Dialectical Behavior Therapy (DBT) 4-Day Intensive Certification Training Course

Lane Pederson, Psy.D., LP

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ZNM044810
12/19

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PO Box 1000
3839 White Ave.
Eau Claire, Wisconsin 54702

Printed in the United States

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12/19

MATERIALS PROVIDED BY

Dr. Pederson has provided DBT training and consultation to over 11,000 professionals in the United States, Australia, South Africa, the Middle East, Canada, and Mexico through his training and consultation company, Lane Pederson and Associates, LLC (www.DrLanePederson.com). Notable organizations he has trained for include Walter Reed National Military Hospital, the Federal Bureau of Prisons, the Ontario Psychological Association, the Omid Foundation, and Psychotherapy Networker. He has provided DBT training for community mental health agencies, chemical dependency treatment centers, hospital and residential care settings, and to therapists in forensic settings. Dr. Pederson also co-owns Acacia Therapy and Health Training (www.AcaciaTraining.co.za) in South Africa.

Dr. Pederson's DBT publications include the award-winning *The Expanded Dialectical Behavior Therapy Skills Training Manual, Second Edition* (PESI, 2017); *Dialectical Behavior Therapy: A Contemporary Guide for Practitioners* (Wiley, 2015); and (PESI, 2013).

A real world practitioner, Dr. Pederson co-owns Mental Health Systems, PC (MHS), one of the largest DBT-specialized practices in the United States with four clinic locations in Minnesota (www.mhs-dbt.com). At MHS Dr. Pederson has developed DBT programs for adolescents, adults, people with dual disorders, and people with developmental disabilities. He has served as clinical and training directors, has directed practice-based clinical outcome studies, and has overseen the care of thousands of clients in need of intensive outpatient services.

In 2011, Dr. Pederson co-founded Dialectical Behavior Therapy National Certification and Accreditation Association (DBTNCAA), now Evergreen Certifications, the first active organization to certify DBT providers and accredit DBT programs.

Dr. Pederson currently serves on the advisory board for the doctorial counseling program at Saint Mary's University of Minnesota and is a peer reviewer for Forensic Scholars Today.

Lane Pederson is not affiliated or associated with Marsha M. Linehan, PhD, ABPP, or her organizations.

Speaker Disclosure

Financial: Lane Pederson maintains a private practice. He is an author for PESI Publishing & Media and receives royalties. Dr. Pederson receives a speaking honorarium from PESI, Inc.
Non-financial: Lane Pederson has no relevant non-financial relationship to disclose.

Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professions standards.

Dialectical Behavior Therapy Intensive Training

Day One: Foundations of DBT and Best Practices

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Why Learn DBT?

- Therapists find DBT philosophies of acceptance and non-judgment to be a natural fit
- DBT offers a breadth of interventions, many of which speak to the treatment alliance
- DBT is a “privileged” approach (i.e., desired by many clients and promoted by payers and policy-makers)
- DBT is a teachable, learnable, and practical approach…this is a relative strength compared to other equally efficacious, yet more complicated approaches to deploy

How to be Effective as a Therapist

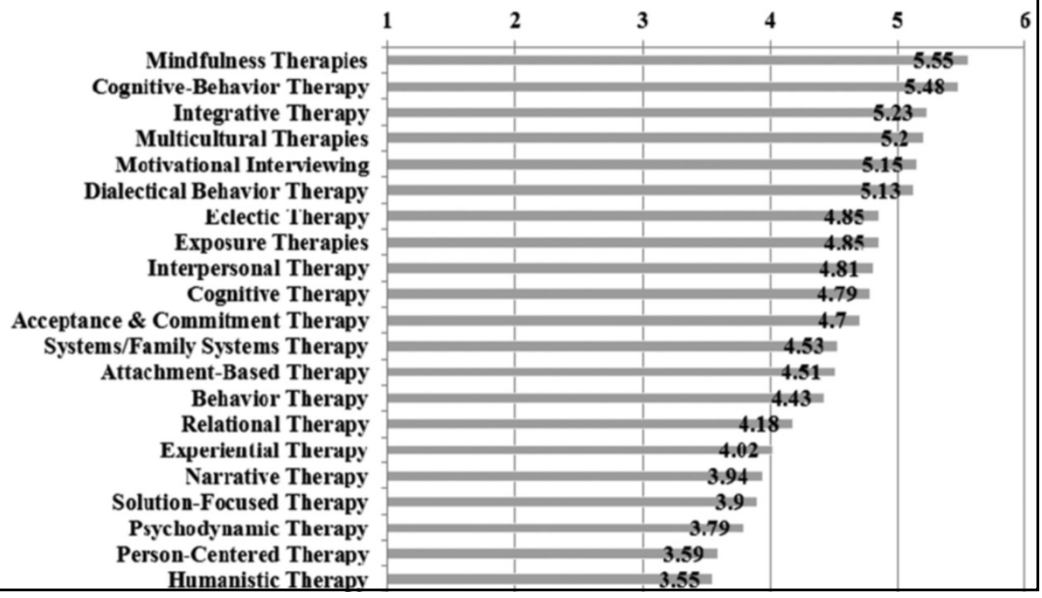
“Therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient’s personal characteristics in view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may involve both educating the patient about the therapist conceptual scheme and, if necessary, modifying the scheme to take into account the concepts the patient brings to therapy” (Frank & Frank, 1991, p.xv).

In other words, it’s about customizing approaches!

Adapt DBT? Yes You Can!

- DBT, which is derivative of CBT and other treatments, is highly adaptable
- Research on adapted DBT outpaces research on “standard” DBT (the original treatment framework/service delivery)
- Anything, and everything, taught in this course can be used in an eclectic and/or integrative manner (and of course in a DBT program)

Psychotherapy in 2022 (Norcross et al., 2012)



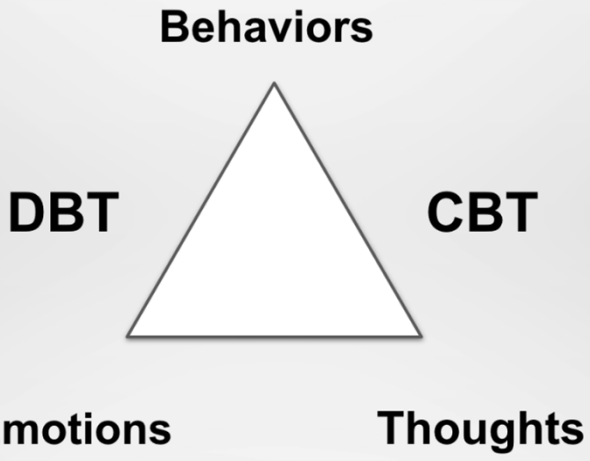
DBT Today: Research and Practice

- DBT owes its development to hundreds of researchers and thousands of practitioners
- DBT has expanded far beyond its original focus on a “standard” model used for a narrow treatment population (BPD)
- DBT is commonly applied across treatment populations and settings, diagnoses, and levels of care ***(Adaptations are both mainstream and evidence-based)***

DBT Originated with CBT

- DBT borrows most heavily from CBT (the original DBT book was titled Cognitive Behavioral Treatment of Borderline Personality Disorder)
- DBT added in Acceptance-Based Strategies (today, third wave CBT treatments have these strategies too)
- The most notable deviation from CBT comes on the theory level: CBT is thought-focused whereas DBT is emotion-focused

DBT Versus CBT



DBT Changes and Additions to CBT

- Emotion-Based Guiding Theory
- Dialectical Process (Synthesis of Opposites)
- Emphasis on Acceptance Strategies
- Organized Psychoeducational Skills Training
- Emphasis on Consultation Among the Treatment Team
- Emphasis on Treatment Stages and Hierarchy

DBT Borrows From Many Approaches

- DBT shares commonalities with CBT, client-centered, psychodynamic, gestalt, paradoxical, and strategic approaches among others (Heard & Linehan, 1994; Marra, 2005)
- Mindfulness has been around awhile
- Dialectics go back to ancient philosophers
- Dialectically, DBT is both innovative and derivative

"There is no new thing under the sun"

DBT and Other Approaches

- **DBT shares with behavioral approaches:**
  - Teaching and reinforcing skills
  - Behavioral analysis (functional analysis)
  - Contingency management
- **DBT shares with cognitive approaches:**
  - Socializing the client to treatment (educate and orient)
  - Self-monitoring techniques (diary card)
  - Adapted cognitive modification (validating and dialectical style)

DBT and Other Approaches

- **DBT shares with client-centered (person-centered, humanistic, Rogerian) approaches:**
  - Acceptance-based, non-judgmental orientation
  - Unconditional positive regard toward clients
  - Validating responsiveness (undertanding clients' experience and perspectives)
  - Genuine and authentic approach

DBT and Chemical Dependency Treatments

- DBT and Motivational Interviewing (MI) ***compliment each other***. Both share client-centered aspects and use dialectical concepts.
- DBT ***overlaps with*** Relapse Prevention. Both embrace concepts of acceptance, learning from setbacks, and developing action plans to prevent future setbacks
- DBT and traditional CD treatments like 12 Step ***can also be combined***
- Importantly, DBT supports harm reduction practices ***while not wavering from promoting abstinence as a treatment goal***

Is it DBT? Major DBT "Ingredients"

Guiding Theories and Philosophies:
- Dialectical Philosophy
- Biosocial Theory
- Client/Therapist Assumptions
- Five Functions of DBT

Treatment Structure:
- Service Delivery/Tx Modes
  - Therapy (Individual/Group)
  - Skills Training
  - Coaching
  - Consultation
- Tx Stages
- Tx Hierarchy
- Rules, Expectations, & Agreements

Skills Training Modules
- Mindfulness
- Distress Tolerance
- Emotion Regulation
- Interpersonal Effective
- Supplemental Modules and Skills

DBT Tools:
- Diary Card
- Behavior & Solution Analysis

Engagement Strategies:
- Educating & Socializing
- Orienting
- Commitment Strategies

Is it DBT? Major DBT "Ingredients"

Acceptance Strategies:
- Validation
- Mindfulness
- Radical Acceptance

Change Strategies:
- Skills
- Behaviorism
- Contingency Management
- Dialectical Strategies

Communication Styles:
- Reciprocol
- Irreverent

Dialectical Philosophy

- Dialectic originated with early philosophers
- No position is absolute; each position has its own wisdom or truth (if only a kernel at times)
- Opposite tensions are interconnected, interrelated, and defined by each other
- The synthesis of opposites, through understanding varying contexts and seeking a workable balance, leads to change
- Change is continual, so dialectics require fluidity
- Dialectics also seek “what’s missing”
- **Dialectics respect subjective “truths” too!**

DBT’s Most Fundamental Dialectic:

Acceptance Versus Change

Dialectic Examples

- Acceptance (validation) and change (challenge)
- Caring (unconditional positive regard) and accountability (conditions)
- Availability and boundaries (limits)
- Active client and active therapist (collaboration)
- Tolerance and Problem-Solving
- Help-Seeking and Self-efficacy
- Self-focused and Other-Focused
- Intervening for client and consultation to the client

Dialectics with Dual Disorders

- The serenity prayer (acceptance and change!)
- Wanting and resisting change
- Using even when it actively causes harm
- Taking a minor lapse to an extreme relapse (dialectical imbalance)
- Realizing that goals or values conflict with behaviors
- Removing triggers AND dealing with triggers (to be successful)

Dialectics with Adolescents

- Not being too strict and not being too lenient
- Not creating dependence and not forcing independence
- Not pathologizing what is normal and not normalizing the pathological
- Self and others
- Responsibility and fun
- Structure and flexibility

When NOT to be Dialectic: Dialectical Abstinence

- Sometimes behaviors are so destructive that there is not middle ground: they must be completely given up
- Shape 100% commitment to abstaining from these behaviors
- When a SLIP happens, Skills Learning Improves Progress; mistakes are teachers
- When a mistake occurs, avoid the “Abstinence Violation Effect” by returning immediately to the commitment
- You are ALWAYS abstinent or working to get back to abstinence

DBT View of Abstinence

- Not all clients can be abstinent at the beginning of treatment, yet abstinence is a primary goal of treatment
- Not all clients entering treatment have the skills to maintain abstinence
- Commitment to abstinence happens with realistic timeframes that will be re-upped
- Therapists take a nonjudgmental approach to relapse
- Clients with high comorbidity can only change so much, so fast
- For polysubstance use, the most problematic substance(s) is targeted first
- Medications are an accepted part of the treatment protocol

DBT Theory: The Biosocial Model

- Clients suffer from emotional vulnerabilities
- Emotional vulnerabilities can come from many sources (e.g., attachment issues, loss, trauma), but is often assumed to be biological
- Chronic and consistent invalidation exacerbates emotional vulnerabilities
- An ongoing, reciprocal relationship exists between emotional vulnerabilities and environments

DBT Theory: The Biosocial Model

- Emotional vulnerabilities are characterized by:
  - Emotional sensitivity
  - Emotional reactivity
  - Slow return to emotional baseline
- Over time emotions get sensitized, leading to a "kindling" effect
- This emotionality (and associated invalidation) is associated with many problems (disorders)
- Emotionality leads to escape and avoidance that leads to chronicity

