

DBT Across Cultures and Within Systems of Oppression

Crosscultural Research

- Rates of BPD appear similar across countries and cultures
- DBT has primarily been implemented in European countries
- Emerging research suggests DBT is effective with culturally specific adaptations
 - Nepal skills study (Ramaiya et al, 2017)
 - Alaska Native/American Indian study (Beckstead, Lambert, DuBose, & Linehan, 2015)
 - Integration of Latinx dialectical dilemmas when working with Latino families (German et al, 2015)

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Anti-Opressive Principles and DBT

Clifford (1995) lays out the following principles:

- **Social Difference:** Social differences arise because of disparities of power between the dominant and dominated social groups
- **Linking Personal and Political:** Personal biographies are placed within a wider social context
- **Power:** Power operates at personal and structural levels
- **Historical and Geographical Location:** Individual life experiences and events are placed within a specific time and place
- **Reflexivity/Mutual Involvement:** The continual consideration of how values, social difference and power affect the interactions between individuals.

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Well Implemented DBT Integrates These Principles

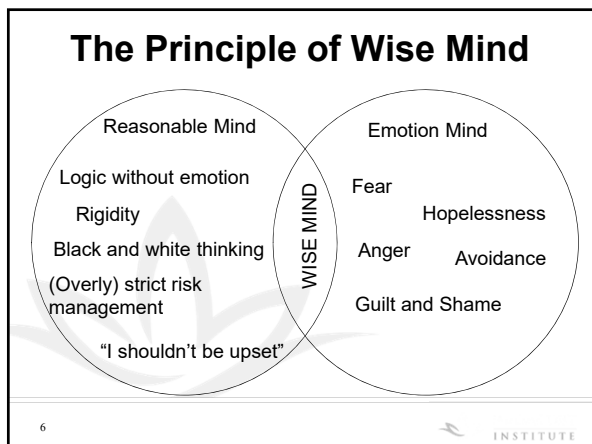
Clifford (1995)	Linehan (1994, 2014)
Social Difference	Invalidating Environment, Biosocial Model, Validation Strategies
Linking Personal and Political	Consultation Team, Self-Involving Self Disclosure
Power	Non Hierarchical Stance, Consultation to Client
Historical and Geographical Location	Validation Strategies, Biosocial Model, Dialectics
Reflexivity/Mutual Involvement	Consultation Team, Consultation to Client/Peer, Treating the Therapists, Therapist Agreements

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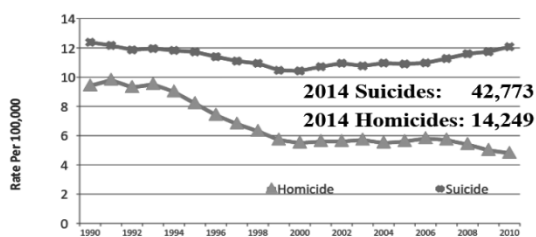
Current Suicide Research, Assessment, and Interventions

Current Suicide Research, Assessment, and Interventions

The Principle of Wise Mind



U.S. suicide rate unchanged in 2 decades



2014 Suicides: 42,773
2014 Homicides: 14,249

Homicides have dropped from 9.8/100,000 in 1992 to 4.8/100,000 in 2010 (<15,000/yr)

SOURCES: Bureau of Justice Statistics (homicide); Centers for Disease Control (suicide)

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Current (2016) Suicide Statistics

44,965
reported
deaths by
suicide per
year

Over 1 million
estimated
suicide attempts
per year

Data Sources: Center for Disease Control Data and Statistics Fatal Injury Report for 2016, McIntosh & Drapeau, 2015

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Current (2016) Suicide Statistics

Suicide is the 10th leading cause of death in the US...

