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DBT SKILLS TO TREAT CLIENTS, MAXIMIZE THERAPEUTIC GAINS AND REDUCE THERAPIST BURNOUT

MONDAY, NOVEMBER 21, 2022 – TUESDAY, NOVEMBER 22, 2022 | VANCOUVER, BC | 8:30AM - 4:00PM

WORKSHOP AGENDA

- Background of DBT
- The DBT Model, Research, Adapting DBT, DBT for Other Diagnoses Biosocial Theory of BPD
- Dialectics, Validation & Other Dialectical Strategies
- Behaviour Theory & Contingency Management
- Behaviour Tracking Sheet
- Limit-setting
- Behavioural Analysis Exercise
- DBT Skills: Mindfulness & How to Teach It
- Core Mindfulness Skills
- Finish off Core Mindfulness Skills
- Introduction to Emotion Regulation Skills
- Complete Discussion of Emotions Regulation Skills
- Introduce Interpersonal Effectiveness Skills
- Finish IE Skills
- Introduce Distress Tolerance Skills
- Finish DT Skills
- Pro's and Con's exercise
- Radical Acceptance
- Willingness vs. Wilfulness
- Solution Analysis

WORKSHOP DESCRIPTION

Sheri Van Dijk, MSW, RSW is a psychotherapist, author of 9 books and international speaker, known for her extensive experience and knowledge of Dialectical Behaviour Therapy and Mindfulness Practice. Join Sheri in her upcoming 2-day workshop, where you will attain the DBT skills to treat emotion regulation disorders. Following an introduction to DBT theory, Sheri will discuss how DBT can be applied to working with clients facing a broad range of conditions such as depression, anxiety, and bipolar disorder, in which emotion dysregulation plays a key role.

Through lecture and experiential exercises, you will explore the four modules of DBT skills (Core Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness) and learn how to teach these skills to your clients. You will learn how to format DBT sessions to provide the structure your dysregulated clients need.

Sheri will introduce DBT strategies to help foster the therapeutic relationship, maximize therapeutic gains and reduce the likelihood of therapist burnout.

LEARNING OBJECTIVES

- How to teach your clients the four sets of DBT skills to help them get through crisis situations without making the situation worse; to manage their emotions more effectively; and to develop and maintain healthier relationships
- How to apply DBT skills to a range of psychiatric illnesses and other problems of daily living (e.g. low self-esteem, difficulties managing anger)
- Dialectical strategies to address clients who are "stuck" in therapy, resulting in inertia or unhealthy mechanisms of escape and avoidance, and how these strategies can lead to transformational healing
- Tools such as the Tracking Sheet and the Behavioural Analysis to increase structure in sessions and to help clients move toward change
- Behaviour Theory techniques to help clients understand what might be maintaining their problem behaviours and to get unstuck from these ingrained patterns
- Skills to help you improve your own sense of efficacy in therapy, and reduce the likelihood of therapist burnout

Sheri Van Dijk, MSW, RSW, is a Social Worker, registered with the Ontario College of Social Workers and Social Service Workers. She has been working in the mental health field since 2000, most of which she has spent both in private practice and at Southlake Regional Health Centre, working with clients with severe mental health problems. Sheri has had extensive training in mindfulness, DBT and CBT, and has been running DBT-informed groups since 2004.

Sunshine Coast Health Centre
A Non-12 Step Mental Health Program

Georgia Strait | WOMENS CLINIC

Calming the Emotional Storm

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Objectives

By the end of this two-day presentation, participants will learn:

- The theories underlying DBT: Dialectics, the Biosocial theory, and Behaviour Theory
- How emotion dysregulation affects clients, and how to teach clients DBT skills to reduce the impact of this problem
- How to use a variety of dialectical strategies to help clients get unstuck and move toward healing
- Ways of reducing feelings of burn-out and ineffectiveness as clinicians

What is DBT?

Dialectical Behavior Therapy is a treatment developed by Marsha Linehan in Seattle, Washington, to treat individuals with Borderline Personality Disorder (BPD)

Marsha and her team were using traditional Cognitive-Behavioral Therapy (CBT) to treat this difficult population, and found that it was not very effective.

What is DBT?

Marsha and her team attributed this to three factors:

1. Clients with BPD receiving CBT found the unrelenting focus on change inherent to the treatment invalidating

What is DBT?

2. Clients punished therapists for effective therapy (e.g. responded with anger, emotional withdrawal, threatened self-harm, etc.); and rewarded therapists when allowed to change the topic from one they didn't want to discuss to one they did want to discuss.

What is DBT?

3. The complexity of problems experienced by clients made it impossible to use standard CBT - therapists simply did not have time to address all of the problems presented by clients (e.g. suicide attempts, urges to self-harm or quit treatment, etc.) AND have session time devoted to helping the client learn and apply more adaptive skills.

What is DBT?

In response to these key problems, Marsha and her team made modifications to CBT to include mindfulness and acceptance techniques.

In this new model, accepting clients as they are (i.e. that their emotions, thoughts and behaviours make sense given their circumstances) is balanced with focusing on change and teaching skills needed to lead a life worth living

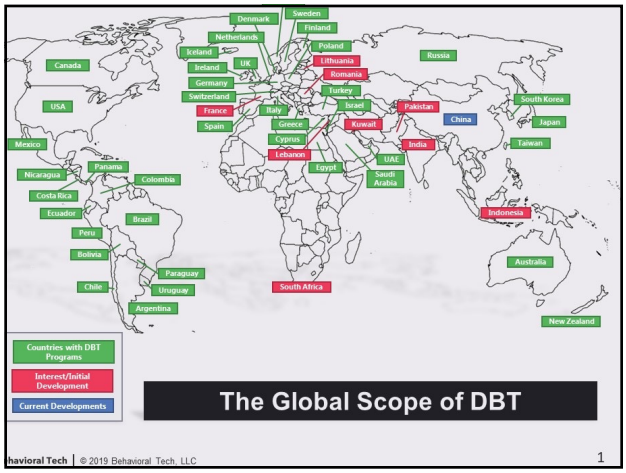
What is DBT?

Some of the differences between DBT and CBT:

- Mindfulness and acceptance
- Principle-driven vs. protocol-driven
- Contingency management
- (in individual DBT therapy there are other differences as well, including heavy emphasis on suicide assessment and commitment strategies)
- Mode of delivery

