Practice-Based DBT Intensive Extras

These handouts (with the exception of the APA Resolution) are taken from The Expanded Dialectical Behavior Therapy Skills Training Manual (Pederson, 2012) and Dialectical Behavior Therapy Skills Training in Integrated Dual Disorder Treatment Settings (Pederson, in press). Intensive participants (and those who purchase the manuals) are permitted to make copies for clinical use with clients. Adapting and customizing these handouts to clients is encouraged.

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Commitment Agreement Form

The following information has been explained to me, with an opportunity to ask questions for clarification:

- My diagnosis
- My expected course of treatment
- My individualized treatment plan with initial goals
- The program and/or individual rules and expectations
- The program and/or individual attendance policy
- The cost and my financial responsibility (e.g., copays, deductibles, payment agreements)
- Other important information

I agree to make a good faith investment in the program and/or individual therapy with my willing participation for a period of _____ or _____ sessions. As a part of this commitment, I agree to follow the program and/or individual rules, expectations, and attendance policy. At the conclusion of this commitment period, my therapist(s) and I will evaluate the course of treatment and decide among the following options:

- Continue the program and/or individual therapy with a new commitment agreement
- Make an appropriate referral
- Other arrangements

Signed by client: _____ Date: _____

Signed by therapist: _____ Date:_____

Original to client; copy to chart

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DBT Individual Expectations

- Clients must attend all scheduled sessions. Cancelled or missed sessions will be treated as therapy-interfering behavior (TIB) unless negotiated up front and cleared by the therapist.
- Clients in the DBT program who miss sessions will be accountable to the attendance policy of the program (i.e., 90% attendance of all DBT sessions).
- Clients not in the DBT program will be accountable for attending 90% (9 out of 10) of all scheduled individual sessions. Two no-shows (not coming to session and not calling ahead to cancel) to individual therapy will result in discharge.
- Clients are expected to be on time for sessions.
- Clients are expected to complete homework and change analysis as assigned.
- Clients are expected to participate in safety assessments and safety planning. Being unable to commit to safety or being unwilling to engage in safety commitments and planning will result in hospitalization.
- Clients are expected to honor payment agreements for copays, deductibles, and uncovered services.
- Clients are expected to follow other rules and policies.

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DBT Program Expectations

- Members are expected to attend all scheduled sessions. All absences must be planned with therapists prior to the absence by phone or in person. Documentation of absences may be requested. Three consecutive absences without approval will be grounds for discharge.
- Members are accountable to the attendance policies and may be discharged for violation of these policies.
- Members are to maintain confidentiality. Group issues are not to be discussed outside of group or during break. Breaking confidentiality may be grounds for discharge.
- Members are expected to participate in skills teaching, to complete assignments, to present Diary Cards, and to give validation, support, and suggestions to peers.
- Members are expected to take time to problem solve and practice skills whenever significant distress is reported.
- Members are expected to complete homework and change analyses as assigned.
- Members are not to engage in SI/SIB/TIB behaviors when on premises. These behaviors on premises will be grounds for immediate discharge.
- Members are not to come to group under the influence of drugs or alcohol.
- Members' feedback and behavior is expected to be respectful at all times. Anyone giving disrespectful feedback or engaging in disrespectful behavior may be asked to leave.
- Members are encouraged to form friendships with others in group. However, members are expected to be clear about their personal boundaries and be respectful of others' personal boundaries.
- Romantic or intimate relationships are not allowed between group members.
- Friendships with others in group may not be private and must remain skillful.
- Members are not allowed to use alcohol, drugs, or engage in unskillful behaviors together.
- Members are not allowed to keep secrets regarding other group members' harmful behaviors.

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- Members are encouraged to use other members for support outside of group. However, members are not obligated to be available to others outside of group. Again, members are expected to be clear about their boundaries and respectful of others' boundaries.
- Members may not call other members after they have been engaged in SI/SIB/TIB.
- Members are expected to attend all scheduled professional appointments and comply with prescribed medications.
- Members are expected to honor payment agreements for copays, deductibles, and uncovered services.
- Violation of group rules may result in consequences including homework, behavior change analysis, suspension, and/or discharge.

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DBT Program Attendance Policy

Consistent attendance of your DBT program is essential for it to be effective for you and other program members. Attendance, timeliness, and consistency are also important life skills.

It is expected that program members attend appointments at or above 90% of all scheduled sessions (individual and group). Please schedule other appointments around your DBT program.

If you fall below 90% attendance, you will be put on an attendance contract, and your treatment team will be contacted. The contract is for 10 sessions; you must attend 9 out of 10 of these sessions to complete and go off of the attendance contract. If you miss more than 1 of these 10 sessions, you will be put on a discharge contract, and your team will be contacted again.

The discharge contract is also for 10 sessions. Like the attendance contract, you must attend 9 out of 10 of these sessions to complete and go off of the discharge contract. If you miss more than 1 of these 10 sessions, you will be discharged from the program and **cannot reapply for 3 months**.

Excused absences are at the discretion of your therapist(s) and may or may not be negotiable. Documentation may be required.

You are responsible for keeping your therapist(s) informed if you have to miss a session. Always call before the session if you will be absent. An absence without a call before the session will most likely not be excused.

Three consecutive no-shows (not coming and not calling ahead to cancel) to the program may result in discharge.

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A leave of absence (LOA) may be granted in some cases at the discretion of the therapist(s) and/or the treatment team. LOAs must be planned with a clear time limit. It is your responsibility to keep your therapist(s) and team informed during an LOA. Documentation of an LOA may be required.

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Diary Card Expectations

Diary Cards help us to track both symptoms and skills. Over time, we gain greater awareness and can see the progress that comes with skill use. Diary Cards also help to identify treatment targets. Please follow these expectations when completing your Diary Card:

- Everyone fills out a Diary Card daily. Diary Cards are filled out mindfully before sessions.
- Incomplete or last-minute attempts to fill out a Diary Card will be treated as Therapy-Interfering Behavior (TIB).
- You will report honestly on your Diary Card. If there is a question of your honesty and the therapist cannot accurately assess you for safety, further assessment will happen at the hospital.
- Anytime you indicate a "yes" for Suicidal Ideation (SI), Self-Injurious Behavior (SIB), or TIB, you will take time to address any or all of those issues before any other problems. Safety planning, if applicable, will be done in the time allotted, or further assessment will happen at the hospital.
- If there is not a clear commitment to safety with a willingness to use your safety plan, you will be hospitalized.
- Anytime you have indicated a "yes" for SI, SIB, or TIB, you will be assigned a Change Analysis to do before the following session. If a clear effort has been put into its completion, you can ask your therapist or the group to assist you further. If a clear effort has not been put into its completion or if it is incomplete, you will be asked to complete it during break and may be assigned an additional Change Analysis for TIB.

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Phone Coaching Expectations

Phone coaching is available to help you practice skills between sessions. Please follow these expectations:

- Phone coaching is for the generalization of skills.
- I cannot use phone coaching for 24 hours after I have engaged in SIB or TIB. I am expected to call *before* acting on urges.
- A phone coaching worksheet must be completed before the call.
- Phone coaching will focus on skills and not be therapy oriented.
- Phone coaching will be limited to 3 to 5 minutes.
- Not respecting the limits of phone coaching will be treated as TIB.
- Phone coaching availability and limits are established and negotiated up front by therapists and clients.

My therapist's availability, limits, and rules for phone coaching:

Signed by client: _____ Date: _____

Signed by therapist: _____ Date: _____

Original to client; copy to chart

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Safety Expectations

Safety will be assessed each session. Identify ALL safety concerns on your Diary Card. Clients with a history of safety issues will also be asked about safety and reinforced for effective safety behaviors.

Please refer to the following safety expectations:

- All clients will accurately report safety issues on the Diary Card.
- All clients with current or a history of safety issues will develop a Safety Plan. The Safety Plan will be practiced, updated, and reviewed regularly.
- Clients will willingly participate in safety assessments in the time allotted. Clients unwilling to cooperate will be hospitalized.
- All safety assessments and safety planning must be completed in the allotted time and by the end of the session. Clients without a safety commitment by the end of the session will be hospitalized.
- All clients with safety issues will be asked to commit to safety. A safety commitment is a "yes" or "no" regarding willingness to use the Safety Plan. Clients without a clear commitment to safety who are suicidal will be hospitalized.
- Clients hospitalized will be sent ONLY by ambulance or police.
- Clients hospitalized will be sent with a Change Analysis to work on and a Safety Plan to update. These assignments will be completed during the hospital stay and/or before returning to the program/individual therapy.

