Dialectical Behavior Therapy Certification Program – Day Three

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Final Day Overview

- DBT Skills
  - Dialectics
  - Distress Tolerance
  - Emotion Regulation
  - Interpersonal Effectiveness
  - Acronyms, Acronyms, and more Acronyms!
- Unique Approaches
  - Diary Cards
  - Behavior and Solution Analysis
  - Irreverence
  - Consultation Groups
- Basics of Self-Directed Violence
- Safety and Suicide Assessment

Volunteers for Mock Sessions?

Revisiting the Basics of DBT Skills (cont.)

Dialectics as a Module

Please review the slides in the Day Two Deck for Dialectics Content

Ways Clients Can Practice Dialectics

- Self-acceptance and change
- Balance of your wants/needs with others' wants/needs
- Wise Mind Basics
- Considering alternative viewpoints and opinions
  - Yes, and…

Dialectical Exercises

- What's going well?
- Strengths and resources
- Silver lining/hidden opportunity
- All or something!
- Recognizing incremental change

Distress Tolerance Module

Please review the slides in the Day Two Deck for Distress Tolerance Content

When To Use Distress Tolerance

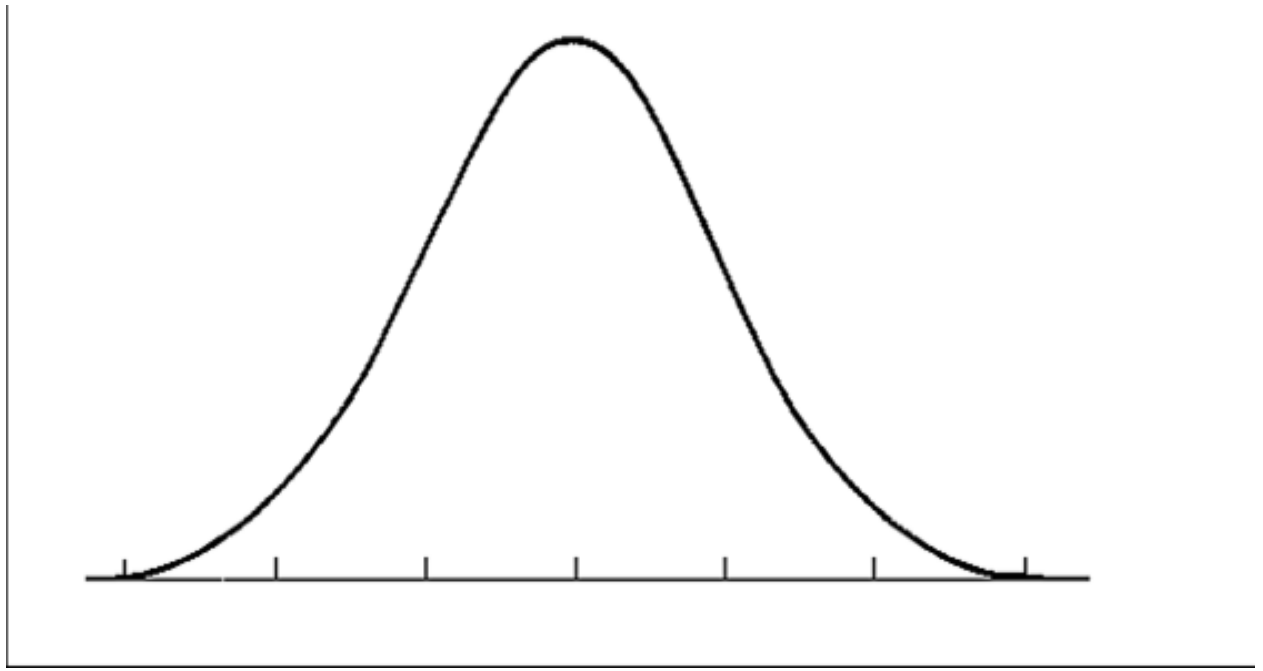
- Am I able to solve the problem?
- Is now a good time to solve it?
- Am I in Wise Mind enough to solve it?
- If “yes” to all three questions, just solve the problem
- If “no” to any of the three questions, distress tolerance may help

Distress Tolerance (cont.)