Standard DBT Model

1. Outpatient individual psychotherapy
2. Outpatient group skills-training
3. Skills Coaching
4. DBT team consultation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Countries with DBT Programs
Interest/Initial Development
Current Developments
The Global Scope of DBT
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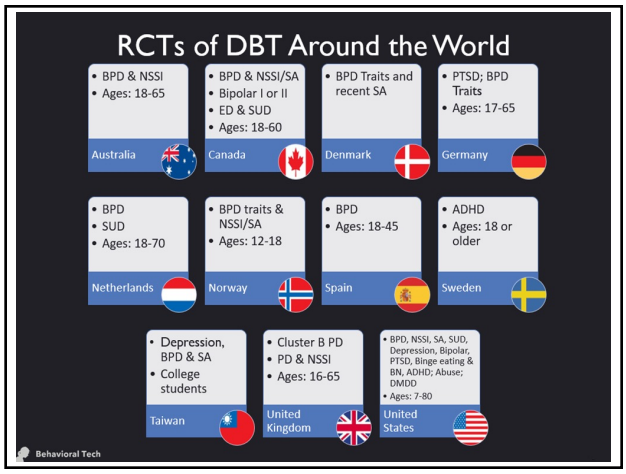
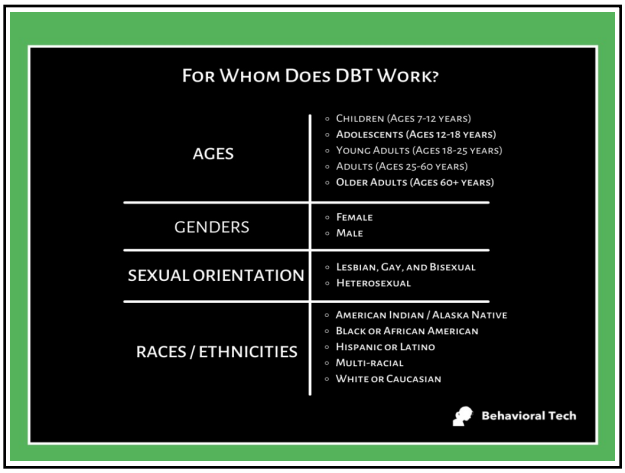

RCTs of DBT Around the World
• BPD & NSSI
• Ages: 18-65
Australia
• BPD & NSSI/SA
• Bipolar I or II
• ED & SUD
• Ages: 18-60
Canada
• BPD Traits and recent SA
Denmark
• PTSD; BPD Traits
• Ages: 17-65
Germany
• BPD
• SUD
• Ages: 18-70
Netherlands
• BPD traits & NSSI/SA
• Ages: 12-18
Norway
• BPD
• Ages: 18-45
Spain
• ADHD
• Ages: 18 or older
Sweden
• Depression, BPD & SA
• College students
Taiwan
• Cluster B PD
• PD & NSSI
• Ages: 16-65
United Kingdom
• BPD, NSSI, SA, SUD, Depression, Bipolar, PTSD, Binge eating & BN, ADHD; Abuse; DMDD
• Ages: 7-80
United States
Behavioral Tech


For what conditions is DBT effective?
• Borderline personality disorder, including those with co-occurring:
◦ Suicidal and self-harming behavior
◦ Substance use disorder
◦ Posttraumatic stress disorder
◦ High irritability
• Cluster B personality disorders
• Self-harming individuals with personality disorder
• Attention deficit hyperactivity disorder (ADHD)
• Posttraumatic stress disorder related to childhood sexual abuse
• Major depression, including:
◦ Treatment resistant major depression
◦ Older adults with chronic depression and one or more personality disorders
• Bipolar disorder
• Transdiagnostic emotion dysregulation
• Suicidal and self-harming adolescents
• Pre-adolescent children with severe emotional and behavioral dysregulation
• Binge eating disorder
• Bulimia nervosa
*DBT has been evaluated for many other conditions in non-RCT research.
Behavioral Tech



Modifying DBT

"In a study by Marsha's team, data showed no significant difference between Comprehensive DBT and a DBT Skills Condition on all major outcome variables during 12 months of treatment, and it looks like Comprehensive DBT begins to slightly outperform the DBT skills condition in the 12 month post-treatment follow-up on certain outcome variables." (The Skills Condition included a Consultation Team, and clients had case managers who were trained in the UWRAP and who assisted with suicide crises as they arose) – Linehan et al, 2015

Modifying DBT

A Canadian study (McMain, Guimond & Streiner –2017) looked at 84 patients with BPD, aged 18 and older:

- Provided 20 weeks of skills training only, compared to a waiting list group
- At 3 months follow-up:
  - Significant reductions in self-harm and suicidal behaviour, anger, impulsivity, and BPD symptoms; and an increase in mindfulness, distress tolerance, and emotion regulation

Modifying DBT

In a recent 2-year study by McMain et al (2022), 12 months of full DBT was compared to 6 months of DBT. The authors concluded that both groups showed "significant improvement from baseline to month 24 on all primary and secondary outcome measures" (p. 12).

The conclusion was that "there was no additional benefit of long-term over short-term DBT for the treatment of a severe, polysymptomatic clinical sample with BPD pathology" (p. 12)

Modifying DBT

- A RCT on the 12-week DBT skills group for Bipolar Disorder I developed demonstrated a reduction in depressive symptoms, an increase in self-efficacy, and an increase in one's ability to manage one's emotions; hospitalizations and ER visits were also reduced in the 6 months post-group compared to 6 months prior to group (*Journal of Affective Disorders*, March 2013)

Research continues to be conducted on adaptations of DBT, and on using DBT for other disorders

(see handout)

Biosocial Theory of BPD

Clients with BPD have pervasive emotional dysregulation. This is the result of two main factors:

1. A biological predisposition to emotional vulnerability:
   - A person who is emotionally vulnerable has a baseline of higher than average emotional pain; reacts emotionally to things others wouldn't typically react to; has more severe emotional responses than what is warranted; and takes longer to return to baseline.

BioSocial Theory: Emotional Vulnerability

Biological factors implicated in emotional vulnerability:

1. Genetics: work done by E. Aron has pointed to the possibility that approximately 30% of individuals are born "highly sensitive", physically & emotionally
2. Trauma: severe emotional or physical trauma causes changes in the brain to make it more vulnerable to intense feeling states (e.g. attachment).

BioSocial Theory: Emotional Vulnerability

Biological factors implicated in emotional vulnerability (continued):

3. Mental illness: Psychiatric disorders, especially when not well controlled by medications, lead to further emotional suffering.

BioSocial Theory:
The Invalidating Environment

2. The second factor contributing to emotion dysregulation is a ***Pervasively Invalidating Environment****:* the tendency to deny or respond unpredictably and inappropriately to the individual's private experiences (e.g. the child expresses an emotion and is judged or punished for this; is told that their experience is incorrect; the experience is minimized or ignored; and so on).

BioSocial Theory:
The Invalidating Environment

Examples of an invalidating environment include:

- The Abusive Home: physical, emotional, sexual or verbal abuse or neglect is the epitome of the invalidating environment
- The Poor Fit: e.g. the creative child in a family of "rational-thinkers"; the emotionally sensitive child in a family without this sensitivity

BioSocial Theory:
The Invalidating Environment

Examples of an invalidating environment include:

- The Chaotic Home: e.g. parents who had an invalidating childhood; who have a mental illness or addiction; who are financially unstable
- Other Invalidating Environments: e.g. school, social media clubs, extra-curricular activities; ***Societal contributors – discrimination and oppression based on race, ethnicity, religion, culture, gender, sexuality, etc…

BioSocial Theory: The Invalidating Environment

Consequences of the invalidating environment:

- The child doesn't learn to label or trust their private experiences, including emotions; instead, they learn to search the environment for cues on how to think, feel, and act (as an adult, this is experienced as "emptiness" or a lack of self-awareness).

BioSocial Theory: The Invalidating Environment

- An extension of not being able to label or trust their experience is that the child doesn't learn to modulate emotional arousal; or how to respond appropriately to distress
  - These emotional problems are not recognized by caregivers, and the child is told to control their emotions without being taught the skills to help them do this.