Signed by client: _____ Date: _____

Original to client; copy to chart

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Diary Card Instructions

Core concept: The Diary Card develops awareness and accountability to help you build a satisfying life.

Follow these directions:

- Fill out your Diary Card *every* day. Do it thoughtfully and bring it to all sessions.
- For the Medications (RX) section, write the number of medications you took over the number you were prescribed to take (e.g., if you took three pills and were prescribed three, you would write "3/3"). If you took all of your medications, you can write in "all" as an alternative.
- For the Depression (DEP), Anxiety (ANX), and Anger (ANG) sections, use a scale of 10 to 0 and rate the *range* of your feelings by noting the highest and lowest levels (e.g., 8–4 for ANX).
- For the Suicidal Ideation (SI), Self-Injurious Behavior (SIB), and Therapy-Interfering Behavior (TIB) sections, use a scale of 10 to 0 and rate the *range* of your urges by noting the highest and lowest levels. Additionally, use a Y (yes) or N (no) to note if you *acted* on SI, SIB, or TIB urges (e.g., 9–2/N for SIB urges).
- For the Sleep section, note the total number of hours of sleep. Make a slash mark (/) through the number if the sleep was not restful or was broken.
- For the Energy section, use a scale of 10 to 0 and rate the *range* of your energy level (e.g., 6–4).
- For the Build Mastery (BM), PLEASED (PL), and Attend to Relationships (A2R) sections use a Y (yes) or N (no). Use Y for *any* efforts to practice these skills.
- For the Other section, track any other symptom, behavior, or issue important to your treatment.
- List the skills you used to address each specific category on the Diary Card (e.g., for DEP, someone might list PL, O2E, and DM).
- On the back side of the Diary Card, write in your feelings, positive events, and things for which you are grateful each day.

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DIARY CARD

	RX	DEP	ANX	ANG	SI	SIB	TIB	Sleep	Energy	BM	PL	A2R	Other
MON													
Skills													
TUE													
Skills													
WED													
Skills													
THU													
Skills													
FRI													
Skills													
SAT													
Skills													
SUN													
Skills													

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FEELINGS	POSITIVE EVENTS	GRATEFULNESS

FEELINGS	POSITIVE EVENTS	GRATEFULNESS

FEELINGS	POSITIVE EVENTS	GRATEFULNESS

FEELINGS	POSITIVE EVENTS	GRATEFULNESS

FEELINGS	POSITIVE EVENTS	GRATEFULNESS

FEELINGS	POSITIVE EVENTS	GRATEFULNESS

FEELINGS	POSITIVE EVENTS	GRATEFULNESS

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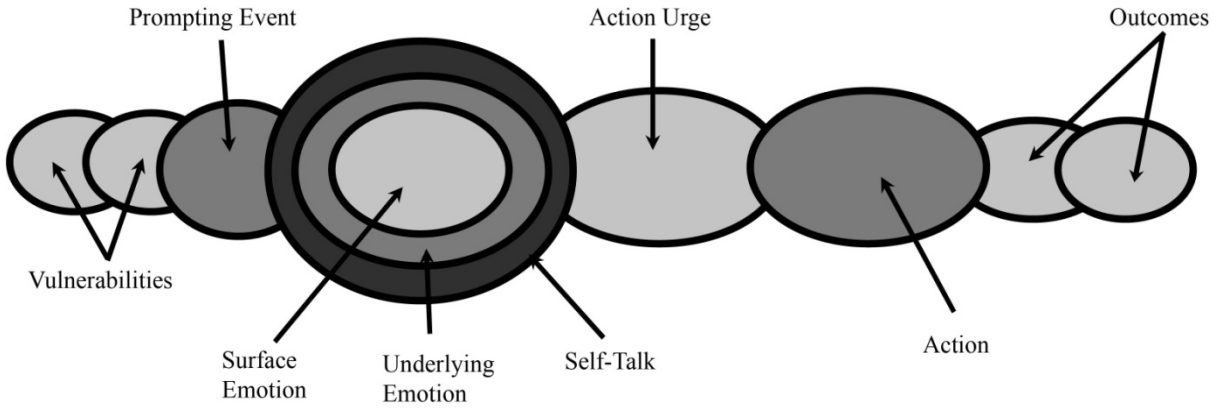
Visual Behavior Change Analysis Directions



DIRECTIONS: The more you understand about behaviors you want to change, the more you can be effective in the use of your skills to meet that goal! Start anywhere on the change (chain) analysis and work forward and/or backward to figure out each link, then identify other skills or choices you could make with your new awareness. Remember to be NONJUDGMENTAL with yourself, the situation, and others. The following explains each identified link, but remember that you can add as many links as you need to understand your process and that EVERY LINK PRESENTS AN OPPORTUNITY FOR CHANGE! Also, look for skills that you might have already been using but had not noticed or for which you need more practice. Chances are you have been using skills!

Vulnerabilities: What made you vulnerable to the prompting event (and what unfolded after it)? Examples might include not doing self-care, having a tough day, getting into a conflict, or other stressors. Be as specific as possible.

Prompting Event: What happened? Describe in nonjudgmental, descriptive words.

Surface Emotion: What feeling(s) occurred after the prompting event that was/were most easily noticed?

Underlying Emotion: Was there a feeling or feelings further below the surface? Examples might include feeling hurt or embarrassed under anger or feeling guilty under depression.

Self-Talk: What automatic thoughts or beliefs were happening that fed your emotions and the following action urge?

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Action Urge: What did the feelings pull you to do? This link is a critical moment of choice in changing a behavior.

Action: This is the behavior you might want to change. However, remember that using skills at earlier links might effectively change your action/behavior.

Outcomes: What happened after the behavior you want to change? What did you gain and/or lose, in both the short term and the long term? Did the outcomes cause a new vulnerability or stressor and/or cycle back to the beginning again?

SOLUTIONS: At each step, brainstorm skills or choices that could create behavior change and more effective outcomes.

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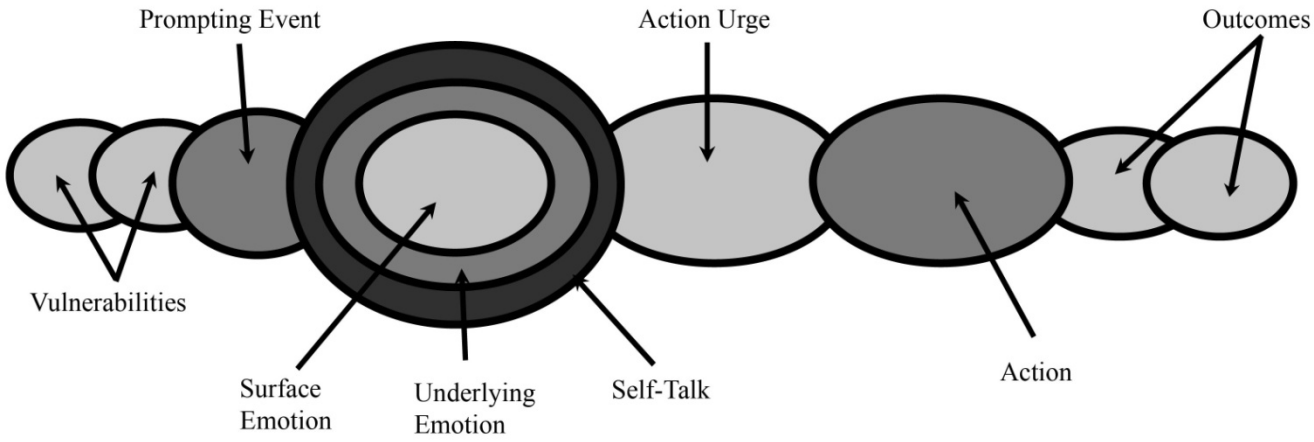
Visual Behavior Change Analysis Form



Describe your vulnerabilities:

Describe the prompting event (what set off the action?):

Describe your emotion on the surface (the one mostly easily noticed):

Describe any underlying emotions (the ones hidden underneath):

Describe your self-talk:

Describe the action urge:

Describe the action:

Describe the outcomes:

NOW GO BACK AND FILL IN SKILLS TO USE NEXT TIME AT EACH STEP

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Safety Contract and Plan

I, _____, contract for my safety. This means that I will not act on my plan to commit suicide. I will use the skills listed below to assist with my safety and call the people in my support system as needed. I will call 911 or admit myself into the hospital if unsafe and BEFORE acting on urges.