Remember:

- You can either stay with the pain until it goes away (and have faith that it will), or
- You can practice skills to make it more comfortable
- You can’t do both at the same time

Anxiety (y axis) and Time (x axis)



More About Distress Tolerance

- Practice skills when NOT in distress
- Skills are short-term – have a lot of options
- As applicable, use the “coping cards” method
- Coach clients to change strategies when a skill does not work
- Evolve skills plans – these should be a “living document”

Distract: Wise Mind ACCEPTS

- **A**ctivities
- **C**ontributing
- **C**omparisons
- **E**motions
- **P**ushing away
- **T**houghts
- **S**ensations

IMPROVE the Moment

- **I**magery
- **M**eaning
- **P**rayer
- **R**elaxation
- **O**ne thing at a time
- **V**acation
- **E**ncouragement

Self-Soothe

Mindful engagement of the senses:

- Vision
- Hearing
- Smell
- Taste
- Touch

Radical Acceptance Module

Please review the Day Two Deck for Radical Acceptance Content

Radical Acceptance

- Choices When Life Is Painful:
  - Change painful situations when you can
  - Shift your perspective of the situation
  - Radically Accept the situation
  - Continue to suffer (remember what we said about Yoda)

Accepting Reality Skills

- Radical Acceptance
  - Freedom from suffering requires acceptance
  - Letting go of fighting reality ends suffering
  - Acceptance may still mean pain exists
  - Acceptance frees psychological/emotional resources
- **Turning the mind**
  - Continuously recommit to accepting reality...over and over again
  - Like mindfulness: if you are doing this correctly, you are failing the entire time

Everyday Acceptance Activities

- Examples:
  - Being stuck in traffic
  - Having a crabby significant other
  - Forgetting something at home
  - Having to wait for something
  - Making a mistake/dealing with someone else's mistake
  - Etc., etc., etc.

Emotion Regulation Module

Please review the Day Two Deck for Emotion Regulation Content

Opposite-to-Emotion Action

- Opposite action: remember that the goal is to create a different emotion
- Often a “gateway” skill similar to mindfulness
- See slide two deck re: action when you are depressed, kindness when you are angry, etc

PLEASED

- **P**hysical health
- **L**ist resources and barriers
- **E**at at least three healthy, balanced meals
- **A**void mood altering drugs
- **S**leep between 7 to 10 hours
- **E**xercise at least 30 minutes
- **D**aily

Not on the list, but: Develop a plan/track on diary card

Build Mastery

- Engage in activities of daily living
- Accomplish tasks that need to be done
- (OHIO): Only Handle It Once
- Engage in tasks that encourage self-efficacy (learning a language, instrument, etc)
- Give yourself credit, as you might be the only one that does!

Build Positive Experience

- Short term
  - Do pleasant things that are possible now
- Long term
  - Invest in relationships (as these need “food and water”)
  - Invest in your goals (and remember what they are)

Build Positive Experience

- Ideally should be planned/scheduled
- Must include mindfulness skills
- Address distractions, judgments, concerns, etc

Interpersonal Skills Module

Please review the Day Two Deck for Interpersonal Skills Content

Interpersonal Skills

- FAST
- GIVE
- DEAR MAN

FAST

- **F**air: be fair to self and to others, and remember that there are almost 8 billion people in the world
- **A**pologies: no unnecessary apologies or apologies for your beliefs, opinions, or for being you
- **S**tick to your values: know your values and what is nonnegotiable to you
- **T**ruthful: Avoid exaggerations, excuses, and lies (even the small ones)

GIVE

- **G**enuine: be authentic and real, and act from your true self
- **I**nterest: make eye contact, show interest, ask lots of questions
- **V**alidate: acknowledge and focus on the other person!
- **E**asy manner: use humor, smile, and be easygoing

VALIDATION

- **V**alue Others
- **A**sk Questions
- **L**isten and Reflect
- **I**dentify with Others
- **D**iscuss Emotions
- **A**ttend to Nonverbals
- **T**urn the Mind (are you noticing a theme here?)
- **E**ncourage Participation

Empathy Statement Basics

- When I imagine I am you…
- I feel X…
- Is that anything close to the truth?
- Remember: this is a guideline; not a script that needs rigid adherence
- Avoid saying “I understand”

DEAR MAN Assumptions

- No one know what you want or need
- You can’t read minds (and neither can others)
- Use words, not just behaviors
- Be clear on your goals (and remember what your goals actually are)
- Consider timing
- Assertiveness is not a guarantee

DEAR MAN

DEAR is the sequence; MAN is the overarching rules

- **D**escribe
- **E**xpress
- **A**ssert
- **R**einforce

- **M**indful
- **A**ppear confident
- **N**egotiate
  - Be willing to offer an alternative!