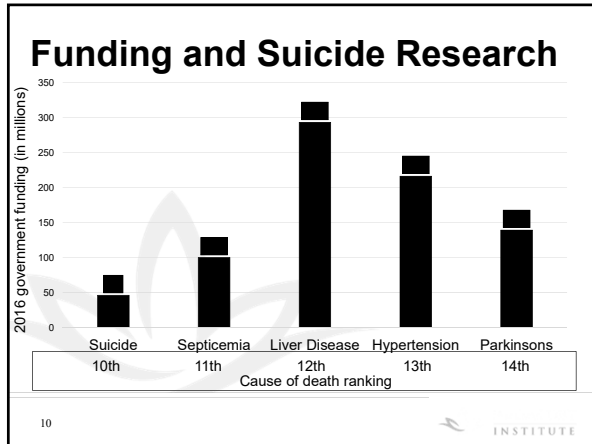
..and the 2nd leading cause of death in individuals aged 15 to 34

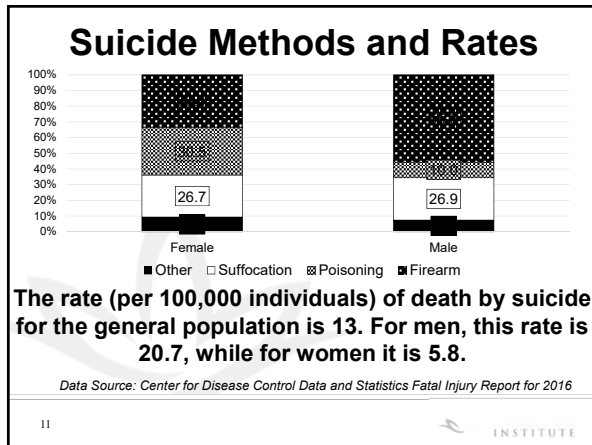
The estimated economic cost of suicide deaths is **\$50.8 billion dollars**

Data Source: Center for Disease Control Data and Statistics Fatal Injury Report for 2016

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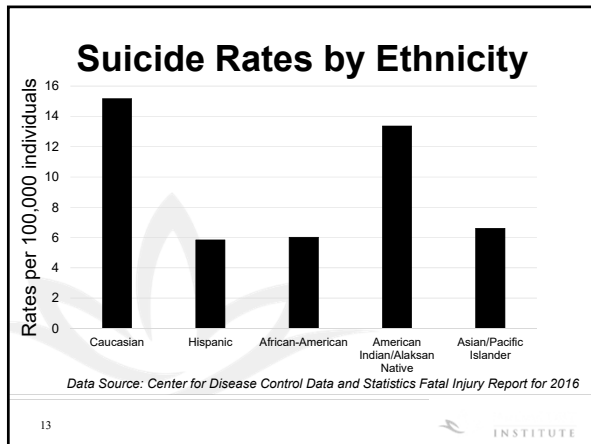




Suicide and Adolescents

- Second leading cause of death (CDC, 2016).
- Alaska Native/Native American youth have the highest rate of suicide, 1.5 times greater than the national average. (CDC, 2015)
- Gay and lesbian youth (age 15-24) suicide attempt rate: 29.4%. (vs. 6.4 %for heterosexual youth) (Center for Disease Control and Prevention, 2015)
- 45% of transgender youth age 18-24 have attempted suicide. (Haas, Rodgers, Herman, 2014)

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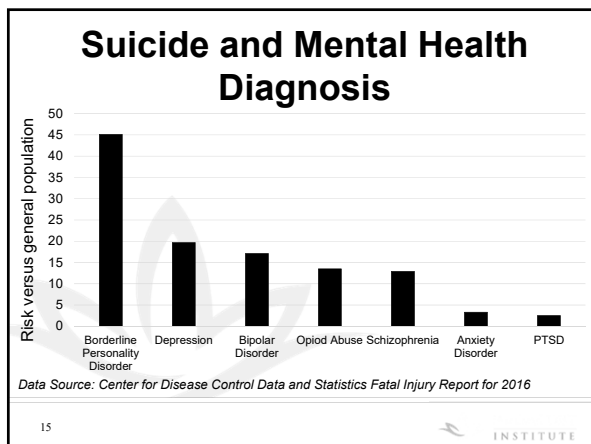