DBT skills I will use to maintain my safety:

1.

2.

3.

4.

5.

6.

7.

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Team members/other people in my support system/crisis numbers I can call for help BEFORE ACTING ON URGES:

1.	Phone number:
2.	Phone number:
3.	Phone number:
4. Crisis Resource(s):	Phone number(s):
5. Emergency	911

Signed by client: _____ Date: _____

Signed by therapist: _____ Date: _____

Original to client; copy to chart

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Crisis Safety Plan

Name:

Crisis Behavior:

Warning Signs and Triggers:

Specific Plan to Maintain Safety until Next Session (list specific skills/behaviors under each section):

Mindfulness Skills:

Interpersonal Skills:

Emotion Regulation Skills:

Distress Tolerance Skills:

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Skills from Other Modules:

Diagnoses and Symptoms:

Medications:

1. Dosage
2. Dosage
3. Dosage
4. Dosage
5. Dosage
6. Dosage

Medical Alerts (Allergies, etc.):

Contacts (People to Call for Support):

Therapist:	Phone number:
Psychiatrist:	Phone number:
Case Manager:	Phone number:
Family:	Phone number:
Friends:	Phone number:

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Other: Phone number:

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Distress Tolerance Crisis and Safety Plan

Core concept: Develop a plan to manage crisis and safety issues.

Begin to fill out this plan and continue to add to it as you learn more skills. Treat this plan as a "living" document: It needs to be continuously reviewed, practiced, and updated.

Make several copies and always know where to find your plan. It is hard to know what to do when you are in the heat of the moment. That is why you have a written plan.

Give copies to the people in your support system and discuss your use of the plan proactively. Again, practice, practice, practice—practice makes you prepared to be effective in life.

My Reasons for Managing Crisis Effectively and/or Staying Safe: List all of your priorities, goals, values, and people that matter to you. These are your "whys:"

My Strengths and Resources: List what you have going for you. Ask for help if you are unsure:

Warning Signs: These are the signals that you may be in crisis or unsafe or about to be in crisis or unsafe. Be as specific as possible. Look to your history for clues:

Feelings: Ask yourself what you are/were feeling before or during this time:

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Thoughts: Ask yourself what you are/were thinking before or during this time:

Behaviors: Ask yourself what you are/were doing and/or not doing before or during this time:

Sensations: Ask yourself what you are/were experiencing physically or in your body before or during this time:

Environment: Ask yourself what your environment is/was like and/or what is/was happening in your environment before or during this time:

Key Triggers: Ask yourself what sets off a crisis and/or being unsafe for you:

Barriers to Skill Use: List what will get in the way of using your skills and this plan *and* list the skills you will use to address each barrier:

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Burn the Bridges: Write how you will remove the means to act on urges and be specific:

Self-Care Skills to Use: List all of the ways you can care for yourself during this time:

Distress Tolerance Skills to Use: List specific behaviors:

My Personal Support System: List names and numbers of people/resources you can call, when they are accessible, and the specific interpersonal and other skills you will need to use these supports:

My Professional Support System: List names and numbers of people/resources you can call, when they are accessible, and the specific interpersonal and other skills you will need to use these supports:

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My Medications and Dosages:

My Hospital of Choice:

My Commitment: I commit to practicing my plan proactively and during times of crisis. I further commit to be safe and call 911 or go to the hospital BEFORE acting on suicidal urges.

Signed by Client: _____ Date: _____

Original to client; copy to chart

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Suicide and Self-injurious Behavior Prevention Plan

Complete this plan as a primary goal of treatment to build awareness about your suicidal and/or self-injurious patterns and to develop alternatives to these behaviors. As you learn more skills, revise the plan, and remember to review it daily and to practice it.

List the reasons why you want to work on eliminating suicidal and self-injurious behaviors:

List the short- and long-term consequences that often follow suicidal and/or self-injurious behaviors and/or how these behaviors interfere with your goals and life:

List your strengths and resources to avoid suicidal and self-injurious behaviors including skills and behaviors that have helped in the past:

List what makes you vulnerable to suicidal and/or self-injurious behaviors (e.g., consider feelings, thoughts, behaviors, what is or is not happening in relationships and your environment, self-care issues, etc.):

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List the skills and behaviors you can use to decrease your vulnerability to suicidal and/or self-injurious behaviors :

List the warning signs that often lead to suicidal and/or self-injurious behaviors (i.e., indications that you are in the danger zone):

List the skills and behaviors you can use to effectively response to your warning signs:

List primary triggers that immediately precede and "set off" suicidal and/or self-injurious behaviors(e.g., consider feelings, thoughts, behaviors, what is or is not happening in relationships and your environment, self-care issues, etc.):

List the skills and behaviors you can use to effectively remove and/or respond to your primary triggers and urges:

List ways you can burn the bridge between your urges and reacting with suicidal and/or self-injurious behaviors:

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List the self-care skills and behaviors that decrease your overall vulnerability and that important to use *at all times*:

List the skills and behaviors to replace suicidal and/or self-injurious behaviors and to tolerate distress and/or crisis:

List the people in your personal support system, their contact information, and their availability:

List the people in your professional support system, their contact information, and their availability:

If you are unable to maintain your safety with suicidal behaviors, call 911 or go to the hospital for assistance.

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Mental Health Symptoms Response Plan

Complete this plan as a primary goal of treatment to build awareness about your symptom patterns and to develop effective ways of managing them. As you learn more skills, revise the plan, and remember to review it daily and to practice it.

List the reasons why you want to work on decreasing and managing your symptoms of mental illness:

List your diagnosis and the symptoms you experience:

List the short- and long-term consequences of when your symptoms are not actively managed and how your symptoms interfere with your goals and life:

List your strengths and resources to decrease and manage your symptoms including skills and behaviors that have helped in the past:

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List the vulnerabilities that might lead to a worsening of your symptoms (e.g., consider feelings, thoughts, behaviors, what is or is not happening in relationships and your environment, self-care issues, etc.):

List the warning signs that your symptoms might worsen:

List the skills and behaviors you can use to effectively respond to your warning signs:

List primary triggers that immediately precede and "set off" an increase in symptoms (e.g., consider feelings, thoughts, behaviors, what is or is not happening in relationships and your environment, self-care issues, etc.):

List the skills and behaviors you can use to effectively remove and/or respond to your primary triggers and urges:

List the self-care skills and behaviors that decrease your overall vulnerability and that important to use *at all times*:

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List the skills and behaviors to decrease and manage your symptoms and tolerate distress and/or crisis:

List the people in your personal support system, their contact information, and their availability:

List the people in your professional support system, their contact information, and their availability:

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Safety Contract

I, _____, contract for my safety. This means I will not act on any plan to commit suicide. I will use my skills to assist with my safety, call my team members, crisis resources, and/or people in my support system BEFORE ACTING ON URGES. I will call 911 and/or admit myself into the hospital if needed.

As a part of my safety contract, I will also attend all scheduled appointments and my DBT program.

Not attending group or other appointments as planned will be considered a violation of my willingness to commit to safety and will be treated as Therapy- Interfering Behavior (TIB).

Signed by client: _____ Date: _____

Signed by therapist: _____ Date: _____

Original to client; copy to chart

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Phone Coaching Worksheet

Please complete this worksheet prior to calling for coaching.

Describe the problem or difficulty:

Describe the skills you have already used:

Describe what specific skills you need help with:

Describe what other skills or supports you can use if your therapist is not immediately available:

Specific Expectations:

- The call will focus on skills and last no more than 5 minutes.
- I will be willing to be coached and practice the specific skills.
- I will be respectful of my therapist's availability and limits.
- I understand that I will be hospitalized if I am unclear about safety issues.

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Behavior Contract

The following behaviors have become disruptive to your therapy, your group, or the clinic:

1.
2.
3.
4.

The purpose of this behavior contract is to help you change these difficult behaviors so you can reach your treatment goals.