BioSocial Theory: The Invalidating Environment

- By punishing communication of painful emotions and intermittently reinforcing displays of extreme emotions, the environment teaches the child to oscillate between emotional inhibition and extreme emotional states.
- In this way, individuals with emotion dysregulation learn extreme ways of getting others to take them seriously (e.g. self-harm, suicidal behaviours and threats)

BioSocial Theory: The Invalidating Environment

- As adults, these clients have difficulty modulating their emotions because they have **not learned** to trust their reactions and to use healthy skills to regulate their feelings and behaviour.

BioSocial Theory

In individual DBT work, understanding the client's early experiences of attachment, relationships with parents/siblings, and temperament, are very important in understanding the client's skill deficits and strengths; the bulk of the work, however, focuses on the here-and-now

The Valuable Aspects of the BioSocial Theory of BPD

It directs our focus to helping clients acquire skills:

- to **modulate** extreme emotions (they become experts at identifying their emotions and choosing behaviours that will reduce their intensity)
- to **reduce** emotional vulnerability (they become experts at being mindful of themselves and their environment, and at making healthier lifestyle choices)

The Valuable Aspects of the BioSocial Theory of BPD

It directs our focus to helping clients acquire skills:

- to reduce **mood-dependent** behaviours (they learn skills that disconnect emotions from behaviour, reducing impulsive drinking, parasuicidal behaviours, etc.)
- to **validate** their own thoughts, feelings, and behaviours (resulting in raised self-esteem/self-respect/self-efficacy)
- locus of control shifts from external to internal

The Valuable Aspects of the BioSocial Theory of BPD

- It facilitates psychoeducation by identifying inadequate **learning** experiences (normalizing maladaptive behaviours learned in childhood)
- The BioSocial Theory reduces the therapist's sense of helplessness and frustration when relapse occurs – it helps us to not to take it personally!

The Valuable Aspects of the BioSocial Theory of BPD

- Considering the fact that over 85% of DSM diagnoses involve emotion dysregulation (Werner & Gross, 2010), it makes sense to look at applying Linehan's (1993) biosocial theory to disorders other than BPD
- Think about your own clients (without BPD)?

Dialectics

DBT is based on a dialectical philosophy:

- "Walking the middle path" (Miller et al, 2007)
- A more balanced way of thinking – getting away from Black & White and moving toward the Grays
- The only thing constant about reality is change! – being dialectical means being flexible

Dialectics

Video

How a Dialectical Worldview Informs Treatment Strategies in DBT

- There are no absolute truths (perspectives); each position has its own wisdom or truth, even if it's only a kernel of truth
- Opposites are interconnected and defined by each other; synthesizing these opposites is what leads to change (e.g. we need to accept the way things are AND move to change them)

How a Dialectical Worldview Informs Treatment Strategies in DBT

- Searching for what is left out in order to thoroughly analyze behaviours, thoughts and feelings
- Highlights oppositions (e.g. good/bad, right/wrong) in order to reduce interpersonal conflict; helps us to see the others' perspective
- Sometimes we need to hold two (or more) truths, without having to make one "right"

Dialectics

Dialectical thinking moves away from all or nothing thinking (e.g. "expressing emotions is good"; or "controlling emotions is good"), and toward a more synthesized, balanced perspective (e.g. "expressing *and* controlling emotions are both good")

And instead of *But*

Dialectics in Therapy:

Activity:

- Acceptance versus Change
- Your goals for your client versus their goals for themselves
- Learning to tolerate versus problem-solving
- Observing limits and being available to clients

Dialectical Strategies: Reciprocal vs. Irreverent Communication

- Reciprocal Communication:
  - Give and take; equality
  - Warmth and genuineness; validating
  - Use of self-disclosure
    - To validate or normalize an experience
    - To problem-solve
    - To model for the client how to self-disclose
    - Self-involving self-disclosure
    - Guidelines

Validation

What is validation?

- Communicating to the client that her responses make sense and are understandable within their current life context or situation
- Communicating acceptance of the client, taking the client's responses seriously and not discounting or minimizing them

Why validate?

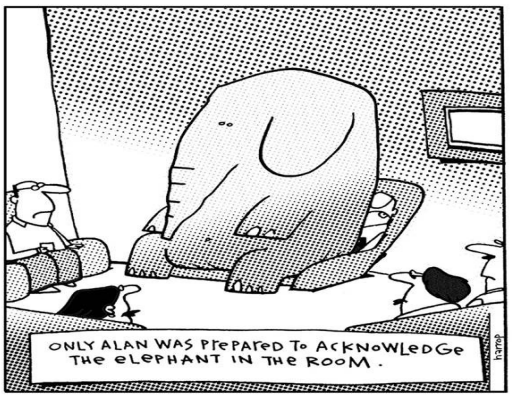
- *Invalidation* increases emotional arousal, which makes it difficult for clients to process information (e.g. "I know you're angry…")
- Validating the emotionally aroused client helps to reduce the intensity of emotions, allowing for new learning and therapeutic change

Benefits of Validation

- Enhances the therapeutic relationship
- Strengthens your empathy toward the client
- Encourages the client to keep going when they're ready to quit
- Teaches the client through modeling, how to trust and validate themself
- Can also serve as a form of exposure therapy to emotions: gives client a chance to feel the feeling, learn that it's tolerable and that, in this situation at least, their experience will be accepted

Validation

Video



Levels of Validation

1. Listening & Observing (listen mindfully, active listening)
2. Accurate Reflection (so what you're saying is…)
3. Articulating the Unverbalized (I would imagine you'd be feeling…)
4. Validate the current state based on history (e.g. of course you don't want to walk down the dark alley, you were assaulted in an alley)

Levels of Validation

5. Communicate the person's behaviour makes sense and is reasonable for anyone (e.g. Of course you don't want to walk down the dark alley, dark alleys are scary and dangerous; example with my cousin)

Levels of Validation

6. Radical Genuineness: treating the person as valid (matter of fact, not treating patient as fragile, direct and challenging)
   - This level of validation must come from the therapist's genuine self; at this level, almost any response by the therapist can be validating
   - Notice your natural, spontaneous reaction (versus the "Twilight Zone" therapist)
   - Not just verbal, but facial expressions and behaviour as well

Levels of Validation

- increase in frequency of high VLs was associated with an increase in positive affect (PA) and a decrease in negative affect (NA)
- increase in frequency of low VLs was associated with a decrease in PA and no change in NA.
- increase in frequency of VL 4 was associated with increase in NA.
- VL 6 was associated with an increase in PA and a decrease in NA.

(Carson-Wong et al, 2018)

Validation Exercise

Activity:

4. Validate the current state based on history
5. Communicate the person's behaviour makes sense and is reasonable for anyone
6. Radical Genuineness

Types of Validation

1. *Explicit verbal validation*: direct verbal validation described in Linehan's (1997) six levels
2. *Implicit functional validation*: the therapist validates with actions, in their response to the client (e.g. moving directly to problem-solving), rather than with words. "Sometimes the most validating response to a client's dilemma is to help them to solve it" (Swales & Heard, 2009 p. 95).