Common Types of Invalidation

- Abuse and neglect
- Inappropriate ignoring
- Open rejection of thoughts, feelings, and behaviors
- Making "normal" responses "abnormal" and vice versa
- Failing to communicate how experience "makes sense"
- Expecting behaviors that one cannot perform (e.g., due to developmental level, emotionality, or behavioral deficits
- Poor environmental "fit"

Biosocial Theory Guides Treatment Targets and Strategies

- **Validation** is a primary intervention to:
  - Reduce acute emotionality
  - Provide gentle exposure to emotions
  - Provide a corrective validating environment (and new learning)
  - Create a bridge to learning self-validation
  - Open the client up to change interventions
- **Emotion regulation** is taught to:
  - Understand how emotion happen
  - Reduce vulnerability to intense emotions
  - Increase opportunities for positive emotions
  - Assist in stepping out of ineffective mood-congruent behaviors

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Biosocial Theory Guides Treatment Targets and Strategies

- **Mindfulness** (non-judgment and acceptance) is taught to:
  - Reduce amplifying emotions
  - Reduce escape and avoidance of emotions
  - Create qualitatively different and effective experience of emotions
- **Distress Tolerance** is taught to:
  - Provide healthy ways of coping with emotions when needed
- Use the theory to conceptualize the purpose of the interventions used

Radically Open DBT (RO-DBT) and the Theory of Over-regulation (Lynch 2003, 2007, 2013)

- Some clients suffer from emotional overregulation
- Leads to inhibited emotional expression, minimized emotional experiencing, and disconnected relationships as well as excessive self-control and lack of adaptive flexibility
- Recognizes environments contributions to overlearning self-control, behavioral self-control, and inflexibility

Radically Open DBT (RO-DBT) and the Theory of Over-regulation (Lynch 2003, 2007, 2013)

- May be useful with some treatment-resistant depressions, anorexia, OCD, OCPD, and autism-spectrum disorders.
- RO-DBT teaches awareness, self-inquiry, flexible control, and flexible social and environmental responding
- To learn more: The Skills Training Manual for Radically Open Dialectical Behavior Therapy: A Clinician's Guide for Treating Disorders of Overcontrol (Thomas R. Lynch, 2018)

Being Flexible to the Client's Theory of Change

- Not all clients fit particular theory
- Inquire about the client's theory about their difficulties and what would help for change
- Client's theories are already accepted by them, which is an advantage
- DBT skills and interventions are widely adaptable
- If DBT cannot be brought into accord with the client's theories, find a more preferable treatment

Core DBT Assumptions: Client Assumptions

- Clients are doing their best in the moment and need to do better
- Clients are responsible for solving their own problems (even if they didn't create them)
- Clients want to, but need skills to, improve
- Skills need to be generalized to all relevant areas of life

Core DBT Assumptions: Therapist Assumptions

- Therapists practice respect, empathy, validation, and nonjudgmental in therapeutic interactions
- Therapist must be unrelentingly, yet genuinely and appropriately. strengths-based
- Therapists seek consultation to stay motivated and effective
- Therapists practice skills too

Core DBT Assumptions: Treatment Assumptions

- The treatment milieu needs to be nonjudgmental and accountable
- Treatment needs to reinforce behaviors that work in life and not allow clients to practice behaviors in treatment that do not work in life
- **See DBT Beliefs About Skills Training, Page 1, in the Handouts Packet**

DBT has Five Functions

- Improve clients' motivation for change
- Enhance clients' capabilities
- Help clients generalize skills/behaviors to their natural environments
- Enhance the motivation and skill of therapists
- Structure the treatment/program and environment

The 5 functions can be (and should be) applied in any and all treatment modes

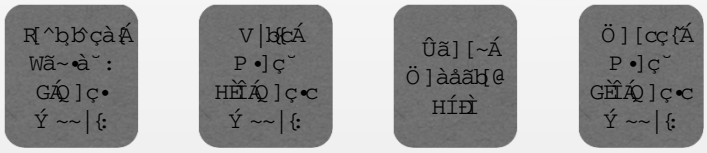
Treatment Structure/Service Delivery:
Full DBT is Multi-Modal with Four Main Modes

- DBT Therapy (Individual or in a Group Format)
- Skills Training (Psychoeducation most often in a Group Format)
- Skills Coaching (Phone, text, email, or on-site)
- Consultation
- **NOTE: How these modes are delivered depends on factors like population, setting, level of care, etc.)**

DBT Applications

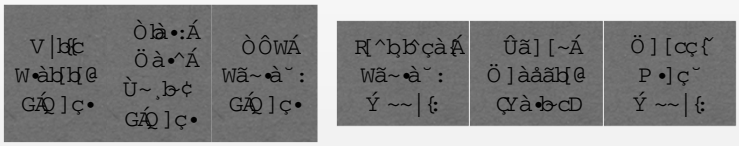
- Treatment Frameworks (Service Deliveries):
  - Standard Model (Also called Linehan or Adherent Model)
  - Adapted Models (e.g., Group Format)
  - Individual Therapy Only
  - Skills Group Only
- Integrate It With Other Models (Technical Assimilation, Eclectic, Integrative)
- Simply be clear with informed consent

Service Delivery (Four Modes) of Standard DBT



- A standard DBT team consists of individual therapists who are also responsible for the telephone coaching and skills trainers who co-conduct skills group
- The consultation group is only for DBT team members, and the content of the consult group focuses on the therapists' needs as well as the clients' needs

Service Delivery of Intensive Outpatient (IOP) DBT



- An IOP DBT treatment day consists of skills training, diary card review, and DBT therapy all done in a group format. A typical band of care is three to five days
- For a shorter treatment day (e.g. adolescent DBT), diary card review can be omitted.
- Individual therapy is required and can be DBT or another approach (if offered by an outside therapist)
- Consult group consists of program and individual therapists. Outside therapists are involved through routine care coordination

Service Delivery of a Skills Group

- Develop a skills group that can be a standalone DBT service or supplement other services.
- Determine frequency and length of the skills group
- Depending on frequency and length, consider adding in skills check-in or even skills-based processing time to supplement skills training

Research Update

- Published in 2015:
  - Component RCT with three conditions: Standard DBT versus Skills Group versus Individual Therapy (i.e., dismantled conditions)
  - NO differences on the major variables of interest; no reliable differences on the minor variables of interest
- Conclusions:
  - All structured approaches worked
  - Supports variations of different treatment formats **AND dismantled DBT applications (especially when cross-referenced with other research findings)**
  - **Most important is that clients get the proper level of care based on medical necessity**

There is More Than One Way to Apply Evidence

- **Treatment Fidelity:** *Competence Plus High Adherence to the Manual/Model* ***(Vital in Research)***
- **Evidence-Based Practice:** *Competence Plus Guided by Manual with Adaptations Based on Expertise and Client Needs* ***(Vital in Practice)***
- **Either Method in the Real World Should Use Practice-Based Evidence:** *Collecting Data on the Practice Level to Determine Effectiveness and to Adjust Treatment as Necessary*

DBT (and other therapies): Prescriptive and Contextual Perspectives

- **Prescriptive (Fidelity to EBT)**:
  - Pair Treatment Manuals to Diagnosis
  - High Adherence Expected
  - Manual at the Center of Treatment
- **Contextual (Following EBP)**:
  - Guided by Manual
  - Customized (programmatically and/or individually)
  - Client and Therapist at the Center of Treatment

Research Best Supports the Contextual Model

- Empirical Findings that support the Contextual Model (Wampold, 2001):
  - Therapy is generally efficacious, with no significant differences between models (Dodo Bird Verdict)
  - Therapeutic factors (i.e., common factors) have greater effects than specific factors (i.e., specific ingredients/interventions found in manuals)
  - High adherence is not necessary, ***but coherence is important*** (See Web et al., 2010)
  - Allegiance (therapist belief in the approach) is very important
  - Therapist effects are greater than treatment effects

The Status of Specific Ingredients and Highly Touted Treatments

"[S]pecific ingredients are not active in and of themselves. Therapists need to realize that the specific ingredients are necessary but active only in the sense that they are a component of the healing context (Wampold, 2001)

Importantly…

- RCTs may lack external validity (generalizability):
  - Real-world clients often differ importantly from research subjects
  - Settings often necessitate changes in the treatment framework (service delivery) for many reasons
- Standard DBT may or may not be the best option
- Therapy "ingredients" constitute an important part of therapy, but they should take a back seat to therapeutic factors
- ***Again, ADAPTING TREATMENT MODELS IS MAINSTREAM PRACTICE AND IS EVIDENCE-BASED PRACTICE***

Since 2006! The American Psychological Association (APA) has advocated for Evidence-Based Practice (EBP)

- APA policy looks to balance:
  - Best Research
  - Clinical Expertise
  - Client Culture, Characteristics, and Preferences
  - Ongoing monitoring and adjustment of therapy through outcome data
- The APA policy is a balanced and dialectic view, integrating research and practice based on client needs

Collecting and Using Clinical Outcomes: *Practice-Based Evidence*

- All providers and programs, standard model included, need to monitor and assess outcomes
- Outcome data is used to guide and improve treatment for individuals as well as programmatically
- Outcomes demonstrate your success to clients and other stakeholders

Behavioral and Other Data to Track

(from Dialectical Behavior Therapy, Pederson, 2015)

- Hospitalizations, including number of days each occurrence
- Emergency-room visits
- Suicide attempts
- Self-injurious behavior
- Substance use behaviors (e.g., frequency of drinking and/or drug use)
- Eating disorder behaviors (e.g., episodes of binging or purging)

Behavioral and Other Data to Track

(from Dialectical Behavior Therapy, Pederson, 2015)

- Days in treatment/length of stay
- Rate at which measurable treatment objectives are met
- Aggressive acts towards others
- Number of incident reports in regard to client behavior
- Days incarcerated
- Days homeless
- Employment (e.g., days weekly, hours weekly)
- Frequency, intensity, and duration of observable symptoms (e.g., panic attacks, time isolating, number of compulsive responses)

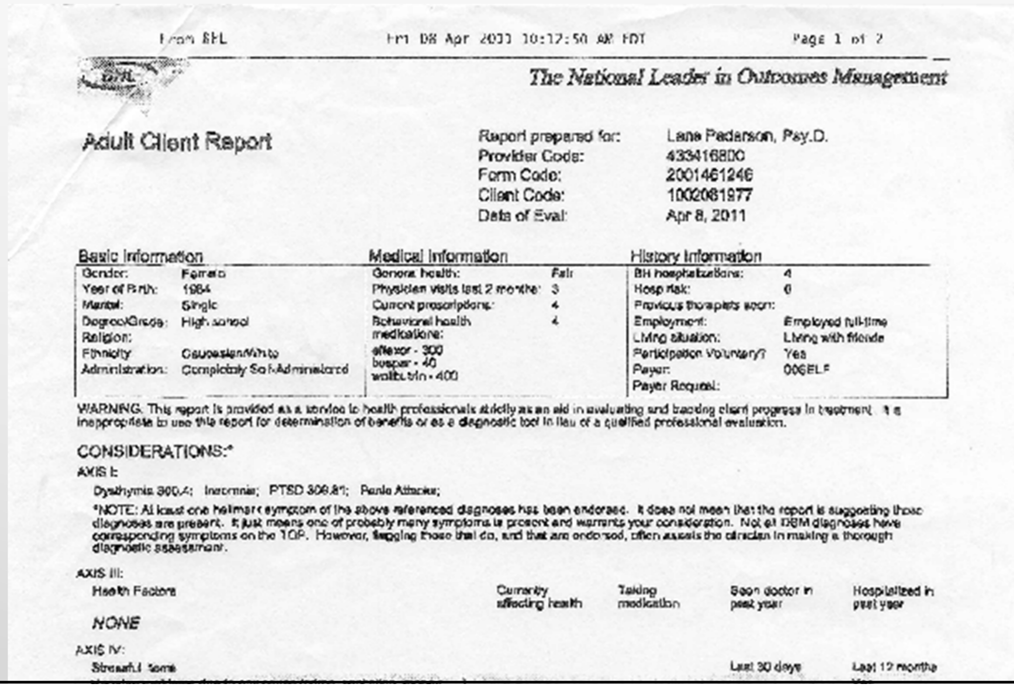
Examples of Reliable and Valid Outcome Measures

- Treatment Outcome Package (TOP)
- Symptom Checklist-90-Revised (SCL-90-R)
- Brief Symptom Inventory (BSI)
- Outcome Rating Scale (ORS) and Session Rating Scale (SRS); PCOMS…www.heartandsoulofchange.com
- Beck Inventories (Depression, Anxiety, Hopelessness, Suicidal Ideation, Youth Inventories)
- Posttraumatic Stress Diagnostic Scale (PDS)
- Alcohol Use Inventory (AUI)

Outcome Assessment Considerations

- Decide how you will assess outcomes (e.g., what you will track and how often)
- Develop appropriate forms or software (e.g., tracking sheets
- Develop a practical tracking system for data, including data entry and maintaining a data-base
- Without getting excessive, gather too much over too little data
- Consider hiring a consultant for outcome design or using administrative help to manage data

Clinical Outcomes: TOP Example



From BHL   Fri 08 Apr 2011 10:12:50 AM EDT   Page 1 of 2

The National Leader in Outcomes Management

Adult Client Report

Report prepared for: Lane Pederson, Psy.D.
Provider Code: 433416800
Form Code: 2001461246
Client Code: 1002081977
Date of Eval: Apr 8, 2011

Basic Information		Medical Information		History Information	
Gender:	Female	General health:	Fair	BH hospitalizations:	4
Year of Birth:	1984	Physician visits last 2 months:	3	Hosp risk:	0
Marital:	Single	Current prescriptions:	4	Previous therapists seen:	
Degree/Grade:	High school	Behavioral health medications:	4	Employment:	Employed full-time
Religion:		effexor - 300		Living situation:	Living with friends
Ethnicity:	Caucasian/White	buspar - 40		Participation Voluntary?	Yes
Administration:	Completely Self-Administered	wellbutrin - 400		Payer:	00SELF
				Payer Required:	

WARNING: This report is provided as a service to health professionals strictly as an aid in evaluating and tracking client progress in treatment. It is inappropriate to use this report for determination of benefits or as a diagnostic tool in lieu of a qualified professional evaluation.