These behaviors will result in homework and/or change analysis. If you engage in these behaviors, your therapist and/or group members will respectfully observe and describe their presence, and you will have an opportunity to redirect the behaviors and practice skills.

If you choose not to redirect the behavior or practice skills, you will be asked to leave for the day, and the session will be counted as an absence. The absence will count toward the attendance policy.

If you are asked to leave, you may be suspended pending a team meeting. The team meeting may involve further problem solving or a decision to discharge you with referrals.

As part of this contract, your therapist and/or group members agree to notice and reinforce your efforts, positive behaviors, and skill use.

Signed by client:_____ Date:_____

Signed by therapist:_____ Date:_____

Original to client; copy to client

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Mindfulness Practice and Application

Core concept: These exercises help us practice the skills that lead to Wise Mind.

Try these Mindfulness exercises and create your own. Mindfulness needs to be part of your daily routine. Enjoy!

Attention to Small Moments: Small moments in our lives include those that we do not typically notice or those we take for granted. It may be having a cup of coffee or a cool glass of water, spending a moment with a child or pet, or performing any "normal" activity that goes by without our attention. Enjoyment, peace, and serenity in life happen in the small moments. Each hour, orient yourself to the small moments that you might otherwise miss.

Focus on Senses: Take time to notice what comes through your five senses: what you see, hear, smell, taste, and/or touch. Your senses are your gateway to the world. (See SELF-SOOTHE)

Breathing: We all breathe, and we can all breathe more effectively. Our breath is our anchor and is an excellent way to center ourselves. Take time to breathe mindfully in and out. Stay focused on the sensation of the air coming into your air passages and lungs, holding it, and then letting it out. Use a mantra, such as "in" as you breathe in and "out" as you breathe out, or count each breath from 1 to 10, starting over when you reach 10 or if you lose count.

Another way to breath mindfully is to notice the beginning, middle, and end of each inhalation and exhalation (like how you can hear the beginning, middle, and end of sounds—another mindfulness exercise). Concentrate on the life of each breath going in and out.

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Quiet/Still Time: Set time aside each day to be quiet and to experience that quiet. Be one-mindful with the stillness, finding your center and noticing comfort in the moment.

Your Favorite Song (or Album): Listen to your favorite song or album with your full attention. Listen closely to the lyrics and their meaning. Be mindful of each word and phrase. Listen to the sounds of the different instruments. Pay attention to the guitar, bass, drums, vocals, or any other instrument that is central to the music. Notice the production values: Is the song basic or elaborate? Bare bones or highly orchestrated? Be mindful of things you have never noticed in music you have listened to many times.

Your Favorite Show: Watch your favorite TV show, paying attention to the small details. Notice what the actors are wearing, how the sets are designed and decorated, and other elaborate details that go into your show.

The Room You Know So Well: Observe and Describe details that you never noticed about your bedroom, living room, office, or any other place in which you have spent significant time.

10 Details: Anyplace, anywhere, pause and Observe and Describe 10 details you would not have otherwise noticed.

Turn Down the Noise (Or Embrace It): Turn off all extra sources of noise in your home. If you are not mindfully listening to the radio or TV, turn it off. Work on being present without the competition for your attention. If you are unable to turn down certain noises, practice being mindfully aware of them, noticing them without judgment.

People (Or Anything) Watching: Be a watcher of people, or of anything that might hold your interest. Remember not to judge what you see, but simply let it into and out of your experience like clouds floating through the sky.

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One Chore / One Task: Do one chore or one task, such as washing the dishes or folding laundry, with all of your attention and care. Be one-mindful with the experience without adding or subtracting.

"Holding" a Feeling: Hold your present feeling like it is a baby. Calming a distraught baby involves compassion and one-mindfulness. Babies can tell when we are either frustrated or do not want to be with them in the moment. Our feelings are like babies: They can tell when we either reject them or are not fully present with them. Holding your feeling and being mindful of it will usually cause it to diminish in intensity. If not, consider distraction skills.

Interconnection: Contemplate how you are connected to all of the items around you, to your surroundings, to all of the people in your life, and/or to the universe in general.

Relative Thinking: Contemplate the upsides and downsides of any judgment without sticking to any conclusions. See how "good" and "bad" depend on the circumstances and are not fixed.

5 / 60: Plan 5 minutes out of every hour to engage in a mindfulness activity. This may include breathing, doing a scan of your body for tension and then relaxing, or one-mindfully accomplishing any task.

Find Your Center: Before engaging in thoughts and behavior, spend a moment to breathe and find your center. Know that finding your center helps you to access your Wise Mind. Practice the directives of the mantra: pause, breath, center … enter.

Fly Away / Balloon Release: Write whatever you would like to let go of on a helium balloon with a permanent marker. Release the balloon into the sky and watch it with your full attention until it is completely out of your vision. Alternatively, write what you would like to let go of on paper and shred or

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burn it or place the paper under water and watch the ink wash away and disappear.

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Activities List

We need to have pleasant activities scheduled every day. Below is a list of pleasant activities, many of which are free. Add specific pleasant activities to the list that you enjoy. Make sure to schedule at least three pleasant activities each day. Also, remember to use Mindfulness skills with each experience.

1. Dress up or down
2. Play board games
3. Have a snack mindfully
4. Appreciate a favorite actor or act yourself
5. Read the Bible or other religious text
6. Advocate for the National Alliance on Mental Illness (NAMI), a political cause, or the environment
7. Stargaze, find constellations, or wonder about the universe
8. Read about animals or visit the zoo
9. Appreciate the arts or create your own
10. Play badminton
11. Redecorate or rearrange your house
12. Join a group
13. Have a conversation with a friend or a stranger
14. Watch or play baseball or softball
15. Make crafts
16. Watch, read about, or fly an airplane or build a model
17. Watch or play basketball or play HORSE
18. Bathe or shower mindfully
19. Relax at (or imagine being at) the beach; look for shells or clean the beach up
20. Do beadwork
21. Beatbox, rap, or sing
22. Ring a bell
23. Breathe mindfully
24. Write a short story
25. Bike
26. Feed or watch birds
27. Blog or visit blogs

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28. Boat
29. Bowl
30. Bet a small amount of money
31. Start a fantasy football league (or join one)
32. Play checkers
33. Help the disabled
34. Contribute at a food pantry
35. Bake a cake and decorate it
36. Go geocaching
37. Do calligraphy
38. Camp
39. Make candles or ice candles
40. Canoe
41. Have a picnic in your home
42. Read about cars or go for a drive
43. Do some cheerleading
44. Take a nap
45. Watch one television show mindfully
46. Window-shop (without spending)
47. Play chess
48. Go to church and associated activities
49. Watch clouds
50. Make a sand castle
51. Collect coins
52. Go to an antique shop to browse
53. Collect artwork
54. Collect albums or CDs or look at and listen to old ones
55. Compose music or lyrics
56. Look at architecture in magazines or around town
57. Enjoy perfume or cologne
58. Do computer activities
59. Cook
60. Crochet
61. Cross-stitch
62. Do a crossword puzzle
63. Dance anywhere
64. Play darts (not lawn darts)
65. Look at your collectibles
66. Bowl with friends or in a league
67. Daydream
68. Juggle
69. Play dominoes or set them up to let them fall
70. Draw
71. Eat out or fix a special meal at home

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72. Take a community education course or educate yourself on a new topic
73. Tinker with electronics
74. Do embroidery
75. Entertain others
76. Exercise: aerobics, weights, yoga
77. Go fishing
78. Watch or play football
79. Take a hot or cool shower
80. Tell jokes and laugh
81. Go four-wheeling
82. Paint a wall
83. Enjoy or maintain an aquarium
84. Play Frisbee® or disc golf
85. Mend clothes
86. Have a spirited debate (without needing to be right)
87. Join a club
88. Play games
89. Garden
90. Swim
91. Keep a dream journal
92. Hug a friend or family member
93. Visit garage sales
94. Be intimate with a loved one
95. Be a mentor
96. Build a bird house
97. Do genealogy
98. Walk your (or a neighbor's) dog
99. Visit an art museum
100. Go to the movies or watch a favorite DVD
101. Golf
102. Practice putting
103. Give yourself a facial
104. Paint a picture or finger-paint
105. Watch funny YouTube® videos (or post one)
106. Find an activity listed more than once on this list
107. Go go-kart racing
108. Play Texas Hold 'Em
109. Volunteer at the Humane Society
110. Write a letter to the editor
111. Light a candle and enjoy the smell or the flame
112. Play video games
113. Scrapbook
114. Become a pen pal
115. Support any cause