Validation

- Pushing for change in the emotionally vulnerable client will likely be perceived as invalidating ("you don't understand how difficult it is if you expect me to change")
- But it will also be perceived as invalidating if all that occurs is validation with no effort to change ("you don't understand how awful it is if you're not helping me to change")

Dialectical Strategies: Reciprocal vs. Irreverent Communication

- Irreverent Communication: an unexpected, somewhat "off the wall" response to a client
  - Blunt, confrontational, honest, challenging
  - Off-beat sense of humor; irony
  - Relies on a good relationship with client; and must be surrounded with validation
  - (Marsha's example)

Dialectical Strategies

- Devil's Advocate
  - e.g. You say you want to stop bingeing, but you're not using skills; I'm not so sure you're really committed to working on this.
- Making lemonade out of lemons
  - e.g. So you're finding it hard to tolerate sitting in group listening to others talk about their problems – that's great, you can practice being nonjudgmental!
- Use of metaphors

Behaviour Theory: Definitions

- Something is *reinforcing* if it makes it more likely the behaviour will happen again (reinforcers can be internal or external).
- *Positively Reinforcing* a behaviour means that something the client sees as positive happens after a certain behaviour occurs.

Behaviour Theory: Definitions

- ***Negatively Reinforcing*** a behaviour means that something the client finds unpleasant is removed after a certain behaviour occurs
- ***Intermittent Reinforcement*** is when the positive or negative reinforcement occurs occasionally rather than every time the behaviour takes place; it is one of the most successful ways of reinforcing a behaviour, since the individual never knows when she'll be reinforced (e.g. the gambler)

Behaviour Theory: Definitions

- *Consequence:* The outcome of something that occurred earlier. In other words, when looking at the consequences of an individual's behaviour, we're asking the question "*what happened after the person acted?*"
- Consequences can be *positive* or *negative*

Behaviour Theory: Definitions

- Shaping: By reinforcing behaviours that are *close to* the desired, end behaviour, you can shape an individual's behaviour (e.g. eliminating physical aggression with anger).
- Modeling: demonstrating a behaviour for someone else to imitate (e.g. validation!)

Behaviour Theory: Definitions

- A *contingency* is when there is a relationship between two events, so that if one event takes place, the other event is more likely to also occur
- *Contingency management*, then, is to "harness the power of therapeutic contingencies to benefit the patient" (Linehan, 1993, p. 294) – i.e. you need to think about how your behaviours will affect your client's.

Behaviour Theory: Contingency Management

For example: the 24-Hour Rule

If a client self-harms, the DBT therapist will not increase therapeutic contact for 24 hours (will keep any previously scheduled contact)

This is meant to increase the client's motivation to seek contact when they need help to not engage in these behaviours; and to ensure the therapist doesn't reinforce the self-harm

Behaviour Theory

- We always have to be considering:
  - Are we (or others) reinforcing behaviours we don't want?
  - Are we (or others) providing negative consequences to behaviours we do want?
  - How can we shape or model positive behaviours so that the client will eventually engage in these behaviours on her own?

Reducing Therapist Burn-Out

Diary Card (PsychSurveys)/Behaviour Tracking Sheet and structuring the individual session:

1. Life-interfering Behaviours (e.g. Suicide attempts or thoughts; self-harming)
2. Therapy-interfering Behaviours (e.g. Late for sessions, homework incomplete)
3. Quality of Life-interfering Behaviours (i.e. Everything else – symptoms of depression, anxiety, substance use, etc.)

This involves some evaluations by therapist regarding where a specific behaviour fits, depending on the client and the situation

Reducing Therapist Burn-Out

Limit-Setting

- Traditionally, we've been taught about the importance of "setting boundaries", especially with our BPD clients
- Try to change your way of thinking about this to be more flexible:
  - observe your limits, rather than expecting someone else to "respect your boundaries"

Reducing Therapist Burn-Out

Limit-Setting

- Neither the client nor the therapist is pathologized for having "inappropriate boundaries" (perhaps there is a poor fit between what one person wants and what the other is willing to give)
- ("Dear Trauma Therapist" letter: https://emdrtherapyvolusia.com/wp-content/uploads/2016/12/Dear_Trauma_Therapist.pdf)

Reducing Therapist Burn-Out

- Observing limits procedures:
  - Monitor your limits (burn-out)
  - Be honest about your limits (not for the good of the client, but of the therapist)
  - Temporarily extend limits when needed (e.g. in response to client's important needs)
  - Be consistently firm (e.g. don't extend limits in response to behavioural escalation; don't respond punitively)

The Behavioural Analysis

- Completing a thorough analysis of a target behaviour is the first step in problem-solving, or in stopping a target behaviour.
- Before you can take steps toward eliminating the problem behaviour, you must first understand it:
  - what purpose does it serve?
  - what triggers it?
  - what maintains the behaviour?

Reducing Therapist Burn-Out

The Behavioural Analysis (BA)

- Helps identify reinforcers and triggers, and to increase overall awareness
- Should be exhaustive
- Done in partnership at first, then as homework
- Can be aversive for clients (and therapists!)
- Emphasizes the client's responsibility

Reducing Therapist Burn-Out

The Behavioural Analysis (BA) Exercise – Part 1

Overview of DBT Skills

There are four modules in DBT:

1. Core Mindfulness Skills
2. Interpersonal Effectiveness Skills
3. Emotion Regulation Skills
4. Distress Tolerance Skills

Core Mindfulness Skills

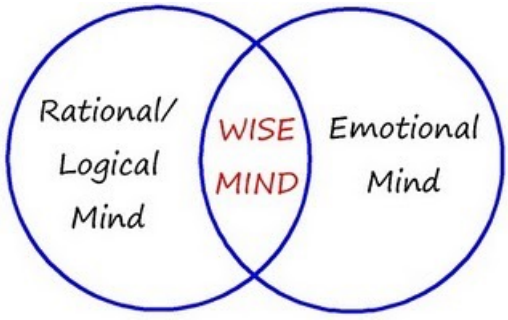
This is a set of skills that teach people to be more aware of what is happening in the present moment, in a nonjudgmental way.

Many of our clients spend a lot of time ruminating about the past and/or having anxiety about the future; Core Mindfulness emphasizes living in the here and now, which reduces the amount of painful emotions.

Core Mindfulness Skills

These skills also help clients get a better sense of themselves, as being mindful involves being much more aware of what is going on within themselves – thoughts, emotions, and physical sensations.

Core Mindfulness Skills: States of Mind



Core Mindfulness Skills: States of Mind

Reasoning Mind:

- Logical, practical, intellectual, rational, straight-forward thinking
- No emotions involved (or very minimal)
- E.g. making a grocery list; following instructions to bake a cake; balancing your chequebook (as long as there's no anxiety involved!)

Core Mindfulness Skills: States of Mind

Emotion Mind:

- This is the part of us that often gets us into trouble!
- You know you're in emotion mind when your *emotions* are controlling your *behaviours*
- E.g. you're feeling anxious so you avoid; your mood is depressed so you withdraw and isolate yourself; you feel angry and you lash out at the people around you
- Emotion mind also includes pleasant emotions

Core Mindfulness Skills: States of Mind

Wise Mind:

- It's not that RM and EM are *bad* and we want to get rid of them; rather, we want to be able to find a balance more often: this is Wise Mind
- Wise Mind = RM + EM + Intuition
- You're in WM when you're thinking about the consequences of your behaviour, and *choosing* how you want to act rather than reacting.