Veteran Suicide Statistics

- In 2016, the VA reviewed 50 million patient records ranging from 1979 to 2014. They found:
- Veterans accounted for 18% of all deaths from suicide in the US, but veterans only account for 8.5% of the US population.
- 65% of all veterans who completed suicide were over 65 years old.
- Veterans have a 21% increased risk of suicide from the general population.
- 66% of suicides resulted from firearms

Data source: VA Suicide Prevention Program, 2016

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Suicide and Borderline Personality Disorder

- Between 8-10% mortality.
- Close to 50 times greater than general population. (Hoffman et al., 2010; CDC, 2016)
- Histories of suicide attempts in population reported as high as 73%. (Soloff et al., 2000)

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Risk Factors for Suicide

General Factors Related to Long Term Risk For Suicide

- Family discord/domestic violence
 - In justice or child welfare setting (APA, 2003; National Strategy for Suicide Prevention, 2012)
- Environmental Characteristics
 - Life changes - losses, disrupted relationships, discharge from psychiatric hospital within 6 – 12 months (Linehan, 1993, 2014)
- Social Support
 - Unemployed, single, less available family, limited social support network (Linehan, 1993, 2014)
- Access to lethal methods
 - Leading methods in USA are firearms, suffocation/hanging, and poisoning (CDC, 2016)

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Social Factors Related to Long Term Risk For Suicide

- Modeling
 - Family history of suicide (Linehan, 1994, 2014)
 - High profile suicide publicity
 - Family history of mental illness or substance use (APA, 2003)
- Cultural or religious beliefs about death or suicide

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Cognitive/Behavioral Factors Related to Long Term Risk

- Cognitive
 - Rigid, impulsive, poor and/or passive problem solving, hopeless, powerless, and negative self concept.
- Physiological/Affective
 - Apathetic, depressed, panic attacks, anxiety, anhedonic, and indifference to treatment (Linehan, 1993, 2014)

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Medical Factors Related to Long Term Risk For Suicide

- Somatic- Poor health, low pain tolerance.
- Serotonergic system abnormality (Chesin & Stanley, 2013; Mann, 2013)
- Major Medical conditions (National Strategy for suicide prevention, 2012)

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Factors Related to Imminent Risk For Suicide

- Fits into high risk population
- Rapid mood cycling
- Alcohol consumption
- Access to lethal means
- Isolation
- Provisions to prevent discovery
- Recent loss of relationship/s
- Negative environmental change in previous month
- deterioration of relationship between client and treaters due to negative perceptions of behavior
- Recent discharge from psychiatric hospital
- Indifference to/Dissatisfaction with therapy
- Hopelessness Ruminative flooding
- Anger/Agitation
- Indirect references toward own death
- Sudden clinical change, positive or negative
- Unusually calm and placid affect
- Suicide attempt or NSSI in past year

Data Sources: Borges et al, 2006; Cassells et al, 2005; Galynker et al., 2014; Galynker, Yaseen & Briggs, 2014; Linehan 1993, 2014)

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And... How Much do we Really Know?

- A recent review of 365 studies over 50 years on suicide found poor ability to predict suicidal behaviors (or ideation) using previously identified risk factors.

Take home points:

- More work is needed in the area of suicide prediction
- Know the risk factors, and know your patients better-
 - What is their unique baseline and changes from baseline?
 - What drives the current urge to die, and what can be done right now to instill hope?
 - Assess deeply, generate reasons for living.
 - **Assess and block lethal means access**

Data Source: Franklin et al., 2017

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Lethal Means Access

- Means restriction in England/Wales (detoxification of gas), Sri Lanka (ban on pesticides), and Israeli Defense Force (locking firearms on base for weekends) resulted in substantial decreases in suicide
- 71% of individuals attempting suicide reported less than an hour between the initial thought and the attempt
- **83% of all deaths from firearms in Oregon from 2010-2014 were from suicide (national number is 61%)**

Data Sources: Bryan et al (2011); Gunnell et al (2007); Lubin et al (2010); Simon et al, 2001; Simon, 2005

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Counseling on Lethal Means Access

