, clients first gain behavioral control to achieve a reasonable life expectancy; then work toward reducing emotional desperation through targeting posttraumatic stress responses and traumatizing emotional experiences; next work on increasing self-respect and solving problems in living; and lastly work towards freedom to accept reality to address a sense of incompleteness that might remain after the first three stages of treatment. For the purposes of this case, we will describe the pretreatment stage and Stage 1.

The pre-treatment stage is the phase in which clients and therapists commit to treatment and agree on goals to be worked on in therapy. The therapist describes the treatment and highlights the importance of a collaborative relationship between client and therapist. The client describes why she is seeking treatment at this time, and the therapist uses the biosocial theory as a framework for discussing the etiology of the client's dysregulated behaviors and emotions. Additionally, any necessary risk assessment is completed during pretreatment, and a full history

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

of suicidal behavior and self-injury is obtained. Pretreatment ends with the client committing to giving up all suicidal and self-harming behaviors, and also committing to being a client in DBT treatment. After commitment is obtained, the stages progress from Stage 1 in which the overarching goal is to move a client from behavioral dyscontrol to behavioral control. Within Stage 1 there is a hierarchy of behaviors to target, beginning with life-threatening behavior, then treatment-interfering behavior, and lastly quality-of-life interfering behavior. The rationale behind this hierarchy is related to DBT's overarching goal of clients "building a life worth living." Clearly, individuals cannot build a life worth living if they are dead or are continuing to threaten their life or safety with behaviors like suicide attempts and self-injury, and therefore this category of behaviors is targeted first.

Next, any behaviors that interfere with therapy are targeted, under the assumption that therapy cannot be effective if it is compromised by behaviors that interfere with treatment progressing. After both life-threatening and therapy-interfering behaviors are decreased or eliminated, the client and therapist address quality-of-life interfering behaviors. Under this category falls many of the reasons why clients come to treatment—impulsive spending, fights with significant others, substance use, depression, and a host of other behaviors that interfere with the client's quality of life. It is also important to note that stages of treatment are not necessarily linear; in fact, it is quite common for clients to shift back and forth between pre-treatment and Stage 1. When this occurs, time is spent recommitting to DBT treatment and the goals agreed upon at the beginning of treatment.

The DBT stages of treatment provide the framework in which the treatment is conducted. That is, the stage model and the treatment hierarchy dictate to the therapist *what* the targets of treatment in any given session need to be. The "*how"* of DBT involves using the full set of DBT strategies to help an individual move from a life of dyscontrol and overwhelming emotions to a life of control, non-anguished emotional experiencing, and freedom from reality nonacceptance. Although a full description of all the DBT strategies cannot be adequately presented within this commentary, a brief description of the core strategies (behavioral problem solving, validation, and dialectics) will be provided.

Behavioral problem-solving strategies are the vehicle of change within DBT. Problem-solving is a two-stage process that first involves understanding the problem, then moves to brainstorming and implementing alternative behaviors if the situation were to occur again. In fact, many sessions are spent utilizing specific problem-solving strategies, like behavioral "chain analysis" (a type of detailed functional analysis [Rizvi & Ritschel, in press]) and solution analysis, to help the therapist and client first define and understand a problematic behavior, and then assess and implement a plan for more adaptive behaviors. Additionally, DBT commitment strategies are considered a part of behavioral problem solving, as they increase client motivation and commitment to address problematic behaviors throughout therapy.

Validation, as defined by Linehan (1993a, 1997), is the communication to the client that her responses in a given situation make sense and are understandable within her current life context. Validation strategies are used in DBT to communicate acceptance and emphasize the understandability of the client's actions, thoughts, and feelings. Pushing a client to change her behavior, emotions, and thoughts without acknowledging the "kernel of truth," the piece that

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

makes sense about their response given the individual's history or current context, can isolate the client and make them feel misunderstood and less motivated to change. Specific DBT validation strategies include identifying, countering, and accepting "shoulds," finding the "kernel of truth," and "cheerleading" the client by focusing on their capabilities and assuming that each client is doing the best she can. Validation strategies are extremely important in DBT; they can increase connectedness between the client and therapist, increase a therapist's own empathic attitude, and teach the client to trust and validate herself (Linehan, 1993a).