Should I Say No/Ask For Something in This Moment? (Pederson)

1. Capability:

- Asking: Is person able to?
- Saying No: Do I have what they want?

2. Priorities: Objectives, Relationship, Self-Respect:

- Is the objective in the moment more important than the relationship?

3. Respect:

- Asking: How does this relate to my goals (therapy or otherwise)?
- Saying No: Will this make me feel bad in the moment?

Should I Say No/Ask For Something in This Moment? (cont)

4. Rights:
   - Asking: Is the person required – by law or otherwise – to give me what I want?
   - Saying No: Am I required – by law or otherwise – to give the person what they want?

5. Authority:
   - Asking: Am I responsible for telling this person what to do?
   - Saying No: Is the what the person is asking for within their authority?

Should I Say No/Ask For Something in This Moment? (cont)

6. Relationship:
   - Asking: Is what I want appropriate to the relationship currently?
   - Saying No: Is what the person asking for appropriate to our relationship currently?
7. Long Versus-Short Term:
   - Asking: Will just backing down make things better right now, but create problems in the long run?
   - Saying No: Is giving in now more important than the long-term welfare of the relationship?
8. Give and Take:
   - Asking: What I have done for this person? Do they owe me a favor?
   - Saying No: What has this person done for me? Do I owe the person a favor?

Should I Say No/Ask For Something in This Moment? (cont)

9. Homework:
   - Asking: Have I clearly outlined what I am asking for? What happens next?
   - Saying No: Is the other person's request clear?
10. Timeliness:
   - Asking: Is this a good time to ask?
   - Saying No: Is this a bad time to say no?

Supplemental Skills

- Many DBT trainers add additional skills and/or modules
- TIP
- ABC's
- Dialectics
- Cognitive Modification
- Problem solving
- Building Structure and Routines
- Healthy Social Media Use
- Teach the skills your clients need!

Supplemental Skills Examples

- Urge-surfing
- Bridge-burning
- Healthy Use of Social Media

Interventions Unique to DBT

Diary Cards

- Self-monitoring of urges, target behaviors, symptoms, skills, emotions, and other relevant information
- Helps to structure session and generalize what is learned in therapy to “the real world”
- Provides information to track how the client is progressing

Diary Card Guidelines

- Orient clients to why the diary card is important and how it will help them reach their goals
- Complete each day, preferably at the same time, for the previous 24 hours
- Review diary cards at the beginning of sessions and use the information to set the agenda with clients
- Address incomplete diary cards as a Therapy Interfering Behavior
  - Decide in advance if you will use this protocol or not
- Remember: Mood monitoring apps are also an option

Diary Card Review

Review of Diary Card Content

Behavior and Solution Analysis

- Develop a picture of what comes before a behavior (antecedents)
- Develop a picture of what comes after a behavior (consequences)
- Understand the context that surrounds behaviors
- Should be used any time there is a TIB or recent SDV/Suicidal behaviors
- Used as a method for adding structure to sessions
- Some clients experience change analysis as punishment – as such, be sure to always validate the experience. Remind them this is a learning tool to help reach their goals

Behavior and Solution Analysis Process (cont.)

- Continue to orient as you go through the change analysis
- Validate the emotions that arise
- Use positive reinforcement for demonstrated efforts and behaviors
  - There are limitations to the positive process – namely difficulty in “explaining how I quit smoking”

Steps in Behavior and Solution Analysis

1. Clearly define the target behavior
2. Ask about frequency, intensity, and duration of the behavior
3. Go step-by-step and outline:
    a. What were the vulnerabilities?
    b. Triggers?
    c. What were the Subjective Units of Distress Scores? (SUDS)
    d. What were the consequences of the target behavior?

Reminder About Standard Subjective Units of Distress (SUDS)

- 0 = State of Complete Calm
- 10-30 – A Little Discomfort
- 40-60 – Moderate Discomfort
- 70-90 – Extreme Anxiety
- 90-100 – Worst Fear Ever Experienced

Steps in Behavior and Solution Analysis (cont.)

4. Go back and have client hypothesize possible skills
5. Have client problem-solve
6. Have client develop a plan to make amends if appropriate (be careful, though)
7. Get commitment!