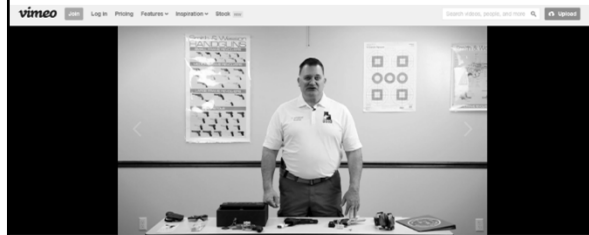
- Alliance: I am concerned about your safety and would like to talk about what we can do to protect you and your family
- Education: We know that removing or reducing access to lethal means for suicide is one of the most effective ways to prevent suicide (similar to removing alcohol while trying to stay sober)
- Therapeutic Task: Can we find a way to temporarily remove or find a safer way to store means with someone you trust while we together on helping you feel better?

Data Source: Bryan et al (2011)

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Utah Firearm Safety Prevention Training



Utah Firearm Suicide Prevention Training Video (5 min)-HD

<https://vimeo.com/176189702>

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Outpatient and Inpatient Treatment of Suicide

To date, there is no data showing the effectiveness of hospitalization for suicidal behavior. In fact.....

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Hospitalization and Suicide

- Several studies show risk in suicidal behaviors during or following hospitalization.
- The risk of suicide is higher during the period immediately following discharge from inpatient psychiatric care than at any other time in a service user's life.
- Suicide is one of most common events in inpatient setting.

Data source: Tishler, 2008; Crawford, 2004

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Hospitalization and Suicide

Researchers of a 16 year longitudinal study found to 2 peaks of risk after hospitalization:

- First week after admission.
- First week following discharge.
- Risk was found to increase with number of psych hospitalizations, especially for women.

Data Source: Qin and Nordentoft, 2005

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Borderline Personality Disorder and Hospitalization

- A recent study found admissions to the psychiatric emergency room while in treatment for women with BPD was a strong predictor of subsequent suicide attempts.
- People with BPD are approximately 28% more likely to complete suicide if they have had any ER contact.

Data Source: Coyle, Shaver & Linehan, 2018

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When to Hospitalize

- Acute psychosis
- Insomnia
- Medication Stabilization
- When you need a break (in collaboration with the client)

Data Sources: McCall, et al, 2010; Nadorff, et al, 2013; Woznica et al, 2015; Bernert and Joiner, 2007)

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When to try to avoid hospitalization

All other times

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“Hospitalize Well”

- Client exerts as much control as possible
- Voluntary over Involuntary
- Wise Mind
- Targets are clear
- More functional, less reinforcing
- Not vacation, more “boot camp”
- Consultation to the client
- Discuss with the client, expectations

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So if hospitalization is not as effective as we would like it to be, where do we go from here in outpatient care?

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Use Validated Risk Assessment and Management Protocols

Examples:

- Linehan Risk Assessment and Management Protocol (LRAMP)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Mood Improvement Protocol
- Crisis Response Plans (Bryan et al, 2017; Fleischmann, et al, 2008; Stanley & Brown, 2012)

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Crisis Response Plan (CRP)

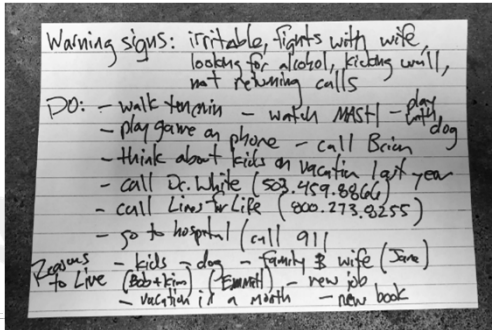
- Is not a contract for safety!
- Use index card/sheet of paper, write out:
 - Personal warning signs for suicide
 - Self management strategies
 - Reasons for living
 - Social Supports
 - Crisis/Emergency Steps
- Verbally review card and seek commitment.

Data source: Bryan et al, 2017

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Crisis Response Plan (CRP)



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Last Note: Know When to Refer and Seek Consultation

- Have access to expert consultation set up ahead of time.
- Know your own limits for individuals you seek in your practice.
 - Who can you effectively treat?
 - Are there limitations in what you offer which could affect individuals you see?

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