The "D" in DBT stands for dialectical, which originates from a dialectical philosophy that views reality as a holistic and ever-changing process that is not stagnant but instead consists of opposing views continually synthesizing and changing. Dialectics are inherent in all aspects of DBT treatment; DBT therapists are aware of dialectical tensions that arise in treatment, and dialectics are represented as a set of concrete strategies used by the therapist to teach and model to the client the inherently dialectical nature of her own reality (Linehan, 1993a). Dialectics as a core strategy aims to balance acceptance and change, which are each represented in the other core strategies, behavioral problem solving and validation, respectively. The dialectical strategies are used to highlight a tension that exists in the client's life or within a therapy session. These strategies are used to help the therapist hold both sides of a dialectic in order to avoid getting into struggles in treatment in which the client and therapist each hold one side of a dialectic and remain stuck in their own position.

CONCEPTUALIZING THE CASE OF SONIA FROM A DBT FRAMEWORK

Based on Scherb's description of Sonia upon entering treatment, we would view Sonia as starting DBT treatment in either pre-treatment or Stage 1 of treatment. The differentiation would be made based on whether Sonia is committed to participating in treatment, eliminating self-harming and suicidal behaviors, and her agreement to goals developed by her and her therapist. During Sonia and Scherb's first sessions, Sonia seemed to vacillate between commitment to the treatment and hesitancy to participate in parts of the treatment that involved other family members. This is an example of how clients often revisit pre-treatment; Sonia's lack of participation in agreed-upon family meetings demonstrated a need for further orientation as to why sessions with her family might be important in helping Sonia reach her treatment goals. To elicit such a commitment, DBT therapists implement a number of strategies. These are designed (a) to link current commitment to treatment and the client's future goals, and (b) to highlight the incompatibility of current dysfunctional behaviors with reaching those goals.

For example, DBT therapists often implement the strategy of "Devil's Advocate." This instructs the therapist to take the opposite side of the argument for stopping dysfunctional behaviors as a way to challenge the client to come up with her own reasons why stopping these behaviors would benefit her. In Sonia's case, Scherb might say something like, "Why would you agree to not shout and scream during these family sessions when your family members are blaming you and treating you like you are not a part of they family? Why not refuse to participate in family sessions, or at least continue to yell at your family when you feel blamed?" The hope in using this strategy is that Sonia would argue against the therapist and jump in with

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

arguments *for* changing her current behaviors. She might point out that in order to avoid her family from hospitalizing her, she needs to sit through family sessions without yelling at them, and her willingness to participate in family sessions would increase the likelihood that her family would continue to agree to pay for the treatment, which she wants to continue individually.

Treatment Targets

Goals of treatment in DBT are defined behaviorally in terms of behaviors to decrease and behaviors to increase. The overarching goal for clients in DBT treatment, as described by Linehan (1993a), is to increase dialectical behavior patterns and decrease extreme behaviors and cognitions so they can respond to each moment with more balanced and integrated responses. In Sonia's case, some typical dialectical tensions that would be a focus in treatment include independence versus dependence, emotional control versus emotional tolerance, and self-efficacy versus help-seeking. Aside from these dialectical behavior targets, Sonia's target behaviors would be addressed in the following order according to the DBT hierarchy.

Life-Threatening Behaviors

Stage 1 of DBT treatment targets life-threatening behaviors, therapy-interfering behaviors, and quality-of-life-interfering behaviors in that order. Sonia had been hospitalized five times in her life, including twice in the three years prior to the beginning of her treatment, and more information is necessary to determine whether any of the behaviors that resulted in her hospitalizations would be categorized as life-threatening. Factors to consider include the presence of suicidal thoughts or intent, and any intent to harm herself or others during violent outbursts. The next behaviors to target are intentional self-injurious behaviors. Scherb categorized Sonia's trichotillomania as self-injury in her conceptualization of the case. In DBT, the function of the hair pulling would need to be explicitly and concretely assessed in order to determine if it is in fact self-injurious. That is, if Sonia pulled out her hair with the intent to induce pain and punish herself, it would be considered self-injury; but if this behavior functioned more as a way to reduce anxiety or other intense emotions, it would be more appropriately conceptualized as a quality-of-life-interfering behavior.

Scherb also noted that Sonia was in a relationship with a man who was physically aggressive and verbally abusive towards her, and she labeled her involvement in this relationship as "self-injury… in a covert manner" (Scherb, 2014, p. 10). While it is apparent that Sonia's continued participation in this relationship resulted in Sonia being belittled and abused, that behavior would be better categorized within a DBT framework as a quality-of-life-interfering behavior. DBT, as all types of behavioral therapy, aims to functionally define problems, that is to describe problems in terms of the specific behaviors that constitute them and the environmental and experiential contingencies that appear from observational evidence to reinforce and maintain those behaviors. The problem in labeling Sonia's relationship as self-harm and using the label of "self-harm" for a wide variety of behaviors that inadvertently harm an individual is that it does not speak to the function of the behavior nor does it help to address the possible contingencies that reinforce and maintain the behavior. The label "self-harm" is reserved in DBT to mean any behavior that functions to purposely inflict physical harm to a person's body.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

If the function of Sonia staying in this relationship was not to directly inflict physical harm onto herself, but rather to serve some interpersonal function, it would not be labeled self-harm.