Core Mindfulness Skills: States of Mind

Exercises to help clients grasp these states:
- What's an occupation that might represent each of these states?
- Who is a TV character that represents each of these states?
- (individual versus group)

Core Mindfulness Skills: States of Mind

Exercises to help clients get to Wise Mind:
- "What does your Wise Mind tell you?"
- Turning inward exercises – e.g. Stone flake on a lake; going down a spiral staircase within yourself
- Breathing exercise: breathing in "Wise", out "Mind"

Core Mindfulness Skills: States of Mind

Often just identifying what state of mind is there can help someone take a step back if they're in EM or RM

Help increase awareness of these states by having clients notice regularly

Mindfulness and many of the DBT skills will help people access WM

The "What" Skills…

1. Observe: just notice the experience without getting caught up in it; just sense what's happening without reacting to it (e.g. no pushing away, no ruminating – Teflon Mind vs. Velcro Mind).

e.g. observe sounds around you, observe body sensations as you sit in your chair, etc.

The "What" Skills…

2. Describe: put words on your experience, nonjudgmentally labeling whatever you're noticing in the moment (sometimes describing can help provide some clarity about our experience).

e.g. describe what you see around you, the thoughts, feelings and sensations you're experiencing, etc.

The "What" Skills…

- The importance of observing and describing to help in relationships
- Reducing personalizing
- Client examples: Taylor; couple/family work

The "What" Skills…

3. Participate: become one with your experience; be mindful, letting go of ruminating and worry; entering completely into the activities of the current moment

- e.g. become the count of your breath, sing in the shower, dance to music
- Experience the sense of connection to others, and to the universe
- How do you connect to others/the universe? Can you share these with clients?

Core Mindfulness Skills: Nonjudgmental Stance

Video

Core Mindfulness Skills: Nonjudgmental Stance

Judgments often increase the intensity of emotions – we need to watch for the judgments that stick to us! reducing these judgments will help us to reduce the painful emotions we're experiencing

**Note that this isn't about stuffing emotions or opinions, but rather helps us express these things more assertively

Core Mindfulness Skills: Nonjudgmental Stance

This skill is about semantics!

Think "inflammatory language" – if you can reduce the use of this language, you can reduce the intensity of emotions

The "How" Skills…

1. Nonjudgmentally:

- Takes the short-form out and says what we really mean
- Won't make the pain disappear, but will prevent extra emotions from arising
- Will be more effective in interpersonal situations

Core Mindfulness Skills: Nonjudgmental Stance

- Judgments versus Evaluations
- What about positive judgments?
- The challenge of self-judgments
- Non-verbal judgments
- Sometimes judgments are hard to catch
- Awareness = Choice – this isn't about eradicating judgments!

Core Mindfulness Skills: Nonjudgmental Stance

Examples:

"I'm lazy" versus "I didn't get everything done I wanted to today and I'm feeling disappointed in myself"

"He's an idiot" versus "He hurt me and I'm feeling angry with him"

Core Mindfulness Skills: Nonjudgmental Stance

What nonjudgmental stance isn't:

- It's not rationalizing or excusing behavior (e.g. "I didn't get everything done that I wanted to because I didn't sleep well last night" or "he said hurtful things because he had a hard day at work")
- It's not providing reassurance (e.g. "it's okay that I didn't get everything done today, I can work on it tomorrow")

Core Mindfulness Skills: Nonjudgmental Stance

Some helpful (nonjudgmental) words to consider:

- Helpful versus unhelpful
- Effective versus ineffective
- Safe versus unsafe or dangerous
- Satisfying versus unsatisfying
- Healthy versus unhealthy

The "How" Skills…

2. One-Mindfully: do one thing at a time; multi-tasking is overwhelming and draining, slows us down - like having too many tabs open on the computer!

The "How" Skills…

3. Effectively: focus on what works; use your wise mind; using skillful means. Do what you need to do in order to get your needs met.

- Stop focusing on what you think "should" be or what's "fair" and focus instead on what IS.
- Is it better for you to be right, or to get what you need or want?

Emotion Regulation

1. Understanding and Naming Emotions

- Look at the function or job of emotions (i.e. communication, motivation, validation)
- Observing and Describing Emotions: this increases awareness of all the components of the emotional experience (prompting event, interpretations, physical sensations, facial expression & body language, action urge and the actual action, and after-effects), which increases the individual's understanding of the emotion and allows for more self-validation.
- (**Sample)

Emotion Regulation

2. Reducing Vulnerability to Emotion Mind

- Vulnerability factors are conditions or events that make an individual more sensitive to a prompting event, more likely to make emotional interpretations, and more biologically reactive to specific events: STRONG (balance Sleep, Treat mental and physical illnesses, Resist drugs and alcohol, One thing a day to build mastery, balance Nutrition, and Get exercise)
- Accumulating Positives: goal-setting and engaging in enjoyable activities

Emotion Regulation Skills

Increase Pleasurable Emotions
Build positive experiences:
in the short-term, do pleasant events daily; in the long-term, work toward goals that lead to a **life worth living** (e.g. productive activity, relationships, health)

Emotion Regulation

3. Changing Unwanted Emotions
- Problem-solving
- Opposite Action

Emotion Regulation Skills: Opposite Action

With Opposite Action, the idea is not to *avoid* the emotion, but rather to help reduce it so that it is more manageable. The idea behind this skill is that, once we have an emotion, we tend to act in ways that keep the emotion going (e.g. when we're angry, we might yell at the other person, which feeds our anger). By acting opposite to the urge attached to the emotion, the emotion is reduced in intensity and we can then access Wise Mind.

Emotion Regulation Skills: Opposite Action

1. Identify the emotion and the urge associated with it
2. Validate the emotion
3. Check the facts (is the emotion warranted or justified?)
4. If the emotion is not warranted (or if it is and you still want to reduce the emotion), act opposite to the urge in order to reduce the emotion.

** Fear is the only emotion that we would want to ensure the client is NOT acting opposite to if it is warranted! The rest of the emotions aren't so black and white.

Emotion Regulation Skills: Opposite Action

Emotion	Urge	Opposite
Anger	Attack civil	Gently avoid/be
Fear	Avoid	Approach
Sadness	Withdraw	Reach out
Guilt/Shame	Stop the behaviour	Continue the behaviour

Emotion Regulation Skills: Opposite Action

- Figuring out if the emotion is warranted/justified
  - e.g. with anxiety – is your life, health, or well-being at risk?
  - e.g. with anger – is an important goal being blocked? Are you or someone you care about being attacked, hurt, threatened, or treated unfairly? (it's not as important if it's justified because anger is often justified, but gets in our way)
  - e.g. with shame – will you be rejected by a person or group you care about if characteristics of yourself or of your behavior are made public?
- Stop feeding the emotion, do the opposite to your urge
- Doing OA with pleasurable emotions?