Commitment Strategies

- Evaluate pros and cons of therapy
- Play the devil's advocate
- Foot in the door/door in the face
- Connect to prior commitments
- Highlight the freedom to choose (but again – be careful about delivery)
- Coach and cheerlead regularly

Commitment Strategies (cont.)

- Initial commitment needs to move to agreement on:
  - Treatment plan, goals, and objectives
  - Treatment method
  - All relevant expectations and agreements
- Commitment in therapy is continually revisited – Linehan emphasized this as an important part of the process

Behavioral Contingencies

- The consequences of behavior influence what we learn
- Structure is key in this approach to therapy
- Highlighting contingencies helps clients learn and be more effective

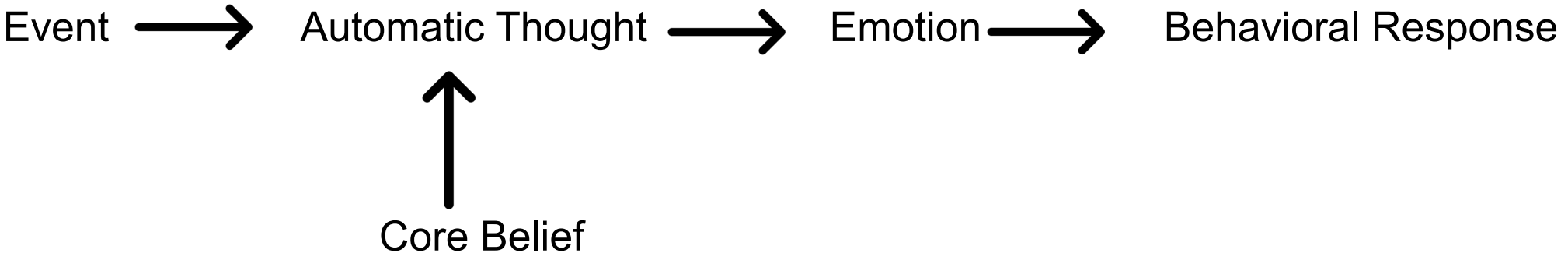
Behavioral Contingencies (cont.)

- Observing limits (boundaries)
- Program rules and expectations with consequences
- Everything the therapist does in session to keep the client focused on goals
- Every observable therapist (or team) response is an informal contingent procedure

Cognitive Interventions

- Have traditionally been de-emphasized in DBT
- Assume that clients are not fragile (“Fragilizing”)
- Clients do benefit from cognitive interventions, but the framing should be different
- DBT-style cognitive interventions take a softer” more validating approach
- As a rule, avoid cognitive interventions with emotionally-activated clients

Schema and Interventions (CBT, but you have to start somewhere)



Cognitive Interventions in DBT

- Guided by different theory – the goal is less about changing thoughts and more about changing behaviors
- Avoids judgmental labels – don't say "maladaptive thoughts"
- Remember to challenge utility of thoughts rather than the belief

Working with Trauma in DBT

- Develop self-care
- Build grounding skills
- Fill the distress tolerance “toolkit”
- Client must be stable before doing exposure-based treatment!
- EMDR is compatible with DBT protocols
  - However, mechanism of change may be ore exposure-based
- Provide/obtain clear informed consent

When Not to Use Exposure

- When there are active suicidal (or homicidal) urges
- When there is regular self-directed violence (timeframes are unclear)
- When there is active or recent psychosis
- When there is significant risk of harm *from* others
- When there is insufficient memory of the trauma (example: *We Believe the Children*)
- When there are more important clinical issues

Alternatives to Exposure

- Mindfulness
- Distress tolerance and emotion regulation skills
- Resolution of current life problems
- Cognitive interventions related to trauma thoughts and beliefs
- Remember that research shows that non-exposure based treatment models are equally effective (e.g., Benish, S., Imel, Z.E., & Wampold, B.E., 2007).

Self-involving disclosure

- The pitfalls of “corrective recapitulation”
- Avoid anecdotes
- Avoid stories
- Remember: just because it meant something to you is no guarantee they will feel the same way
- With anything: Does it pass the “public” test?

Irreverent Communication

- Irreverence is an offbeat style intended to:
  - Get the client's attention
  - Create a shift with emotions, thoughts, or behaviors
- Irreverence works best if it is your natural style
- Irreverence is not necessary to be an effective DBT therapist
- Avoid the "archetype of the therapist"

Irreverent Communication (cont.)