CONSIDERATIONS:*

AXIS I:

Dysthymia 300.4; Insomnia; PTSD 309.81; Panic Attacks;

*NOTE: At least one hallmark symptom of the above referenced diagnoses has been endorsed. It does not mean that the report is suggesting those diagnoses are present. It just means one of probably many symptoms is present and warrants your consideration. Not all DSM diagnoses have corresponding symptoms on the TOP. However, flagging those that do, and that are endorsed, often assists the clinician in making a thorough diagnostic assessment.

AXIS III:

Health Factors	Currently affecting health	Taking medication	Seen doctor in past year	Hospitalized in past year
NONE				

AXIS IV:

Stressful Items	Last 30 days	Last 12 months

Clinical Outcomes: TOP Example

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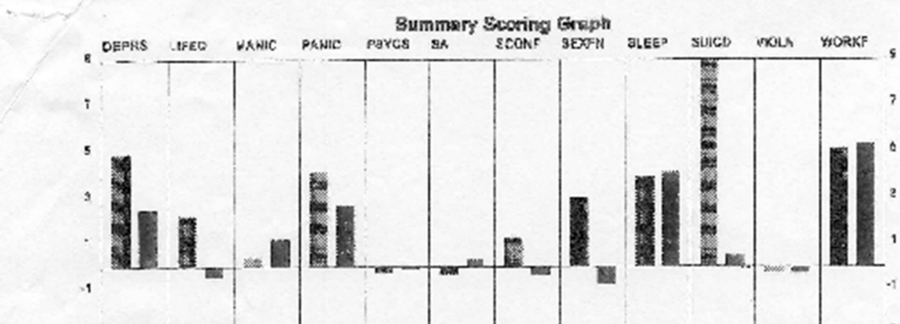


	DEPRS	LIFED	MANIC	PANIC	PSYCS	SA	SCONF	SEXFN	SLEEP	SUICD	VIOLA	WORKF
04/08/2011	[illegible]	-0.48	1.21	[illegible]	-0.10	0.30	-0.85	-0.80	[illegible]	0.47	-0.28	[illegible]
01/24/2011	[illegible]	[illegible]	0.41	[illegible]	-0.24	-0.34	1.32	[illegible]	[illegible]	[illegible]	-0.28	[illegible]

Severity of current administration: ***=extreme, **=moderate, *=mild, ?=questionable.

Scores are reported as standard deviations away from a non-clinical population which has an average score of 0. Lower scores are considered better. The scale of the graph goes from -3 to + 8 standard deviations. Bars on graph are plotted from left to right, from the earliest administration to the most recent one. Change greater than 1.0 is statistically and clinically significant.

Critical items marked as occurring during the past two weeks (selected from 17 key TOP items):

found yourself thinking about a drink or getting high   A little of the time

Clinical Outcomes: TOP Example

From BBL   Wed 01 Apr 2015 08:36:47 AM EDT   Page 1 of 2

The National Leader in Outcomes Management

Adult Client Report

Report prepared for: Lana Pederson, Psy.D.
Provider Code: 433416600
Form Code: 2000980066
Client Code: 1002169562
Date of Eval: Mar 31, 2015

Basic Information		Medical Information		History Information	
Gender:	Female	General health:	Very Good	BH hospitalizations:	11 or more
Year of Birth:	1964	Physician visits last 2 months:	2	Hosp risk:	0
Marital:	Widowed	Current prescriptions:		Previous therapists seen:	4
Degree/Grade:	Four-year college	Behavioral health medications:	3	Employment:	Unemployed, not looking for work
Religion:	Other Christian	effexor - 153		Living situation:	Living alone
Ethnicity:	Caucasian/White	hydroxyzine - 25		Participation Voluntary?	Yes
Administration:	Completely Self-Administered	trazodone - 150		Payor:	006ELF
				Payer Request:	

WARNING: This report is provided as a service to health professionals strictly as an aid in evaluating and tracking client progress in treatment. It is inappropriate to use this report for determination of benefits or as a diagnostic tool in lieu of a qualified professional evaluation.

CONSIDERATIONS:*

AXIS I:

Dysthymia 300.4; Insomnia; Major Depressive Episode; OCD 300.3; PTSD 309.81; Panic Attacks; Sexual Functioning Disorder;

*NOTE: At least one hallmark symptom of the above referenced diagnoses has been endorsed. It does not mean that the report is suggesting those diagnoses are present. It just means one or probably many symptoms is present and warrants your consideration. Not all DSM diagnoses have corresponding symptoms on the TOP. However, flagging those that do, and that are endorsed, often assists the clinician in making a thorough diagnostic assessment.

AXIS III:

Health Factors	Currently affecting health	Taking medication	Seen doctor in past year	Hospitalized in past year
Allergies	Yes	No	No	Yes
Hormonal abnormalities (hypothyroidism, hypothyroidism, ...)	Yes	Yes	Yes	No

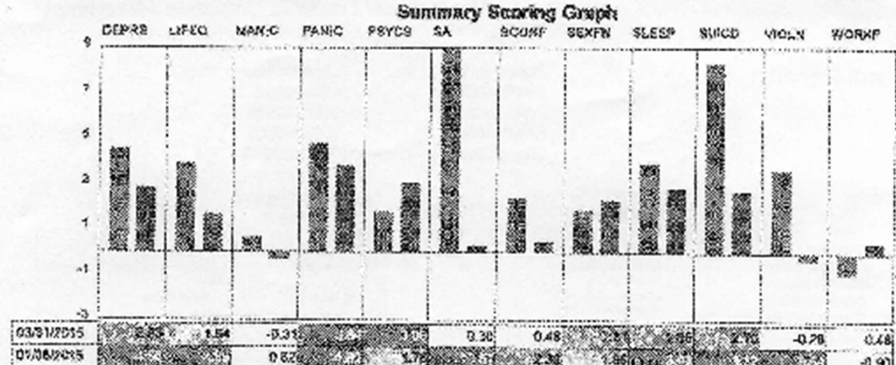
AXIS IV:

Stressful items	Last 30 days	Last 12 months

Clinical Outcomes: TOP Example

From BBL   Wed 01 Apr 2015 08:36:47 AM EDT   Page 2 of 2

Summary Scoring Graph



Severity of current administration: ***extreme, **moderate, *mild, ?questionable.

Scores are reported as standard deviations away from a non-clinical population which has an average score of 0. Lower scores are considered better. The scale of this graph goes from -3 to +8 standard deviations. Bars on graph are plotted from left to right, from the earliest administration to the most recent one. Change greater than 1.0 is statistically and clinically significant.

Critical items marked as occurring during the past two weeks (selected from 17 key TOP items):

thought about killing yourself or wished you were dead	Some of the time
worried that someone might hurt you	Some of the time
had unwanted thoughts or images	Some of the time
found yourself thinking about a drink or getting high	A little of the time

Importance of Treatment Structure

- Clear treatment framework/service delivery and other structure is a common factor in empirically supported treatments for borderline personality disorder (BPD) (Weinburg et al., 2011)
- Research shows that more complex client presentations require greater treatment structure
- Structure creates predictability, safety, and success for clients and therapists
- “Saying what you do, and doing what you say” is the foundation of trust, and it speaks to the therapy alliance

Examples of Treatment Structure

- Treatment Framework/Service delivery
- Detailed therapy agreements, rules, and expectations (of therapists too)
- Following the typical routines of therapy and/or each part of a program
- Use of treatment stages and the treatment hierarchy
- Use of diary cards, behavioral analysis, homework, and written safety and skills plans
- Treatment plans with clear goals and objectives, created early in the therapy process
- Detailed protocols for dealing with safety and other issues
- Even starting and ending on time!

Structure of Individual Therapy

Have a clear framework in mind (the greater the difficulties, the more important the structure). Here is a suggested framework:

- 3 to 5 minutes of mindfulness
- Review homework and inquiry about other treatment modes (if applicable)
- Review diary card to determine treatment targets
- Set the agenda based on diary card and client input, including client's description of his/her current emotional state
- Do identified work of the session
- Assign homework for the next week
- End with 3 to 5 minutes of mindfulness

Leave sufficient time to close session, especially if difficult material is covered

Structure of Individual Therapy

- End the session on time
- Be prepared with handouts and remember to interweave skills throughout treatment
- Use behavioral analysis as needed (nice way of "structuring" a session)
- Solicit feedback by asking (e.g., did you get what you needed today?, what was helpful, not helpful?)

Structure of Skills Group

- Determine the skills curriculum; have a syllabus while also being flexible to the needs of the group
  - Common curriculum rotates through the modules, revisiting mindfulness at each change
  - Revisit skills when needed; occasionally “mix-it-up” for interest
- Begin with 3 to 5 minutes of mindfulness
- Review homework assignments
- Cover the scheduled skills lesson
- Assign individualized homework
- End with 3 to 5 minutes of mindfulness

Structure of DBT Therapy Done in a Group

- Start with 3 to 5 minutes of mindfulness
- Review homework
- Set the agenda for the group (e.g., what are the therapy needs of the day and who needs therapy “time”; all clients with identified target behaviors need to take therapy time)
- Each person gets equal time (there are pros and cons of group-managed time versus use of a timer)
- Be sure to generalize what is discussed in time to life outside of therapy
- Assign homework
- End with 3 to 5 minutes of mindfulness

DBT Group-Based Programs and Contagion

- Contagion is when a person copies the behavior of another
- It happens when a model has social influence and the behavior has a clear gain…two incentives for another to copy the behavior.
- **Contagion is a two-way construct: It can be helpful (e.g., copying skill use) or destructive (e.g., copying a self-harm behavior). Effective programs promote helpful contagion**
- Beware the "instigator" and the "imitator" with destructive contagion. The instigator needs accountability and the imitator needs identity work. Destructive contagion is most likely when harmful behaviors are allowed to be promoted and/or glamorized. Media is a common culprit.
- Contagion is most common in settings in which clients have significant unmonitored time

Treatment Stages

- **Pretreatment stage:** Oriented client and the environment to the treatment and establish commitment (i.e., agreement on goals and methods)
- **Stage 1 with treatment targets and hierarchy of:**
  - Decrease life-threatening behaviors
  - Decrease therapy interfering behaviors
  - Decreased quality of life interfering behaviors
  - Increase skill use to address targets

Treatment Stages

- **Stage 2:** Decrease PTSD (if applicable) and other major stress responses while increasing more complete emotional experiencing and expression
- **Stage 3:** Increase self-respect, achieve individual goals, and address ordinary problems of living
- **Stage 4:** Find fulfillment, become more actualized, and increase personal spirituality

The DBT Hierarchy In Detail

- The Treatment Hierarchy determines "what to treat when" and sets the following priorities (i.e., treatment targets):
  - Suicidal behaviors and intense suicidal urges
  - Self-injurious behaviors (SIB) and Substance Use Behaviors (SUB)
  - Treatment-interfering behaviors (TIB)
  - Quality-of-life-interfering behaviors (QIB)

The hierarchy is a set of guidelines that can be adjusted based on expertise and client needs

Note: The Hierarchy is Especially Used During the 1st Stage of Treatment that is focused on *Stability*

Hierarchy Guidelines Exercise

A client:

- Has low to moderate suicidal thinking. No history of acting on SI and is currently committed to safety
- Has been drinking to the point of intoxication every evening for the past week
- Has superficial self-injury, scratching arms, leaving marks, but no bleeding
- Has missed the last three sessions
- Reports that house is in foreclosure; will be homeless in two months
- Reports high anxiety and depression
- Was cut off by another driver in traffic

Rank your targets with a rationale

Implementing a DBT Program: What to Consider

- Target population (inclusionary/exclusionary criteria)
- Level of care needed for population
- Program goals (e.g., acute stabilization, symptom reduction, long-term improvements in functioning)
- Available resources (staffing, space, other)
- Staff “buy in” (allegiance) with the approach
- Sustainability of the approach

Implementing a DBT Program: What is Needed

- Clear treatment framework
- Clear program expectations
- In-depth DBT and skills training for all staff
- Ongoing consultation
- Ongoing training and program development
- Monitoring outcomes and using them to improve services

Common Considerations with DBT Programs

- Separate or mixed programs for males and females?
- Open or closed groups?
- Length of stay?
- When to start new clients?
- Program manuals/curriculum?
- How long to teach each skill?
- For adolescents: To include parents in skills training or not?