Emotion Regulation

4. Managing Extreme Emotions
   - Mindfulness to Current Emotion
   - Self-Validation

Emotion Regulation Skills

Mindfulness of Current Emotion:

- Often when a person is experiencing pain, they focus not just on the pain in the present, but on their expectation that the pain will continue, and perhaps that it's already gone on for so long.
- Being mindful to the current emotion is about focusing on the pain – or the pleasure – just in this moment.
- Being mindful to pleasant emotions helps us to enjoy them more.
- ("foreboding joy")

Emotion Regulation Skills

Mindfulness of Current Emotion: radically accept your emotion and allow it to flow over you like a wave; experience it without being taken over by it.

(Practice)

Emotion Regulation Skills

Self-Validation: The client must learn to validate themselves, accepting their emotions, thoughts and experience in general rather than judging these; and learning to trust that their response is valid even if it's not what others want or expect.

Example: "Joe"

Emotion Regulation Skills

Primary Emotions:

Situation – Interpretation – Primary Emotion

Secondary Emotions:

Situation – Interpretation – Primary Emotion – Interpretation – Secondary Emotion

- How you feel about your feelings
- Family of origin messages often feed into these patterns; identifying these messages can be helpful

Emotion Regulation Skills

There are three ways to self-validate (Van Dijk, 2012):

1. Acknowledging the presence of the emotion: for example, "I feel anxious."

- By just acknowledging the emotion, and putting a period on the end of that sentence rather than going down the road of judging it, you are validating your anxiety.

Emotion Regulation Skills

There are three ways to self-validate:

2. Allowing: giving yourself permission to feel the feeling: for example, "It's okay that I feel anxious."

- Here, not only are you not judging the feeling, but you're going one step further and saying "this is okay" – again, not that you like it or want it to hang around, but that you're allowed to feel it.

Emotion Regulation Skills

There are three ways to self-validate:

3. Understanding: this is the highest level of self-validation and the most difficult.

- In this form of validating, not only are you not judging the emotion and saying it's okay to feel it, you're going one step further and saying you understand it: "it makes sense that I feel anxious being at home by myself, given the fact that I was at home alone when thieves broke in and threatened me with a gun."

Emotion Regulation Skills

Cope Ahead: Scuba example

When to use Cope Ahead:

- For situations you're fearing
- When you know your emotions are likely to interfere with your skills use
- In new situations where you're unsure of your skills, and this insecurity may elicit an emotional reaction that will make it very difficult for you to manage the situation effectively

Emotion Regulation Skills

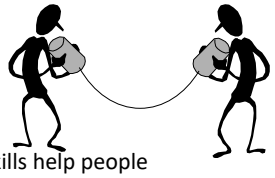
Steps to Cope Ahead:

1. Describe the situation that is expected to be a problem (what's the catastrophe?)
2. Decide which skills you'll use to help you cope effectively
3. Practice! – imagine yourself in the catastrophe, using the skills and being effective – be specific!

Interpersonal Effectiveness

The IE module teaches clients skills to help them be more effective in relationships – e.g. assertiveness, maintaining a balance in relationships, and the importance of having a balance of responsibilities as well as enjoyable activities in their lives

Interpersonal Effectiveness



Many individuals have a hard time communicating effectively, especially when emotion regulation is a problem. The IE skills help people learn how to ask for what they want (get their needs met), or say no (observe a limit) in a way that makes the other person want to accept the request or the "no". Essentially, these are assertiveness skills.

Interpersonal Effectiveness

There are three sets of skills in this module:

1. Objective Effectiveness – skills to help you reach a goal or say no to another's request
2. Relationship Effectiveness – skills to help ask for something while maintaining or improving relationships
3. Self-Respect Effectiveness – skills to assist you in asking for something while maintaining respect for yourself.

Objective Effectiveness: "DEAR MAN"

Describe what the situation is; stick to the facts, no judgments.

Express your feelings or beliefs (e.g. "I feel…")

Assert yourself – ask for what you want; clearly state your objective

Reinforce the person by telling them what any positive or negative consequences might be

Objective Effectiveness: "DEAR MAN"

Stay **M**indful – stay focused on your request; ignore distractions

Appear confident – look and sound self-assured, no matter how you feel!

Negotiate – find something you can offer in exchange; look for alternative solutions; ask for the other person's assistance in problem-solving if they reject your ideas

Relationship Effectiveness: "GIVE"

Be **G**enuine (Gentle) – act from your wise mind, your true self, be sincere

Act **I**nterested – be patient and listen; show you care about what they think

Validate – demonstrate that you understand their perspective and emotions

Use an **E**asy manner – no judging or blaming, smile, look and sound friendly, use a light tone and even humor

Self-Respect Effectiveness: "FAST"

Be **F**air – both to yourself and the other person

No **A**pologies – at least not for having an opinion or being alive!

Stick to Values – be clear on your own values and stand up for them

Be **T**ruthful – avoid lying, acting helpless, exaggerating or making up excuses

Interpersonal Effectiveness

Activity:
Communication Exercise

Interpersonal Effectiveness

Balancing Priorities and Demands

1. A priority is something we do for ourselves because it's enjoyable, peaceful, calming; something we do just because we want to do it
2. A demand is external, placed on us by others; responsibilities, things that are expected of us

Interpersonal Effectiveness

- It can be an eye-opening experience to have clients do an inventory of their priorities and demands
- Discuss what it means to be overwhelmed versus underwhelmed

Interpersonal Effectiveness

Factors reducing Interpersonal Effectiveness:

If a client is not reaching their IE goals, it is important to assess why; there are many reasons why this might be the case:

a. Lack of skill – e.g. not knowing what to say

b. Worry thoughts or other emotions interfere with ability to act skillfully

Interpersonal Effectiveness

Factors reducing Interpersonal Effectiveness:

c. Indecision – they may be ambivalent about their goals; need to clarify objectives in the situation

d. Environment – some environments will not result in you getting what you want, regardless of how skillful you are acting.

Interpersonal Effectiveness

Finding new relationships:

- Finding friends and getting people to like you (reducing interpersonal isolation and loneliness)
- It's important that people recognize the role of social anxiety, since we all have different needs for relationships; wise mind!
  - Reconnecting with old friends
  - Deepening relationships with current people
  - Finding new friends

Interpersonal Effectiveness

- Being mindful of others
  - Stop multi-tasking
  - Pay attention with interest and curiosity to others
  - Stay in the present rather than planning what to say next
  - Notice judgmental thoughts about others, and let them go
  - Give up clinging to always being right
  - Avoid assumptions and questioning others' motives (unless good reason to do so)
  - Observe, Describe, and Participate (throw yourself in, go with the flow rather than trying to control the flow)

Interpersonal Effectiveness

Ending Relationships

- Be sure to end relationships from Wise Mind, not from Emotion Mind
- If the relationship is important and NOT destructive, try problem-solving/repairing first (using DEAR MAN skills); practice Cope Ahead
- Practice Opposite Action for love when you love the wrong person
- Safety First!

Interpersonal Effectiveness: Behavior Theory

We train people how to be in relationships with us

- What problem behaviors are you reinforcing?
- What positive behaviors are you punishing or providing negative consequences for?
- How can you get more of what you're looking for?