- Assumes that the client is not fragile
- Needs to be surrounded by validation
- Know your goal!
- Do not use when frustrated or at the expense of the client!

Irreverent Communication (cont.)

- Responding to or reframing a client's communication in an unexpected way
- Picking up on a subtle or unspoken aspect of the communication
- Taking a direct route: PG-13
- Being confrontational (again, PG-13)

Phone (and Other) Coaching

- Determine yours (or your program's) availability – this part is not for everyone
- Set clear contingencies about phone coaching:
  - Clients must observe agreed upon limits
  - Clients fill out a coaching informed consent form that you develop with your practice
  - Call are intended to be brief (3 to 5 minutes) and:
- Are focused on problem-solving with skills
- Are not "therapy" focused or "venting" calls
- Consider scheduling coaching calls proactively, especially when client is working skills
- Do not underestimate how effective message check-ins are for some clients!!!

Consultation

Consultation Groups

- Enhance therapist skill and motivation
- Improve effective therapeutic responses
- Always consult on any challenging behavior, but make sure you have a consultation group to meet with

Consultation Groups (cont.)

- Ensure integrity to DBT program (even though we have some creative liberty here)
- Provide checks and balances: It's easy to go "rogue"
- Provide support for the therapist: Increase motivation and skill (Linehhan has indicated her increased commitment to this in recent years)

Consultation Groups (cont.)

- In standard DBT, the DBT team consists of:
  - the individual therapist
  - the skills trainers
  - anyone else who is providing services to the client under the “umbrella” of the program
- DBT consultation group is its own stand-alone meeting separate from required groups within the agency or practice

Consultation Groups (cont.)

- Members need to
  - attend, be prepared, and be active
  - practice humility and reciprocal vulnerability
  - Practice skills
  - Be open to change analysis
  - Use and receive both validation and feedback from other members

Consultation Groups (cont.)

- Decide frequency of consultation meetings (weekly for 1.5 hours is the DBT standard)
- Structure meetings based on needs
- Agree on expectations of consultation meetings
- Build a consultative “milieu:
  - Use consultation in an open, ongoing manner
  - Keep everyone informed and involved
  - Seek diversity in consultative feedback (i.e., go to the person that will tell you want you need to hear, not what you want to hear)
- Devote time to mindfulness: the standard is 3-5 minutes at the beginning and end of each meeting

Consultation Groups (cont.)

- Define the client/therapist concern
- Discuss if policy addresses this concern
- Discuss dialectics and behavior chain analysis
- Make a plan moving forward that honors the needs and concerns of all involved (but particularly the client)

Consultation Groups (cont.)

- Do my consultants need to be DBT trained?
  - Yes
- How many consultants do I need?
  - Tree minimum, but (ideally) eight maximum
- Where do I find consultants?
  - Options and concerns about virtual supervision

Consultation Groups (cont.)

Common Concerns:

- Is there a solid therapy alliance?
- Are the agreed upon goals clear? Is there commitment?
- Does the client believe in the approach? Is there “buy-in?”
- Is the client’s biology or external environmental factors interfering with therapy? Is medication a consideration?

Suicide and Self-Directed Violence

Supportive Evidence

- D’Anci et al., 2019 – DBT is at the top of the list regarding treatments that reduce SI
- DeCou et al., 2019 – same as above

Not so Supportive Evidence

- **Rizvi & Fitzpatrick, 2020 – DBT's impact on NSSI/SDV is less clear**

Self-Directed Violence (SDV) and Suicidal Ideation (SI)

- These presenting problems are common to BPD
- Keep assessment separate from therapy – no moving on without a commitment
- SDV is often either a means to manage emotions or a way to obtain social support (avoid the term “manipulation”)
- SI is when life is overwhelming and there is no means of “escape” and/or hope of change

Setting Safety Contingencies

- Orient clients to your safety procedures: if x, then y. Make it clear in your informed consent!
- Use consistent follow-through
- Take all suicidal comments seriously
- Safety is a “yes” or “no” with clear safety plan
  - If clients cannot commit to safety by the end of the session, the outcome must be clearly explained well in advance
- Clients hospitalized will be sent ONLY by ambulance or police (but discuss this with your practice as needed).
- Assessments and safety planning happen in the time allotted and stop at the end of the session

SDV Chain Analysis Considerations

- What did they do?
- Where did they do it?
- How severe is it?
- Is medical intervention necessary?
- When did it happen?
- What were they hoping to accomplish?
- What was happening that led to all of this (vulnerabilities, SUDs, chain of events…)
- Does the individual still have the means to do this again?
- Can the individual meet safety planning commitment, or is a higher level of care indicated?