DBT Research Exists For These Settings:

- Residential
- Corrections
- Hospital
- Intensive Outpatient/Day Treatment
- College
- School
- Skills Group Only
- Check the research literature to guide you!

For Tomorrow

- Review Pages 1-19 in the DBT Intensive Handouts packet (Especially the Master Skills List the Dialectics 3: Exercises)
- Optional: Read from one or more of the main four skills modules (Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness) if you have a manual
- If you do not have a manual…do some research and get one!

Dialectical Behavior Therapy Intensive Training

Day Two: Skills Training

Lane Pederson, PsyD, LP, DBTC

One Skill Can be a Game-Changer

A story of Bridge-burning…

DBT Skills...

- Provide a common language for effective behaviors
- Help clients label, remember, and use effective behaviors
- Teach new behaviors to reinforce (one of the most benevolent ways of changing behaviors)
- Provide a “safety net” in therapy...therapists and clients can almost always “fall back” on skills

On Skills Training Manuals…

“There is no a priori reason why one skills training program cannot be substituted for another...In a sense, what I am recommending is that if you do not use the DBT skills training manual as is, you consider writing one of your own or modifying the manual to suit your own purposes” (Linehan, p. 155)

Four Original Skills Modules (Categories of Skills)

- **Mindfulness**
  - Wise Mind and Core "What" and "How" Skills
- **Distress Tolerance**
  - ACCEPTS, IMPROVE, Self-Soothe, Pros and Cons, Radical Acceptance, Willingness
- **Emotion Regulation**
  - Model of Emotions, PLEASED, BPE, BM, O2E
- **Interpersonal Effectiveness**
  - FAST, GIVE, DEAR MAN

Skills in Individual Settings

- Recommended for low intensity clients (where some time in individual can be devoted to teaching skills)
- Set aside time in the beginning or end of the session for skills training
- Follow a curriculum and/or customize based on client needs and preferences
- Consider a bibliotherapy approach with some clients
- Interweave skills for all types of clients (i.e., "talk" and apply skills throughout sessions)
- **Note: Some high-intensity clients require individual skills training for a variety of reasons**

Skills in Skills Group Settings

- Recommended for high intensity clients (where there will not be enough time to teach skills in individual sessions)
- Length of group/number of hours of skills training is variable based on level of care, client factors, etc.
- Skills are usually taught “classroom” style
- Be sure to make teaching experiential
- Be sure to individualize skills training

Most Common Curriculum

- Mindfulness
- Distress Tolerance
  - *Review Mindfulness*
- Emotion Regulation
  - *Review Mindfulness*
- Interpersonal Effectiveness

- **What you teach can depend on your setting, length of stay, etc.**

Skills Training Checklist

- **Follows a clear overall structure** (i.e., greets clients, begins session with mindfulness, reviews homework from previous sessions, introduces skills lesson, presents skills lesson, assigns homework, ends with mindfulness, closes session)
- **Begins with mindfulness practice**
- **Reviews homework assignments** (i.e., reinforces accomplishments, addresses barriers that arise, and treats unfinished homework as treatment-interfering behavior, triaging to individual or group therapist as needed)
- **Introduces skills topic.** (i.e., defines skill, orients clients to the purpose of the skill taught and how it relates to clients' identified goals)
- **Shows conceptual mastery of skill(s) presented** (i.e., clearly shows advanced understanding of the skill, including how it relates to other skills, can discuss the skill fluently, and is able to answer questions)
- **Is prepared with examples and/or experiential exercises for clients** (i.e., takes the skills training beyond lecture)

Skills Training Checklist

- **Holds focus of the skills training session.** (i.e., minimizes off-topic discussions, redirects tangential and/or irrelevant feedback, eliminates side conversations and cross-talk, and maintains command of the skills training session.)
- **Encourages and reinforces balanced client participation.** (Engages clients in discussion. Elicits feedback.)
- **Adapts training appropriately to the treatment population** (i.e., teaching and examples are relevant to the treatment population, and the teaching style matches the learning abilities and pace of the client population. Considers cultural issues and shows cultural competence with individuals and/or client population)
- **Maintains a psycho-educational focus.** (i.e., keeps client examples on a psycho-educational and not therapeutic level. Avoids getting into therapy issues and process, and refrains from interventions that are obviously therapy-related. Triages therapy issues that arise to identified therapist and/or therapeutic session)
- **Assigns homework to clients** (Assigns relevant homework, tasks, experiments, etc. Emphasizes importance of homework in skills acquisition and reinforces efforts and accomplishments)
- **Ends with mindfulness practice.**

Skills Training Approaches

- Interactive lecture (good for conveying a lot of information quickly)
- Questions/discussion
- Assigning teaching to clients
- Learn/do/teach model
- Experiential exercises
- Using media

Tips to Improve Skills Training

- Be strengths-based (often we think of skills deficits and forget to identify what is working)
- "Catch" and label skill use continuously
- Reinforce anything and everything that is not a problem behavior
- Shape emerging behaviors
- Orient to purpose and goal of skills taught
- Assign individualized homework and get commitment to follow-through
- Use Worksheets! **(See Worksheets in Handouts Packet, pages 6-19)**
- **Give everyone a binder with the curriculum and all other important documents**

Mindfulness Module

- **Mindfulness Skills teach:**
  - Awareness
  - How to direct your mental processes
  - How to be in the moment
  - How to be responsive with behavior
  - Increased emotion regulation and decreased (ineffective) mood congruent behavior
  - Improved connection to experience, enjoyment, and peace…as well as increased tolerance of what is uncomfortable or even painful

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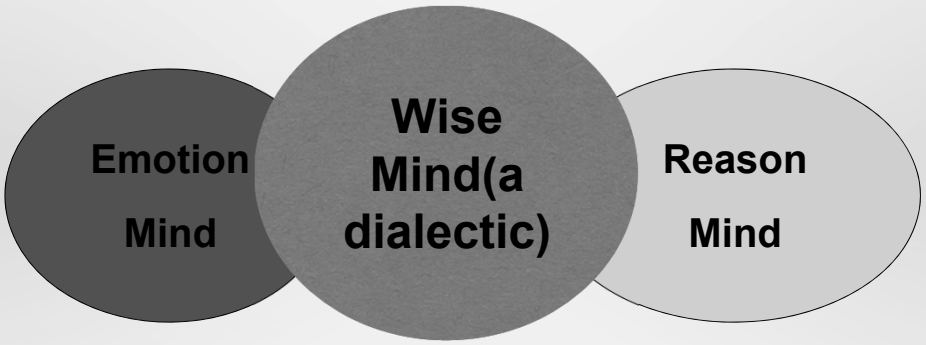
What is Mindfulness?

States of Mind



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Two Steps to Wise Mind

- **Step One:** Observe and Describe Non-judgmentally and One-mindfully
- **Step Two:** Participate Effectively

Observe and Describe ("What Skills")

- **Observe** (watch and become aware)
  - Feelings, thoughts, urges, physical sensations, behaviors, information from senses, etc.
  - Environment...what information is around me?
  - Experience integrated (i.e., life here and now)
- **Describe**
  - Put your experience into words (and vice versa)
  - Words make it clear for you and others

Non-judgmentally and One-mindfully
("How" Skills)

- **Non-judgmentally**
  - Describing without attaching a label or opinion
  - Being open to continued evaluation, based on facts
  - Focus is on "what is" not the "goods," "bads," shoulds," and "should nots"
- **One-mindfully**
  - Choose, direct, and focus your attention and concentration on one thing
  - Gently let go of distractions, refocusing over and over

Participate (A "What Skill) Effectively (A "How" Skill)

- **Participate**
  - Make a mindful choice about what you are doing
  - Practice your skills until they are a part of "you"
  - Immerse yourself and be one with your experience
- **Effectively**
  - Focus on what the situation or moment requires
  - Remember your goals and do what "works" to meet them
  - Play by the rules
  - Do not "cut of your nose to spite your face"

Mindfulness-enhancing Qualities

- *Beginner's Mind*: Do not let past experiences cloud the here and now
- *Compassion*: For self and others. Everyone suffers, and empathy and concern heals
- *Tolerance*: Learn to experience without judgment or trying to change it
- *Trust*: Be assured of the benefits of mindfulness
- *Patience*: Reality unfolds in its own time, without regard to preferences
- *Nonstriving*: Be without clinging to a goal or outcome
- *Practice*: Benefits come from consistency

Mindfulness: Practice and Application

- Must practice daily (multiple times)
- Begin and end of each session with mindfulness
- Address barriers to mindfulness (e.g., judgments, environmental, etc.)
- Make it relevant, interesting, and enjoyable
- Mindfulness is essential to effective skill use...it is a "gateway skill"
- When skills lack effectiveness, often concurrent mindfulness is what is needed

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Mindfulness Exercise

Distress Tolerance Module

- **Distress Tolerance teaches:**
  - Ability to tolerate painful emotion
  - Distraction without avoiding
  - Pathways to other skills
  - Action instead of reaction
  - Managing crisis without making it worse

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When To Use Distress Tolerance

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

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More About Distress Tolerance

- Practice skills when NOT in distress
- Skills tend to be short-term...must have many skills listed
- Skills must be connected to specific behaviors
- Coach clients to change strategies when a skill does not work
- Evolve skills plans (written down)consistently...treat like a "living document" and USE PROACTIVELY **(See Safety and Crisis Plans in the Handouts Packet, pages 51-57)**

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Dealing with Distress…

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Distract: Wise Mind ACCEPTS

Activities

Contributing

Comparisons

Emotions

Pushing away

Thoughts

Sensations

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IMPROVE the Moment

Imagery

Meaning

Prayer

Relaxation

One thing at a time

Vacation

Encouragement

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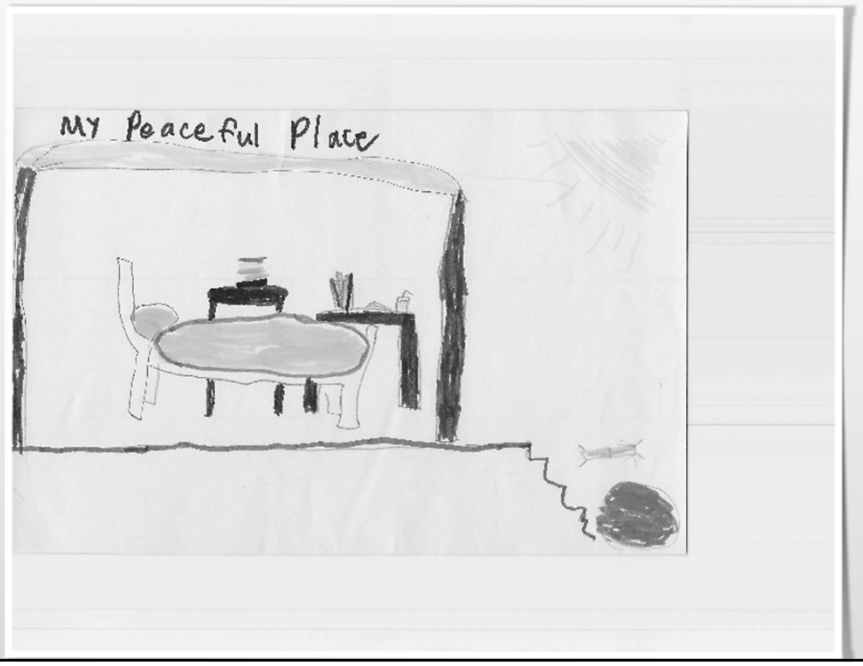
Imagery (7 years old)



Self-Soothe

Mindful engagement of the senses to comfort:

Vision
Hearing
Smell
Taste
Touch

Remember Mind-sense and Spiritual-sense

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Pros and Cons

- List positive consequences
- List negative consequences
- Weigh short-term vs. long-term consequences
- Is it worth it?
- Make a decision
- Pros and cons are dialectical and activate Wise Mind

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Pros and Cons (P&C) Application Example

My Basic Choices Are: Using self-injury versus using skills

Short-Term PROS of Self-Injury	Short-Term CONS of Self-Injury
Numbed my feelings! *Worked* *Blood grounded me know*	*Missed chance to use plan* *worried about upcoming group* *Had to hide it*
Long-Term PROS of Self-Injury	**Long-Term CONS Self-Injury**
None really	*Lost trust* *Lost self-respect* *More scars* *Shame sets me up*
Versus	
Short-Term PROS of Skill Use	**Short-Term CONS of Skill Use**
No need to lie or cover up *Feel good if I make it* *No hassle with blood and stuff* *NO CHANGE ANALYSIS!!*	*Hard and might not work* *Don't know* *Maybe more emotional pain*
Long-Term PROS of Skill Use	**Long-Term CONS of Skill Use**
RESPECT! *Learn to handle life and get somewhere*	*More expectations?* *Pressure, I don't know*

My Decision: *Skills, I guess!!*

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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

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Accepting Reality Skills

- Radical Acceptance
  - Freedom from suffering requires acceptance of “what is” from within. Letting go of fighting reality ends suffering
  - Acceptance may still mean tolerating pain
  - *Acceptance frees psychological and emotional resources to move forward*
- Turning the mind
  - Continuously recommit to accepting reality...over and over again

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Stages of Acceptance (from Kubler-Ross)

- Denial: not wanting to believe its real
- Anger: feeling that it is unjust and should not have happened or be happening
- Bargaining: trying to make a deal to escape the reality
- Depression: having reality set in and feeling the impact
- Acceptance: acknowledging the reality of “what is”

No matter where you are, you are in the process

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Everyday Acceptance

- We meet everyday realities (i.e., hassles) with resistance, creating unneeded suffering and exhausting our psychological and emotional resources
- Examples:
  - Being stuck in traffic
  - Having a crabby significant other
  - Forgetting something at home
  - Having to wait for something
  - Making a mistake (or dealing with someone else’s mistake)
  - Etc., etc., etc.
- These are all opportunities to practice acceptance
- Acceptance of these realities does not mean being passive, giving in, or giving up: many of these realities require problem-solving
- Acceptance frees up our resources to be response and effective

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Willingness (vs. Willfulness)

- Willingness is doing what is needed, not sitting on your hands
- Willingness means dealing with reality, not what you wish it would be
- The concept contrasts our Western philosophy of “when there’s a will there’s a way”
- “Where there is willingness, there is a way” is the message
- What are you willing to do given the situation?