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116. Play guitar
117. Write a handwritten letter
118. Hike
119. Do home repair
120. Breath in fresh air
121. Build a home theater system
122. Record your favorite shows and watch back to back
123. Air drum or air guitar to a cool song
124. Ride a horse
125. Write a thank you letter
126. Hunt
127. Surf the Internet
128. Fix a bike
129. Make jewelry
130. Browse your favorite store
131. Put together a jigsaw puzzle
132. Build a fort with your kids
133. Journal
134. Juggle
135. Kayak
136. See life like a young child
137. Say a prayer
138. Build or fly kites
139. Knit
140. Tie knots
141. Sing a silly song
142. Pick flowers
143. Learn anything new
144. Learn a foreign language
145. Practice telling a joke
146. Learn an instrument
147. Listen to music
148. Macramé
149. Color with kids (or without)
150. Smile at someone
151. Be affectionate
152. Do a magic trick
153. Meditate
154. Use a metal detector
155. Teach a child something
156. Build models
157. Ride or look at motorcycles
158. Play with children
159. Go mountain biking
160. Work with a team
161. Plant an herb garden
162. Go to a community center
163. Grow a Chia® pet
164. Climb a mountain
165. Make a root beer float
166. Lie in the grass
167. Scrapbook
168. Practice a musical instrument
169. Needlepoint

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170. Read reviews on a topic of interest
171. Do origami
172. Play Trivial Pursuit® or any trivia game
173. Clean out a closet and donate unneeded items
174. Plan a movie marathon
175. Look at StumbleUpon.com
176. Join a chat room
177. Play paintball
178. Go to a water park
179. Pass on something thoughtful found on the Internet
180. Go to a video arcade
181. Indulge in a guilty pleasure
182. Email friends and family
183. Join a drum circle
184. Rollerblade
185. Swing at a playground
186. Go to the mall to walk or browse (without spending)
187. Water your plants
188. Make a collage
189. Hang with a friend
190. Listen to music and read the lyrics
191. Try a new recipe
192. Paint your nails
193. Sit by any body of water
194. Go to the library
195. Organize a neighborhood garden
196. Groom a pet
197. Watch a sunrise or sunset
198. Take a walk
199. Go the a health club or YMCA
200. Go to a coffee shop

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List the activities you like (or have liked) to do:

Circle at least 10 new activities from the list that you are willing to try.

Describe how your life will be different when you schedule and involve yourself in activities:

Activities Worksheet

Activities provide healthy distractions and create enjoyment. Getting active alleviates the symptoms of mental illness and provides alternatives to substance use. Use this worksheet to list activities you plan to do today. Notice how you feel before and after each activity.

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

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Distress Tolerance Worksheet

Many people develop a few distress tolerance skills and then quit actively exploring and practicing new skills. Just as carpenters, computer programmers, artists, mechanics, students, therapists, and other people work to acquire new tools and techniques, you need to continue to work on new Distress Tolerance skills to be effective in challenging situations. Use the checklist spaces below to list new Distress Tolerance skills to practice today or this week, and be sure to check them off after you have practiced them. Notice how you feel before and after each Distress Tolerance skill.

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

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Build Positive Experience Worksheet

Identify at least one BPE for each day this week, including the details of where and when you will participate in those experiences. Also record your distress and/or urge levels before and after the mindful participation in each BPE. Notice how BPE tends to be beneficial to improving emotions and managing urges. Check off the completion of your daily BPEs.

☐ **Monday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

☐ **Tuesday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

☐ **Wednesday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

☐ **Thursday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

☐ **Friday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

☐ **Saturday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

☐ **Sunday** BPE:_____Where and When:_____

Distress/urge level before:_____Distress/urge level after:_____

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PLEASED Worksheet

Improving our PLEASED skills significantly impacts how we feel and lowers our vulnerability to feeling negative and intense emotions. PLEASED skills also require daily attention and follow-through. Use the checklist spaces below to list your PLEASED behaviors for today, and be sure to check them off when they are completed. Notice how you feel before and after each PLEASED skill.

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

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Build Mastery Worksheet

Certain activities and behaviors help us feel competent and in control (and overwhelmed and out-of-control when we neglect them). Build Mastery behaviors may vary day-to-day or week-to-week. Use the checklist spaces below to list your Build Mastery behaviors for today or this week, and be sure to check them off when they are completed. Notice how you feel before and after each accomplishment.

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

☐ _____

Distress/urge level before:_____Distress/urge level after:_____

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Values Application

Core concept: Identify values to practice them with behaviors.

This is a partial list of values. You might have a value that is not on the list or notice some overlap between values. Review the list and circle your top 10 values. Use your selected values in the exercise that follows.

Acceptance	Comfort	Duty
Achievement	Commitment	Education
Activity	Compassion	Effectiveness
Adaptability	Confidence	Empathy
Adventurousness	Connection	Encouragement
Affectionateness	Consistency	Endurance
Altruism	Contentment	Energy
Ambition	Contribution	Enjoyment
Assertiveness	Cooperation	Enthusiasm
Attentiveness	Courage	Excellence
Availability	Courteousness	Exploration
Awareness	Creativity	Expressiveness
Balance	Credibility	Fairness
Belongingness	Decisiveness	Faith
Bravery	Dependability	Family
Calm	Determination	Fidelity
Capability	Devotion	Financial independence
Caring	Dignity	Firmness
Challenge	Discipline	Fitness
Charity	Discretion	Freedom
Cleanliness	Diversity	Friendship
Closeness	Drive	Fun

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Generosity
Giving
Grace
Gratitude
Happiness
Harmony
Health
Honesty
Honor
Hopefulness
Humility
Humor
Hygiene
Imagination
Independence
Integrity
Intelligence
Intensity
Intimacy
Joy
Kindness
Knowledge
Leadership
Learning
Love
Loyalty
Mindfulness
Modesty
Motivation
Neatness
Openness
Optimism
Order
Passion
Peace
Persistence
Playfulness
Pleasantness
Pleasure
Popularity
Practicality
Pragmatism
Privacy
Professionalism
Prosperity
Relaxation
Reliability
Religion
Resilience
Resoluteness
Respect
Restraint
Sacrifice
Security
Self-control
Self-reliance
Sensitivity
Service
Sharing
Simplicity
Sincerity
Spirituality
Spontaneity
Stability
Strength
Structure
Success
Support
Teamwork
Thankfulness
Thoughtfulness
Trust
Truth
Usefulness
Warmth
Willingness
Wisdom

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Once your values are identified, you can describe specific behaviors that you can practice to live your values with intention. The following are examples for how you can complete this exercise:

I value: TRUTH

Describe three specific ways you can live this value:

1. Fill out my Diary Card more accurately
2. Tell important others when I make a mistake
3. Stop hiding liquor bottles in the garage

I value: FRIENDSHIP

Describe three specific ways you can live this value:

1. Return phone calls from my friends
2. Respect Tammy's boundaries
3. Practice GIVE skills in group

I value: PEACE

Describe three specific ways you can live this value:

1. Not yell at my wife and kids when I am angry
2. Practice MINDFULNESS exercises in the morning and at bedtime
3. Use RADICAL ACCEPTANCE to stop beating myself up for mistakes

I value: GIVING

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Describe three specific ways you can live this value:

1. Give my group feedback on what they are doing well
2. Donate possessions that I have not used for a year
3. Be present in my relationships

Now it's your turn:

I value:

Describe three specific ways you can live this value:

1.
2.
3.

I value:

Describe three specific ways you can live this value:

1.
2.
3.

I value:

Describe three specific ways you can live this value:

1.
2.
3.

I value:

1.
2.
3.

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I value:

Describe three specific ways you can live this value:

1.
2.
3.

I value:

Describe three specific ways you can live this value:

1.
2.
3.

I value:

Describe three specific ways you can live this value:

1.
2.
3.

I value:

Describe three specific ways you can live this value:

1.
2.
3.

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Effective Thinking: Shifting and Expanding Interpretations of Events

Our emotions affect our thinking, and our thinking affects our emotions. An interpretation is simply an internal behavior that determines the meaning of an event, and we all know that meaning depends on perspective. To be most effective, it is important not to be stuck to an interpretation, but to be open to further evaluation and shifting and expanding interpretations. Dialectically speaking, no interpretation can be the absolute truth.