Therapy-Interfering Behaviors

While Scherb's summary of Sonia's treatment plan did not explicitly address treatment-interfering behaviors as a specific target, it could be assumed that Sonia occasionally behaved in a way that interfered in the treatment. The description that Scherb gave of Sonia yelling and leaving during a family session is an example of a non-collaborative, therapy-interfering behavior. In DBT, this behavior would be addressed as a target in the following session. Both a chain analysis of what events, thoughts, and feelings led up to the problem behavior, as well as a solution analysis of ways to intervene in the future before the problem behavior occurs again, would be conducted in the next session with Sonia. Other therapy-interfering behaviors that Sonia may have engaged in, given the information that Scherb shared in her treatment summary, might have included Sonia's willfulness to participate in skills practice with her therapeutic coach or yelling during sessions. Some therapist-initiated, treatment-interfering behaviors that Scherb herself may have engaged in include treating Sonia as fragile or failing to see the dialectic around a particular issue in treatment. These are common therapist responses to clients who express feeling helpless or conversely hold tightly onto their own agenda, and it can be assumed that within ten years of treatment Scherb engaged in these behaviors at some point.

Quality-of-Life Interfering Behaviors

Many of Sonia's presenting problems as outlined by Scherb's problem list fall into this category of behaviors to target. These targets include decreasing depressive symptoms, decreasing financial dependence on her parents and increasing control over her own spending and finances, increasing responsibility over her son's care, decreasing anger and fights with her parents, increasing social contact and supports, and increasing self-care as it relates to her obesity. Addressing these target behaviors could both improve Sonia's functioning as an independent adult and also improve her quality of life by increasing positive events and relationships as well as addressing her health concerns.

Biosocial Theory

A cornerstone of DBT case conceptualization is utilizing the biosocial theory to understand how an individual's biology and environment transact over time to contribute to the client's current maladaptive behavioral patterns. The biosocial theory is mapped onto each client's personal developmental history as a way to conceptualize the client's current difficulties, and it is also discussed with the client within the first few sessions as a way of communicating in a non-pejorative fashion the therapist's understanding of how the client developed maladaptive behavioral patterns over time. The biosocial theory proposes that the transaction between emotional vulnerability and an invalidating environment lead to the development of emotion dysregulation and other characteristics associated with borderline personality disorder.

In the section labeled "Origin of Mechanisms," Scherb describes the transaction between Sonia's inherent emotional vulnerability and her family's invalidation of her emotions. Scherb

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

(2014) describes Sonia as having an "emotionally sensitive disposition and modest cognitive resources" (p. 9). In DBT, this is labeled "emotional vulnerability" and is described as a biological predisposition to being highly sensitive to emotional stimuli, highly reactive to emotional experiences, and having a slow return to emotional baseline. In Sonia's case, the invalidating environment might be defined by her parents' failing to acknowledge her internal emotional experience. A transactional process occurred between these two factors: Sonia's parents intermittently reinforced her escalated displays of emotion by first punishing these, then reacting when she escalated her displays of emotion—bursting into tears and becoming violent—by becoming overprotective and trying to fix Sonia's problems. As noted by Scherb (2014), "…this method of influencing the world was effective for Sonia" (p. 9), and therefore she missed the opportunity to learn more effective ways to self-regulate. This resulted in Sonia's deficit in regulating her own emotions and behavior, as her parents swooped in to fix the problem each time Sonia became more emotionally dysregulated.

COMPARISON OF SCHERB'S ACTUAL TREATMENT TO A DBT APPROACH

Much of the Scherb's treatment with Sonia is consistent with a DBT framework and philosophy. Over the ten years that Scherb worked with Sonia, she shifted back and forth between implementing strategies aimed at helping Sonia change her behaviors and helping Sonia restructure her maladaptive schemas to increase acceptance. This flow between acceptance and change is consistent with a dialectical approach to treatment. In Scherb's description of the treatment, it seems as if there was a balance between validating Sonia, especially in regards to her feeling blamed and abandoned by her family members, and supporting her in making changes such as acquiring a job.