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Emotion Regulation Module

- **Emotion Regulation teaches:**
  - How emotions work
  - How to reduce emotional vulnerability
  - How to create positive emotions
  - How to step out of ineffective mood congruent behaviors
  - How to develop and maintain emotional balance

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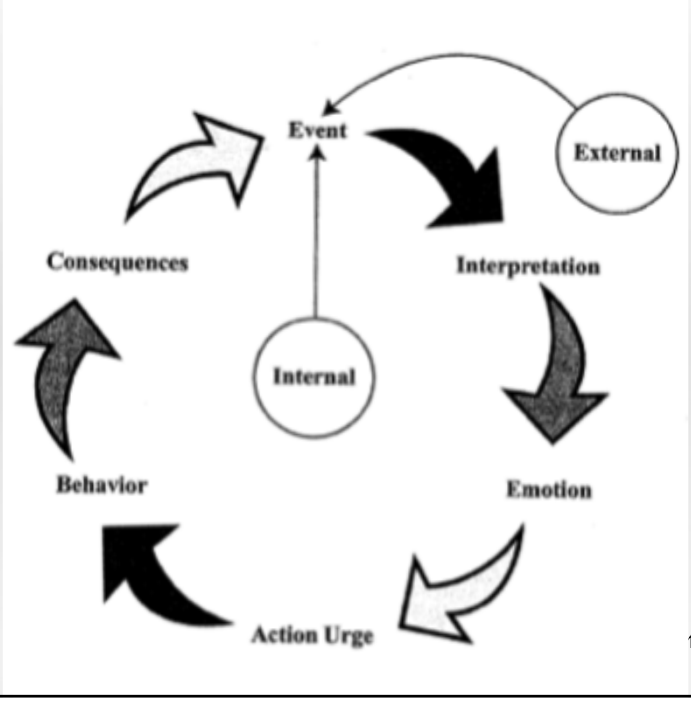
Model for Emotions



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PLEASED

Physical health

List resources and barriers (each area)

Eat three healthy, balanced meals

Avoid mood altering drugs

Sleep between 7 to 10 hours

Exercise at least 20 minutes

Daily

- Address Barriers
- Develop a plan/track on diary card

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Build Mastery

- Engage in activities of daily living
- Accomplish tasks that need to be done
- Take steps toward a challenging goal
- Build a sense of control, confidence, and competence
- Give yourself credit!

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Build Positive Experience

- Short term
  - Do pleasant things that are possible now
- Long term
  - Invest in relationships (Attend to Relationships-A2R)
  - Invest in your goals
  - Build a satisfying life
  - Take one step at a time

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Build Positive Experience

- Must be planned/scheduled
- Must include mindfulness skills
- Address distractions that interfere with BPEs
- Address judgments that interfere with BPEs (e.g., not deserving, etc.)
- Address concerns about expectations

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Opposite-to-Emotion Action

- Break ineffective emotional cycles by acting opposite to behaviors that are mood congruent
- Opposite action may also create a different emotion
- Often a “gateway” skill
- Examples include activity when depressed, approaching when anxious, and being kind when angry

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O2E Behaviors

- Activity and social contact when depressed
- Approach fears when anxious
- Gently avoid (not attack) when angry
- Apologizing with **justified** guilt
- Continue to do what leads to guilt with **unjustifed** guilt (coach yourself)
- Just do it! with approaching life in general

Interpersonal Skills Module

- Interpersonal Effectiveness teaches:
  - How to build self-respect
  - How to make and maintain relationships
  - How to meet wants and needs
  - How to set effective boundaries and say “no”

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Interpersonal Skills

- Self-respect effectiveness skills: **FAST**
- Relationship effectiveness skills: **GIVE**
- Objective (goal) effectiveness skills: **DEAR MAN**

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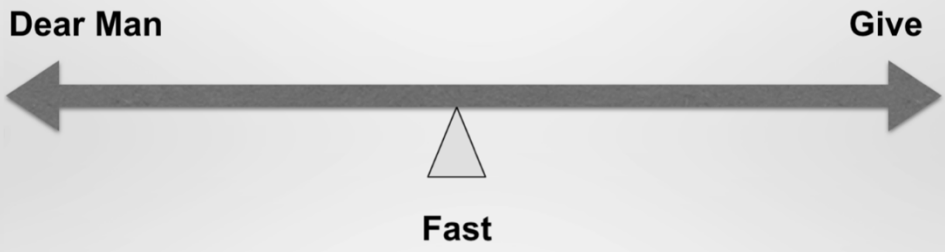
Dialectical Balance of the Interpersonal Skills



Self balanced with others guided by values

Self-Respect Effectiveness: FAST

Fair: be fair to self and to others

Apologies: no *unnecessary* apologies or apologies for your beliefs, opinions, or for being you

Stick to your values: know your values and what is non-negotiable. Resolve value conflicts effectively

Truthful: Avoid exaggerations, excuses, and lies. Be accountable to yourself and others

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Relationship Effectiveness: GIVE

Genuine: be authentic and real, and act from your true self

Interest: make eye contact, show interest to be interested, allow reciprocity in interactions

Validate: acknowledge what you heard without judging or fixing. Focused on the other person!

Easy manner: use humor, smile, and be easygoing

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VALIDATION

Value Others: Seeking the inherent value in others is essential to validation.

Ask Questions: Use questions to draw out others' experience.

Listen and Reflect: Listen to others' answers to your questions and reflect back the major themes.

Identify with Others: Work to see the world through the eyes of others.

Discuss Emotions: Talk about others' feelings and how they affect them from their perspective (not how it affects you).

Attend to Nonverbals: Notice others' nonverbal communication to give you information about their experience.

Turn the Mind: Validation does not mean that we agree with others. Turning the mind is especially important when it is difficult to relate and during conflicts.

Encourage Participation: Validation can be a difficult process at times, so we need to encourage ourselves and others to be engaged with each other.

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DEAR MAN Assumptions

- No one know what you want or need
- Don't read minds: Ask!
- Use words, not behaviors
- Be clear on your goals
- Consider timing, intensity, and other factors
- Assertiveness is not a guarantee

Objective Effectiveness: DEAR MAN

Describe the details of the situation

Express your emotions and thoughts

Assert by asking for what you want (or saying no)

Reinforce by rewarding, not punishing

Mindful: Stay focused on the issue

- Avoid attacks, distractions, and side tracking
- Broken record: assert again and again and again

Appear confident

- Talk, walk, and act with confidence (act "as if" if needed)

Negotiate

- Be willing to offer an alternative
- Be willing to ask for an alternative
- Turn the tables

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Supplemental Skills

- Many DBT experts have added additional skills and/or modules (TIP; ABC's)
- Dialectics; Cognitive Modification, Problem-solving; Building Structure and Routines; Social Media
- Teach the skills your clients need!

Exercises

- Pick a skill to explain to a colleague (or someone else)
- Pick a "skill of the day" to practice each day for yourself

For Tomorrow

- Review Handouts on the Diary Card and Behavior and Solution Analysis in the Handouts Packet, especially pages 20-22 and 29.
- Review Basics of Behavior Handout, pages 37-40.

Dialectical Behavior Therapy Intensive Training

Day Three: The Diary Card, Behavioral Analysis, and DBT Therapy Techniques

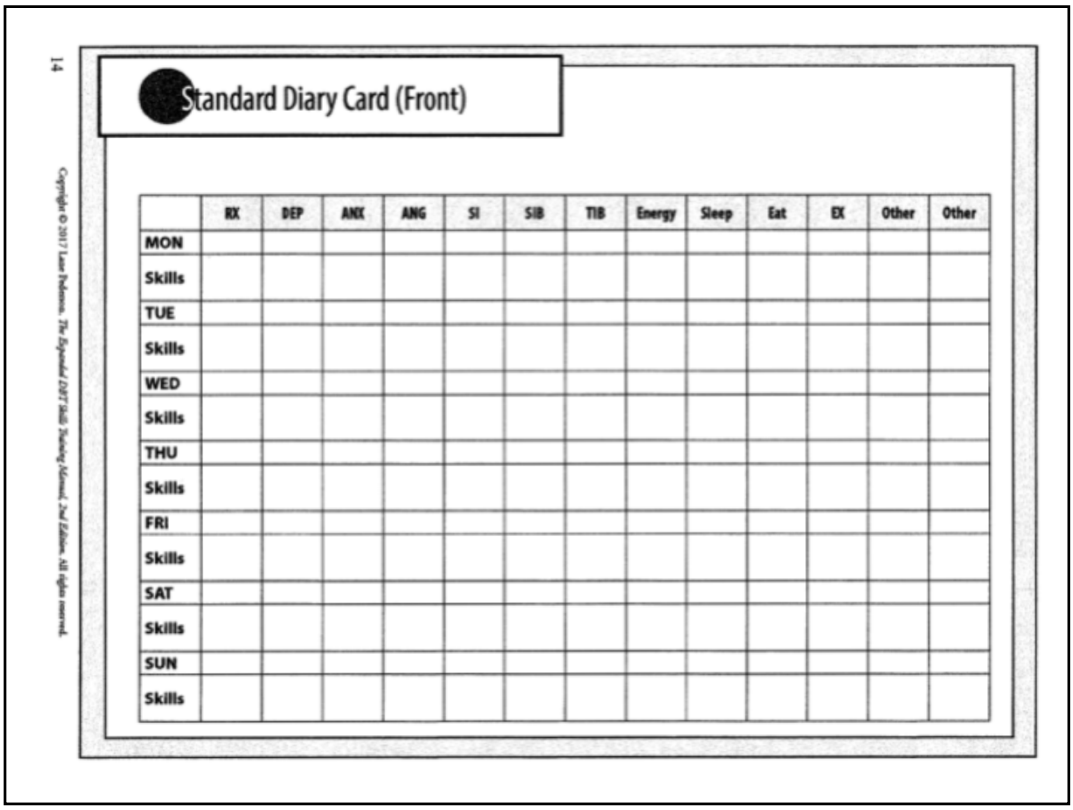
Lane Pederson, PsyD, LP, DBTC

Diary Cards

- Self-monitoring of urges, target behaviors, symptoms, skills, emotions, and other important information (e.g., positive experiences (highlights), treatment objectives, gratefulness)
- Helps to structure and generalize what is learned in therapy to natural environments; builds awareness and skill use
- Provides a tremendous amount of information to track how the client is doing, determine if there are target behaviors on the treatment hierarchy to prioritize, and to set the treatment agenda
- Also provides opportunities to positively reinforce success and to inquire about extra-therapeutic factors

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 TIB



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Standard Diary Card (Front)

	RX	DEP	ANX	ANG	SI	SIB	TIB	Energy	Sleep	Eat	EX	Other	Other
MON													
Skills													
TUE													
Skills													
WED													
Skills													
THU													
Skills													
FRI													
Skills													
SAT													
Skills													
SUN													
Skills													