Note the following types of interpretations with suggestions on how to dialectically shift them.

Black and White Interpretations (Either/or; Dichotomous; or All-or-Nothing Thinking): Language that signals this interpretation includes *always*, *never*, *every*, and *all the time*, among others. Black and white interpretations rarely see the whole picture and feed emotion mind. These interpretations lead to rigidity and inflexibility, the opposite of a dialectical orientation.

Dialectical Shift: If your interpretations seem extreme, think of opposite thoughts or beliefs, and then identify middle-ground ways of thinking. You may not believe the opposite thoughts or beliefs, but the intention is to practice flexibility in your interpretations.

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Regret Orientation (Woulda, Coulda, Shoulda Thinking; or Hindsight Bias): A common idiom is "hindsight is 20/20." This means that past choices seem clear with the benefit of knowing all of the outcomes now. Regret orientation keeps you stuck in the past, rather than focusing on what you can do effectively right now.

Dialectical Shift: Rather than fixating on past mistakes, focus on what you can do to be effective in the present moment.

Mind-Reading: An interpretation that you already know how others are thinking or feeling leads you to feel or act in a certain manner. None of us can read other peoples' minds.

Dialectical Shift: When you catch yourself mind-reading, check out your assumptions with other people, especially the person whose mind you are trying to read. The only way to know is to ask.

Minimization: Minimization happens when something large or significant is reduced to something that is very small. Sometimes this reduces the emotional impact of a situation (in the short-term), but the result is emotional invalidation.

Dialectical Shift: Observe and Describe the situation accurately without adding or subtracting, validating your feelings.

Magnification: Magnification is the opposite of minimization. It happens when something that is small or insignificant is exaggerated it into something that is very large. It is similar to looking at a kitten through a magnifying glass and seeing a tiger.

Dialectical Shift: Like with minimization, Observe and Describe the situation accurately without adding or subtracting.

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Catastrophizing: Catastrophizing is an extreme form of magnification. It involves taking a situation and continuing to build it and build it and build it in your mind into a calamity with dire consequences.

Dialectical Shift: Focus on the *one* situation or problem at hand without exaggerating it. Most situations do not end up with extreme and dire consequences, so take one thing at a time. Alternatively, purposefully catastrophize to the point of absurdity to break you out of this interpretation.

Fortune-Telling (Crystal Ball Gazing): Fortune-telling interprets the future in negative ways, assuming that you already know what is going to happen.

Dialectical Shift: Rather than let a negative prediction of the future paralyze you, focus on what you can do effectively right now to cope with your situation or problem. Stay in the present moment.

Overgeneralization: Overgeneralization involves taking a small bit of information and applying it broadly across all kinds of different people and situations.

Dialectical Shift: Do not assume that your knowledge fits all people and all situations. Acknowledge when your information does fit, and actively look for times when it does not. Be open to not knowing all of the facts.

Selective Information Gathering (Selective Abstraction; Mental Filter; or Confirmation Bias): Sometimes you gather information that fits with your current thought or belief, ignoring evidence to the contrary. Some other interpretations may be missing here.

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Dialectical Shift: Actively gather information and viewpoints that are different from your own. Remember that you do not need to agree with these different perspectives, but that they may lead you to greater flexibility and more effective choices.

Labeling (Judging): Labeling reduces a person or situation to only a name. Labels fail to look at people and situations in a more holistic manner and miss important subtleties or nuances.

Dialectical Shift: Let go of the urge to label a person or situation, as the world is usually more complex than labels and judging.

Personalization: Personalization makes it all about you. Frankly, most everything in the world is not about you.

Dialectical Shift: Remember that most of the time it is not about you. Take responsibility for what is yours and gently let go of the rest. Enjoy the ensuing freedom!

Emotion Mind "Reasoning": Emotion mind reasoning happens when emotion, and not reason, is the only filter for interpretations.

Dialectical Shift: Use mindfulness to move to Wise Mind and then re-evaluate.

Should Statements: These statements focus on judgments rather than the realities of a particular situation or interaction. Reality unfolds in ways that do not fit our preferences (i.e., what "should" happen).

Dialectical Shift: Focus on "what is," not what "should be." Stop "shoulding" on yourself and others.

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Discounting Positives: Negatives and the downsides of situations blind you to positives. Minimizing or negating positives about yourself, others, situations, or the world is undialectical.

Dialectical Shift: Seek out positives, upsides, and silver linings for balance. Own the positives about yourself and give yourself credit. Seek the positives in people and situations that seem negative.

Blaming: Blaming makes everyone but you responsible for your problems and difficulties; blaming gives up your power and control and leaves you dependent on others to fix a situation or your life.

Dialectical Shift: Someone or something else may be responsible for a problem, but your power and control comes from focusing on how you can influence situations and your life, if only through choosing how you respond.

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Shifting and Expanding Interpretations Worksheet

Identify your current interpretation, thought, belief, or self-talk:

Identify the origins of this interpretation, thought, belief, or self-talk. Where did it come from and how could it have been useful at that time or in certain situations?:

Describe how this interpretation, thought, belief, or self-talk is facilitating (or not facilitating) your goals and/or what you want or need in the current situation.

What alternative interpretations, thoughts, beliefs, or self-talk are possible? Can you identify an expansion or shift?

Describe how these alternatives, expansions, or shifts might facilitate your goals and/or what you want or need in the current situation.

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DBT-oriented Interventions to Use with Resistance

Lane Pederson, PsyD, LP, DBTC

Most of these will work when a therapy alliance is in place: *remember that techniques are active only in the context of the relationship and a healing environment*

Rules of thumb:

1. Check in on the Therapy Alliance first
2. Check in on if you have agreement on goals/objectives second
3. Orient client to the situation and what is needed
4. Do not personalize and use nonjudgmental stance
5. Recognize that the client has valid reasons to resist
6. Find those reasons and validate them
7. Slow down and resist the urge to push too hard and/or work too hard
8. Move fluidly between validation and change

Interventions (in no particular order):

1. Three “safety nets”: Validation, Skills, the Moment (i.e., bringing it to the here and now)
2. Observe and Describe and Reinforce what seems to be skillful
3. Highlight choices (don’t direct)
4. Discuss Pros and Cons of choices
5. Let client sit with distress (don’t fix it)
6. Roll with Resistance (e.g., prescribe the symptom)
7. Use formal or informal behavior analysis

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8. Use behavior contracting (if A, then B)
9. Create cognitive dissonance/entering the paradox (e.g., pointing out differences between words and actions or goals and actions)
10. Highlight dialectical conflict
11. Highlight “boomerang feedback”
12. Give a directive (e.g., use “X” skill now)
13. Use process observations
14. Play “dumb” (e.g., “I’m confused about what’s happening here, etc.)
15. Discuss probabilities of outcomes
16. Use direct confrontation
17. Use DBT cognitive approach (i.e., identifying stuck thought, validating origin, and suggesting a shift)
18. Highlight choice in the absence of alternatives
19. Use another DBT commitment strategy
20. Connect present effort needed to past success using skills/doing something difficult (a version of a commitment strategy)
21. Setting limits (adjusting contingencies)
22. Make a “hit and run” observation (i.e., make observation and move on without further discussion)
23. Ask client for help
24. Use space and silence
25. Refuse to take responsibility for the client/don’t work harder (highlights a contingency)
26. Consult with the group (e.g., “Anyone here have any ideas?”)
27. Use foot in door or door in face techniques (a commitment strategy)
28. Make an interpretation (proscribed in DBT, but it might work)
29. Radically accept the moment out loud (with the client/group too)
30. Identify stage of change (use of transtheoretical model)
31. Examine willingness versus willfulness (can client identify willfulness?)