SDV Chain Analysis Considerations (cont.)

- Do I look at the SIB? How do I determine if medical treatment is needed?
- What if the client is unwilling to provide details?
- Does the client have the right to not follow medical routines?
- Do I confiscate or hold “tools” for clients? What about medication?
- When does SDV need to be treated like SI?

Suicide Assessment

- History of suicidal attempts is one of the most important indicators of future completed suicide
- Hopelessness (BHS)
- Remember to use the “four standards” – ideation, plan, means intent
- The fifth question: future orientation

Suicide Assessment (cont.)

- Age, gender, race, and other factors in the U.S.:
  - Caucasian – highest incidence overall when compared with other groups
  - Cis Males – highest prevalence when compared with cis-females
  - Transgender – highest prevalence when compared with cis-males and females

Essentials of Safety Assessment

- All clients need to be assessed for suicide, self-injury, and homicide
- Clear planning needs to be established for at-risk clients
- Follow-through needs to happen according to the plan
- Consultation is important!!!
- Clear documentation is critical:

If you didn't write it down, it didn't happen

Safety Plan

- Have at least three potential social supports identified
- Have at least three coping skills identified
- Have at least one crisis resource identified
- Have at least one hospital identified

Case Example

You are the director of residence life, and one of the RAs has expressed concerns about a student. Emily, a 19-year-old sophomore, is distraught and crying, stating that she broke up with her boyfriend this morning and “just can’t take it anymore.” She says that she has been thinking about what life would be like if she simply didn’t exist, and has been fantasizing about “jumping off a bridge,” but states that she has no intention of following through with this.

What do you do? What information do you need to gather here? Is there enough concern here to consider recommending hospitalization? If not, what will you do to ensure her safety?

Safety Plan Documentation Example

D: Emily has indicated an increase in depression and suicidal ideation, but denies present intent, plan, or means when questioned directly. Emily commits to keep herself safe until her follow up appt scheduled for (date). She reports her family, her career, and her dog at home are all reasons for living. She reports an orientation to the future in that she is planning for summer vacation.

We discussed a basic safety plan which Emily has agreed to adhere to. She agreed to first reach out to her friend Kristen (phone number was verified), her boyfriend, and her mother if Kristen is unavailable. We again reviewed the TIP skills (breathing, exercise, and temperature exercise), as she indicated that these have been useful in the past. She has agreed to call the crisis hotline (number verified) or visit CAPS if her condition worsens or she believes she will have difficulty maintaining safety.

A: Emily appears genuine in her denial of current SI and in her commitment to the safety plan (reach out to the aforementioned, make use of TIP skills, call crisis number or visit CAPS if her condition worsens). As previously stated, she reports an orientation to the future in that she is planning for summer vacation.

P: Emily and I will follow up in 2 days for another individual counseling session. She has agreed to the safety plan as outlined above.

Hospitalizations

- Use when no clear safety commitment
- Reinforce “skillful hospital use”
- Remember that these treatment options may be best suited for individuals that meet the criteria for BPD

When to Refer

- When safety issues are not adequately addressed in current level of care
- Potentially when there are concerns about progress such that the client is no linger benefitting from treatment
- Remember: Codes of ethics differ from profession to profession

Screening Tools and Additional Support

The ASQ

NIMH TOOLKIT

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

SAMHSA Guidelines

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

Columbia Suicide Severity Rating Scale

	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		High Risk

Is Path Warm?

I Ideation - Active or passive ideas (content) Substances on board?
S Substances – Use of any kind?

P Purposeless - Psychic pain – reasons for living/dying
A Anxiety - Anxiety/agitation
T Trapped - ineffective coping
H Hopelessness - important, as this is a research-based indicator

W Withdrawn – alienation/isolation
A Agitation – anger, self-loathing, acting out
R Recklessness – impulsivity and poor judgment
M Mood – Lability, shifts

The 988 Line

- 24/7 Call and text
- Staff are paraprofessionals
- Referral to hospital is a possible outcome