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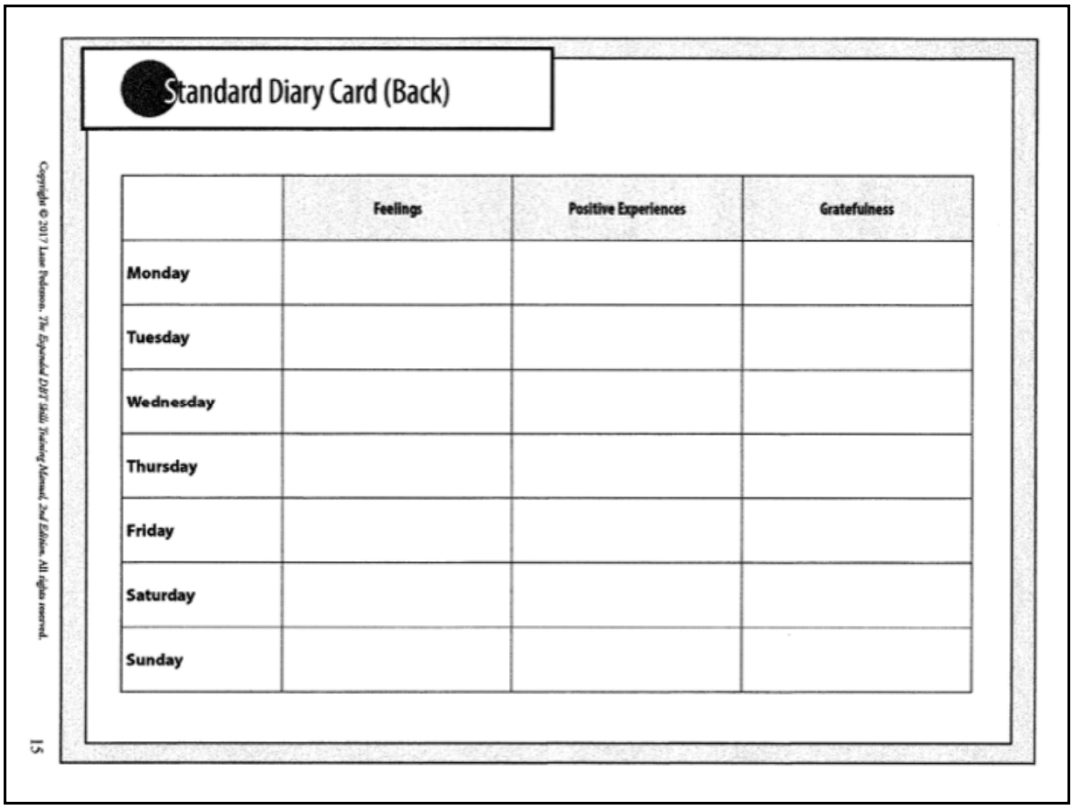

Standard Diary Card (Back)

	Feelings	Positive Experiences	Gratefulness
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

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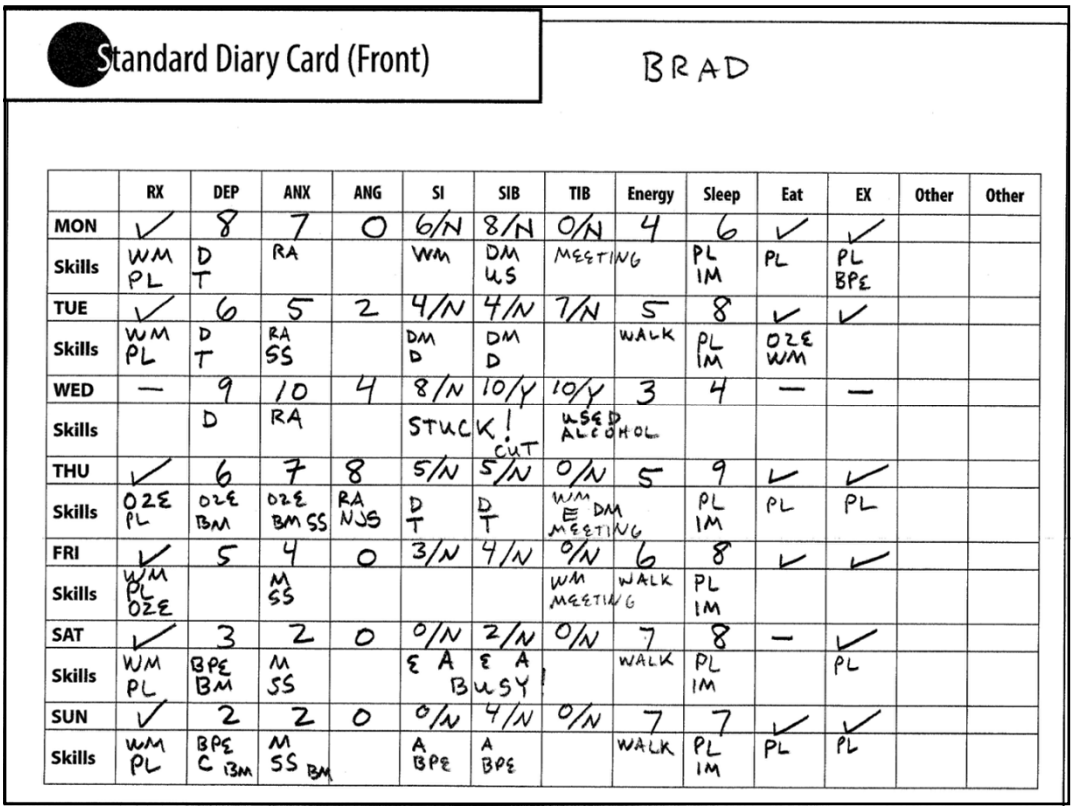

Standard Diary Card (Front)

BRAD

	RX	DEP	ANX	ANG	SI	SIB	TIB	Energy	Sleep	Eat	EX	Other	Other
MON	✓	8	7	0	6/N	8/N	0/N	4	6	✓	✓		
Skills	WM PL	D T	RA		WM	DM US	MEETING		PL IM	PL	PL BPE		
TUE	✓	6	5	2	4/N	4/N	7/N	5	8	✓	✓		
Skills	WM PL	D T	RA SS		DM D	DM D		WALK	PL IM	OZE WM			
WED	—	9	10	4	8/N	10/Y	10/Y	3	4	—	—		
Skills		D	RA		STUCK!	CUT	USED ALCOHOL						
THU	✓	6	7	8	5/N	5/N	0/N	5	9	✓	✓		
Skills	OZE PL	OZE BM	OZE BM SS	RA NJS	D T	D T	WM E DM MEETING		PL IM	PL	PL		
FRI	✓	5	4	0	3/N	4/N	0/N	6	8	✓	✓		
Skills	WM PL OZE		M SS				WM MEETING	WALK	PL IM				
SAT	✓	3	2	0	0/N	2/N	0/N	7	8	—	✓		
Skills	WM PL	BPE BM	M SS		E A B	E A BUSY!		WALK	PL IM		PL		
SUN	✓	2	2	0	0/N	4/N	0/N	7	7	✓	✓		
Skills	WM PL	BPE C BM	M SS BM		A BPE	A BPE		WALK	PL IM	PL	PL		

Standard Diary Card (Back)

	Feelings	Positive Experiences	Gratefulness
Monday	DOWN / SAD ANXIOUS CALM	MEETING VOLUNTEER	FAMILY GROUP
Tuesday	MAD (SELF) DOWN	OUT TO EAT !	?
Wednesday	ANGRY (SELF) DEPRESSED URGES! ANXIOUS	NONE	NONE
Thursday	SOME CALM DETERMINED! MAD (SELF).	MEETING MOVIE	NICE DAY
Friday	SAD HAPPY SOME STRESS	PARK MEETING	FRIEND AMY
Saturday	BETTER HAPPY DETERMINED	NETFLIX PARK	FRIEND AMY
Sunday	SPIRITUAL MORE HAPPY SOME URGES	VOLUNTEER CHURCH DOG PARK	DOG PARK !

DAILY LOG

Date:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Take medications? (Yes or No)	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Anger (0- 5/action)							
Depression (0- 5)							
Anxiety (0- 5)							
Joy (0- 5)							
Safety: SI (0-5/action)							
Safety: Self Harm (0-5/action)							
Sleep (# of hours)							
BPE (Yes or No)	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Me (0- 5)							
List skills used:							
I'm thankful for...							

0=not at all 1=a little bit 2=somewhat 3=strong 4= very strong 5=extremely strong

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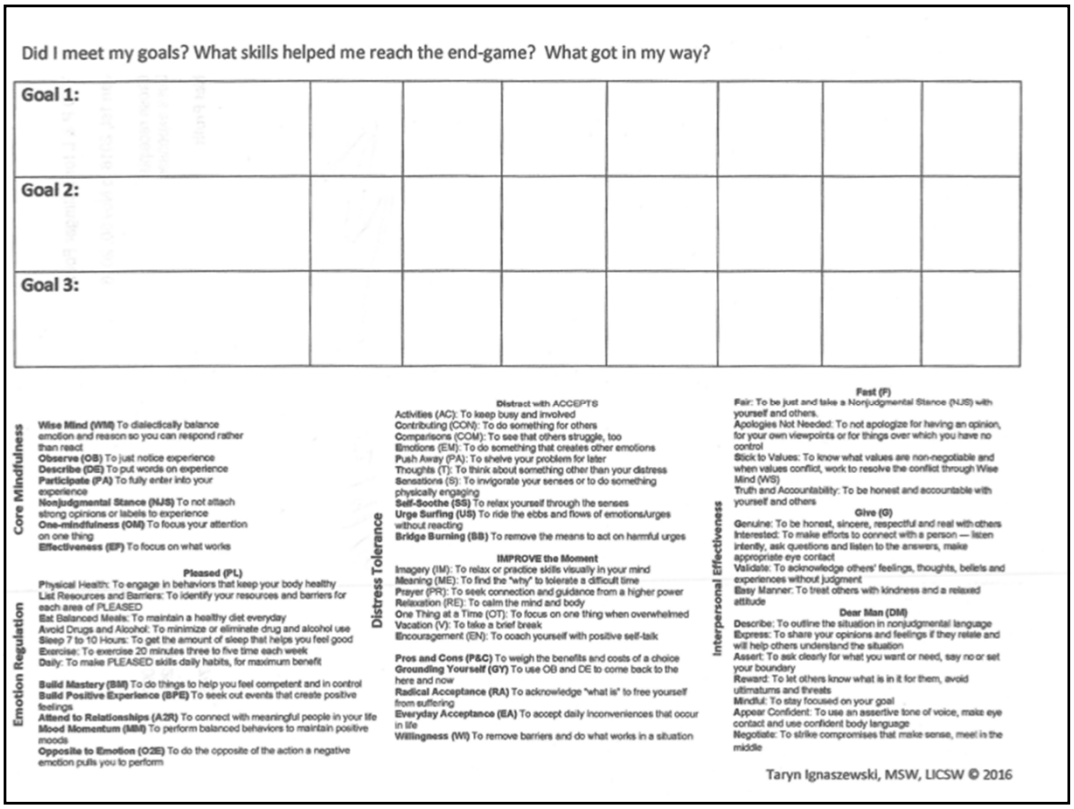

Did I meet my goals? What skills helped me reach the end-game? What got in my way?

Goal 1:							
Goal 2:							
Goal 3:							

Core Mindfulness

Wise Mind (WM) To dialectically balance emotion and reason so you can respond rather than react
Observe (OB) To just notice experience
Describe (DE) To put words on experience
Participate (PA) To fully enter into your experience
Nonjudgmental Stance (NJS) To not attach strong opinions or labels to experience
One-mindfulness (OM) To focus your attention on one thing
Effectiveness (EF) To focus on what works

Emotion Regulation

Pleased (PL)
Physical Health: To engage in behaviors that keep your body healthy
List Resources and Barriers: To identify your resources and barriers for each area of PLEASED
Eat Balanced Meals: To maintain a healthy diet everyday
Avoid Drugs and Alcohol: To minimize or eliminate drug and alcohol use
Sleep 7 to 10 Hours: To get the amount of sleep that helps you feel good
Exercise: To exercise 20 minutes three to five time each week
Daily: To make PLEASED skills daily habits, for maximum benefit

Build Mastery (BM) To do things to help you feel competent and in control
Build Positive Experience (BPE) To seek out events that create positive feelings
Attend to Relationships (A2R) To connect with meaningful people in your life
Mood Momentum (MM) To perform balanced behaviors to maintain positive moods
Opposite to Emotion (O2E) To do the opposite of the action a negative emotion pulls you to perform

Distress Tolerance

Distract with ACCEPTS
Activities (AC): To keep busy and involved
Contributing (CON): To do something for others
Comparisons (COM): To see that others struggle, too
Emotions (EM): To do something that creates other emotions
Push Away (PA): To shelve your problem for later
Thoughts (T): To think about something other than your distress
Sensations (S): To invigorate your senses or to do something physically engaging
Self-Soothe (SS) To relax yourself through the senses
Urge Surfing (US) To ride the ebbs and flows of emotions/urges without reacting
Bridge Burning (BB) To remove the means to act on harmful urges

IMPROVE the Moment
Imagery (IM): To relax or practice skills visually in your mind
Meaning (ME): To find the "why" to tolerate a difficult time
Prayer (PR): To seek connection and guidance from a higher power
Relaxation (RE): To calm the mind and body
One Thing at a Time (OT): To focus on one thing when overwhelmed
Vacation (V): To take a brief break
Encouragement (EN): To coach yourself with positive self-talk

Pros and Cons (P&C) To weigh the benefits and costs of a choice
Grounding Yourself (GY) To use OB and DE to come back to the here and now
Radical Acceptance (RA) To acknowledge "what is" to free yourself from suffering
Everyday Acceptance (EA) To accept daily inconveniences that occur in life
Willingness (WI) To remove barriers and do what works in a situation

Interpersonal Effectiveness

Fast (F)
Fair: To be just and take a Nonjudgmental Stance (NJS) with yourself and others.
Apologies Not Needed: To not apologize for having an opinion, for your own viewpoints or for things over which you have no control
Stick to Values: To know what values are non-negotiable and when values conflict, work to resolve the conflict through Wise Mind (WB)
Truth and Accountability: To be honest and accountable with yourself and others