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32. Use self-involving disclosure (e.g., share what works when you're stuck, have a "heart-to-heart" discussion)
33. Treat the client like an expert (i.e., you know yourself, what is needed now?)
34. Shift to distress tolerance skills/plan
35. Ask what client has done or is doing to cope with this situation
36. Ask what skills the client is using now
37. Play the "caring and respect" card (e.g., "I wouldn't be showing much caring or respect for you if I…")
38. Do values work/identify prevailing value
39. Tell a story/use a metaphor
40. If extremely stuck, move on
41. Other:

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DBT Consultation Team Questionnaire: Assessing Strengths, Areas of Growth, Vision, and Goals

Your Therapist Attributes:

Flexible **Rigid**

Independent **Team-focused**

Validating **Challenging**

This is what I like/what works in my approach:

This is what I would like to develop/change:

DBT Knowledge

Low **High**

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These are ways I can contribute to the team with my knowledge:

These are the areas where I need ongoing consultation to grow/develop in the approach:

These are my individual goals for learning and implementing DBT:

These are the program goals I would like to see happen:

These are my ideas about how I want my team to operate:

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August 9, 2012

Resolution on the Recognition of Psychotherapy Effectiveness – Approved August 2012

Recognition of Psychotherapy Effectiveness[1]

Introduction

Council voted to adopt as APA policy the following Resolution on the Recognition of Psychotherapy Effectiveness:

WHEREAS: psychotherapy is rooted in and enhanced by a therapeutic alliance between therapist and client/patient that involves a bond between the psychologist and the client/patient as well as agreement about the goals and tasks of the treatment (Cuijpers, et al., 2008, Lambert, 2004; Karver, et al., 2006; Norcross, 2011; Shirk & Karver, 2003; Wampold, 2007);

WHEREAS: psychotherapy (individual, group and couple/family) is a practice designed varyingly to provide symptom relief and personality change, reduce future symptomatic episodes, enhance quality of life, promote adaptive functioning in work/school and relationships, increase the likelihood of making healthy life choices, and offer other benefits established by the collaboration between client/patient and psychologist (American Group Psychotherapy Association, 2007; APA Task Force on Evidence-Based Practice, 2006; Burlingame, et al., 2003; Carr, 2009a, 2009b; Kosters, et al., 2006; Shedler, 2010, Wampold, 2007, 2010);

Definitions

WHEREAS: evidence-based practice in psychology is "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA Task Force on Evidence Based Practice, 2006, p. 273);

WHEREAS: a working definition for Psychotherapy is as follows: "Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Norcross, 1990, p. 218-220);

WHEREAS: a working definition for Treatment is as follows: Treatments when used in the context of health care, refer to any process in which a trained healthcare provider offers assistance based upon his or her professional expertise to a person who has a problem that is defined as related to "health" or 'illness." In the case of "mental" or "behavioral" health, the conditions for which one may seek "treatment" include problems in living, conditions with discrete symptoms that are identified as or as related to illness or disease, and problems of interpersonal adjustment. The treatment consists of any act or services provided by a bonafide health provider intended to correct, change or ameliorate these conditions or problems (Beutler, 1983; Frank, 1973);

Research on Effectiveness

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WHEREAS: the effects of psychotherapy are noted in the research as follows: The general or average effects of psychotherapy are widely accepted to be significant and large, (Chorpita et al., 2011; Smith, Glass, & Miller, 1980; Wampold, 2001). These large effects of psychotherapy are quite constant across most diagnostic conditions, with variations being more influenced by general severity than by particular diagnoses—That is, variations in outcome are more heavily influenced by patient characteristics e.g., chronicity, complexity, social support, and intensity—and by clinician and context factors than by particular diagnoses or specific treatment "brands" (Beutler, 2009; Beutler & Malik, 2002a, 2002b; Malik & Beutler, 2002; Wampold, 2001);

WHEREAS: the results of psychotherapy tend to last longer and be less likely to require additional treatment courses than psychopharmacological treatments. For example, in the treatment of depression and anxiety disorders, psychotherapy clients/patients acquire a variety of skills that are used after the treatment termination and generally may continue to improve after the termination of treatment (Hollon, Stewart, & Strunk, 2006; Shedler, 2010);

WHEREAS: for most psychological disorders, the evidence from rigorous clinical research studies has shown that a variety of psychotherapies are effective with children, adults, and older adults. Generally, these studies show what experts in the field consider large beneficial effects for psychotherapy in comparison to no treatment, confirming the efficacy of psychotherapy across diverse conditions and settings (Beutler, 2009; Beutler, et al., 2003; Lambert & Ogles, 2004; McMain & Pos, 2007; Shedler, 2010; Thomas & Zimmer-Gembeck, 2007; Verheul & Herbrink, 2007; Wampold, 2001). In contrast to large differences in outcome between those treated with psychotherapy and those not treated, different forms of psychotherapy typically produce relatively similar outcomes. This research also identifies ways of improving different forms of psychotherapy by attending to how to fit the interventions to the particular patient's needs (Castonguay & Beutler, 2006; Miklowitz, 2008; Norcross, 2011);

WHEREAS: comparisons of different forms of psychotherapy most often result in relatively nonsignificant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, affect the results (Castonguay & Beutler, 2006; Livesley, 2007; Norcross, 2011);

WHEREAS: in studies measuring psychotherapy effectiveness, clients often report the benefits of treatment not only endure, but continue to improve following therapy completion as seen in larger effect sizes found at follow-up (Abbass, et al., 2006; Anderson & Lambert, 1995; De Maat, et al., 2009; Grant, et al., 2012; Leichsenring & Rabung, 2008; Leichsenring, et al., 2004; Shedler, 2010);

WHEREAS: research using benchmarking strategies has established that psychotherapy delivered in routine care is generally as effective as psychotherapy delivered in clinical trials (Minami, et al., 2008; Minami, et al., 2009; Minami & Wampold, 2008; Nadort, et al., 2009; Wales, Palmer, & Fairburn, 2009);

WHEREAS: the research evidence shows that psychotherapy is an effective treatment, with most clients/patients who are experiencing such conditions as depression and anxiety disorders attaining or returning to a level of

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functioning, after a relatively short course of treatment, that is typical of well-functioning individuals in the general population (Baldwin, et al., 2009; Minami, et al., 2009; Stiles, et al., 2008; Wampold & Brown, 2005);

WHEREAS: research will continue to identify factors that make a difference in psychotherapy, and results of this research can then be reported to clinicians who can make better decisions (Gibbon, et al., 2010; Kazdin, 2008);

WHEREAS: researchers will continue to examine the ways in which both positive and possible negative effects of psychotherapy occur, whether due to techniques, client/patient variables, therapist variables, or some combination thereof, in order to continue to improve the quality of mental health interventions (Barlow, 2010; Dimidjian & Hollon, 2010; Duggan & Kane, 2010; Haldeman, 1994; Wilson, Grilo, & Vitousek, 2007);

Effectiveness Related To Health Care Policies

WHEREAS: the effects produced by psychotherapy, including the effects for different age groups (i.e. children, adults, and older adults) and for many mental disorders, exceed or are comparable to the size of effects produced by many pharmacological treatments and procedures for the same condition, and some of the medical treatments and procedures have many adverse side-effects and are relatively expensive vis-a-vis the cost of psychotherapy (Barlow, 2004; Barlow, Gorman, Shear, & Woods, 2000; Hollon, Stewart, & Strunk, 2006; Imel, McKay, Malterer, & Wampold, 2008; Mitte, 2005; Mitte, Noack, Steil, & Hautzinger, 2005; Robinson, Berman, & Neimeyer, 1990; Rosenthal, 1990; Walkup, et al., 2008; Wampold, 2007, 2010);

WHEREAS: a substantial body of scholarly work (e.g., Henggeler & Schaeffer, 2010; Roberts, 2003; Walker & Roberts, 2001; Weisz et al., 2005) have documented the effectiveness of psychotherapy across a range of problems affecting children and adolescents;

WHEREAS: large multisite studies as well as meta-analyses have demonstrated that courses of psychotherapy reduce overall medical utilization and expense (Chiles, Lambert, & Hatch, 2002; Linehan, et al., 2006; Pallak, Cummings, Dorken, & Henke, 1995). Further, patients diagnosed with a mental health disorder and who received treatment had their overall medical costs reduced by 17 percent compared to a 12.3 percent increase in medical costs for those with no treatment for their mental disorder (Chiles, Lambert, & Hatch, 2002);