Distress Tolerance

The second set of skills (which I'm teaching first!) helps people to accept reality, rather than continue to fight it, which creates painful emotions:

1.Radical Acceptance

- "It is what it is"
- "Acceptance" does NOT mean approval
- RA reduces the amount of pain in our lives

Distress Tolerance

2. Turning the Mind

- This is how we radically accept: you notice you're fighting reality; and you turn your mind back to acceptance
- The "Internal Argument"

Distress Tolerance

- Four steps to RA:
  1. First step is deciding to practice this skill
  2. Next, making the commitment to yourself: as of this moment, I'm going to work on accepting this situation
  3. Notice when you're not accepting, but fighting reality
  4. Turn your mind back to acceptance

Distress Tolerance

Techniques to help your client get to Radical Acceptance:

1. Breathing
2. Taking an open posture
3. Half-Smile

Distress Tolerance

Video

Radical Acceptance: Problems Clients Often Encounter

- ACCEPTANCE DOES NOT MEAN APPROVAL!!!
- "Doesn't acceptance mean that I'm giving up or being passive?"
- "How can I accept that I will be alone for the rest of my life?"
- "How can I accept that I'm a bad person?"
- "Some things in life are just too awful to accept"

Radical Acceptance: Problems Clients Often Encounter

Don't just practice RA with "big", painful situations; daily practice helps us to be more accepting of the "little" things that will occur in our daily lives that trigger fighting reality and emotional suffering; for example:

- Being stuck in traffic
- The weather
- Waiting in line
- Distracting noises during session

Distress Tolerance

3. Willingness vs. Wilfulness

Wilfulness is refusing to do your best with what you've got; sitting on your hands and refusing to try; giving up; "whatever"

Willingness is being open to the possibilities, doing your best to act skilfully; playing the cards you're dealt

Distress Tolerance

3. Willingness vs. Wilfulness

When life gets difficult, our clients will often become wilful and want to resort to old habits rather than try to use skills – they need to accept that wilfulness has arisen within them, and do their best to be more willing.

- You can teach your clients the same 3 techniques to get to RA to help them get to willingness; also: "What's the threat?"

Distress Tolerance

The first set of skills (which I'm teaching second!) teaches people skills that help them survive crisis situations without making things worse.

If there is a problem that can be solved, SOLVE IT!

Distracting skills are not meant to be used long-term; distracting in the long-term isn't distracting, it's AVOIDING.

Distress Tolerance

F-TIPP Skills:

1. Forward Bend (baroreceptors activate PNS)
2. "TIP" the temperature of your face (mammalian dive reflex; **caveat re: anorexia/bulimia, heart problems, beta blockers)
3. Intense exercise (generates endorphins)
4. Paced Breathing (PNS)
5. Paired breathing and PMR (PSN)

Distress Tolerance

Distracting Skills:

Activities (e.g. TV, reading, walking, Zentangle)

Contribute to others (e.g. volunteer, do something kind for someone else)

Comparisons (e.g. to others, to yourself)

Emotions (e.g. TV, music)

Pushing Away (with imagery)

Thoughts (ie. Generate neutral thoughts, such as counting, singing a song, etc.)

Sensations (e.g. take a bath, elastic band, ice)

Distress Tolerance

Self-soothing with the senses:

1. Sight (e.g. flowers, clean room)
2. Hearing (another person's voice, nature, music)
3. Touch (e.g. clean sheets, pets)
4. Taste (e.g. herbal tea, a favourite food, mint)
5. Smell (flowers, perfume, etc.)

- Helpful during a crisis, and also as general self-care
- Note that some people over-use this; others feel guilt and so tend to avoid self-soothing; the challenge with both instances is to help the client find balance.

Distress Tolerance

IMPROVE the moment:

I – Imagery (container, secure/calm place)
M – finding Meaning
P – Prayer
R – Relaxation
O – One thing in the moment
V – take a Vacation
E - Encouragement

Distress Tolerance

Pro's and Con's: four columns; written out ahead of time while in Wise Mind

- Four columns instead of two gives the client a broader perspective
- Written engages the frontal lobes
- Can then be used as a reminder as to why the person doesn't want to act on the problem behaviour
- Consider short-term as well as long-term

Distress Tolerance

Activity:
Pro's and Con's Exercise

Distress Tolerance

Pros of Cutting

Cons of Cutting

Pros of NOT Cutting

Cons of NOT Cutting

Distress Tolerance

Urge Management: What to do when crisis strikes

1. Rate the intensity of the urge from 0 (no urge) to 10 (intense urge)
2. Set a timer for 15 minutes.
3. In the meantime…
   - Mindfully distract yourself with distracting and self-soothing
   - Read your pro's and con's list

   When your 15 minutes is up, re-rate your urge

Behavioural Analysis
Exercise Part Two:
The Solution Analysis

Thank You!!!

DBT for Problems Other Than BPD

More and more research is being done on using DBT to treat illnesses other than BPD, and chronic suicidality and self-harm. DBT, either the full model or in a modified or adapted form, has also been studied and found helpful in the following contexts:

- other personality disorders (Springer et al, 1996 (and others))
- binge eating disorder (Telch et al, 2000)
- anger in male forensic patients (Evershed et al, 2003)
- people diagnosed with HIV/AIDS, substance use disorder and BPD (Wagner et al, 2004)
- oppositional defiant disorder (Nelson-Gray et al, 2006)
- bipolar disorder in adolescents (Goldstein et al, 2007)
- treatment-resistant depression (Harley et al, 2008)
- anorexia and bulimia (Salbach-Andrae et al, 2008)
- depression (Feldman et al, 2009; Lynch et al, 2003)
- family members of people with BPD (Rajalin et al, 2009; Hoffman et al, 2007)
- suicidality in intellectually disabled forensic patients (Sakdalan, Shaw, and Collier, 2010)
- trichotillomania (Keuthen et al, 2011)
- PTSD related to childhood sexual abuse (Steil et al, 2011)
- nonsuicidal self-harming behaviors and suicidal ideation in children (Perepletchikova et al, 2011)
- caregivers of family members with dementia (Drossel et al, 2011)
- ADHD (Hirvikoski et al, 2011)
- bipolar disorder in adults (Van Dijk, Jeffery, & Katz, 2013)
- intellectual disabilities and challenging behaviors (Brown, Brown &Dibiasio, 2013)
- breast cancer patients (Cogwell et al, 2013)
- family members of teens with symptoms and behaviors associated with borderline and externalizing pathology (Uliaszek et al, 2013)
- in a Disciplinary Alternative Education Program (Ricard, Lerma & Heard, 2013)
- in adolescent chronic kidney disease (Hashim, Vadnais & Miller, 2013)
- emotion regulation group in a college counseling service (Meaney-Tavares &Hasking, 2013)
- in post-disaster psychotherapy (Martin, 2015)
- for chronic pain related to gastrointestinal disorders (Sysko, Thorkelson & Szigethy, 2016)
- for marijuana use disorder (Davoudi et al, 2021)
- for Irritable Bowel Syndrome (Mohamadi et al, 2019)

Research has been conducted on the use of DBT in different contexts to treat adolescents, adults and the elderly; as well as in in-patient, out-patient, forensic settings and ACT teams. Many of these studies involved the full DBT model, but many are on the use of adapted models of DBT, especially for disorders other than BPD.