Scherb states that a primary mechanism maintaining Sonia's current problems is a disturbance in emotion regulation. A DBT conceptualization would support this, as Linehan (1993a) posits that symptoms associated with BPD primarily result from a deficit in emotion regulation. One difference between a DBT approach compared to Scherb's treatment, however, might be DBT's focus on behaviorally defining the problems that Sonia experiences as a result of this emotion regulation deficit, whereas Scherb often defines Sonia's problems in the context of maladaptive schemas and core beliefs. DBT incorporates cognitive strategies, such as cognitive modification or restructuring; however, behavioral theory is the underlying theoretical basis for DBT and therefore problems are defined behaviorally, with an emphasis on understanding problematic patterns as failures to regulate one's emotions.

The order in which Scherb and Sonia worked toward certain treatment goals was similar to the approach that a DBT therapist might take in individual therapy. In conjunction with the target hierarchy, the goals of DBT therapy are first to acquire basic capacities and a reasonable life expectancy, then to reduce PTSD symptoms, and lastly to increase self-respect and work toward achieving individual goals (Linehan, 1993a). Scherb's treatment with Sonia followed a very similar path. The treatment began with helping Sonia gain some basic capacities; they worked to increase her effectiveness in communicating with her family, helped her gain control over her finances, and worked on reducing maladaptive behaviors like yelling at others when

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

angry. Scherb (2014) notes that the first step in Sonia's treatment was "…to find some aspect in which Sonia could believe in herself (the beginning of self-esteem)" (p. 11). While increasing self-esteem would not be the first goal in DBT treatment, the ways in which Scherb and Sonia worked toward increasing mastery and self-esteem is still consistent with a behavioral approach. Specifically, Scherb used contingency management strategies to shape Sonia towards desired behaviors, like naturally rewarding Sonia's progress by increasing her independence from her therapeutic coach or rewarding her with vacations when she accomplished a treatment goal.

After Sonia made significant gains in basic capacities like getting a job and better tolerating her emotions during family sessions, they moved on to reducing Sonia's interpretations of others' behaviors as rejecting and abandoning. This helped to increase Sonia's sense of mastery as she reduced behaviors that distanced herself from others through a process of challenging her negative interpretations of her family's and coworkers' behaviors. During the final stages of Sonia's treatment, Sonia accomplished two goals that previously interfered with her quality of life: finding a more appropriate living situation for her son and beginning to treat her obesity. From a DBT perspective, it is important to note that treatment targets are flexible and subject to change with continuous assessment. For example, at the beginning of treatment, Sonia's living situation with her son may have been categorized as "quality-of-life-interfering." However, as time went on and their relationship became violent and the potential for harm between Sonia and her son became more evident, the relationship may have been moved higher up in the hierarchy of targets and addressed before other quality-of-life-interfering targets.

A number of other points about Scherb's treatment in comparison to DBT treatment are noteworthy. First, the focus on skills acquisition and generalization is seen as a great strength in Sonia's treatment from a DBT perspective. In DBT, one mode of treatment is a skills group, in which clients are taught new skills—mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness—and are asked to practice these skills to increase generalization of these skills in their environment outside of treatment. Additionally, the individual therapist acts as a skills coach as needed and is available by phone for the purpose of in-vivo skills coaching to increase skills generalization in specific challenging situations. In Sonia's case, she was assigned a therapeutic coach who helped Sonia acquire new skills and practice them in various contexts like work and at her parent's home. While the mode of delivery of skills may be different between the two approaches, the importance that Scherb placed on Sonia's skill development likely contributed significantly to Sonia's continued progress throughout treatment. DBT places great importance on skills acquisition and generalization to the extent that individual therapists take time in sessions to model skillful behavior, are available outside of session for skills coaching, and dedicate a mode of treatment entirely to skills acquisition. Sonia's access to a therapeutic coach, assuming their work was similar to a skills coach as described above, is similar to the various modes of skills work done in DBT.

Some final points of comparison between the two treatment approaches have to do with treatment efficiency and continued assessment. DBT is an outcome-oriented treatment; efficacy of treatment is measured by the reduction of target behaviors like self-harm and hospitalization and the increase of more skillful behaviors and positive outcomes like employment and improved relationships. For this reason, client progress in DBT is assessed at regular intervals by the use of a daily Diary Card and often more structured assessments at designated intervals

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

throughout treatment. The use of the Diary Card determines the direction of treatment each session and ensures that behaviors are being targeted according to the hierarchy. Regular assessment allows the therapist to assess whether they are on track in terms of reaching their treatment goals, and allows for changes to be made to the treatment plan as necessary. Scherb's monitoring of Sonia's progress using the List of Problems and Behaviors Questionnaire (LOPBQ) demonstrates that over the course of treatment Sonia made significant progress towards her goals. In DBT, assessment procedures would ideally consider similar problematic behaviors on a more frequent basis.