Give (G)
Genuine: To be honest, sincere, respectful and real with others
Interested: To make efforts to connect with a person — listen intently, ask questions and listen to the answers, make appropriate eye contact
Validate: To acknowledge others' feelings, thoughts, beliefs and experiences without judgment
Easy Manner: To treat others with kindness and a relaxed attitude

Dear Man (DM)
Describe: To outline the situation in nonjudgmental language
Express: To share your opinions and feelings if they relate and will help others understand the situation
Assert: To ask clearly for what you want or need, say no or set your boundary
Reward: To let others know what is in it for them, avoid ultimatums and threats
Mindful: To stay focused on your goal
Appear Confident: To use an assertive tone of voice, make eye contact and use confident body language
Negotiate: To strike compromises that make sense, meet in the middle

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Diary Card Example and Exercise

Purpose of 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
- Use this understanding to actively problem-solve and develop skill use
- Used often during Stage 1 for targets on the treatment hierarchy (SI, SIB, TIB)
- Also an excellent method for adding structure to sessions

How to Frame Behavior and Solution Analysis

- Some clients experience change analysis as punishment; if this happens, be sure to validate the experience
- **However, discuss how change analysis is a learning tool to help clients reach their goals**
- Discuss expectation that change analysis will be used for target behaviors on the hierarchy (i.e., SI, SIB, TIB), and for both in-session and out-of-session behaviors that require problem-solving
- Also consider using change analysis for positive behaviors

During the Behavior and Solution Analysis Process

- Orient clients to the procedure and continue to orient as you go through the change analysis (Why is this important to the client?)
- Validate the emotions that arise and that change analysis can be difficult. Attending to emotions also provides exposure effects
- Use positive reinforcement for efforts and breakthroughs
- Remember that the end goal is to learn skills and solve problems
- Coordinate what is learned with crisis, safety, and other skills plans

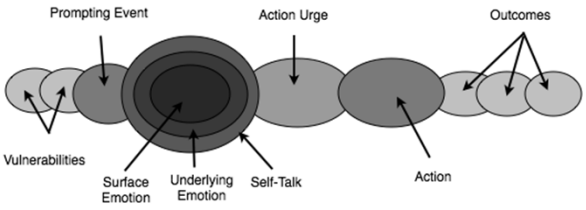
Steps in Behavior and Solution Analysis

1. Clearly define the target behavior
2. Ask about frequency, intensity, and duration of the behavior
3. Go step-by-step until you have a clear picture of the following:
   a. What made the client vulnerable
   b. What was the prompting event (trigger)
   c. What are the links between the prompting event and the target behavior (e.g., emotions, thoughts, physical sensations, other behaviors, what is happening or not happening in the environment)
   d. What were the consequences of the target behavior

Steps in Behavior and Solution Analysis

4. Go back and have client hypothesize possible skills to use to address vulnerabilities and intervening links, as well as skills to replace target behaviors (take out safety plan if applicable)
5. Have client problem-solve how to skillfully deal with consequences so they do not develop into vulnerabilities
6. Have client develop a plan to make amends with others for the target behavior if applicable
7. Get commitment from client that he/she will actively practice the identified skills

Behavioral Analysis Form



Describe your vulnerabilities:

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

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:

FILL IN SKILLS TO USE NEXT TIME AT EACH STEP

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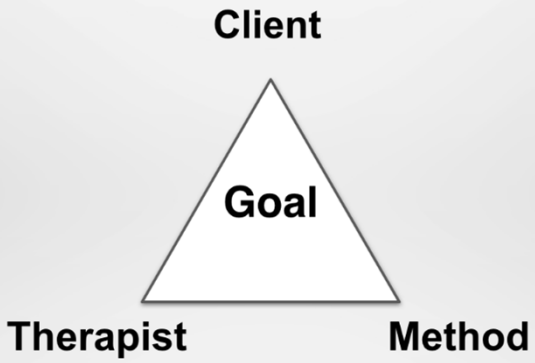
Behavior and Solution Analysis Exercise

Understanding the Treatment Alliance



Starting Out (pre-treatment stage): Socializing the Client to Treatment

- Define what DBT is!
- Clarify the client's and your respective roles (as well as the role of other program members and service providers as needed)
- Define the goals and tasks of each service delivery
- Review important protocols, rules, guidelines, and agreements
- Establish goal(s)
- Be clear that DBT works when you "work" the treatment!

Starting Out (pre-treatment stage): Commitment Strategies

- Evaluate pros and cons of therapy
- Foot in the door techniques
- Door in the face techniques
- Highlight the freedom to choose (especially in the absence of alternatives)
- Play the devil's advocate
- Connect to prior commitments
- Shape stronger commitment (as therapy progresses)
- Coach and cheerlead

Initial Commitment Interventions

- Initial commitment needs to move to agreement on:
  - Treatment plan goals and objectives
  - Treatment method and means of accomplishing goals and objectives
  - Relevant expectations and agreements
- Commitment in therapy is continually revisited for many of the tasks of therapy, big and small, including revisiting initial commitment

Interventions and Orienting

- Orienting is explaining the rationale for why treatment tasks are necessary for the *client's* goals: this means really understanding what the client want and needs
- Orienting begins during pretreatment and is continuous throughout treatment
- Orienting helps to maintain commitment and to keep therapy *client-driven*
- Successful orienting keeps clients active and cooperating

Validation: The Keys to the Kingdom

- Validation is the non-judgmental acknowledgement of the client's experience
- Validation creates the conditions of acceptance that usually precede change
- As a rule, start with validating the client, and return to validation when the client is "stuck" (remembering that rules have exceptions)

Slowing Down and Pacing

- Validation is NOT a means to an end
- Validation requires time to be processed
- Moving too quickly sends unintended messages about emotions and distress
- Clients will typically let you know if too much time is spent on validation

Levels of Validation (Linehan, 1997)

- Being acutely attentive
- Reflecting verbal communication
- Describing non-verbal communication
- Expressing how experience makes sense given history or biology
- Expressing how experience makes sense in the present moment and context
- Being in genuine, human contact

Validation as an Exposure Technique

- Regulates emotions by decreasing their intensity
- Provides gentle, informal exposure to emotions with a sense of self-efficacy
- Allows for a more complete expression of emotions, cueing a fuller adaptive response

Balance of Validation and Change

- Validation opens clients to change:
  - Lets clients know you understand the nature of their issues and pain
  - Exposure to painful emotions create a qualitative difference in relating to emotions (decreasing ineffective escape and avoidance behaviors)
  - Exposure to painful emotions can create motivation to invest in change

Validation Exercise

- Form a dyad or triad. Role-playing your client, begin to introduce a therapy issue to your therapist. The therapist (for this exercise), will resist problem-solving and instead stick with validation as the primary intervention. Aim to validate on the highest level possible.
- After 5 minutes, switch roles

Change Interventions

- Behavioral interventions
- Contingency management
- Cognitive interventions
- Exposure techniques
- Skills training

Behavioral Principles

- ***Positive Reinforcement:*** behavior is followed by a reward, increasing the b's frequency
- ***Negative Reinforcement*** *(think avoidance learning):* behavior is followed by removal of something aversive, increasing the b's frequency
- ***Positive Punishment:*** behavior is followed by something aversive, decreasing the b's frequency
- ***Negative Punishment*** *(think response cost):* behavior is followed by removal of something, decreasing the b's frequency
- ***Extinction:*** removal of reinforcement for a behavior, leading to a decline in the b
- ***Generalization:*** performing desired behavior outside of treatment setting

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Behavioral Considerations

- Are effective behaviors reinforced? On what schedule? Be careful to *maintain* desired behaviors!
- How are ineffective behaviors reinforced (maintained)?
- How can I shape effective behaviors while extinguishing ineffective behaviors?
- Consider relevant behavioral principals when analyzing

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Behavioral Contingencies

- The consequences of behavior influence what we learn
- A temporally close relationship between behavior and consequence influences what will happen the next time we are in a similar situation with similar context
- Highlighting contingencies (e.g., structure, expectations, safety, immediate feedback, etc.) helps clients learn and be more effective

Examples of Contingency Management

- Observing boundaries (limits)
- Defined plans with consequences for specific behaviors
- Program rules and expectations with consequences
- Changes to environment to reinforce or extinguish behaviors
- Every observable therapist (or team) response is an informal contingent procedure
- **See Handouts on DBT Skills Group and Program Expectations and DBT Individual Therapy Expectations on pages 42-44. See also Phone Coaching Expectations, page 45 and ConsultationGroup Agreement, page 47)**

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Most Effective Behavior Change Methods

- Provide non-contingent reinforcement
- Model effective behavior
- Reinforce non-problem behaviors (especially incompatible ones)
- Train skills to reinforce
- Make a high-probability behavior contingent on a low-probability behavior
- Lower vulnerability and meet organismic needs proactively
- Harness high level motivations to leverage change

Behavioral Interventions Exercise

Identify a client with a problem behavior.

What vulnerabilities or other factors are contributing to the behavior?

How is the behavior reinforced (rewarded/maintained)?

Are differential other behaviors being reinforced?

What skills would be helpful to address vulnerabilities or to provide alternatives to the problem behavior?

Dialectical Strategies

- Enter the paradox by highlighting:
  - Mismatch between words and behaviors
  - Discrepancy between values and behaviors
  - Inaction in light of knowledge of what would be helpful
  - Tension between preferred reality and actual reality
  - When client wants relationship but actively works to destroy it
  - Strength and resiliency behaviors that contrast a poor self-concept

Dialectical Strategies

- Refusing right and wrong/answers can be yes and no (e.g., a therapist can care and still set limits on availability)
- Use of metaphors or stories
- Devil's advocate
- Extending
- Wise Mind activation
- Making lemonade out of lemons

Dialectical Strategies

- Prescribing the feared behavior
- Using the "exception rule"
- Role reversal
- Allowing natural change

Cognitive Interventions

- Have traditionally been de-emphasized in DBT
- Assume that clients are not fragile; they are able to evaluate thoughts and beliefs
- Clients do benefit from cognitive interventions (e.g., non-judgmental stance is a cognitive intervention)
- DBT-style cognitive interventions take a “softer”, more validating approach
- Avoid cognitive interventions with emotionally-activated clients

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DBT-style Cognitive Interventions

- Guided by different theory (i.e., emotion dysregulation), so emotions remain the primary target, with thoughts and beliefs being a secondary target
- Avoids judgmental labels (i.e., distortions, errors, maladaptive thoughts, etc.). Uses traditional cognitive “distortions”, but without the labels
- Validates origin and adaptation that comes from the thought or belief
- Analyzes dialectically rather than categorically
- Emphasizes shifting and expanding rather than a “cut and paste” style of addressing thoughts and beliefs; we do not talk clients out of thoughts and beliefs
- Points out effective thinking to develop sense of self-trust

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! Goals of Stage One must be met before Stage Two**
- EMDR is compatible with DBT protocols
- Provide/obtain clear informed consent

When Not to Use Exposure

- When there is active suicidal (or homicidal) urges
- When there is regular self-injury (or the risk of serious self-injury)
- When there psychosis
- When there is significant risk of harm from others
- When there is insufficient memory of the trauma
- When there is clinical issue that has more importance (resolve first)

Alternatives to Exposure

- Mindful, present-centered approach to life
- Re-connection to emotions (especially positive), relationships, and the future (including plans for the future)
- Distress tolerance and emotion regulation skills
- Resolution of current life problems
- Cognitive interventions around trauma-related thoughts and beliefs
- Provide a clear rationale for these alternatives to exposure along with the coherent application of techniques that accomplish these goals
- **Research shows that non-exposure based treatment models have equivalent efficacy when compared to exposure-based treatment models. Benish, S., Imel, Z.E., & Wampold, B.E. (2007).**

Reciprocal Communication

- Engaging and responsive, taking clients wants and needs seriously
- Being authentic and genuine, not staying in a "therapist" role
- Using self-disclosure thoughtfully in the service of therapy

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Reciprocal Communication: Self-involving disclosure

- Sharing “benign” and human examples of skill use and practice
- Using examples of how you have approached and solved a problem
- Sharing when you would have felt, thought, or responded similarly to how a client reports in a given situation
- Sharing your reactions to the client in the moment, providing information that manages relationship contingencies (creating new learning)
- Letting the client know about the current state of the relationship, to manage contingencies or address feared reactions

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Self-disclosure of Personal Information

- Personal information may not relate to client or the therapy; if it is not relevant, do not share it as a rule
- Observe and disclose your limits in regard to personal information when needed (ok to explore what personal inquiries mean to the client)
- Never share personal problems/issues!
- Does it pass the “public” test? In other words, would you share it in front of an audience of your colleagues?

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Irreverent Communication

- Irreverence is an offbeat style intended to:
  - Get the client's attention through surprise or an unexpected response
  - Show another point of view or get the client to process on a different level
  - Create a shift with emotions, thoughts, or behaviors
- Irreverence works best when used by therapists with a naturally irreverent style
- Irreverence is not necessary to be an effective DBT therapist; use it only if it comes from a genuine place

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Essentials of Irreverent Communication

- Assumes that the client is not fragile
- Needs to be surrounded by validation
- Needs a "solid" therapeutic relationship
- Know your goal, observe the effects, and balance with validation
- Consider if it fits your style (or fits your style too well!)