Client #1: Marianne

Marianne hadn't slept well on Friday night. Saturday morning she got up feeling irritable. She knew she had a long day as she and her partner, Rob, had planned to do some painting and other things around the house to get it ready to sell. On her way to the kitchen, she noticed Rob's shoes by the front door and she started yelling at him for leaving his shoes in front of the door…Again. He knew this was one of her biggest pet peeves, yet he continued to do it.

Marianne and Rob argued. Things got out of hand. She cried, they both yelled, and finally Marianne went into the bedroom, slammed the door, and laid down on the bed crying. "My life sucks!" she thought to herself. "Why can't Rob and I ever get along? The last time we argued like this we didn't talk for three days; I don't think I can go through that again." Marianne began thinking about killing herself. She got off the bed and locked the door to the bedroom, yelling to Rob that he would be sorry. Then she actually started feeling a little happy because she could finally win the argument this way; she could get back at Rob for hurting her so much by hurting him back. She also realized she was feeling a little hopeful that he would come to her and apologize and make these problems go away.

Marianne walked into the bathroom and took her razor out of the cabinet. She started running water in the bathtub so she wouldn't make a mess; she got undressed, got in the tub, and heard Rob coming down the hallway asking what she was doing. She listened to him at the door, but didn't answer him and instead cut her left wrist. The pain brought immediate relief.

Rob started banging on the door and calling to her, but she continued to ignore him; after a few moments he broke the door down, came running into the bathroom looking terrified, and the scared look on his face made Marianne feel both regret for hurting him like this, but also relief because she knew he was going to take care of her. Rob came to the tub and hugged her, told her how sorry he was, that he loved her and that everything would be okay. He went back into the bedroom and called 911, then came back into the bathroom and helped her out of the tub. He put towels around her wrist, helped her get dressed, then sat with her stroking her hair and soothing her until the ambulance came. He rode with her to the hospital, at her side the whole way.

Marianne was admitted to hospital for two weeks. Rob called her work to inform them she was ill. She was referred to a DBT therapist upon her discharge from hospital.

Behavior Tracking Sheet

Name: **Week of:**

Mon.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		
Tues.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		
Wed.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		
Thurs.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		
Fri.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		
Sat.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		
Sun.	**Emotions**	How strong?	**Urges**	How strong?	**Behaviors** (number)
	▫	0----------5	▫ suicide	0----------5	▫ suicide attempt ____
	▫	0----------5	▫ self-harm	0----------5	▫ self-harm ____
	▫	0----------5	▫	0----------5	▫ ____
	▫	0----------5	▫	0----------5	▫ ____
	Did you use a skill? Yes No		If yes, which one(s)? _____		
	Did it help? Yes No		If you didn't, why not?_____		

Behavior Tracking Sheet

Notes for the Week

Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

Problem-Solving Strategies:
The Behavioral Analysis

Completing a thorough analysis of a target behavior is the first step in problem-solving, or in stopping a target behavior. Before you can take steps toward eliminating the problem behavior, you must first understand it – what purpose does it serve? what triggers it? what maintains the behavior? and so on.

I've provided a sample Behavioral Analysis (BA) that will help you and your client to thoroughly analyze the problem behavior: what factors made her vulnerable to engaging in the behavior? What was the trigger or prompting event for the behavior? What were the events, however small, that took place between the trigger and when she actually engaged in the behavior? What were the consequences – positive or negative – of engaging in the behavior? Remember when looking at the consequences that you're not just focusing on the negative consequences – most clients understand what the negative outcomes are of their behavior, but they have a difficult time using this understanding to help them stop engaging in that behavior. Looking at the positive consequences – what is the client getting out of this behavior? – can often help the client develop more insight and awareness into why she continues to engage in the behavior in spite of the harm it does to her.

The Solution Analysis then helps you and your client look at possible ways to prevent the behavior from happening again in the future: what could she do to make herself less vulnerable to experiencing the urge to engage in the behavior? Are there things she can do to avoid the trigger? Where would she be able to intervene in the future by using skills instead, so that the end result is something other than the problem behavior? And are there things she needs to do now to correct any harm that was done?

Many therapists might find that they do a sort of verbal analysis when a problem behavior has occurred, asking questions like, “What triggered the urge?” “Did you do anything to try to stop it?” “What happened between you feeling triggered and when you actually acted on the urge?” At the beginning of treatment, however, or whenever a new problem behavior emerges, the BA should be written in order to ensure that all factors are considered (Linehan, 1993).

The BA should initially be completed by therapist and client together to ensure the client understands how to complete the BA; the goal is for the client to learn how to do thorough and accurate BA’s on her own when a problem behavior occurs, until you both have a good understanding of why and how these behaviors are occurring.

Linehan (1993) notes that most therapeutic errors are based on faulty assessment, which leads to an inaccurate understanding of the behavior and why it’s happening. She suggests, therefore, that the task when completing the BA is to walk your client through the situation, creating an exhaustive description of the chain of events that led up to and followed the behavior.

Chain Analysis of Problem Behavior

Date Filled Out: _____Date of Problem Behavior: _____

What is the ***problem behavior*** that I am analyzing?
What things in myself and in my environment made me ***vulnerable*** to engaging in the problem behavior?
What prompting event ***in the environment*** started me on the chain to the problem behavior?
What are the *LINKS* in the chain between the prompting event and the problem behavior? (make sure you're very specific and detailed about what happened between the prompting event and the problem behavior)
Keeping in mind that consequences can be immediate or delayed, answer the following questions about your behavior: 1. What were the ***negative consequences***? 2. What were the ***positive consequences***?

Solution Analysis of Problem Behavior

Ways to reduce my ***vulnerability*** in the future:
Ways to prevent the ***prompting event*** from happening again (we don't always have control over this, but see what ideas you can come up with):
Ways to work on changing the ***links*** in the chain from the ***prompting event*** to the ***problem behavior*** (how can you interrupt the links in the chain so that you'll be less likely to engage in the problem behavior next time)?
Are there things that you need to do to correct or repair the harm caused by the problem behavior?

It's also important to make validation a part of the BA. While we'll discuss validation in more detail in the next chapter, for now remember that the BA often is distressing for clients to complete, especially at the beginning of treatment. We can make this a little bit less aversive for them by letting them know that we understand their emotions and even the problem-behavior (this is the acceptance we help the client with before pushing for change).

A lot of attention should be paid to the Solution Analysis – helping the client come up with ways to reduce the likelihood of the behavior occurring again. Assist the client in looking at each of the links in the chain; once she has learned some of the DBT skills, you'll have more options in

terms of what she could have done differently and where she might intervene with skills the next time this urge arises.

It's interesting to note that the BA itself can also play a role in helping to extinguish the problem behavior if the client finds doing behavior analyses aversive – she may develop the ability to see that this will be an inevitable consequence to her behavior, and will decide to not act on the urge in order to avoid the discomfort of having to complete a BA!

(Adapted from *DBT Made Simple – Van Dijk, 2013)*

Pro's and Con's Chart

Pro's of _____ (not using skills)	**Con's of _____ (not using skills)**
Pro's of NOT _____ (using skills instead)	**Con's of NOT _____ (using skills instead)**

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