WHEREAS: there is a growing body of evidence that psychotherapy is cost-effective, reduces disability, morbidity, and mortality, improves work functioning, decreases use of psychiatric hospitalization, and at times also leads to reduction in the unnecessary use of medical and surgical services including for those with serious mental illness (Dixon-Gordon, Turner, & Chapman, 2011; Lazar & Gabbard, 1997). Successful models of the integration of behavioral health into primary care have demonstrated a 20-30 percent reduction in medical costs above the cost of the behavioral/psychological care (Cummings, et al., 2003). In addition, psychological treatment of individuals with chronic disease in small group sessions resulted in medical care cost savings of $10 for every $1 spent (Lorig, et al., 1999);

WHEREAS: there is strong scientific evidence to support the links between mental and physical health, and a growing number of models and programs support the efficacy of the integration of psychotherapy treatment within the

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primary health care system (Alexander, Arnkoff, & Glass, 2010; Felker, et al., 2004; Roy-Byrne, et al., 2003). In fact, early mental health treatments that include psychotherapy reduce overall medical expenses, simplifies and provides better access to appropriate services and care to those in need, and improves treatment seeking;

WHEREAS: many people prefer psychotherapy to pharmacological treatments because of medication side-effects and individual differences and people tend to be more adherent if the treatment modality is preferred (Deacon & Abramowitz, 2005; Paris, 2008; Patterson, 2008; Solomon et al., 2008; Vocks et al., 2010). Research suggests that there are very high economic costs associated with high rates of antidepressant termination and non-adherence (Tournier, et al., 2009), and psychotherapy is likely to be a more cost effective intervention in the long term (Cuijpers, et al., 2010; Hollon, et al., 2005; Pyne, et al., 2005);

Effectiveness with Diverse Populations

WHEREAS: the best research evidence conclusively shows that individual, group and couple/family psychotherapy are effective for a broad range of disorders, symptoms and problems with children, adolescents, adults, and older adults (American Group Psychotherapy Association, 2007; Burlingame, et al., 2003; Carr, 2009a, 2009b; Chambless, et al., 1998; Horrell, 2008; Huey & Polo, 2008, 2010; Knight, 2004; Kosters, et al., 2006; Lambert & Archer, 2006; Norcross, 2011; Pavuluri, Birmaher, & Naylor, 2005; Sexton, Alexander, & Mease, 2003; Sexton, Robbins, Hollimon, Mease, & Mayorga, 2003; Shadish & Baldwin, 2003; Stice, Shaw, & Marti, 2006; Wampold, 2001; Weisz & Jensen, 2001);

WHEREAS: the development and/or adaptation of evidence-based psychotherapy practices for each age group have further demonstrated effectiveness in reducing symptoms and improving functioning across the lifespan. Specific challenges that emerge with age are addressed by developmental research that pinpoints the most efficacious content, vocabulary, and techniques used for different ages. As a result, substantial evidence supports psychotherapy as a front line intervention for community dwelling older adults, older adults with medical illnesses, who are low-income, ethnic minority and have co-occurring mild cognitive impairments. In addition, increasing evidence has documented that older adults respond well to a variety of forms of psychotherapy and can benefit from psychological interventions to a degree comparable with younger adults. Furthermore, many older adults prefer psychotherapy to antidepressants, and psychotherapy is an important treatment option for older adults who are often on multiple medications for management of chronic conditions and are more prone to the adverse effects of psychiatric medications than youner adults (Alexopoulos, et al., 2011; APA, 2004; Areán, et al., 2005a; Areán, et al., 2005b; Areán, Gum, Tang, & Unutzer, 2007; Areán, et al., 2010; Arnold, 2008; Gum, Areán, & Bostrom, 2007; Cuijpers, van Straten & Smit, 2006; Kazdin, et al., 2010; Kaslow, et al., 2012);

WHEREAS: researchers and practitioners continue to develop culturally-relevant, socially-proactive approaches and modalities that will allow psychologists to extend psychotherapeutic services to vulnerable and currently underserved populations such as adults, children, and families living in poverty (Ali, Hawkins, & Chambers, 2010; Belle & Doucet, 2003; Goodman, Glenn, Bohlig, Banyard, & Borges, 2009; Smith, 2005, 2010; Smyth, Goodman, & Glenn 2006);

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WHEREAS: both evidence-based psychotherapy practice for the general population and culturally adapted interventions are generally effective with racial/ethnic minorities, psychologists who work with marginalized populations, such as people living in poverty and/or other socially-excluded groups, can improve the effectiveness of their interventions through awareness of unintentional age, race, class, and/or gender bias. The acquisition of multicultural competence and the adaptation of psychotherapy, whether in content, language, or approach, can improve client engagement and retention in treatment and can enhance development of the therapeutic alliance (Griner & Smith, 2006; Horrell, 2008; Huey & Polo, 2008, 2010; Miranda, et al., 2005; Miranda, et al., 2006; Vasquez, 2007; Whaley & Davis 2007);

WHEREAS: the research continues to support that psychotherapy, both group and individuals models of clinical interventions, is effective treatment for individuals with disabilities. The studies also indicate that psychotherapy is effective for a variety of disability conditions including cognitive, intellectual, physical, visual, auditory, and psychological impairments. The research supports that psychotherapy is effective for individuals with disabilities over the life span. A sample of the research reflecting the effectiveness of therapy with individuals with disabilities include: Glickman (2009), Hibbard, Grober, Gordon, & Aletta (1990), Kurtz & Mueser (2008), Livneh & Sherwood (2001), Lysaker, Glynn, Wilkniss, & Silverstein (2010), Olkin (1999), Perlman, Cohen, Altiere, Brennan, Brown, Mainka, & Diroff, (2010), Rice, Zitzelsberger, Porch, & Ignagni (2005), Radnitz (2000), and Vail & Xenakis (2007);

WHEREAS: research indicates the beneficial effects of psychotherapy as a means of improving mood and reducing depression among individuals with acute and chronic health conditions (e.g., arthritis, cancer, HIV/AIDS) (Fisch, 2004; Himelhoch, et al., 2007; Lin, et al., 2003);

WHEREAS: although some cultural adaptations already have demonstrated effectiveness as mentioned above, many underserved communities can continue to benefit from specific adaptations or demonstrated effectiveness of evidence-based psychotherapy practice. For example, current psychotherapy research suggests that racial/ethnic minorities, those with low socioeconomic status, and members of the LGBT community may face specific challenges not addressed by current evidence-based treatment. In conducting psychotherapy, practitioners are sensitive to these challenges and pursue appropriate adaptations (Butler, O'Donovan, & Shaw, 2010; Cabral & Smith, 2011; Gilman, et al., 2001; Smith, 2005; Sue & Lam, 2002);

THEREFORE: Be It Resolved that, as a healing practice and professional service, psychotherapy is effective and highly cost-effective. In controlled trials and in clinical practice, psychotherapy results in benefits that markedly exceed those experienced by individuals who need mental health services but do not receive psychotherapy. Consequently, psychotherapy should be included in the health care system as an established evidence-based practice.

Be It Further Resolved that APA increase its efforts to educate the public about the effectiveness of psychotherapy; support advocacy efforts to enhance formal recognition of psychotherapy in the health care system; help ensure that policies will increase access to psychotherapy in the health care system, with particular attention on addressing the needs of underserved populations and encourage integration of research and practice; and support advocacy for funding.

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Be It Further Resolved that APA encourages continued and further research on the comparative effectiveness and efficacy of psychotherapy.

[1] While statements about the effectiveness of psychotherapy must be accurate yet generalized in a policy document format, research studies have not equitably investigated all factors that either enhance or diminish psychotherapy effectiveness. Full explication of the differential status of any given variable and the state of research of any given factor in the practice of psychotherapy is beyond the scope of this document. The research citations that accompany each statement provide specificity of scope, limitations, and implications for psychotherapy practice and identify the therapeutic circumstances in which research has determined that psychotherapy is soundly effective. Examples of these important moderating variables include client/patient characteristics, clinician characteristics, context factors, diagnostic classification and severity, developmental status, and factors related to such human and cultural diversity as race, ethnicity, gender, sexual orientation and disability status (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009; Curry, Rohde, Simons, Silva, Vitiello, Kratochvil, et al., 2006; Hinshaw, 2007; Kazdin, 2007; Kocsis, Leon, Markowtiz, Manber, Arnow, Klein, & Thase, 2009; McBride, Atkison, Quilty, & Bagby, 2006; Miklowitz, Axelson, George, Taylor, Schneck, Sullivan, et al., 2009; Ollendick, Jarrett, Grills-Taquechel, Hovey, & Wolff, 2008).

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