Be careful: do not use when frustrated or at the expense of the client!

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Examples of Irreverent Communication

- Responding to or reframing a client's communication in an unexpected way, usually picking up on a subtle or unspoken aspect of the communication
- Taking a direct route: "Going where angels fear to tread"
- Being confrontational (e.g., calling "bullshit" on client)
- Call a "bluff" while providing a (well-timed) way out
- Switch intensity levels (e.g., between humor and seriousness)
- Using silence while waiting for a particular response
- Express impotence or omnipotence

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Phone (and Other) Coaching

- Determine your (or your program's) availability
- Set clear contingencies about phone coaching:
  - Clients must observe agreed upon limits
  - Clients fill out a coaching worksheet first
  - Call are intended to be brief (3 to 5 minutes) and:
    - Are focused on problem-solving with skills
    - Are not "therapy" focused
    - Are not "venting" calls
  - Call must happen before acting on a target behavior (no calls within 24 after acting)
- Consider scheduling coaching calls proactively, especially when client is working skills
- Do not underestimate how effective message check-ins are for some clients

For Tomorrow

Review Safety and Crisis Plans in the Handouts Packet, pages 51-57

Dialectical Behavior Therapy Intensive Training

Day Four: Consultation, Safety, and Putting it all Together

Lane Pederson, PsyD, LP, DBTC

Functions of Consultation

- Enhance therapist skill
- Enhance therapist motivation
- Build effective therapeutic responses
- Reduce ineffective therapeutic responses

As a best practice, consult on any challenging behavior

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Consultation Goals

- Ensure integrity to DBT program (e.g., structure, protocols, guidelines, etc.)
- Provide checks and balances: Minimize rogue therapy and groupthink
- Provide support for the therapist: Increase motivation and skill
- Determine effective treatment planning for the client (e.g., interventions, solving problems, addressing referral/discharge issues)

Consultation Team

- In a DBT Program setting, the DBT team consists of the individual therapist, the skills trainers, and 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 other mandated case conferences

Expectations of Consultation Members

- Members need to attend, be prepared, and be active
- Members practice humility and reciprocal vulnerability
- Members, like clients, are doing their best but need to do better
- Members, like clients:
  - Practice skills
  - Are open to change analysis
  - Need to use and receive both validation and change strategies from other members

Consultation

- Decide frequency of consultation meetings (weekly preferred)
- Structure meetings based on needs (prioritize situations with the highest order target behaviors)
- Agree on expectations of consultation meetings
- Build a consultative “milieu” in clinic and program settings:
  - Use consultation in an open, ongoing manner
  - Keep everyone “in the loop” and involved
  - Seek diversity in consultative feedback (i.e., not defaulting to same, similarly-minded consultants)
- Devote some time to mindfulness (e.g., 3-5 minutes at the beginning and end of the meeting) and to continuing education

Guiding Principles in Consultation (adapted from Beauchamp & Childress, 2008)

- **Beneficence:** will what is suggested in consultation likely provide benefit to clients (or the therapist) and be helpful?
- **Non-malfeasance:** will what is suggested have a low risk for harm?
- **Autonomy:** will what is suggested respect clients’ ability to choose and make decisions? Consistent with “consulting to the client,” does the intervention and approach empower clients to use their skills and be their own agents in life?
- **Fidelity:** will what is suggested be true to informed consent and the treatment agreements, including what was promised and the discussed rules and expectations?
- **Justice:** will what is suggested equitably balance the needs, rights, and resources of one client versus others in a group, program, or clinic?

Consultation Decision-Tree Process

- *One*: Define the client/therapist concern
- *Two*: See if concern is addressed by policy, procedure, protocol, agreements, or other guidelines
- *Three*: Discuss positions on the dialectic
- *Four*: Move toward synthesis with these considerations:
  - Does the position best fit established program guidelines?
  - Is there training/clarification needed for the client or therapist
  - Does the plan benefit the client, minimize risk, respect client autonomy, and stay true to agreements?
  - Is the plan respectful and accountable?

Working With Non-DBT Teams

- Client is the leader of the treatment team
- Practice DBT philosophy: Non-judgmental and non-pejorative of clients, therapists, and teams
- Collaborate: dogmatic views and radical conversions not needed
- Team members do not need to agree; client may need to decide what makes most sense for his/her treatment (i.e., consultation to the client)
- Communicate, communicate, communicate

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Hierarchical Tasks with Fellow Consultants

- Check consultative alliances
- Seek agreement on goals
- Seek synthesis centered in program guidelines
- Support appropriate action
- Support fellow therapists

Consultation FAQ

- Do my consultants need to be DBT trained?
- How many consultants do I need?
- Where do I find consultants?
- Other?

Problem-solving Challenging Behaviors

- Consider:
  - A precise definition (behaviorally) of the problem
  - Is sufficient structure in place?
  - What agreement(s) are in place? Is the client and/or therapist sticking to the agreement(s)?
  - What has been tried? Analyze why solutions have not worked (and what has worked)
  - Has the client (and/or therapist) been **validated**?
  - How can the client be **oriented** toward solving the problem (what is in it for him/her)?
  - What are potential solutions?
  - Can the client (and the therapist) **commit** to trying a chosen solution?

Problem-solving Challenging Behaviors

- Practical issues to consider (adapted from Beck, 1995):
  - Is there a solid therapy alliance?
  - Are the agreed upon goals clear and is there a commitment to working on them?
  - Does the client believe in the method?
  - Is the client socialized to the treatment (e.g., does the client actively collaborate and contribute)?
  - Is the client's biology or external environmental factors interfering with therapy?
- Problem-solve based on relevant issues
- Consider a behavior contract for some difficult behaviors
- **See Behavior Contract and GIVE Contract in Handouts Packet, pages 48-49**.

Hierarchical Tasks with Clients in Challenging

- Check alliance issues first
- Seek agreement and commitment on goals
- Remind the client of agreement(s)
- Orient the client to the purpose(s) of the intervention(s)
- Seek commitment to follow the plan
- Follow through with the plan

Self-Injurious Behaviors (SIB) and Suicidal Ideation (SI)

- These issues are common to BPD
- Keep assessment separate from therapy
- SIB is a means to manage emotions
- SI is prevalent when life is overwhelming and there is no means of “escape” and/or hope of change

Set Clear Safety Contingencies

- Orient clients to your safety procedures: if x, then y. Use clear contingencies.
- Use consistent follow-through and do not make exceptions to protocols
- 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.
- Take all suicidal comments seriously: there are no “games”
- Assessments and safety planning happen in the time allotted and stop at the end of the session (i.e., no post-session assessment and planning). Clients unwilling to cooperate will be sent to the hospital for further assessment.
- Safety is a “yes” or “no” with clear safety plan
- **See Safety Expectations on page 50 in the Handouts Packet**

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Common Reasons For SIB

- Distract from emotional pain
- Provide a sense of release and relief
- Ground oneself, to feel real
- Make emotional pain “tangible”, to see it
- Communicate emotional pain to others
- Punish oneself to alleviate guilt
- Other reasons

SIB Assessment

- Get Baseline Data on Frequency, Severity, and Duration
- What was the SIB? What specifically was done?
- Where did the SIB occur on the body?
- How severe or to what extent did the SIB occur?
- Did the SIB or does the SIB require medical attention? Why or why not?
- Did the individual seek medical attention?
- When did the SIB occur?
- What was the intent of the SIB?
- What were the contextual factors surrounding the SIB (use change analysis)?
- What is the individual's current emotional state, urge level, and need for safety planning?
- Does the individual still have access, means, and intent to act on SIB?
- Can the individual meet safety planning expectations, or is a higher level of care indicated?

SIB Assessment Dilemmas

- Do I look at the SIB?
- Do I and/or how do I determine if medical treatment is needed?
- What amount of detail do I need (e.g., individual vs. group formats)?
- What if the client is unwilling to provide information?
- Do I confiscate or hold "tools" for clients?
- Do I keep or dispose of medications for clients?
- Who is responsible for client safety?
- **When does SIB need to be treated like SI?**

Common Suicide Risk Factors

- Current ideation, method/plan with access and means, and intent to act
- High co-morbidity and chronicity (physical and mental)
- Co-existing substance abuse and substance use disorders (especially escalating)
- History of suicidal attempts (especially serious)
- History of impulsivity
- History of suicide with family and/or friends
- Recent losses (e.g., relationships, physical health, financial, etc.)
- Acute and extreme distress (e.g., despondency, humiliation, guilt and shame, agitation, insomnia)
- Hopelessness, feeling useless or trapped, or having no purpose in life

Common Suicide Risk Factors

- Withdrawal from others and/or society
- Unexplained shifts and changes in mood (especially dramatic)
- Making unexplained “visitations” or giving away meaningful items
- Member of the military/veteran
- GLBTQIA (especially young with limited support)
- Age, gender, race, and other factors:
  - young and elderly adults
  - unmarried and/or living alone
  - Caucasian
  - Male

Suicide Protective Factors

- Positive therapeutic relationship(s)
- Positive social support
- Religion/spirituality
- Children in the home
- Coping and problem-solving skills
- Sense of responsibility, meaning, and/or life satisfaction

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 (that meets or exceeds the standards of the profession) according to the level of treatment intensity indicated
- Follow-through needs to happen according to the plan
- Consultation is important, especially in higher risk situations
- Clear documentation of assessment, plan, follow-through, and all consultation (if it is not documented, it did not happen)

Suicide Assessment (Do all of this with specificity)

- Assess for suicidal thinking and urges, both current and by history
- Assess intensity level of thinking and urges, 0 to 10, and ask questions needed to understand what that level means to the client. Assess frequency and duration
- Assess history of attempts
- Assess level of hopelessness

Suicide Assessment (Do all of this with specificity)

- Assess if client has a plan, and if the clients has the means to act on the plan, and access to the means. How lethal is the plan? (High probability of completion with low probability of intervention most serious)
- Assess if the client has taken any steps to act
- Assess the level of intent (none, low, medium, high)
- Consider relevant risk factors
- Assess client's ability to control the thinking and urges and/or ask for help. What protective factors are available and what has worked to stay safe? **Start the creation of a safety plan.**

From Assessment to a Safety Plan

- Start with **existing safety behaviors** (skills) to build a foundation
- Identify **vulnerabilities** and **warning signs** for SI and SIB (includes thoughts, feelings, behaviors, and situations)
- Identify what **prompts** and **triggers** for SI and SIB (includes thoughts, feelings, behaviors, and situations)
- Identify **specific skills and behaviors that are alternatives** to SI and SIB (building on existing safety behaviors)
- Identify **specific support people** to access when in crisis (professional and personal)
- Identify barriers to using plan with specific skills and behaviors to use to overcome barriers
- Make multiple copies

Safety Plan Tips

- **All** clients with safety issues need a **written** safety plan as an initial goal
- Clients need to be expected to review and practice the skills and behaviors on the safety plan daily
- Review safety plans each session until safety issues have been resolved
- Expect clients to practice skills and behaviors on safety plan when not in distress
- Have clients actively revise and update safety plans. These are "living" documents, both metaphorically and literally

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No-Harm Contracts

- Do NOT lower liability, but…
  - Can be used as a part of comprehensive assessment, safety planning, follow-through, and documentation
  - Can be effective when there is a solid therapy alliance

Suicide Information Resources

- Suicide Prevention Resource Center www.sprc.org
- American Foundation of Suicide Prevention www.afsp.org
- American Association of Suicidology www.suicidology.org
- Suicide Prevention Action Network www.spanusa.org

Hospitalizations

- Use when no clear safety commitment with plan to stay safe (rarely for SIB, though)
- Reinforce “skillful” hospital use
- Actively remove reinforcement from “unskillful” hospitalizations
- Create a “benevolent ordeal” for unskillful hospitalizations (uses behavioral contingencies)
- Keep contact with clients in the hospital to a minimum
- Adjust environmental contingencies around hospitalizations
- Transport only by ambulance or police
- Communicate with the hospital
- Document fully

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When to Refer

- When client needs “more” than allowed by treatment protocol, model, or framework
- When client fails to make progress after barriers and goals are adequately addressed
- When safety issues are not adequately addressed in current level of care

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Video of DBT Session

Time to Do DBT: Experiential Practice

- Reform your dyad or triad. Using the video as an example, conduct a DBT session with your partner. Switch roles halfway through the allotted time
- Remember: Be authentic in your client presentation, but do not be an impossible client!
- Other options: Practicing coaching around a typical problem your clients might present or practice teaching a skill

Next Steps: Ideas for Development as a DBT Therapist

- Assess your current understanding and skill level
- Seek ongoing supervision and/or consultation
- Find other interested therapists to create a consortium
- Pursue continuing education (preferably from different instructors)
- Review books, manuals, and research articles
- Seek out online resources
- Develop your own skills materials and worksheets (perhaps even a specialized manual for your population)
- Do periodic program development
- Professionals are ultimately responsible for their own development!

Thank You

www.DrLanePederson.com

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