Continued assessment also impacts treatment efficiency, with the goal being to deliver a treatment that is effective and also time-limited and cost-effective (Rizvi & Harned, 2013). Little has been published about DBT beyond Stages 1 and 2 during which time behavioral control is achieved, partly as a result of the time-limited nature of research studies and grant funding. DBT treatment outside of a research setting is not confined to a 6-month or 12-month course of treatment, and most DBT clinicians would agree that for clients with severe psychopathology like Sonia's, 12 months of treatment would not be sufficient.

However, a ten-year course of DBT treatment would likely not be favorable. Aside from the costs of treatment, DBT's overarching goal of "building a life worth living" would not necessarily be in line with remaining in intensive therapy for 10 years. Rather, once Sonia achieved certain treatment gains like maintaining a job, handling her own finances, and eliminating hospitalizations she might be referred to a DBT-informed clinician in the community for once-weekly psychotherapy rather than continuing to participate in a comprehensive DBT program. In Scherb's (2014) case study, she presents a helpful Table 1, labeled "Sonia's Treatment Phases, Treatment Resources and Frequency Over Time." Summarizing the table, Scherb states that Sonia's contact with other treatment providers declined greatly by her fourth year in treatment, leaving her with individual therapy once weekly and monthly family sessions. This decrease in treatment intensity, and subsequent increase in other activities like going to work and participating in hobbies, is a desirable outcome according to DBT.

CONCLUSION

Scherb's execution of the Integrated Psychotherapy Model shares many similarities with a DBT conceptualization and treatment approach for the case of Sonia. Both models emphasize the need for a structured treatment plan to systematically address the numerous problems with which Sonia presented to therapy. Scherb's focus on helping Sonia change ineffective behavioral patterns, acquire and generalize more skillful behaviors in various contexts outside of therapy, and improve the quality of her life by targeting problems like her obesity is consistent with a DBT approach. Some differences exist, however, in how Scherb formatted treatment as compared to a DBT approach. For example, in our discussion above, we pointed out how DBT takes a more behavioral and a more functional analytic approach to developing a case formulation and treatment plan; a more formalized approach to focusing the therapy on different stages; and more frequent monitoring of the client's progress, yielding the possibility of improved treatment efficiency. Still, Scherb's approach to treating Sonia resulted in the reduction of many of Sonia's problems over the course of treatment and contributed to a vast improvement in Sonia's quality of life.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 10, Module 1, Article 2, pp. 30-39, 03-21-14 [copyright by author]

REFERENCES

Fernández-Álvarez, H. (1992). *Fundamentos de un modelo integrativo*. Buenos Aires: Paidos.

Fernández-Álvarez, H. (2001). *Fundamentals of an integrated model of psychotherapy*. New York: Guilford.

Koerner, K. (2007). Case formulation in dialectical behavior therapy for borderline personality disorder. In T.D. Eells (Ed.), *Handbook of psychotherapy case formulation, 2nd edition,* 317-348. New York: Guilford.

Linehan, M.M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

Linehan, M.M. (1993b). *Skills training manual for treating borderline personality disorder.* New York, NY: Guilford Press.

Linehan, M.M. (1997). Validation and psychotherapy. In A. Bohart & L. Greenberg (Eds.), *Empathy reconsidered: New directions in psychotherapy*, 353-392. Washington DC: American Psychological Association.

Linehan, M.M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991) Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

Linehan, M.M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., Korslund, K., Tutek, D., Reynolds, S., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, *63*, 757-767.

Linehan, M.M., Heard, H., & Armstrong, H. (1993). Naturalistic follow-up of a behavioral treatment for chronically suicidal borderline patients. *Archives of General Psychiatry*, 50, 971-974.

Lynch, T., Trost, W., Salsman, N., & Linehan, M.M. (2007). Dialectical behavior therapy for borderline personality disorder. *Annual Review of Clinical Psychology, 3*, 181-205.

Rizvi, S.L, & Harned, M.S. (2013). Increasing treatment efficiency and effectiveness: Rethinking approaches to assessing and treating comorbid disorders. *Clinical Psychology: Science and Practice, 20.* 285-290.

Rizvi, S.L., & Ritschel, L.A. (in press). Mastering the art of chain analysis in dialectical behavior therapy, *Cognitive and Behavioral Practice.*

Scherb, E. (2014). The case of "Sonia": Psychotherapy with a complex, difficult patient grounded in the integrated psychotherapy model of Héctor Fernández–Álvarez. *Pragmatic Case Studies in Psychotherapy*, *10* (1), Article 1, 1-29. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal