



**Dialectical Behavior Therapy
Comprehensive Implementation and
Training Intensive (DBT-CITI)**

**Virtual Training
October 6-8 & 14-15, 2025**


Andrew White, PhD, ABPP, DBT-LBC &
Ashley Maliken, PhD, DBT-LBC

5100 S Macadam, Ste 350, Portland OR 97239 | www.pdbti.org

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Day One

**Introductions, Orientation,
Mindfulness, Team Agreements**



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Mindfulness

- The quality or state of being mindful (attentive, thoughtful, intentional)
- A particular way of paying attention and directing one's focus, in the present moment, without judgment.
- Awake!
- The repetitive act of directing and redirecting one's attention to only one thing moment by moment.
- Attention control

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Introductions

- Who are you?!
- What is one thing (or more) you really want to get from this training, and would be disappointed if you didn't get it?
- Anything else to know about you?

4

Why Do DBT-CITI or another intensive training?

- Motivate therapists to use evidence-based practices (EBPs) to treat complex, multi-diagnostic clients with severe problems.
- Teach effective use of DBT strategies
- Facilitate development of a DBT consultation team
- Facilitate adherent development of a DBT program

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Why Learn a New Treatment?

- Old one doesn't work
- New one has better outcomes
- New one has same outcomes, but...
 - More efficient, cost-effective
 - More preferred by clinicians
 - Is more humane to deliver

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Team Agreements

- To accept a dialectical philosophy.
- To consult with C on how to interact with other therapists and not to tell other therapists how to interact with C.
- Consistency of therapists with one another (even with same C) is not necessary or expected.
- Therapists are to observe their own limits without fear of judgmental reactions from other consultation team members.
- To search for non-pejorative, phenomenological empathic interpretation of C's behavior.
- Therapists are fallible.


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Training-Specific Agreements to Consider

- To throw self into learning & applying DBT throughout training phase
- To do DBT all-the-way (and not other approaches for DBT cases) in the service of learning DBT and building a DBT program.
- To stay on team for x months beyond the training phase.
- To apply DBT principles, strategies, and theory in all relevant treatment contexts.

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Break!




A slide with a yellow background and a red footer bar. The word "Break!" is centered in bold green text. Below it is a green lotus flower icon.

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Day One

Overview of DBT: History, Philosophical Assumptions, Research to Date, DBT Assumptions

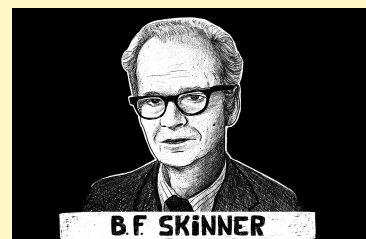


A slide with a yellow background and a red footer bar. The text "Day One" is centered in bold green. Below it is the text "Overview of DBT: History, Philosophical Assumptions, Research to Date, DBT Assumptions" in green. At the bottom is a green lotus flower icon.

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History of CBT (in a nutshell)

First Wave: Behavioral Conditioning- Operant and Respondent paradigms (e.g. Skinner)



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History of CBT (in a nutshell)

Second Wave: People are more affected by their thoughts about events than the event themselves (e.g. Aaron Beck, Judith Beck, Albert Ellis)



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History of CBT (in a nutshell)

Third Wave: Combining core process of behavior change with mindfulness and values work/life worth living goal setting (e.g. Linehan, Hayes, etc.)

- Mindfulness Based Cognitive Therapy
- Dialectical Behavior Therapy
- Acceptance and Commitment Therapy
- Compassion Focused Therapy
- Functional Analytic Psychotherapy



DBT was developed by
Marsha M. Linehan, PhD for

**multi-diagnostic, severe,
difficult-to-treat chronically suicidal
individuals**

DBT is a principle-driven treatment that includes protocols.

DBT is Flexible, personalized, and ideographic in approach.



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DBT is for People with Many Complex & Severe Problems

- substance abuse
- unrelenting crises
- intimate partner violence
- trouble making therapy work
- relationship problems
- medical problems
- self loathing/self-disgust
- dissociation
- eating disorders
- childhood sexual abuse
- repeated suicide attempts
- non-suicidal self-injury
- extreme emotions
- psychiatric hospitalization



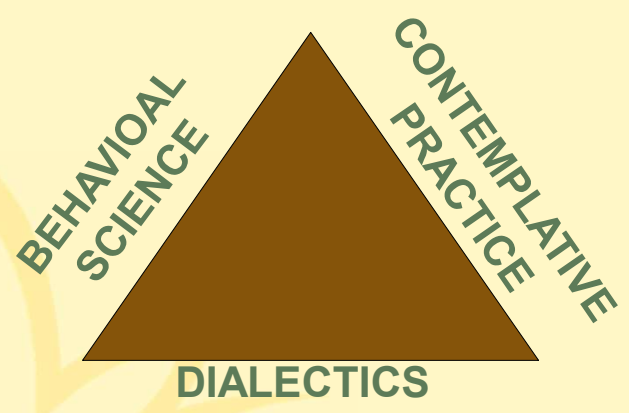
16

Many problems caused and/or exacerbated by Pervasive Emotion Dysregulation



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PHILOSOPHICAL ASSUMPTIONS

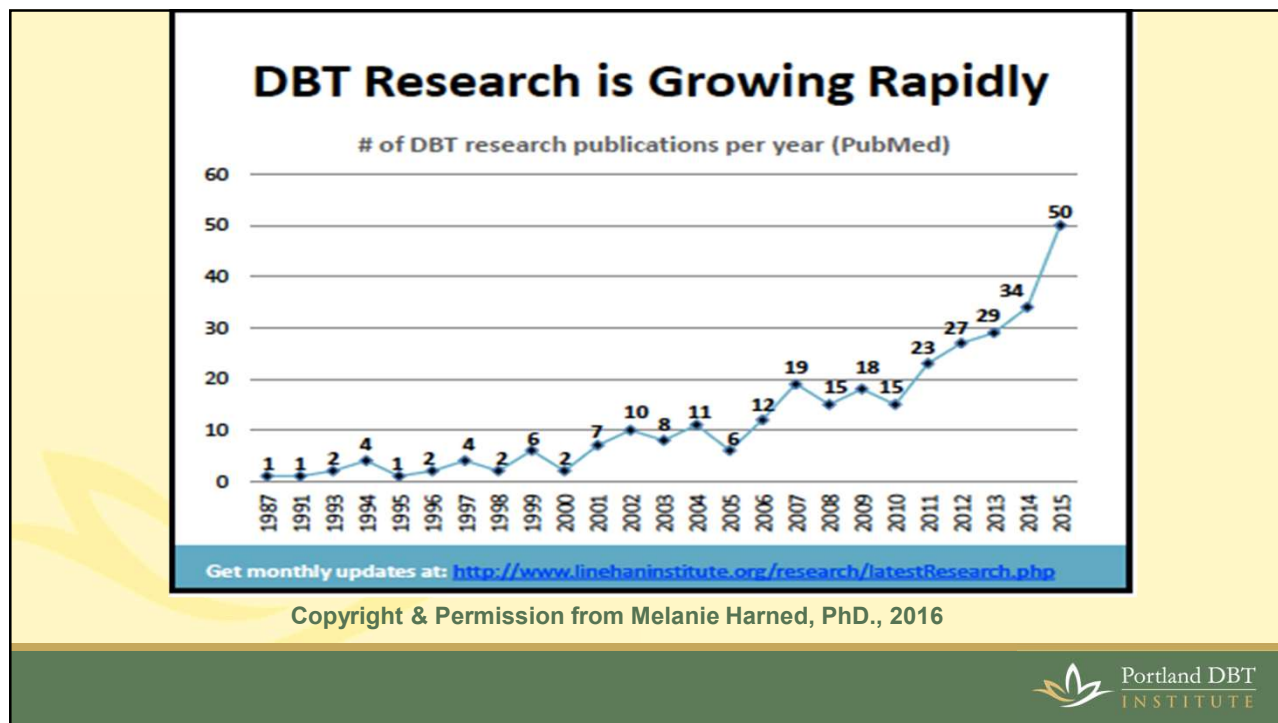


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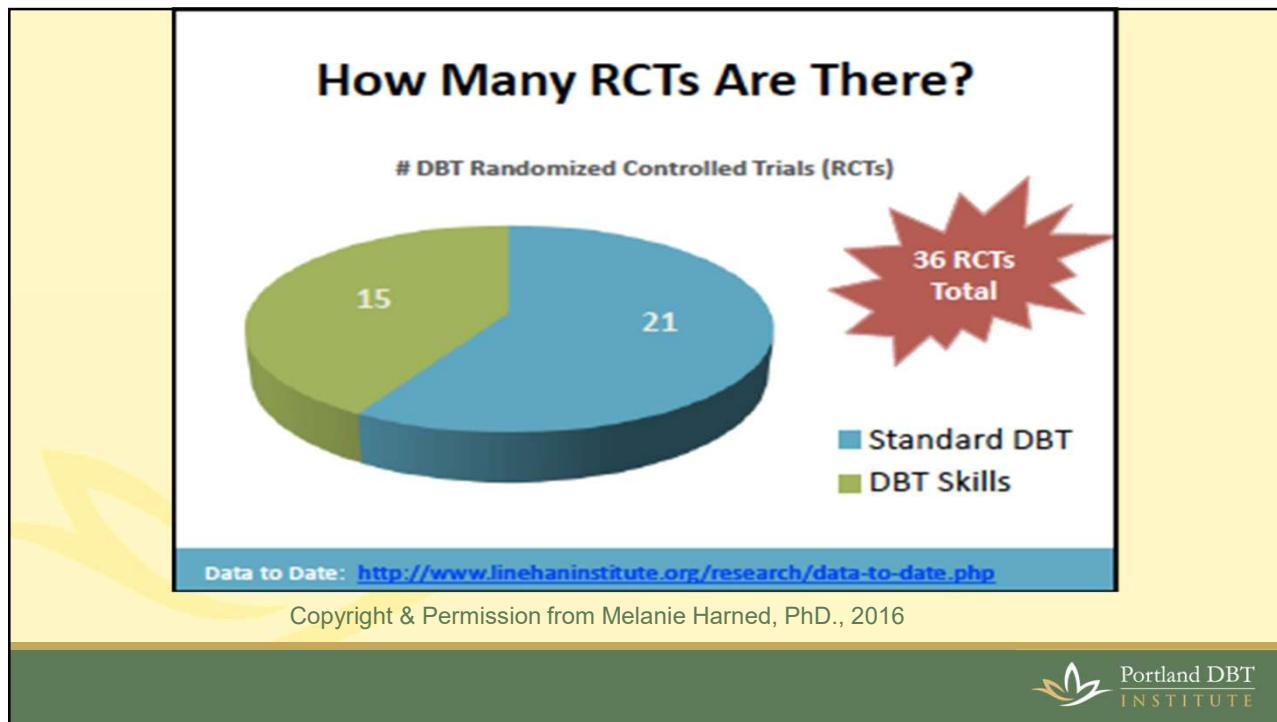
Empirical Basis for DBT: What Do We Know?

Review of the Data to Date

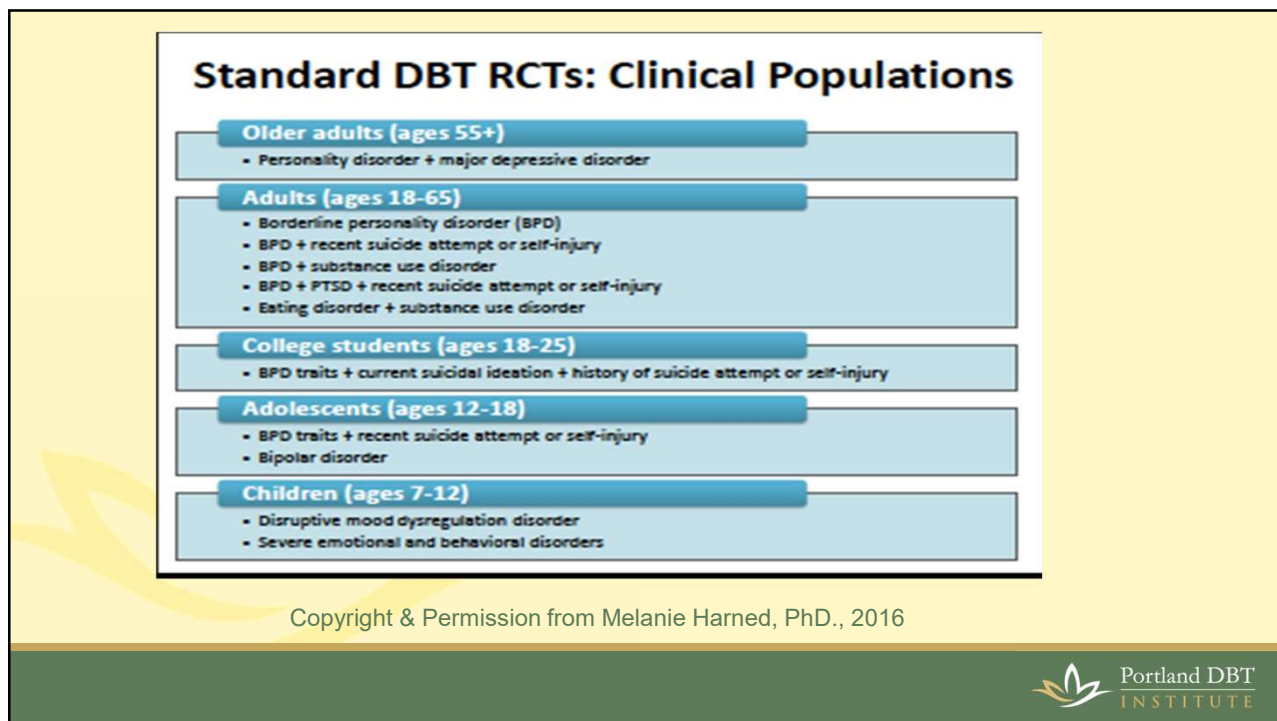
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20



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DBT Skills RCTs: Clinical Populations

| |
|---|
| Older adults (ages 60+) |
| <ul style="list-style-type: none">• Major depressive disorder |
| Adults (ages 18-65) |
| <ul style="list-style-type: none">• Borderline personality disorder• Binge eating disorder• Bulimia nervosa• Childhood abuse• Major depressive disorder• ADHD• Bipolar I or II• Emotion dysregulation + anxiety or depressive disorder |
| College students (ages 18-25) |
| <ul style="list-style-type: none">• Emotion dysregulation• ADHD |

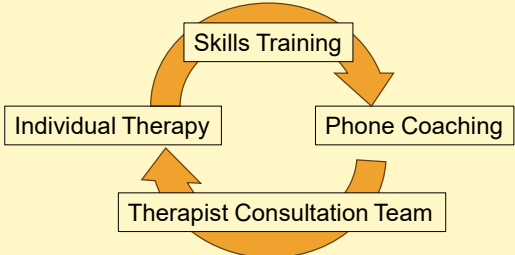
Copyright & Permission from Melanie Harned, PhD., 2016



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What we know about DBT

- DBT is a comprehensive treatment, with each component supporting each other component
- DBT is non hierarchal
- DBT is strongly supported by science
- DBT is focused on keeping people in the community (versus hospitalization or residential)
- DBT is focused on increasing the capabilities of the community
- Adherence to the model and skills training matter!



```
graph TD; Skills[Skills Training] --> Phone[Phone Coaching]; Phone --> Therapist[Therapist Consultation Team]; Therapist --> Individual[Individual Therapy]; Individual --> Skills;
```

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What we know we don't know about DBT

- How we increase long term functioning in folks who do DBT?
- How can we scale DBT up (and scale DBT down) in a way which keeps therapeutic outcomes?
- Are there folks who whom the therapy causes harm?
- How do we increase access to the treatment and increase providers who know the treatment?

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The screenshot shows a journal article page with the following content:

- Journal Info:** Curr Behav Neurosci Rep (2017) 4:21–30, DOI 10.1007/s40473-017-0103-z
- Section:** PERSONALITY AND IMPULSE CONTROL DISORDERS (R. LEE, SECTION EDITOR)
- Title:** What Works in the Treatment of Borderline Personality Disorder
- Authors:** Lois W. Choi-Kain¹ · Ellen F. Finch¹ · Sara R. Masland¹ · James A. Jenkins² · Brandon T. Unruh¹
- Published online:** 3 February 2017
- Abstract:** Purpose of the Review This review summarizes advances in treatments for adults with borderline personality disorder (BPD) in the last 5 years. Recent Findings Evidence-based advances in the treatment of BPD include a delineation of generalist models of care in contrast to specialist treatments, identification of essential effective elements of dialectical behavioral therapy (DBT), and the adaptation of DBT treatment to manage post-traumatic stress disorder (PTSD) and BPD. Studies on pharmacological interventions remain limited and have not provided evidence that any specific medications can provide stand-alone treatment. Summary The research on treatment in BPD is leading to a distillation of intensive packages of treatment to be more broadly and practically implemented in most treatment environments through generalist care models and pared down forms of intensive treatments (e.g., informed case management plus DBT skills training groups). Evidence-based integrations of DBT and exposure therapy for PTSD provide support for changing practices to simultaneously treat PTSD and BPD.
- Keywords:** Borderline personality disorder · Psychotherapy · General psychiatric management · Dialectical behavior therapy · Mentalization-based treatment · Transference-focal psychotherapy · Schema-focused therapy
- Introduction:** Once thought to be an untreatable condition, borderline personality disorder (BPD) is now effectively treated by a growing number of evidence based psychotherapeutic treatments. Twenty-five years ago, Marsha Linehan published the first randomized control trial (RCT) for dialectical behavioral therapy (DBT), which yielded more significant reduction in the disorder's most challenging features—parasuicidal behavior, inpatient psychiatric stays, and treatment drop out—than treatment as usual (TAU). Since then, over 13 manualized psychotherapies for BPD have been tested. Five major treatments—DBT, mentalization-based treatment (MBT) [1], schema-focused therapy (SFT) [2], transference-focused psychotherapy (TFP) [3], and systems training for emotional predictability and problem solving (STEPPS) [4]—have been established as evidence based treatments (EBTs) for BPD [5]. In contrast,

On the right side of the page, there are five portrait photos of the authors: Lois W. Choi-Kain, Ellen F. Finch, Sara R. Masland, James A. Jenkins, and Brandon T. Unruh.

DOI: <https://doi.org/10.1007/s40473-017-0103-z>

Portland DBT INSTITUTE logo is at the bottom right.

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Myth: “DBT informed individual therapy is as effective as the full treatment”

- Associated myths:
 - Adherence isn't that important, don't be so strict!
 - I can pick and choose which parts of therapy to add in
- Synthesis:
 - We are skill learning about the “active ingredients” in DBT
 - Case conceptualization matters

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Myth: “DBT informed individual therapy is as effective as the full treatment”

Original Investigation

Dialectical Behavior Therapy for High Suicide Risk in Individuals With Borderline Personality Disorder: A Randomized Clinical Trial and Component Analysis

Marsha M. Linehan, PhD; Kathryn E. Korslund, PhD; Melanie S. Harned, PhD; Robert J. Gallop, PhD; Anita Lungu, PhD; Andrada D. Neacsu, PhD; Joshua McDavid, MD; Katherine Anne Comtois, PhD; Angela M. Murray-Gregory, MSW

IMPORTANCE Dialectical behavior therapy (DBT) is an empirically supported treatment for suicidal individuals. However, DBT consists of multiple components, including individual therapy, skills training, telephone coaching, and a therapist consultation team, and little is known about which components are needed to achieve positive outcomes.

OBJECTIVE To evaluate the importance of the skills training component of DBT by comparing skills training plus case management (DBT-S), DBT individual therapy plus activities group (DBT-I), and standard DBT which includes skills training and individual therapy.

DESIGN, SETTING, AND PARTICIPANTS We performed a single-blind randomized clinical trial from April 24, 2004, through January 26, 2010, involving 1 year of treatment and 1 year of follow-up. Participants included 99 women (mean age, 30.3 years; 69 [70%] white) with borderline personality disorder who had at least 2 suicide attempts and/or nonsuicidal self-injury (NSSI) acts in the last 5 years, an NSSI act or suicide attempt in the 8 weeks before screening, and a suicide attempt in the past year. We used an adaptive randomization procedure to assign participants to each condition. Treatment was delivered from June 3, 2004, through September 29, 2008, in a university-affiliated clinic and community settings by therapists or case managers. Outcomes were evaluated quarterly by blinded assessors. We hypothesized that standard DBT would outperform DBT-S and DBT-I.

INTERVENTIONS The study compared standard DBT, DBT-S, and DBT-I. Treatment dose was controlled across conditions, and all treatment providers used the DBT suicide risk assessment and management protocol.

Author Audio Interview at jamapsychiatry.com

Supplemental content at jamapsychiatry.com

CME Quiz at jamanetwork.com and CME Questions page S20



DOI: <https://doi.org/10.1001/jamapsychiatry.2014.3039>

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Myth: “DBT informed individual therapy is as effective as the full treatment”

> J Consult Clin Psychol. 2022 Mar;90(3):272-281. doi: 10.1037/ccp0000714. Epub 2022 Jan 27.

The temporal relationships between therapist adherence and patient outcomes in dialectical behavior therapy

Melanie S Harned¹, Robert J Gallop², Sara C Schmidt¹, Kathryn E Korslund³

Affiliations + expand

PMID: 35084894 DOI: 10.1037/ccp0000714

Abstract

Objective: Although Dialectical Behavior Therapy (DBT) is a well-established evidence-based psychotherapy, little is known about the role of therapist adherence in promoting positive outcomes. This study evaluated the temporal relationships between therapist adherence to DBT and patient outcomes, as well as potential moderators of these relationships.

Method: Data were from six clinical trials conducted in research and community settings with a variety of patient populations. In these trials, trained observers rated 83 therapists for adherence during 1,262 DBT individual therapy sessions with 288 patients. Patient outcomes included suicide attempts, nonsuicidal self-injury (NSSI), treatment dropout, psychiatric hospitalizations, and global functioning. Longitudinal mixed-effects models evaluated the time-ordered, bidirectional relationships between adherence and outcomes.

Results: Higher therapist adherence significantly predicted fewer subsequent suicide attempts ($p = .002$, $\eta^2 = 0.32$) and a lower risk of dropout ($p = .002$, $\eta^2 = 0.33$), and the latter relationship was strongest among patients with comorbid opioid dependence. Higher therapist adherence predicted fewer subsequent hospitalizations among community therapists ($p = .001$, $\eta^2 = 0.35$) and patients that were not exclusively suicidal/self-injuring ($p < .001$, $\eta^2 = 0.41$). Conversely, more frequent NSSI ($p = .03$, $\eta^2 = 0.22$) and worse global functioning ($p = .01$, $\eta^2 = 0.26$) predicted higher subsequent therapist adherence, and the latter relationship was moderated by patient population.



DOI: <https://doi.org/10.1037/ccp0000714>



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Adherence and Fidelity Matters: Suicide and Self-Harm

- For each standard deviation increase in therapist adherence, there was a 19.6% decrease in subsequent suicide attempts
- For each standard deviation increase in adherence, there was a 23.8% decrease in the odds of dropout
- No effect on NSSI [may be more related with replacement behavior of DBT skills training]. See component analysis.
- Higher therapist adherence significantly predicted fewer subsequent psychiatric hospitalizations among community therapists but not among research therapists
- Among community therapists, for each standard deviation increase in therapist adherence there was a 40.1% decrease in subsequent psychiatric hospitalizations (RR = 0.60, 95% CI = 0.45–0.81)

Harned, M. S., Gallop, R. J., Schmidt, S. C., & Korslund, K. E. (2022). The temporal relationships between therapist adherence and patient outcomes in dialectical behavior therapy. *Journal of Consulting and Clinical Psychology*. <https://doi.org/10.1037/ccp0000714>



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Adherence and Fidelity Matters: Suicide and Self-Harm

“Among clients with expert nonbehavioral therapists, higher perceived levels of therapist affirmation were associated with increased nonsuicidal self-injury. They speculate that the affirmations of nonbehavioral therapists might have inadvertently been timed to reinforce nonsuicidal self-injury, whereas behavior therapists contingently provided warmth and autonomy for improvement. These findings illustrate the kinds of interplay between specific and nonspecific factors that may impact outcome”

Koerner, K. (2011). *Doing Dialectical Behavior Therapy: A Practical Guide*.

ISBN: 9781462502325



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Myth: “DBT is not culturally informed”

- Associated myths:
 - DBT is only for upper class individuals
 - DBT (and behaviorism) doesn't include cultural elements or issues related to oppression
 - DBT is not a feminist therapy
- Synthesis:
 - Oppression and disenfranchisement is pervasive- work in this area is a continual process of assessment and change, not a one-time-deal
 - There is always more to know about translations of the treatment, and more ways to involve community members

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Myth: “DBT is not culturally informed”



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Journal of Consulting and Clinical Psychology

2022, Vol. 90, No. 10, 707-801
<https://doi.org/10.1037/ccp000730>

Cultural Adaptations of Dialectical Behavior Therapy: A Systematic Review

Stephanie L. Hafn¹, Sinclair M. O’Grady¹, Esme A. L. Shaller^{1, 2}, and Nancy H. Liu¹
¹Department of Psychology, University of California, Berkeley
²Department of Psychiatry and Behavioral Sciences, University of California, San Francisco

Objective: Adapting mental health care interventions to the race, ethnicity, or culture of the target group can enhance the acceptance and effectiveness of the treatment. Dialectical behavior therapy (DBT) is an evidence-based treatment that is principle-driven, rendering it well-suited for adaptations across cultural contexts. This article conducts a systematic review of the literature to determine the nature and extent of cultural adaptations of DBT to date. **Method:** We searched databases for original articles describing cultural adaptations of DBT, as applied to both (a) people of color within Western countries and (b) populations within non-Western countries. Consistent with the focus on descriptively characterizing extant DBT cultural adaptations, we included both published and nonpublished studies, as well as both observational and experimental studies. **Results:** Our search yielded 18 articles that met inclusion criteria. Of these articles, half described adaptations made with people and communities of color within the U.S. Most adaptations involved modifications to language, metaphors, methods, and context. **Conclusions:** Culturally adapted DBT has been implemented and accepted among several racial, ethnic, and cultural groups, although there is insufficient evidence to determine whether culturally adapted DBT is more efficacious than nonadapted DBT. We conclude with recommendations for best practices for DBT researchers and clinicians, and situate our findings among larger efforts to render existing evidence-based psychotherapies more optimal for people of color and people from non-Western countries.



DOI: <https://doi.org/10.1037/ccp000730>



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Myth: “DBT is not culturally informed”



Cognitive and Behavioral Practice
Volume 29, Issue 4, November 2021, Pages 796-815

“You Didn’t Cause Racism, and You Have to Solve it Anyways”: Antiracist Adaptations to Dialectical Behavior Therapy for White Therapists ☆

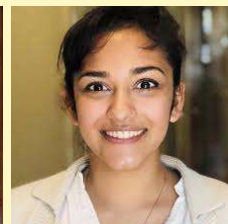
Ashley M. Pierson[✉], Vinushini Arunajiri, Debra M. Bond

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<https://doi.org/10.1016/j.cbpra.2021.11.001>

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DOI: <https://doi.org/10.1016/j.cbpra.2021.11.001>



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Myth: “DBT is not culturally informed”

Therapists must assess their competencies in antiracism prior to beginning treatment with clients or as soon as possible once they enter the therapeutic relationship. This is advised for work with clients of any identity and background, and is absolutely required as preparation for working with racially marginalized clients. This agreement is incumbent on White DBT therapists without exception, and is encouraged for all DBT therapists. Therapists will share their self-evaluation of competencies in antiracism with consultation team members, in order to facilitate effective team support for therapists’ growth in this competency area. Therapists will make every reasonable effort to increase their competencies in antiracism, including but not limited to: engaging in consultative discussion, openly receiving feedback from others about racist behavior, completing self-reflective exercises about race-related values, attitudes, and beliefs, increasing race specific knowledge through educational activities, completing homework assigned by consultation team members in order to foster growth in specific antiracist competencies, and making repairs to team members and/or clients when therapist racist behavior is identified.

Myth: “DBT is not culturally informed”

Dialectical Behavior Therapy: A Feminist-Behavioral Treatment of Borderline Personality Disorder

Marsha M. Linehan
Amy W. Wagner
University of Washington

Borderline personality disorder as an official diagnostic category is relatively new, appearing first in the third edition of the DSM (APA, 1980). Its history, however, is quite lengthy within the psychoanalytic community. The term was first used by Adolf Stern in 1938 to describe a group of out-patients who, in the view of analysts, did not profit from classical psychoanalysis and did not seem to fit into the then standard neurotic or psychotic psychiatric categories. The current diagnostic criteria according to DSM III-R (APA, 1987) are characterized by four types of pervasive instability: interpersonal, affective, behav-

This is the third in a series of articles on women's issues, presented by the Women's Issues in Behavior Therapy Special Interest Group. In this article, Marsha Linehan and Amy Wagner discuss dialectic behavior therapy, a feminist-behavioral approach for treating clients with Borderline Personality Disorder. Borderline Personality Disorder typically begins by early adulthood and is diagnosed in women more often than in men (American Psychiatric Association, 1987). The authors present a theory of Borderline Personality Disorder and a treatment program for helping Borderline clients. Some aspects of this treatment program are common to other types of behavior therapy, while other aspects are drawn from other sources such as feminist therapy. For example, dialectic behavior therapy emphasizes the client's invalidating environment, similar to the way that feminist therapy emphasizes the client's sexist environment that makes incompatible and contradictory demands on women. This article will be useful to therapists who see female Borderline clients and who want to use a treatment approach that is both behavioral and feminist.



DBT Assumptions

About Patients and Therapists



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DBT Assumptions about Patients

1. Patients are doing the best they can.
2. Patients want to improve.
3. Patients need to do better, try harder, and/or be more motivated to change.
4. Patients may not have caused all of their own problems, but they have to solve them anyway.
5. The lives of suicidal individuals with BPD are unbearable as they are currently being lived.
6. Patients must learn new behaviors in all relevant contexts.
7. Patients cannot fail in DBT.

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DBT Assumptions about Therapy

1. The most caring thing a therapist can do is help patients change in ways that bring them closer to their own ultimate goals.
2. Clarity, precision, and compassion are of the utmost importance in the conduct of DBT.
3. The therapeutic relationship is a real relationship between equals.
4. Principles of behavior are universal, affecting therapists no less than patients.
5. DBT therapists can fail.
6. DBT can fail even when therapists do not.
7. Therapists need support

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Lunch!



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Day One

BPD and Biosocial Theory, BPD Reframed, Dialectics



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Prevalence Rates of BPD

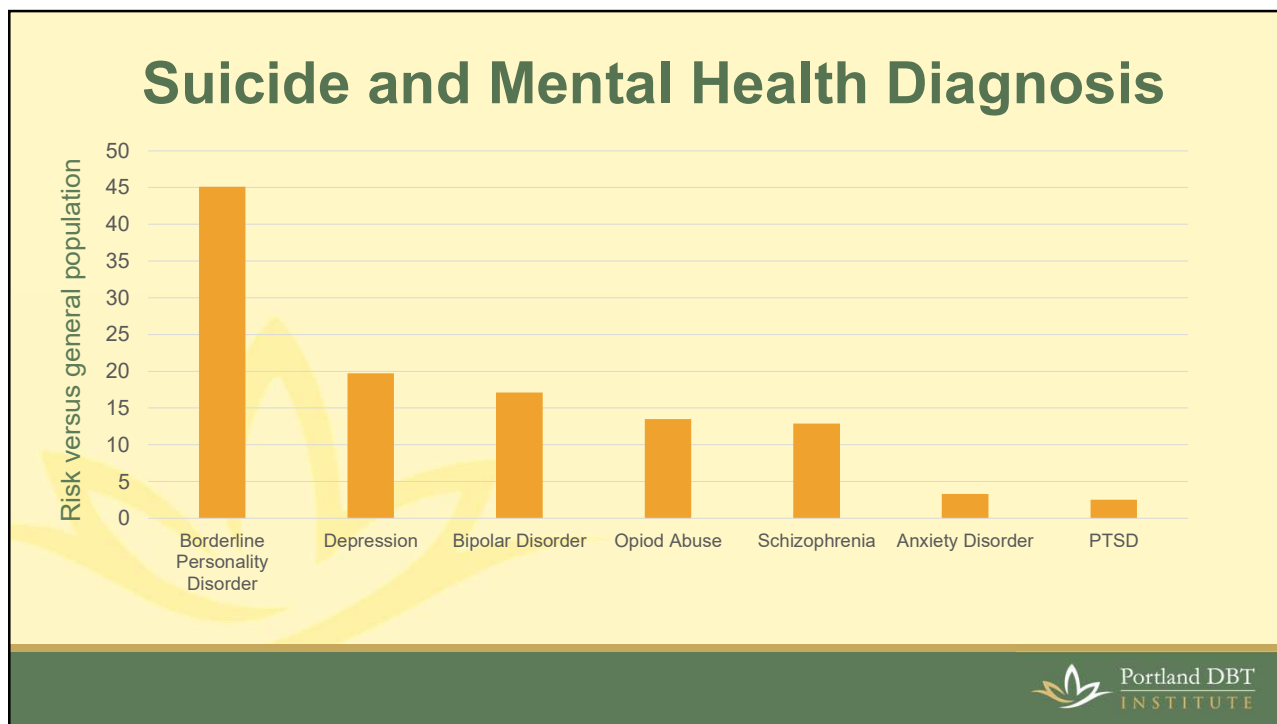
A large scale community survey in 2008 (SAMHSA, 2008) found a lifetime prevalence of 5.9% (18 million individuals) with no significant difference across gender in the United States.

By comparison, the lifetime prevalence rate for schizophrenia is .4%, PTSD is 7.8%, and Bipolar Disorder is 1.4%

<https://store.samhsa.gov/sites/default/files/sma14-4879.pdf>




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Challenges in Treating Persons with BPD

- Multiple diagnoses/problems
- Poor client retention
- Easily emotionally dysregulated in session
- Often non-compliant or quit treatment
- Engage (sometimes often) in life-threatening behaviors
- Don't demonstrate usual clinical progress



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People with BPD are High Utilizers of Health Services

- 8-11% of outpatients
- 14-20% of inpatients
- Up to 40% of highest utilizers

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Health Service Utilization Among Individuals Meeting BPD Criteria

- 97% receive outpatient treatment
 - From an average 6.1 therapists
- 72% receive inpatient treatment
- Compared to MDD, individuals with BPD receive:
 - 4.7 x individual, 2.7 x group, 2.8 x day treatment
 - 5 x inpatient treatment, 2.1x antidepressants
 - 6.2x mood stabilizers, 10.5 anti-psychotics
 - 2.2x anti-anxiety medications

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Outcomes of Treatment-as-Usual Health Service Utilization

Severe impairment in:

- Employment (52%)
- Global satisfaction (55%)
- Social adjustment (71%)
- Overall functioning (47%)

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TABLE 1. Studies examining various facets of employment in individuals with borderline personality disorder (BPD)

| First Author/Year of Publication/Country | Sample Size/Description | Follow-Up Period (Years) | Comparison Group | Work Variable | Outcome |
|--|---|--------------------------|--|--|---|
| Pope/1983 United States* | 33 BPD patients initially hospitalized | 4-7 | Patients with schizophrenia, schizoaffective, and bipolar disorder | Best occupational or academic functioning | BPD patients higher functioning than schizophrenic patients, but lower functioning than schizoaffective and bipolar patients |
| McGlashan/1986 United States* | 61 BPD patients initially hospitalized | 15 | Patients with schizophrenia and bipolar affective disorder | Work time (4-all the time), level (1-most complex), and quality (past year (4-every competent); further education) | Mean: BPD, schizophrenic unipolars for work time: 2.7, 1.2, 2.5, work level: 2.9, 4.2, 3.3, work quality: 3.1, 2.0, 2.8; further education: 51%, 36%, 50% |
| Moskowitz/1989 Switzerland* | 18 BPD patients initially hospitalized | 4.6 | Patients with other personality disorders | Work <20 hours per week and disability status | No differences between groups: 50% of BPD patients working <20 hours/week and 22% on disability |
| Mohrman/1991 Norway* | 26 BPD patients initially in day treatment | 2-5 | None | Employment and self-supporting status | 56% employed and 38.5% self-supporting |
| Najavits/1995 United States* | 8 BPD patients initially hospitalized | 3 | None | Social Adjustment Scale | While there was no baseline data, work functioning did not significantly change from Year 1 (2.89) to Year 3 (2.33), but samples were not identical. |
| Trull/1997 United States* | 35 college students with BPD features | 2 | 30 college students without BPD features | Cumulative grade-point average; semesters on probation; % ineligible to enroll | BPD vs. non-BPD Grade-point: 2.34 vs. 2.91 Semesters on probation: 1.17 vs. 0.63 % ineligible to enroll: 20% vs. 0% |
| Paris/2001 Canada* | 64 patients, average age 50, initially hospitalized | 27 | Community norms | Social Adjustment Scale | BPD patients' mean work score, 1.5; community norms work score, 2.1; 20% of BPD patients on long-term waitlist |
| Stevenson/2005 Australia* | 30 BPD patients initially seen as outpatients | 5 | None | Time off work | From baseline, patients experienced significant reduction in time off from work at follow-up |
| Yoshida/2006 Japan* | 19 BPD patients initially hospitalized | 17+ | None | Employment status | 54.2% employed |
| Zanarini/2009 United States* | 249 BPD patients initially hospitalized | 10 | None | Social Security Disability | 40.7% on Social Security disability at baseline and 44.2% at follow-up |
| Combs/2010 United States* | 50 BPD patients initially seen as outpatients | 1 | None | Employed or in school; employed at least 20 hours per week | Employed/school before treatment: 10% Employed/school after treatment: 50% 20 hours/week employed before: 3% 20 hours/week employed after: 37% |

Sansone & Sansone, 2012, Employment in BPD

- Analysis of 11 studies between 1983 & 2010
- Nearly half remained unemployed at follow up
- 20% to 45% subsisted on disability.
- Zanarini (2009): 40.7% on SSD at baseline; 44.2% at follow up.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC347289/>

DOI: <https://doi.org/10.1111/j.1600-0447.2009.01448.x>

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DSM-V Diagnostic Criteria for BPD

A pervasive pattern of instability of interpersonal relationships, self-image, and affect, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the diagnostic criteria.

DSM-V Diagnostic Criteria for BPD

at least 5 of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of intense and unstable interpersonal relationships
3. Identity disturbance or problems with sense of self
4. Impulsivity that is potentially self-damaging
5. Recurrent suicidal or non-suicidal self-injurious behavior
6. Affective instability
7. Chronic feelings of emptiness
8. Inappropriate intense or uncontrollable anger
9. Transient stress-related paranoid ideation or severe dissociative symptoms

BPD Criteria Reorganized

Emotion Dysregulation

- Affective lability
- Problems with anger

Interpersonal Dysregulation

- Chaotic relationships
- Fears of abandonment

Self Dysregulation

- Identity disturbance/difficulties with sense of self/sense of emptiness

Behavioral Dysregulation

- Suicidal behaviors
- Impulsive behaviors

Cognitive Dysregulation

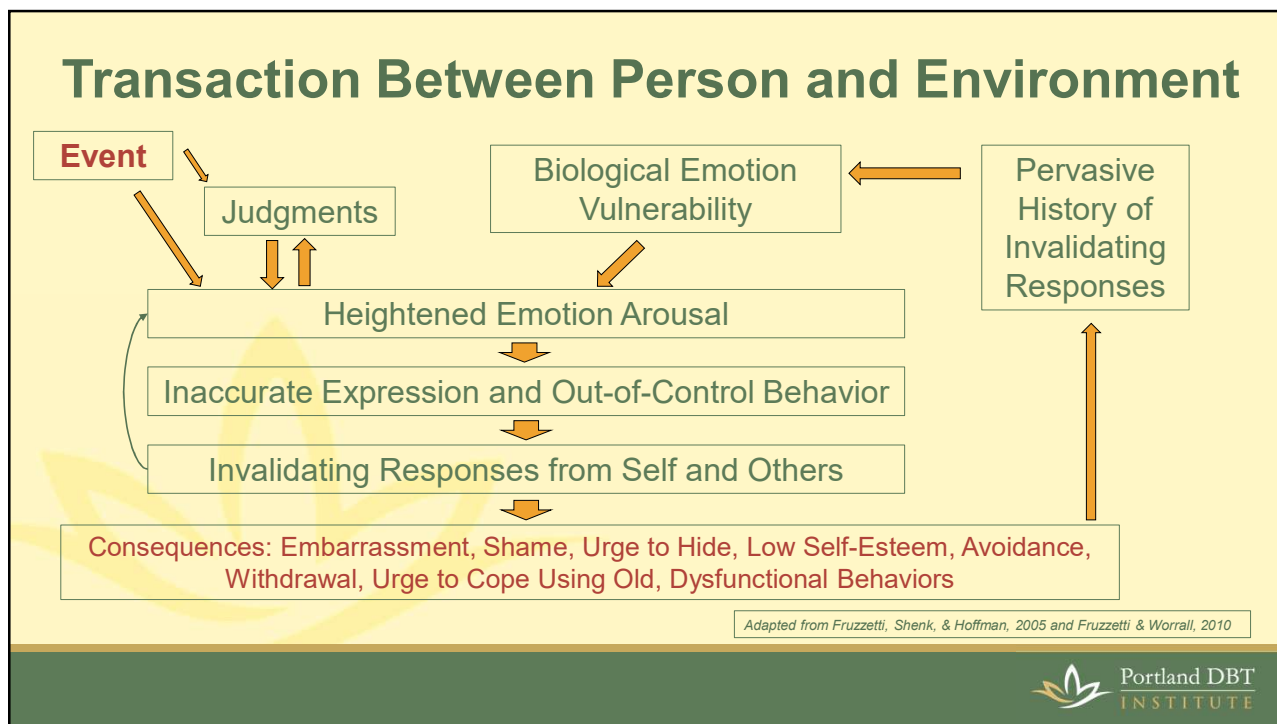
- Dissociative responses, paranoid ideation

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Bio Social Model




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Remember: Let's Stay Behavioral!



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Sidebar: What does behaviorism mean?

- DBT is based on a bio-social framework, and is a behaviorally oriented treatment
- Radical Behaviorism (BF Skinner): Private events (thoughts and experiences) are behaviors
- All emotions, thoughts, memories, etc are prompted by external events

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Implications for Language and Terminology

- Attachment Theory
- Boundaries
- Transference
- Countertransference
- Unconscious
- Self Sabotage



- Biosocial Model
- Limits
- Parallel Process
- Mindfulness/Mindlessness
- Functions of Behaviors

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Behavioral Orientation Principle

Conceptualize clients' and each other's behavior from a behavioral perspective; do not combine or add in other theoretical models. Many providers prefer eclecticism rather than a single theoretical approach. In DBT, maintaining a consistent, single, comprehensive philosophical approach with compatible theories is essential to inform the conceptualization of client and provider behaviors and related treatment decisions. The overarching theory for DBT and the DBT team is behaviorism. Dialectics, biosocial theory, Zen practice, acceptance strategies, and change strategies are all viewed through a behavioral lens. Changing theories within a client's treatment (e.g., from behavioral to psychodynamic and back again) can lead to less precise explanations for behavior and therefore less leverage when generating solutions.

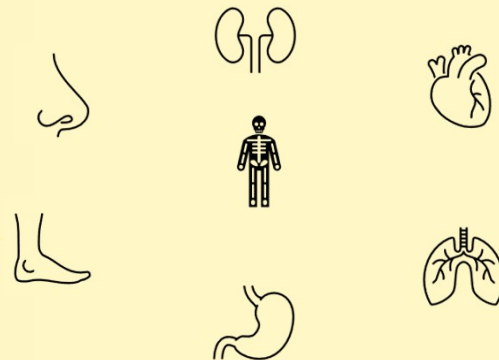
Sayrs & Linehan, 2019, *DBT Teams*



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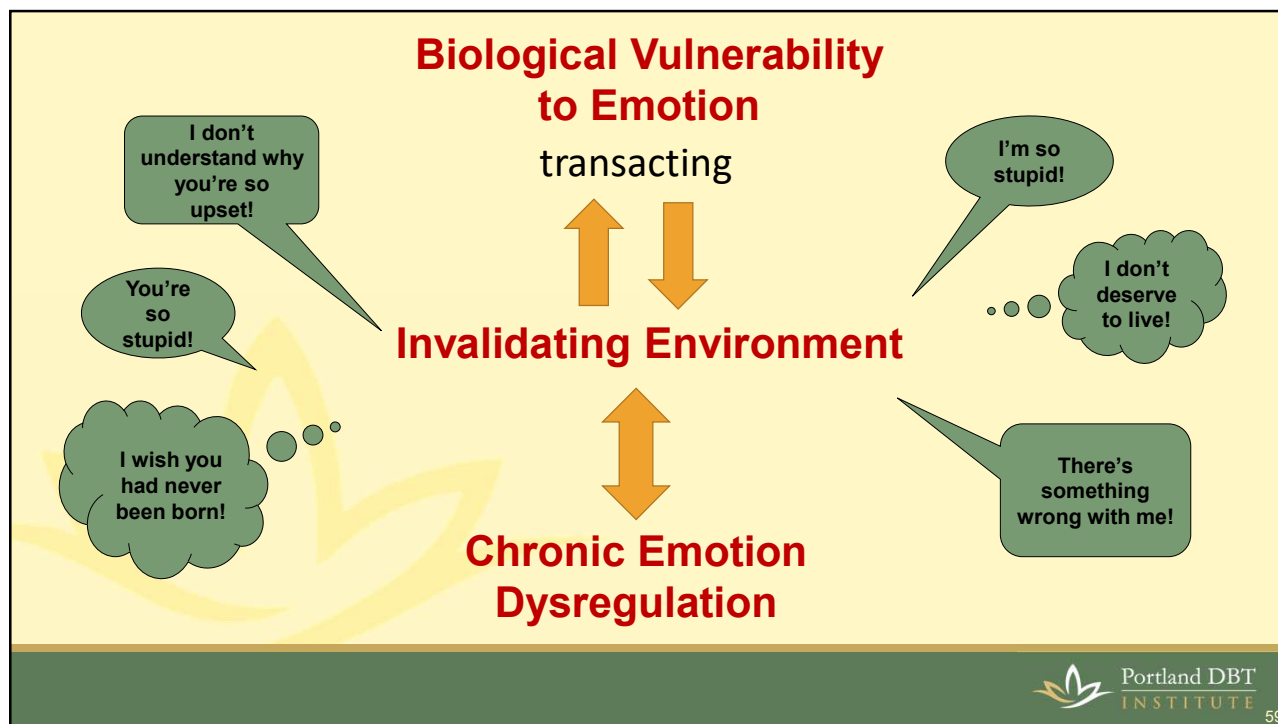
**BPD criterion behaviors
function to regulate emotions
or are a natural consequence
of emotion dysregulation.**

**BPD is a Systemic
Emotion Regulation
Disorder**



58

58



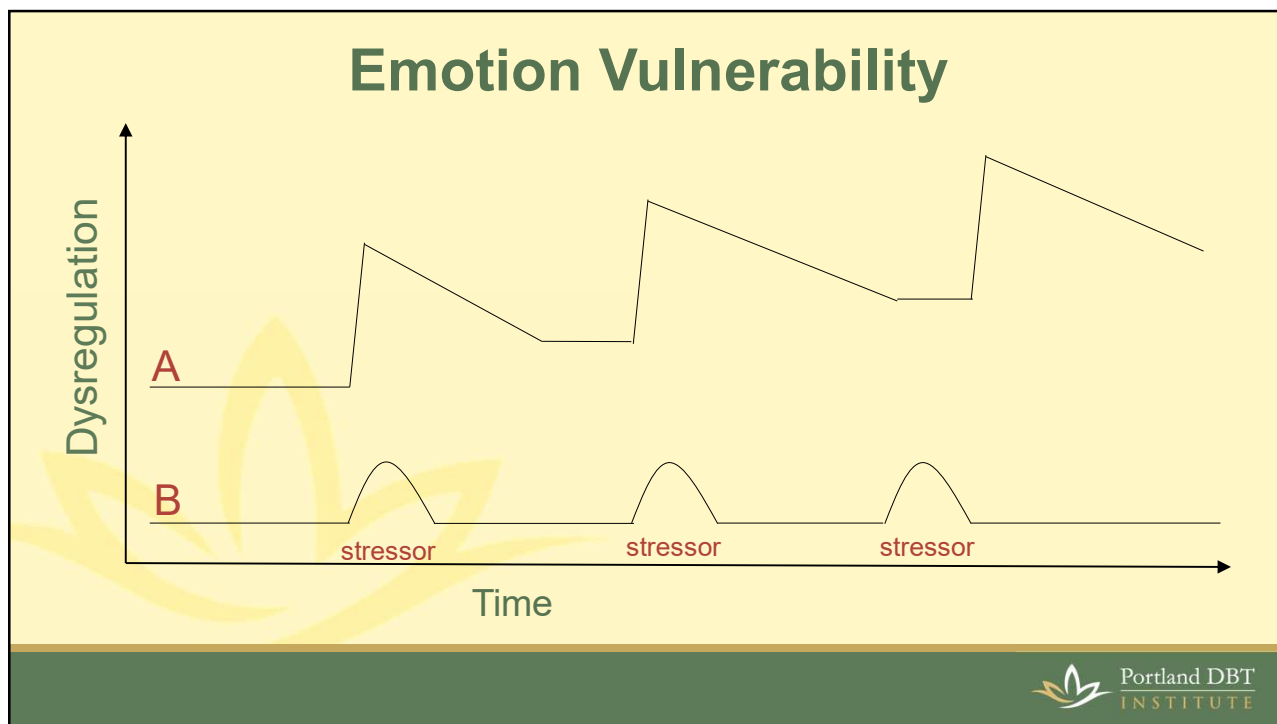
59

Emotion Vulnerability

- **High Sensitivity**
 - Immediate reactions
 - Low threshold for emotional reaction
- **High Reactivity**
 - Extreme reaction
 - High arousal dysregulates cognitive processing
- **Slow Return to Baseline**
 - Long lasting reactions
 - Contributes to high sensitivity to next emotional trigger

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Linehan's Hypothesis

BPD results from **transaction** of biological vulnerability with invalidation over time.

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Invalidating Environment

***Pervasively* invalidates**

(punishes, negates,
dismisses, ignores) behavior
**independent of the actual
validity** of the behavior

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Characteristics of an Invalidating Environment

1. **INDISCRIMINATELY REJECTS** communication of private experiences and self-generated behaviors
2. **PUNISHES** emotional displays and **INTERMITTENTLY REINFORCES** emotional escalation
3. **OVER-SIMPLIFIES** ease of problem solving and meeting goals

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Examples of Invalidating Responses

- Reject self-description as inaccurate
- Reject response to events as incorrect or ineffective
- Dismiss or disregard
- Directly criticize or punish
- Overly simplify

Examples of Invalidating Responses

- Neglect
- Pathologize normative responses
- Reject response as attributable to socially unacceptable characteristic (e.g., over-reactive emotions, paranoia, naiveté, manipulative intent, lack of motivation, negative attitude, etc.)

Consequences of Invalidating Responses

- Environment does not teach individual to:
 - Label private experiences in a manner normative in larger social community
 - Effectively regulate emotions
 - Trust experiences as valid responses to events
- Instead, environment teaches individual to:
 - Actively self-invalidate and search social environment for cues about how to respond

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Consequences of Intermittent Reinforcement of Escalated Emotional Displays

- Environment does not teach individual to:
 - Accurately express emotions
 - Communicate pain effectively
- Instead, environment teaches individual to:
 - Oscillate between emotional inhibition and extreme emotional styles

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Consequences of Oversimplifying

- Environment does not teach individual to:
 - Tolerate distress
 - Solve difficult problems in living
 - Use shaping and other behavioral strategies to effectively self-regulate own behavior
- Instead, environment teaches individual to:
 - Respond with high negative arousal to failure
 - Form unrealistic goals and expectations
 - Hold perfectionistic standards

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Factors That Increase Probability of an Invalidating Response

- Behavior communicates private experience
- Behavior puts demand on environment above preferred level
- Environment has no readily available response to meet need communicated by emotional display and/or pain behavior
- Individual is different from others in environment

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Types of Invalidating Families

- Chaotic Family
- Perfect Family
- Ordinary Family

71

Think about a patient of yours


1. How might they have experienced pervasive invalidation in their home environment?
2. What are examples for how they may experience invalidation in treatment?

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The borderline interpersonal-affective systems (BIAS) model



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Clinical Psychology Review

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Review

The borderline interpersonal-affective systems (BIAS) model: Extending understanding of the interpersonal context of borderline personality disorder

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ARTICLE INFO


Keywords:
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 Emotion dysregulation
 Interpersonal
 Self-injury
 Suicide

ABSTRACT

Prominent explanatory models for borderline personality disorder (BPD) are intrapersonal in nature and hold that it is an emotional disorder. However, the empirical support for emotional models of BPD is mixed. Refinements to BPD explanatory models are needed to increase the precision with which BPD can be understood and treated. Drawing on existing theoretical and empirical research in BPD, this manuscript presents the Borderline Interpersonal-Affective Systems (BIAS) model. The BIAS model purports that harmful early life re-

<https://doi.org/10.1016/j.cpr.2021.101983>



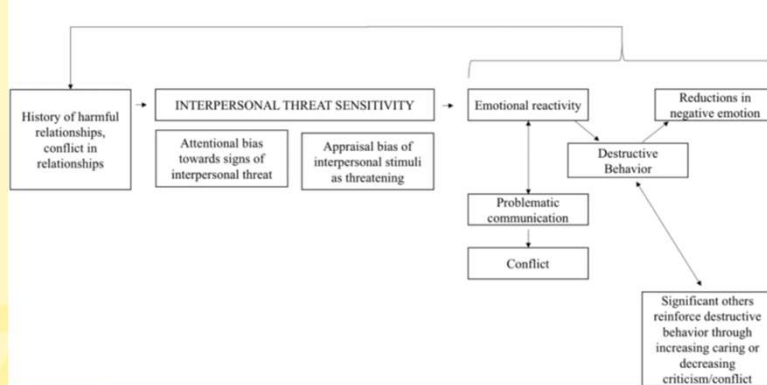
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The BIAS Model

- *Interpersonal and intrapersonal interactions maintain BPD over time*
- “Interpersonal threat sensitivity elicits heightened emotional reactivity...which is not pervasive but is specific to interpersonal stimuli and cues”

Core components of the Borderline Interpersonal-Affective Systems (BIAS) model



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BIAS Model (Borderline Interpersonal-Affective Systems)

- Overview:
 - Research on differences in emotional reactivity between individuals with and without BPD have had mixed results regarding emotion reactivity and rate of return to baseline during stressful cues
 - “Not all emotion processes are dysregulated in BPD across all indices”
 - There is a need to update the thinking around when emotion regulation issues present in order to be consistent with the goal of DBT of having precision and specify

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What we know about BPD and interpersonal issues

- As many as 73% of lethal suicide attempts in BPD are prompted by interpersonal events (Brodsky, Groves, Oquendo, Mann, & Stanley, 2006)
- Individuals with BPD have relationships with less social support, more arguments, more romantic dysfunction
- Interpersonal conflict is a frequent predictor of suicide threats and NSSI
- DBT addresses the role of interpersonal processes (e.g. invalidation) in the development of the disorder, but does not specifically address this in the treatment (we focus on *intrapersonal*).

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The BIAS Model Components

- Histories of problematic relationships
 - Childhood maltreatment, adult relationship aggression, preference for fewer relationships which are more intense, preference for exclusive relationships
- Sensitivity to interpersonal threat
 - Attentional biases towards negative or threatening information
 - More likely to appraise interpersonal information as negative
 - More likely to perceive rejection
- Heightened reactivity to interpersonal threat
- Problematic Communication and destructive emotion regulation behaviors
 - Self-harm, aggression, substance abuse

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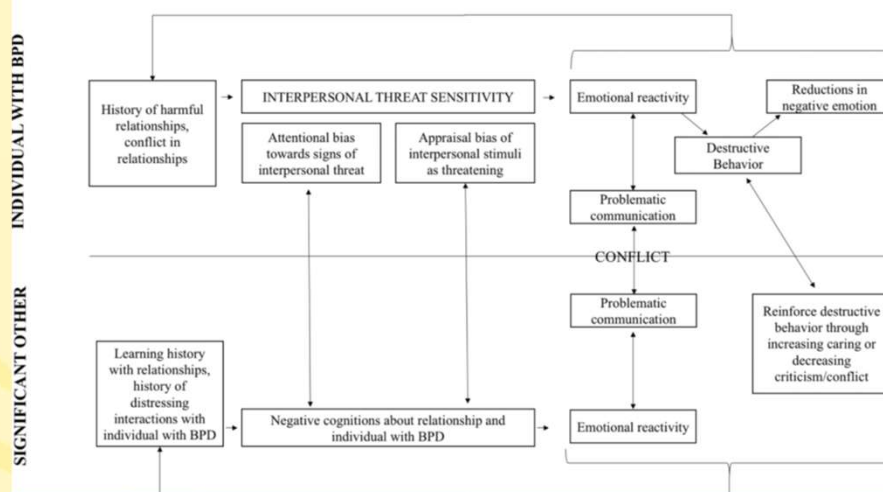
Clinical Implications

- Engage significant others in treatment to improve their communication skills (e.g. validation, non-judgmental communication, decreasing avoidance)
- Don't assume emotion deficits in BPD are pervasive- look at the interpersonal cues
- Use accurate targeting of emotion regulation processes related to interpersonal processing- target attentional biases (mindfulness skills) and appraisal issues (emotion regulation/checking the facts)

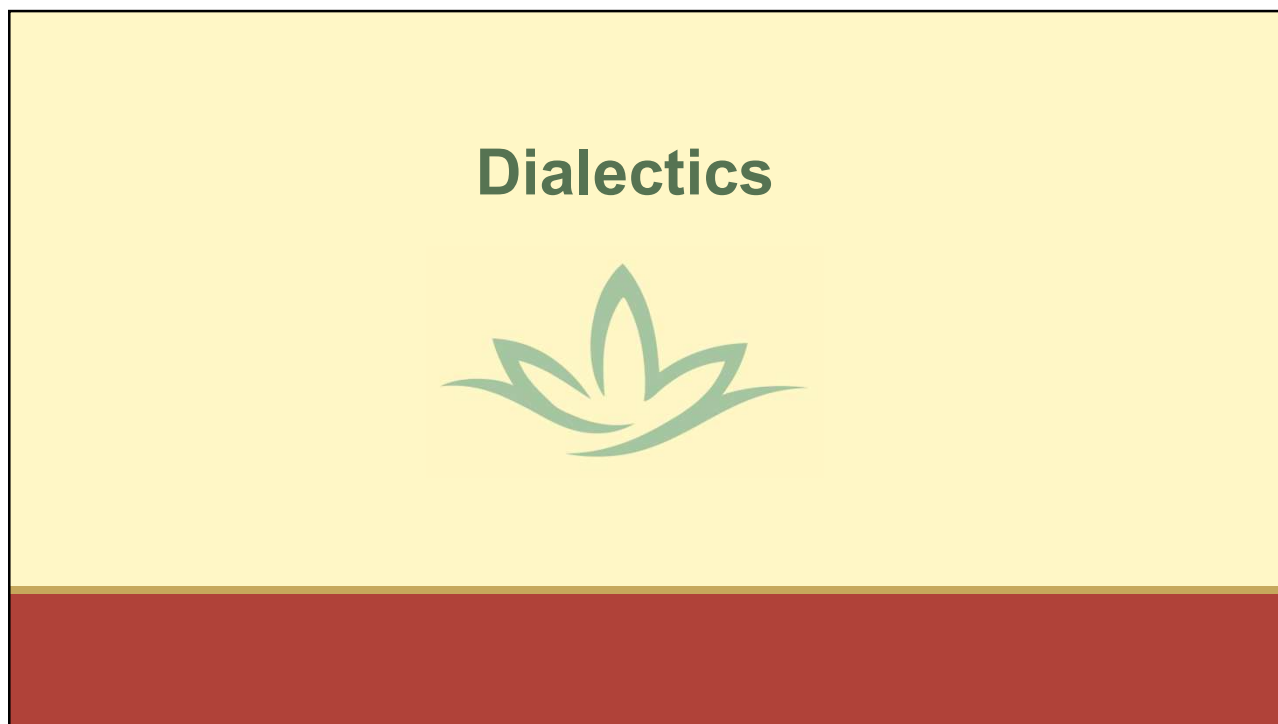
79

The role of significant others

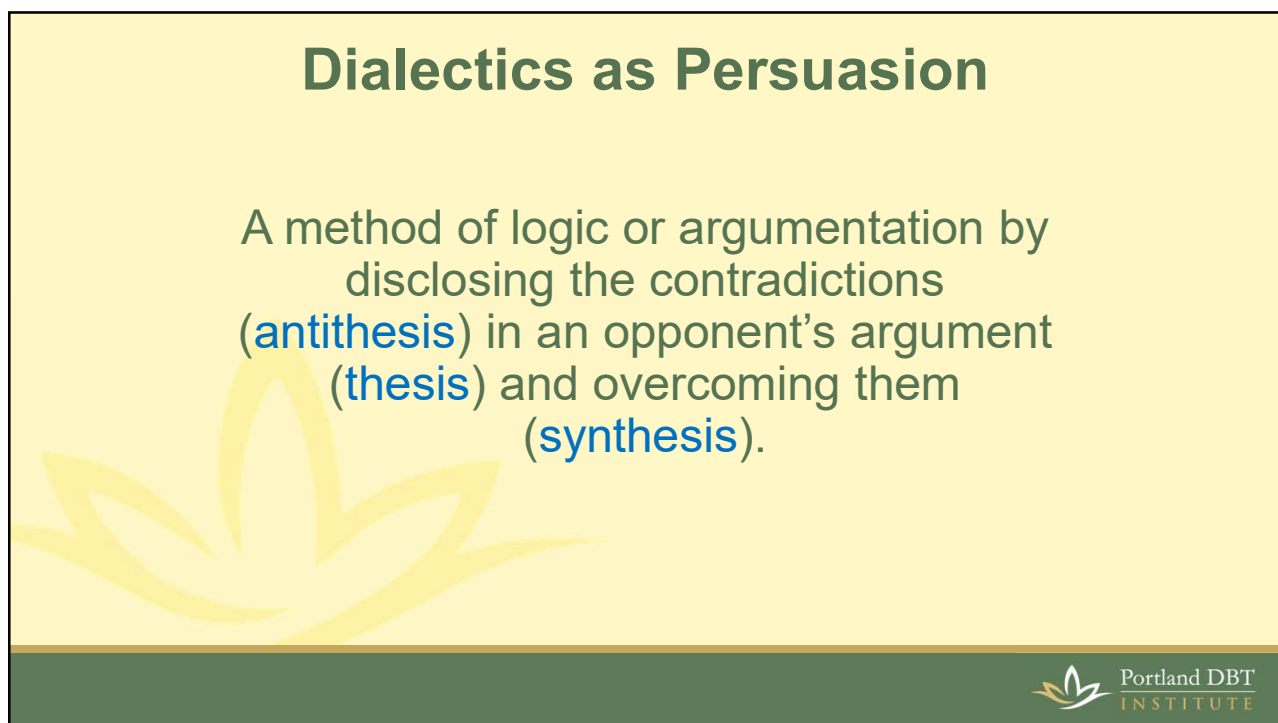
Elaborated Borderline Interpersonal-Affective Systems (BIAS) model, including significant other components



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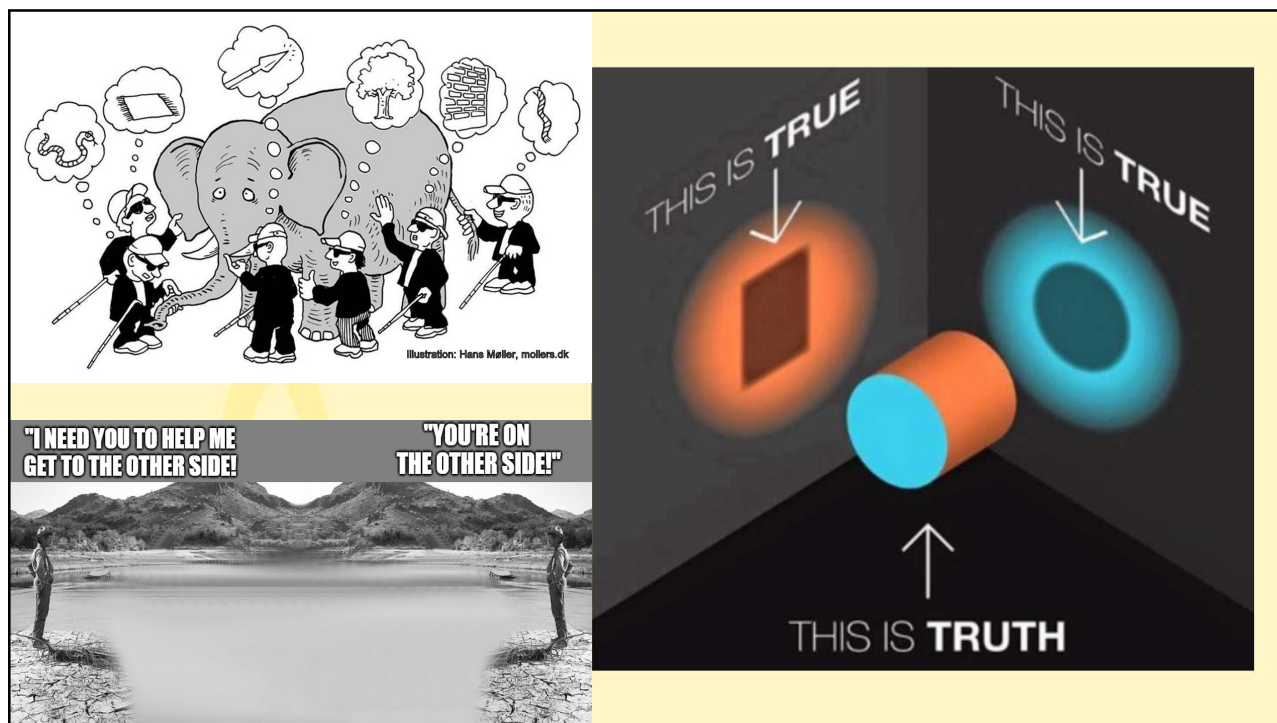


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Dialectics as World View

- Holistic, connected and in relationship
- Complex, oppositional, and in polarity
- Change is continuous
- Change is transactional
- Identity is relational and in continuous change

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Where Dialectics Show Up in DBT

Biosocial theory of BPD etiology

- Transaction between biology and environment over time.
- Systemic disorder

Treatment Strategies

- Balance of change vs. acceptance
- Search for “what is being left out”, a synthesis, and function within dysfunction
- Emphasis on movement, speed, and flow
- Skills modules

Dialectical Philosophy

Teaches that:

- Everything and every person is connected in some way.
- Everything is made of opposing forces/opposing sides.
- Change is the only constant.
- Change is transactional

Dialectics

Everything and Every Person is Connected in Some Way

- "What goes around comes around."
- The waves and the ocean are one.
- We are all connected to each other physically
- Each of us has parts (e.g., arms, legs, blood vessels, cells) and each of us is part of a greater whole
- Modern physics tells us that separation is an illusion

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Dialectics

Everything is Made of Opposing Forces or Sides


- "He who knows only his own side knows little of it."
- Balancing of opposites is walking the Middle Path.
- All people have unique qualities and different points of view
- It is important to let go of seeing the world in "black-or-white," "all-or-nothing" ways.
- Two things that seem like opposites can both be true

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Dialectics

Change is the Only Constant

- "You can't step in the same river twice."
- Even one vote changes the outcome.
- Meaning and truth evolve over time.
- Change is transactional.




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Dialectics

Change is Transactional

- "The doors we open and close each day decide the lives we live."
- When "A" influences "B" the change in "B" influences "A"
- We are all simultaneously making (influencing) this moment.



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How a **Dialectical Perspective** helps

- Get unstuck during standoffs and conflicts with others
- Be more flexible and approachable
- Avoid blaming either ourselves or others for difficulties or problems
- Find the synthesis in opposing points of view
- Recognize that skills help learn how to "walk the middle path" in how we think and act.

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Dialectics in Action

- Looking for synthesis in apparent conflicts
- Requires finding something valid in other perspective (do not compromise or agree with invalid information)
- Opposite of adversarial
- NOT compromise and NOT autocratic
- Search for "what's left out"
- Agree on rules of the game (all players must agree to adopt dialectical position)

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A “HOW TO” GUIDE FOR THINKING AND ACTING DIALECTICALLY:
Be Aware That You Are Connected

- Treat others as you wish them to treat you. Remember that if you are harsh, critical or invalidating, you will likely be treated the same way.
- Notice how your mood affects others around you, and how other people's moods affect you.

A “HOW TO” GUIDE FOR THINKING AND ACTING DIALECTICALLY:
Walk the Middle Path

- Fine tune and balance the opposites in your life e.g., balance accepting reality and working to change it; validating yourself and others and also pointing out errors; both working and resting.
- Practice looking at all sides of a situation. Find the kernel of truth in every side. .

A "How To" GUIDE FOR THINKING AND ACTING DIALECTICALLY:

Walk the Middle Path

- Move away from extremes, such as "either-or" (to "both-and") "always," "never," (to sometimes) "you made me" (to concrete descriptions).
- Accept that different opinions can be valid even when you disagree.

A "How To" GUIDE FOR THINKING AND ACTING DIALECTICALLY:

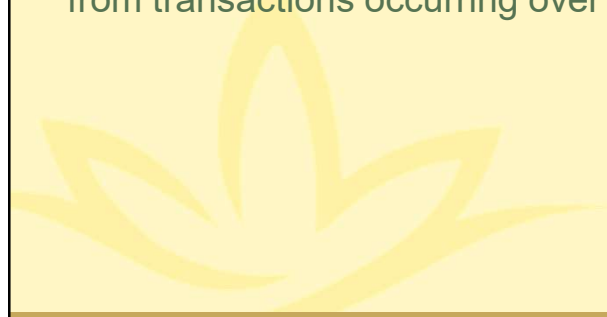
Embrace Change

- Allow those you care about to grow, develop, and change over time.
- Practice radical acceptance when people and relationships begin to change in ways you wish they wouldn't.
- Let go of clinging to the present; remember every moment is unique.
- Be patient with gradual changes; be prepared for sudden changes.

A “HOW TO” GUIDE FOR THINKING AND ACTING DIALECTICALLY:

Remember Change is Transactional

- Pay attention to the effect of what you do and say on others and how what they do and say affects you.
- Let go of blame by seeing your own and others’ behaviors as arising from transactions occurring over time.



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Break!



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Day One

Structuring Up BPD Treatment: DBT
Treatment Functions & Modes,
Engagement and Motivation



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**Structuring Up DBT
Treatment**

DBT Treatment Modes & Functions
DBT Stages & Targets
Building a Life Worth Living



100

Structure the Treatment

*Decide whom you will serve with
DBT and where clients will
receive it*

101

Standard DBT Modes

- Outpatient Individual Psychotherapy
- Outpatient Group Skills Training
- Telephone Consultation
- Therapists' Consultation Meeting
- Uncontrolled Ancillary Treatments
 - Pharmacotherapy
 - Acute-Inpatient Psychiatric

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DBT Treatment Functions

- Enhance capabilities
- Improve motivational factors
- Assure generalization to natural environment
- Structure the environment
- Enhance therapist capabilities and motivation to treat effectively

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Residential Treatment Modes

- Individual DBT
- Group Skills Training
- Milieu Treatment
- Coaching on the Fly
- Consultation Team
- Egregious Behaviors Protocol
- Uncontrolled Ancillary Treatments
 - Pharmacotherapy

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Structuring Treatment Team

DBT requires each **client to have one** (and only one) primary therapist.

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Role of Primary Therapist

Responsible for:

- Treatment planning
- Ensuring progress across treatment targets
- Ensuring success in other modes
- Consultation to patient on being effective consumer of care
- Management of suicide and other crises

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And every DBT therapist must have **one primary DBT team**

Team is responsible for:

- Helping plan/trouble-shoot treatment
- Monitor adherence to DBT
- Ensure progress toward DBT competence
- Consult to therapist on effective engagement with other MH networks, providers
- Provide support, particularly when limits stretched

Function of **DBT Consultation Team**

To enhance the capability and motivation of clinicians to treat complex, difficult to treat patients and to stay within the treatment frame through consultation practices.

Day One

End of Day

- Homework for tomorrow
- Housekeeping
- Closeout




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Day Two




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Day Two
Mindfulness
Homework Debrief/Discussion



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Day Two
Structuring up the Treatment: Levels of
Disorder, Stages, & Targets



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Structure the
GOALS of Treatment
by Levels of Disorder

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DBT's Overarching Goal
is
a life worth living

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**The path to a “Life Worth Living”...
...all depends on where
you start**

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Levels of Disorder


Level 1: **Behavioral Dyscontrol**

Level 2: **Quiet Desparation**

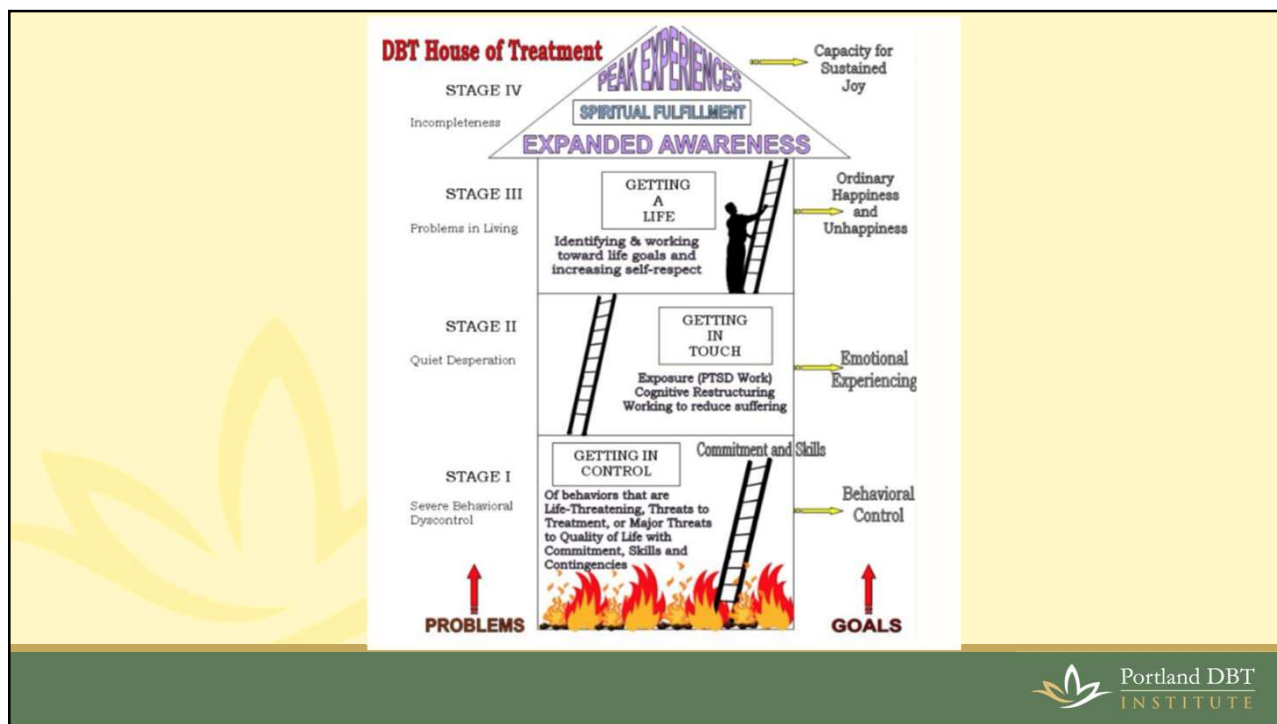
Level 3: **Problems of Living**

Level 4: **Incompleteness**

Significant
Psychopathology



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Structure the Primary Treatment Targets

in hierarchical order by importance and grouped by
level of disorder

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Stage 1 Primary Targets Dialectical Synthesis

Pretreatment  *Commitment and Agreement*

- Decrease
 - Life-threatening behaviors
 - Therapy-interfering behaviors
 - Quality-of-life interfering behaviors
- Increase behavioral skills using DBT skills (Mindfulness, Distress Tolerance, Emotion Regulation, & Interpersonal Effectiveness) as well as other behavioral skills.

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Suicidal and Life Threatening Behaviors

- **Suicidal and Life-Threatening Crisis Behaviors** (indicates risk of imminent suicide, suicide attempt, homicide, and serious aggression)
- **Non-suicidal self-injury (NSSI)**
 - Intent to cause harm to self
 - Deliberate action
 - Acute Injury (tissue damage, ingests poisons or drugs over reasonable prescription; serious risk without outside intervention)

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Therapy-Interfering Behaviors (Patient)

- 1. Behaviors that interfere with receiving therapy**
 - Non-collaborative behaviors
 - Non-compliance
 - Non-attending behaviors
- 2. Behaviors that interfere with other patients**
- 3. Behaviors that burn out therapist**
 - Behaviors that push therapist's limits
 - Behaviors that reduce therapist's motivation to treat

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Therapy-Interfering Behaviors (Therapist)

1. Behaviors that unbalance therapy

- Extreme acceptance or change
- Extreme flexibility or rigidity
- Extreme nurturing or withholding
- Extreme vulnerability or irreverence

2. Disrespectful behaviors

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Quality of Life Interfering Behaviors

- Incapacitating DSM-V disorders
- Unemployment
- High risk or unprotected sex
- Extreme financial problems
- Criminal activities
- Severe interpersonal dysfunction
- Physical, medical problems
- Homelessness, unstable, unsafe housing
- Intimate partner violence

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Stage 1 Primary Targets: Order it Up

- Used cocaine 1x in past week (but didn't use meth, drug of choice)
- Urges to kill self (4 on 5 point scale)
- Threw up (intentionally)
- Intentionally cut self ("just a scratch")
- Disruptive in group and rolls eyes when Client B is sharing
- Hit the wall causing physical damage when staff said "no" to request for cigarette break.
- Frequent flashbacks during the week (a janitor looks like client's perpetrator)
- The new resident and your client have a violent, extremely problematic past.

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DBT Skills Training TARGETS

- DECREASE behaviors likely to **destroy** therapy.
- INCREASE skills acquisition & strengthening
 - Mindfulness, Emotion Regulation, Interpersonal Effectiveness, Distress Tolerance
 - Self-Management
- DECREASE therapy-interfering behaviors

(Question: How is this similar to/different from DBT standard targets for Stage 1 clients? What is the rationale?)

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DBT Phone Coaching Targets

- **INDIVIDUAL THERAPIST:**

- DECREASE suicide crisis behaviors
- INCREASE generalization of DBT skills
- DECREASE sense of conflict, alienation, & distance with therapist.

- **SKILLS TRAINER:**

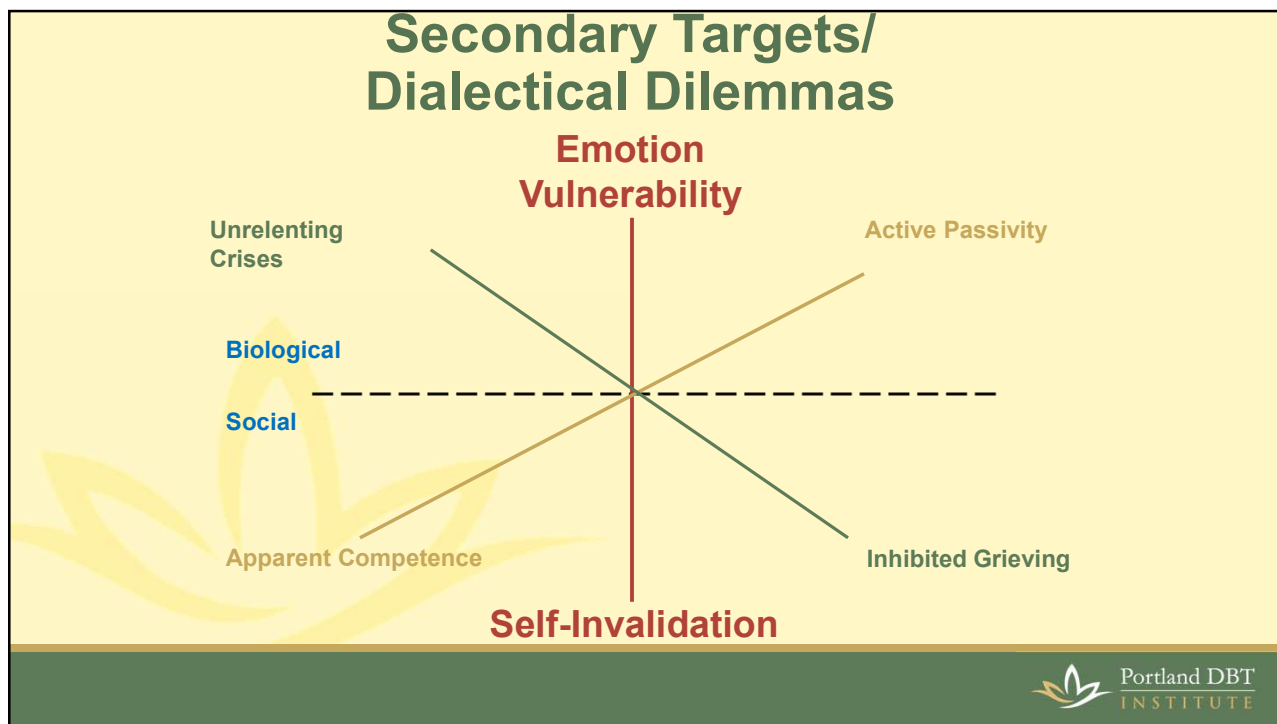
- DECREASE therapy destructive behaviors
- INCREASE immediate contacting of primary therapist

127

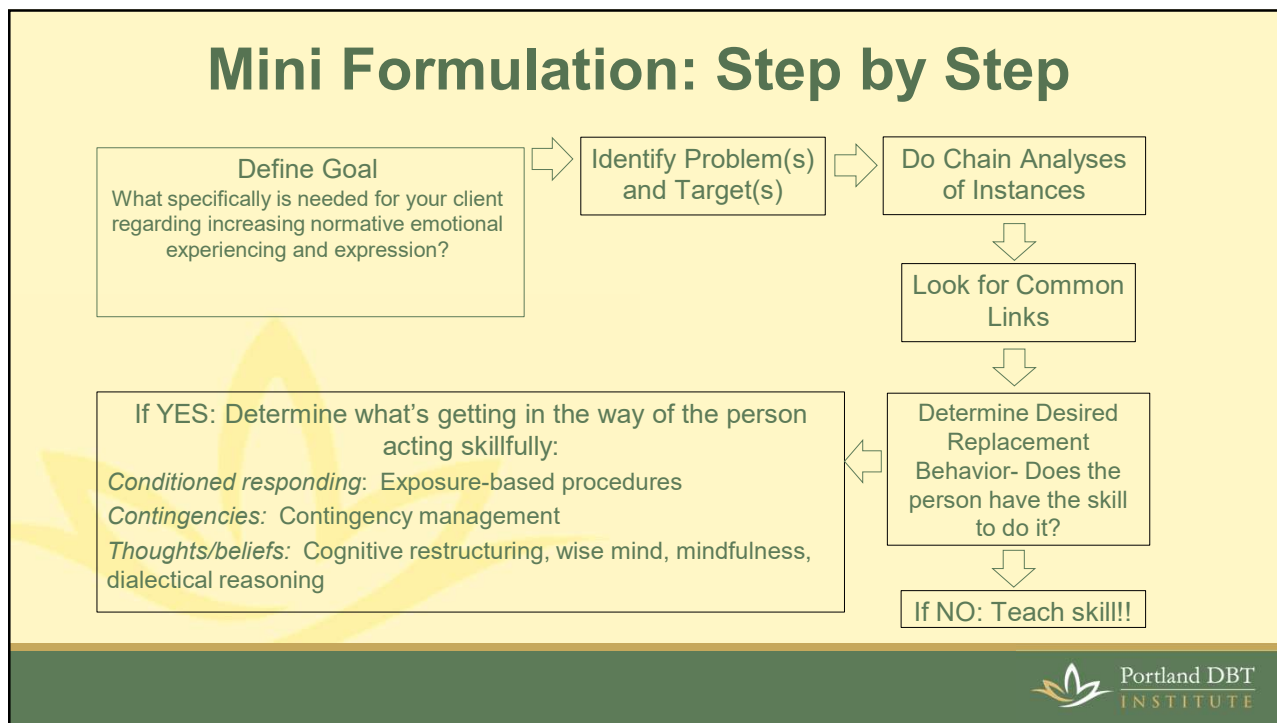
DBT Secondary Targets Stage I BPD Clients

DBT selects secondary targets by their positions and functions on the chain analysis of most significant problem behaviors.

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Break!



131

**Pre-Treatment:
Getting the Commitment &
the First Four Sessions**



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Getting Started with Pre-Treatment

DBT requires clear, voluntary, and fully informed agreement before starting treatment of any sort.

1. Commitment to Change: Therapist & Client agree on treatment goals and approach
2. Agreement to Treatment: Therapist & Client agreements
3. Agreement to Therapist-Client Relationship

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Patients' Agreements in Standard DBT

- Stay in therapy for specified time period
- Attend scheduled therapy sessions
- Work towards changing targeted behaviors
- Work on problems that arise in therapy that interfere with its progress
- Participate in skills training for specified time period (Stages 1 & 2)
- Abide by clinic and financial policies

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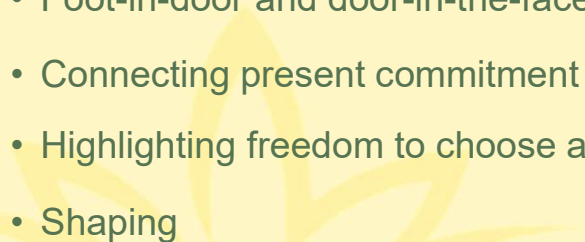
Motivation and Engagement Strategies

- Linking to Goals
 - Validation
 - Commitment Strategies
- 

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Commitment Strategies

pp. 284-291

- Selling commitment: evaluating the pros and cons
 - Playing the devil's advocate
 - Foot-in-door and door-in-the-face techniques
 - Connecting present commitment to prior commitments
 - Highlighting freedom to choose and absence of alternatives
 - Shaping
- 

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Commitment Tips for Your Back Pocket

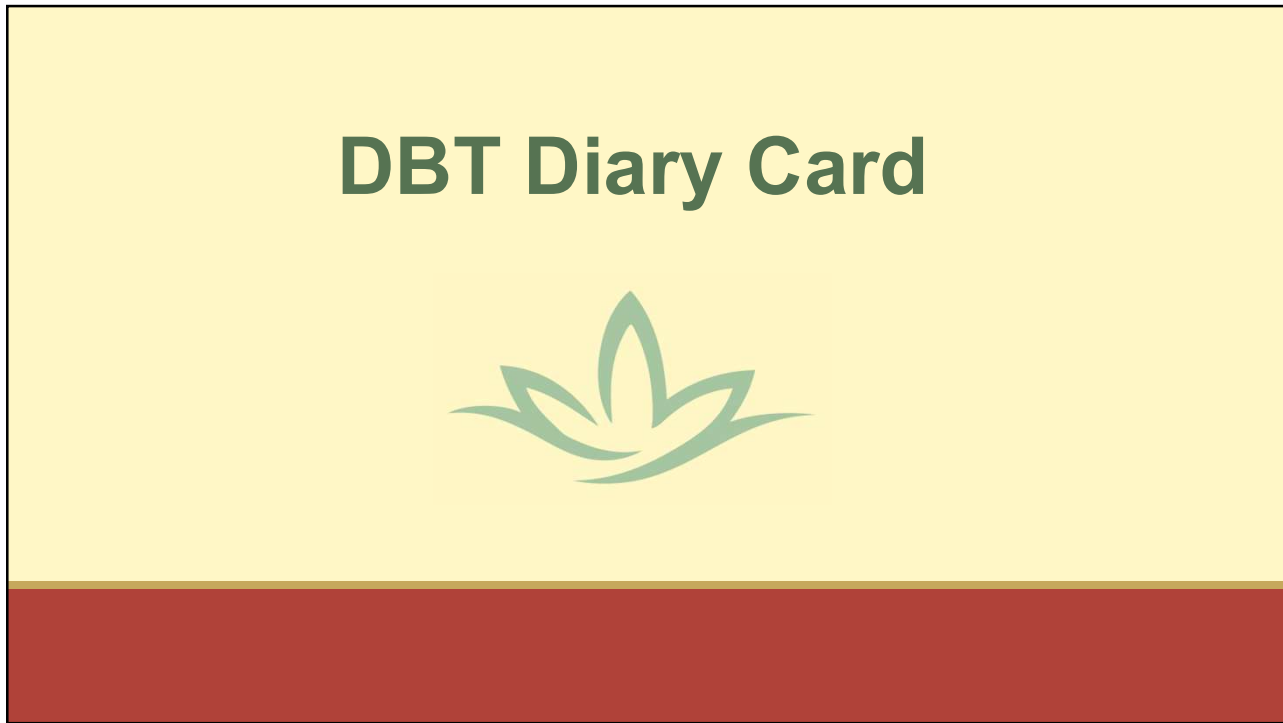
- *All things being equal, if you could give up X, would you want to?*
- *If I have a magic wand in my pocket and could magically take away X, would you want me to?*

Remember:

1. **Take what you can get; get what you can take.**
2. **Shake it up with stylistic strategies; oscillate intensity**
3. **Movement, speed, flow**

What's Needed in **FIRST FOUR** Sessions?

- Overall philosophy: *Skills over pills.*
- Introduce C to other modes, biosocial theory, BPD (if they have it).
- Orient to the DBT Diary Card and get them using it.
- And...Establish **Treatment Expectations**
 - What are they?
 - Why do they matter?



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DBT Diary Card

- What should be on it?
- What's its value/purpose?
- How do you use it in milieu setting with youth?
- How do you overcome obstacles?

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DBT Diary Card Essentials

- Purpose
- What to include
- When and how do I use it?
 - Review out loud
 - Review strategically with eye to targets
 - Be mindful to YOUR behavioral response when

141

Common Objections to Diary Card

- C doesn't want to use it.
- C can't use it (e.g., *it's too complex; C is too dysfunctional*)
- *I am tired of battling its use with my client.*

Others?

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Lunch!



A slide with a yellow background and a red footer. The word "Lunch!" is centered in a bold, dark green font. Below it is a green lotus flower icon.

143

Day Two
Validation



A slide with a yellow background and a red footer. The text "Day Two" is centered in a bold, dark green font, with "Validation" centered below it in a smaller, dark green font. Below the text is a green lotus flower icon.

144

Defining Validation

The action of validating or making valid; a strengthening, reinforcing, confirming; establishing something as valid.

Confirming
Authenticating
Verifying
Substantiating

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Important Constructs to Validate Particularly for those with BPD

Problem Importance
Task Difficulty
Emotional Pain
Sense of Being Out-of-Control
Self-Dysregulation
Location Perspective

Wisdom of Ultimate Goals

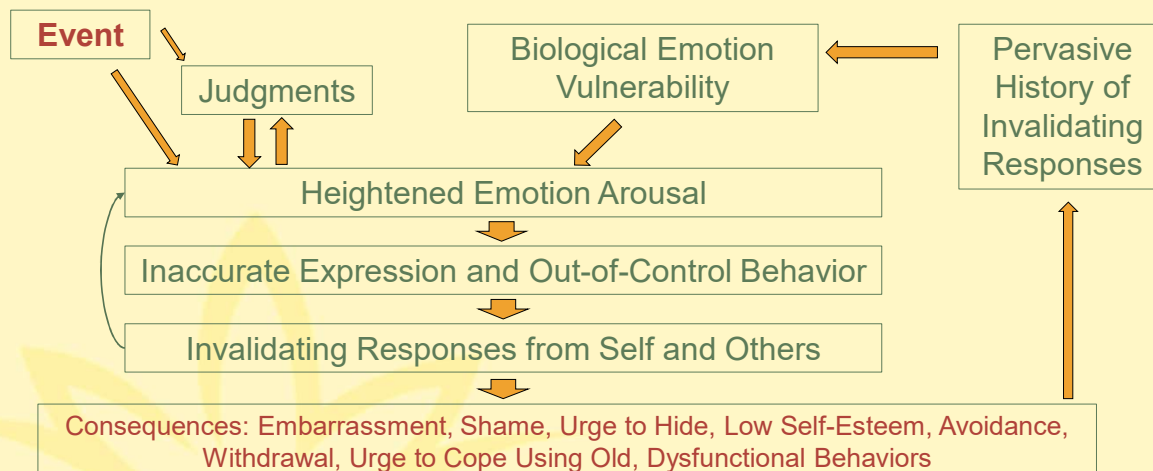
146

Functions of Validation

- To strengthen clinical progress
- To dialectically balances change
- To strengthen self-validation
- As feedback
- To strengthen the therapeutic relationship
- **To strengthen individual's capacity to see, know, & rely on inner wisdom (i.e., Wise Mind).**

147

Transaction Between Person and Environment



DOIs: <https://psycnet.apa.org/doi/10.1017/S0954579405050479>
<https://doi.org/10.1093/acprof:oso/9780195380170.001.0001>

Adapted from Fruzzetti, Shenk, & Hoffman, 2005 and Fruzzetti & Worrall, 2010

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Validation Strategies

1. Emotional

- Encourage emotional expression
- Teach emotion observation & labeling
- Read emotions
- Directly validate emotions

2. Behavioral

- Teach behavioral observation & labeling skills
- Identify, counter, & accept the “should”
- Move to disappointment

Validation Strategies

3. Cognitive

- Elicit and reflect thoughts & assumptions
- Find the “kernel of truth”
- Acknowledge “Wise Mind”
- Identify and respect one’s own values

Cheerleading Strategies

- Assume the best
- Actively encourage
- Focus on strengths/capabilities/successes
- Contradict/modulate external criticism
- Be realistic
- Stay near

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Levels of Validation

1. **Staying Awake:** Unbiased listening & observing
2. **Accurate Reflection**
3. **Mind-Reading:** Articulating the un verbalized thoughts, emotions, behavioral patterns
4. Validation in terms of **past** learning or biological dysfunction.
5. Validation in terms of **present** context or **normative** functioning
6. **Radical Genuineness**

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What Makes Validation Difficult?

- Severe individual distress and disorder
- Bad habits, patterns, etc.: forgetting that this is a person you actually care about
- Judgments (right/wrong, should/shouldn't)
- Negative emotions (anger!)
- Poor (inaccurate) self-expression
- Lack of understanding
- Poor conflict management skills
- Lack of acceptance

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Levels of Invalidation

| Level | Label | Description |
|-------|------------------|--|
| 1 | Empathic Failure | Undesirable behavior receives attention and emotional experience is ignored; may be intended as loving |
| 2 | Dismissive | One person invalidates another person's specific behavior |
| 3 | Stigmatizing | One person or small number of people invalidate a person's specific behavior or experience |
| 4 | Gaslighting | Maintains that the person deserves or caused mistreated; accuses person of misperceiving |
| 5 | Internalized | Beliefs, actions, behaviors collude with invalidation |
| 6 | Abusive | Invalidation threatens safety, blames the victim, may include actual harm |
| 7 | Systemic | Many people in the person's community invalidate their essential worth, value, legitimacy |

Pierson, Vinushini, & Bond (2022): <https://doi.org/10.1016/j.cbpra.2021.11.001>
(adapted from Fruzzetti & Vijay, 2020)

154

Break!



A slide with a yellow background and a red footer. The word "Break!" is centered in a bold, dark green font. Below the text is a green lotus flower icon with five petals.

155

Day Two
Emotion Regulation



A slide with a yellow background and a red footer. The text "Day Two" is centered in a bold, dark green font, with "Emotion Regulation" centered below it in a regular dark green font. Below the text is a green lotus flower icon with five petals.

156

What is Emotion Regulation Anyway?

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Emotion Regulation

- James Gross, PhD
- Stanford psychophysiology Laboratory (<https://spl.stanford.edu/>)
- Model for describing emotion responses as well as model for how we modulate and regulate our emotion responses
- Great resource- Handbook of Emotion Regulation (Gross, 2014, 2024)



158

Don't Go Wasting Your Emotions

“...therapists often over-rely on coaching distress tolerance skills... It is possible that while the Distress Tolerance chapter is appropriately named, both therapists and clients wishfully misread the title as either Distress Elimination or Distress Reduction”.



Christine Dunkley, DClinP, The Oxford Handbook of DBT, 2018.



James Gross, PhD, Handbook of Emotion Regulation, 2014, 2024



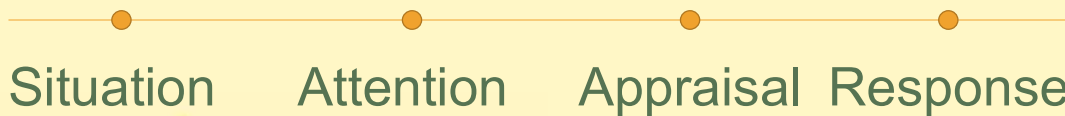
ABBA, 1980

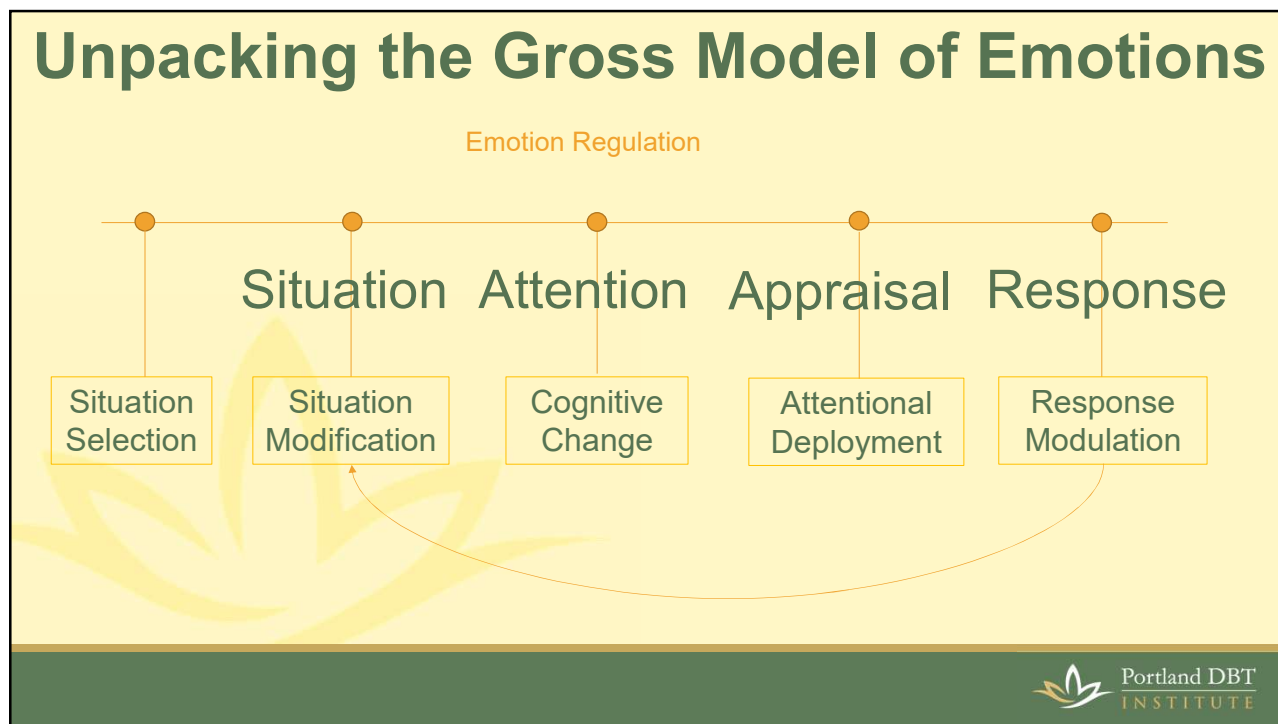


Public Image Limited, 1986

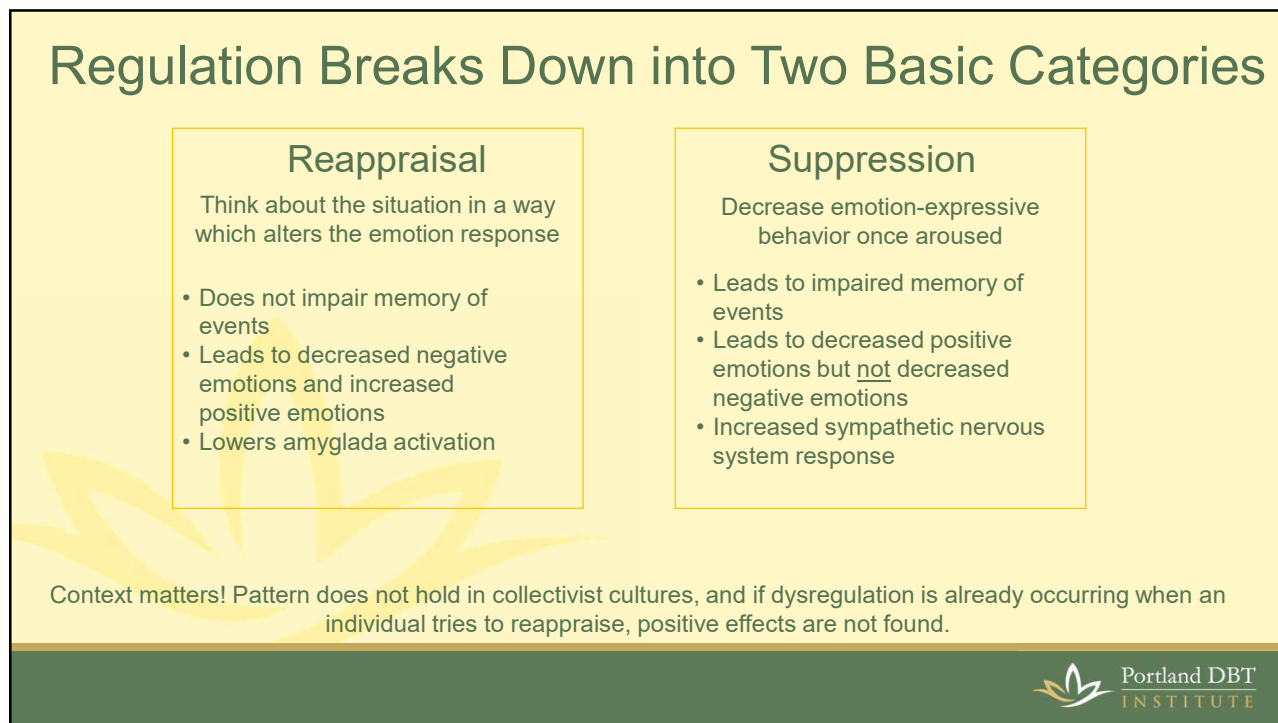
Unpacking the Gross Model of Emotions

General Model





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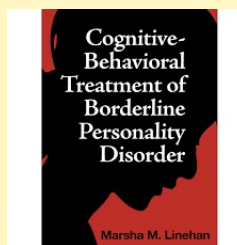
162

Flexibility Matters!

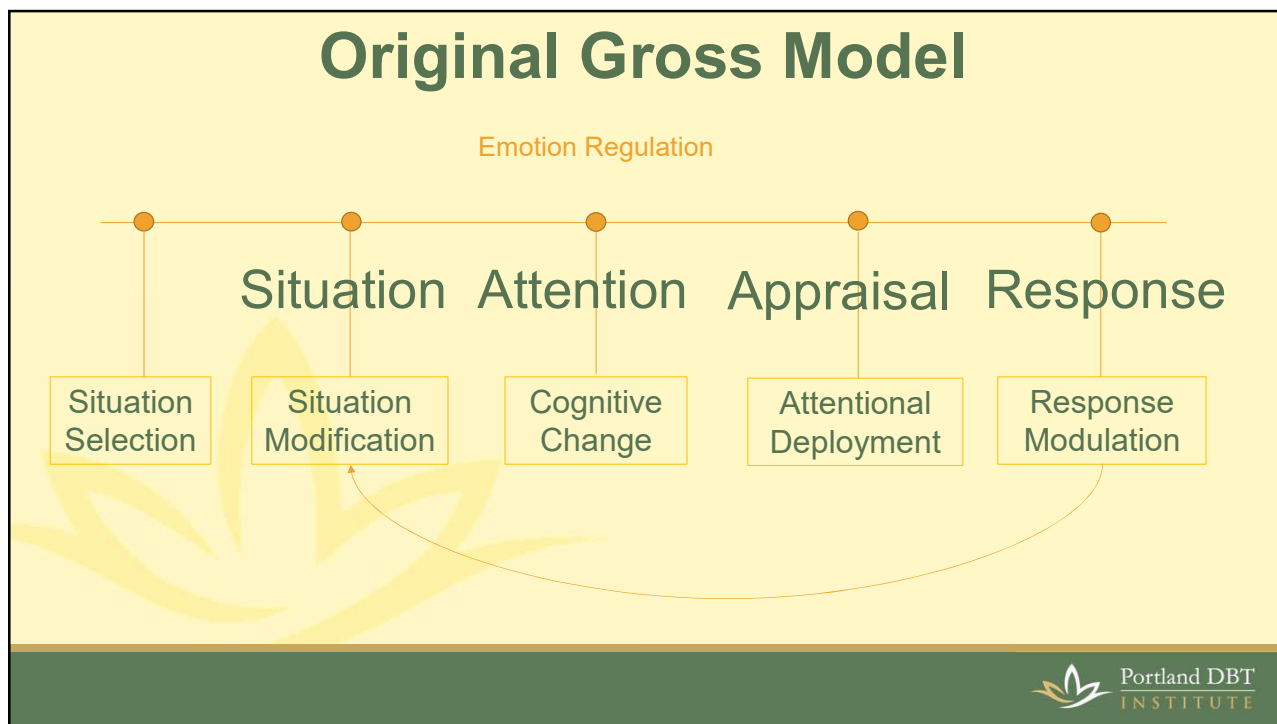
- Suppression can be beneficial in extremely adverse situations
- Suppression/Distraction are maladaptive where long-term adjustment is required
- Reappraisal is not as effective when dealing with high intensity emotions in the moment
- Flexibility of emotion regulation skills increases resilience in when presented with stress or trauma

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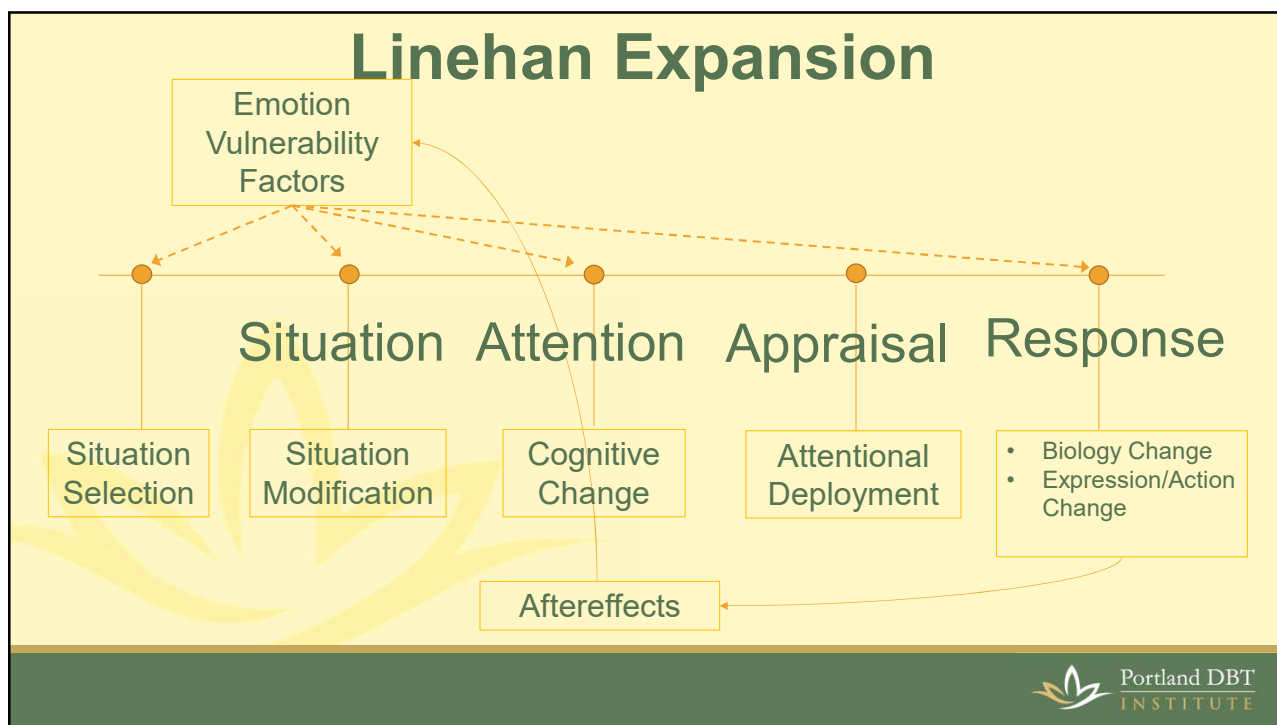
How Did Linehan Expand on the Gross Model?



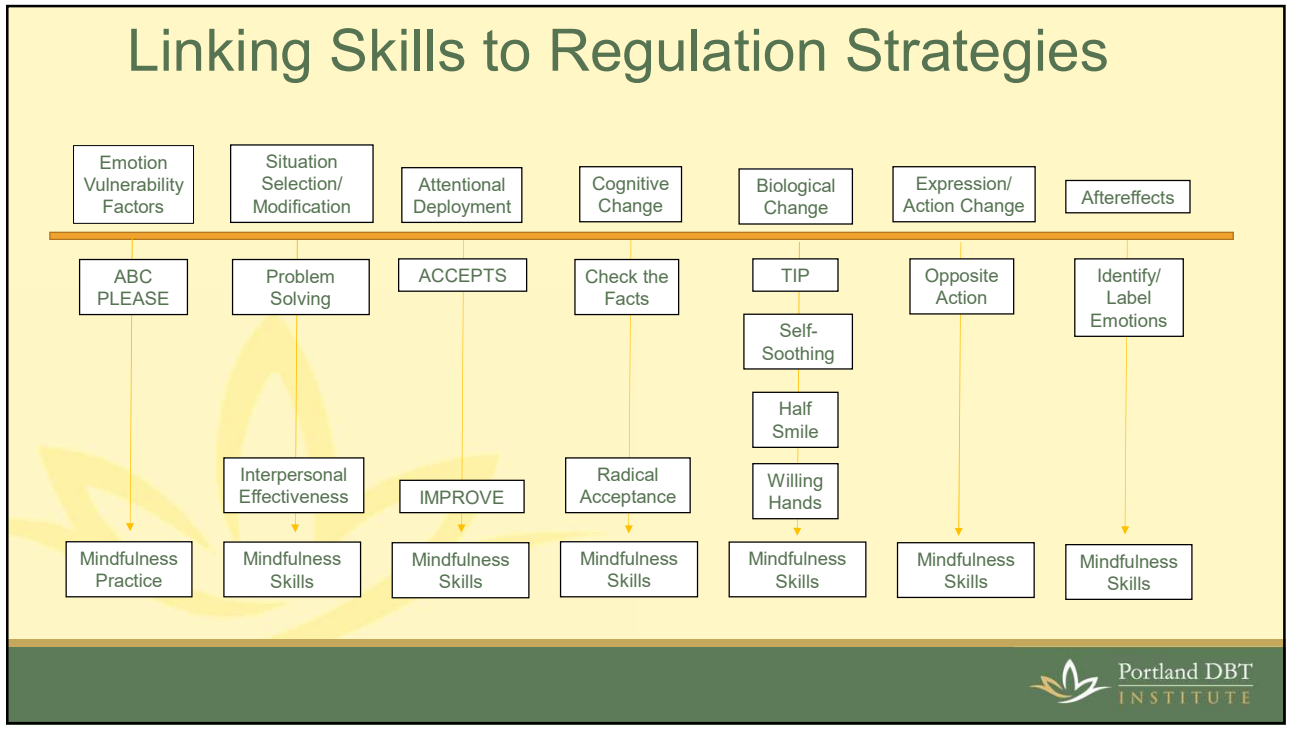
164



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Day Two

Skills Crash Course



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Day Two

End of Day

- Homework for tomorrow
- Housekeeping
- Closeout



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Day Three

Mindfulness

Homework Debrief/Discussion



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DBT as Cognitive Behavioral Therapy & Problem Solving

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Behavioral Analysis
Insight
Solution Analysis
Skills Training
Contingency Management
Exposure
Cognitive Modification
Didactic
Orientation
Commitment

Standard Problem Solving
Used in DBT



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DBT Treatment Plan

1. Solves the problems that **interfere** with C having/keeping a LWL,
2. Works strategically & systematically to help C **build** a LWL.

Reduce
disorders, problematic behaviors


Increase
Global Assessment of Functioning



173

Figure out the problem: **Behavioral Analysis**

- Define problem as behavior (with focus on emotion)
- Conduct chain analyses



174

Fundamentals for Behavioral Analysis

- **What is a behavior?** Anything a person does (public or private) including thinking, feeling, acting.
- **What are the elements used to describe a behavior?** Frequency, intensity, duration, topography
- **How can you define a behavior?** Excess, deficit, faulty stimulus control (e.g., behavior shows up in wrong context, or doesn't show up in context where it's needed).

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Which Variables Control the Behavior?

- **Classically conditioned** (respondent) behaviors?
 - Behaviors learned under the control of the stimulus (i.e., a conditioned stimulus).
- **Instrumental (Operant)** behavior?
 - Learned behaviors that are under the control of the consequences.

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Classical Conditioning Examples

| (UC)S | (C)S | (UC)R = (C)R |
|--------------|----------|--------------|
| Attack | Alley | Fear |
| Drugs | Bathroom | High |
| Nurturing | Hospital | Seeking |
| Nausea | Bathroom | Vomiting |
| Urge to cut | Razor | Cutting |
| Car accident | Car | Fear |

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Examples of S-S Problems

- A **neutral** stimuli (e.g., men in baseball caps) is associated with an **aversive** stimuli (e.g. physical abuse).
 - Max avoids men in baseball caps.
- A **positive** stimuli (e.g., being with son) is associated with an **aversive** stimulus (e.g., intensive guilt).
 - Lisa avoids contact with son.
- An **aversive stimuli** (involuntary hospitalization) is associated with a **positive** stimuli (e.g., nurturance).
 - Maria works to get into the hospital.

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Instrumental/Operant Conditioning

Learned behavior that is under the control of the consequence.




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Instrumental/Operant Conditioning

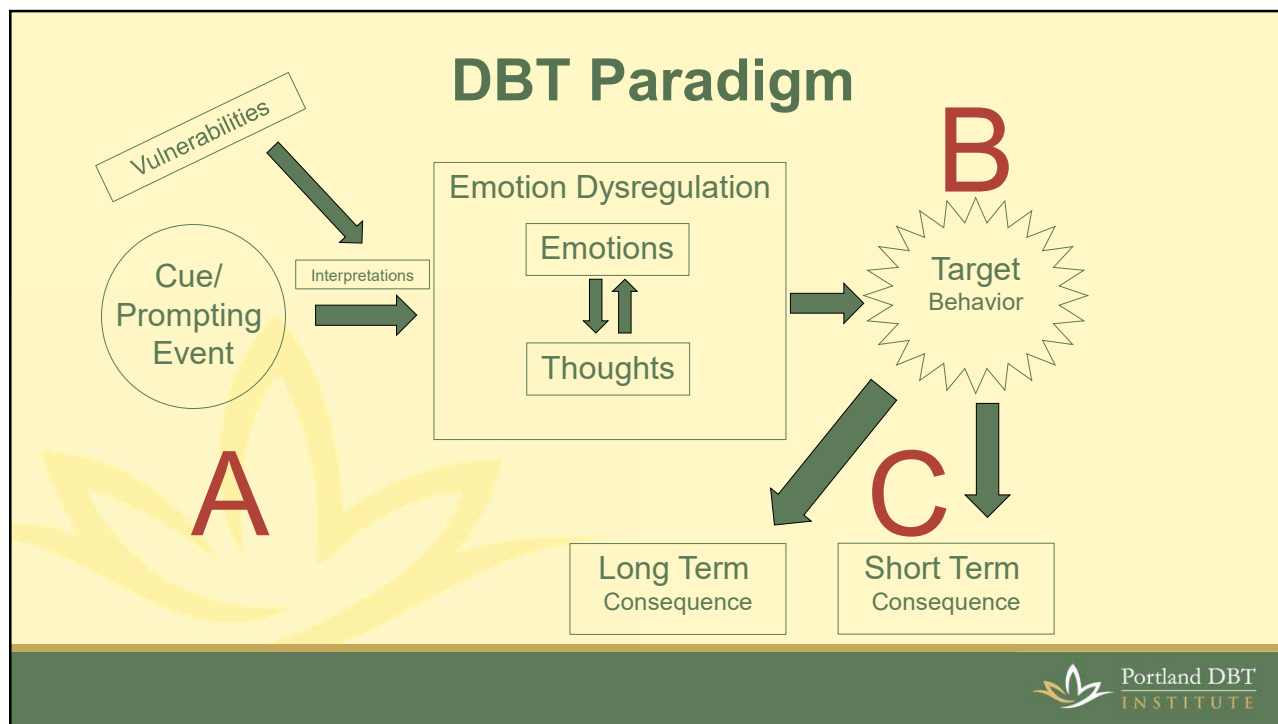
A Antecedent/Trigger/Cue

B Behavior

C Consequence



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Principles of Learning: REINFORCEMENT

Consequences that in general result in an INCREASE in a behavior in a particular situation.

Positive Reinforcement
Increases probability of a behavior by providing positive consequence.

Negative Reinforcement
Increases probability of a behavior by removing or stopping an aversive stimulus.

The Portland DBT Institute logo is in the bottom right corner.

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Principles of Learning: PUNISHMENT


Consequences that in general result in a DECREASE in a behavior in a particular situation.

Positive Punishment

Decreases probability of a behavior by providing an aversive consequence.

Negative Punishment


Decreases probability of a behavior by removing or stopping a positive stimulus.



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To Summarize...

| | Increases likelihood of behavior | Decreases likelihood of behavior |
|------------------------|--|---|
| + Something added | Positive Reinforcement: Increasing a behavior by providing a rewarding consequence | Punishment: Actions used to decrease a behavior that doesn't have a natural consequence |
| - Something removed | Negative Reinforcement: Increasing a behavior by removing an aversive consequence | Extinction: Reduction in a behavior because the reinforcement associated with it is removed |

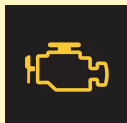


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Unpacking Negative Reinforcement

Example 1: Distracting yourself with your car radio



Negative stimulus: A scary warning light (or sound) on your dashboard

Behavior: You turn up the radio which distracts you from the light (or sound)



This is *negative reinforcement*- you are being rewarded for a behavior (turning up the radio) by the removal of something you don't like (the warning light/sound). You are now more likely to use the radio again when a warning light comes on

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Unpacking Negative Reinforcement

Example 2: Ruminations and suicidal ideation



Negative stimulus: A text message from your partner rejecting or breaking up with you which prompts a strong abandonment response

Behavior: You think over and over again about suicide (or another rumination)





This is *negative reinforcement*- you are being rewarded for a behavior (suicidal ideation/ruminating) by the removal of something you don't like (feeling abandoned). You are now more likely to use suicidal ideation or rumination when feeling abandoned in the future


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Unpacking Classical Conditioning


Example 1: The stomach flu and cherry cough drops


Unconditioned Stimulus
 Stomach flu


Unconditioned Response
 Nausea

Conditioned Stimulus (taking cough drops a lot while having the stomach flu)


So then... after the flu is over...

Conditioned Stimulus



Conditioned Response
 Nausea





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Unpacking Classical Conditioning

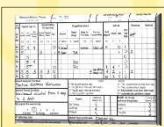
Example 2: Therapy and diary cards


Unconditioned Stimulus
 Previous therapy


Unconditioned Response
 Dysregulation

Conditioned Stimulus (diary card presented frequently during dysregulation)


So then... after therapy is over...

Conditioned Stimulus


Conditioned Response
 Dysregulation



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Principles of Learning

Extinction

Reduction in the likelihood of a behavior because reinforcement is no longer provided in a particular situation.

Extinction Burst

Temporary INCREASE in frequency & intensity of a behavior when reinforcement is withdrawn.

Shaping

Process of reinforcing successive approximations in the direction of the desired behavior.

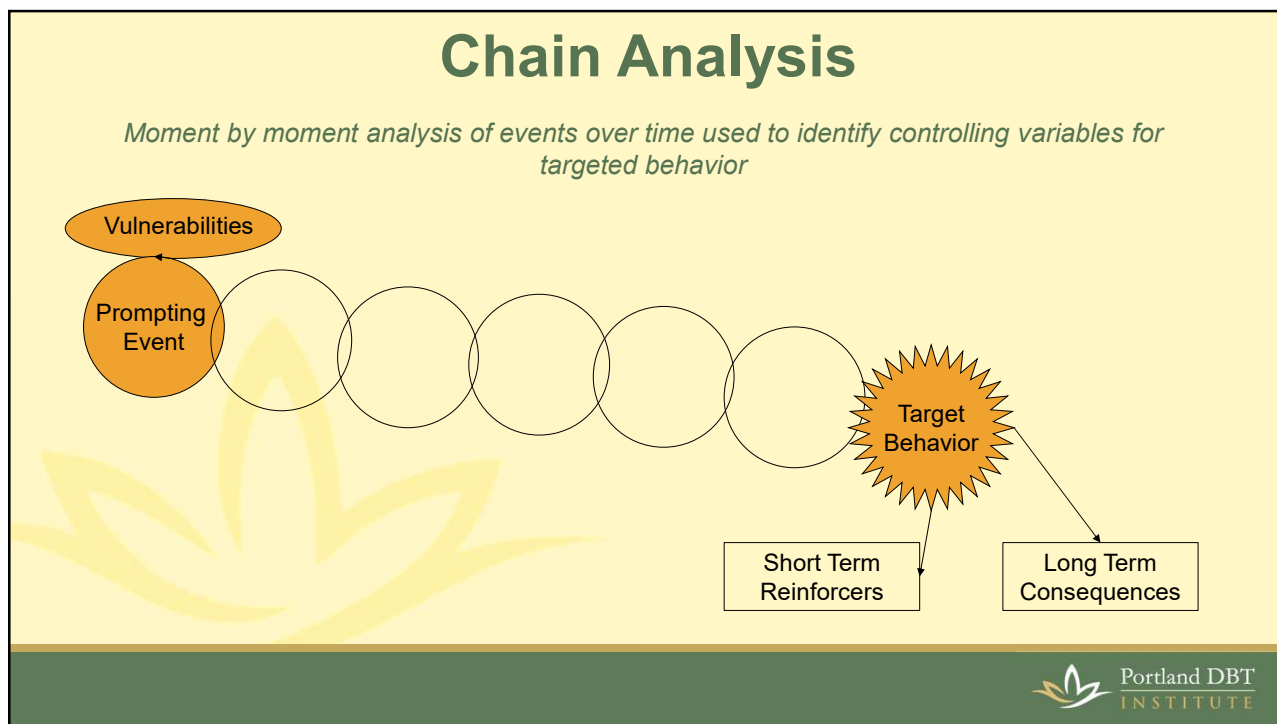


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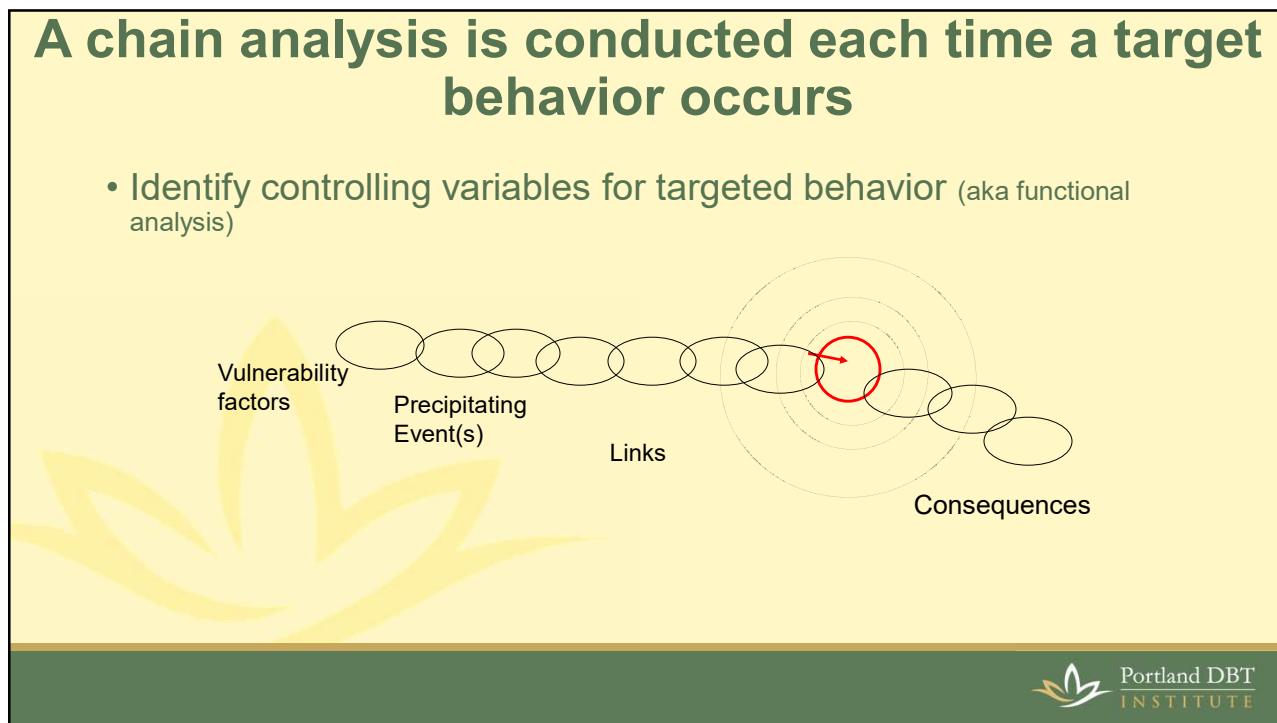
Treating the Primary Behavioral Targets



190


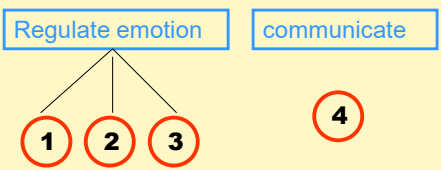
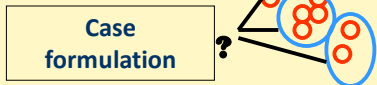



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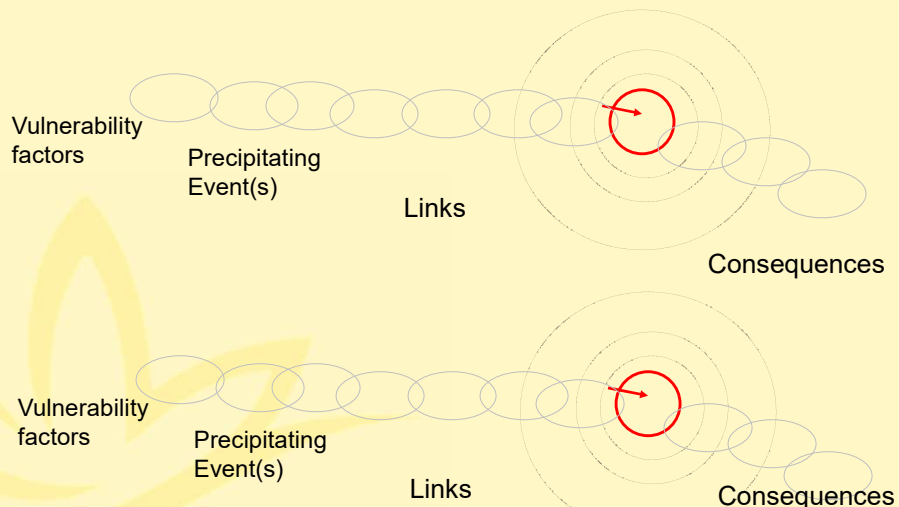
Building an Understanding in order to **SOLVE** the Problem(s)


- **Chain Analysis:** specific instance of behavior Instances of intentional self-injury

- **Behavioral Analysis:** classes of behavior

- **Case Formulation** link problems together




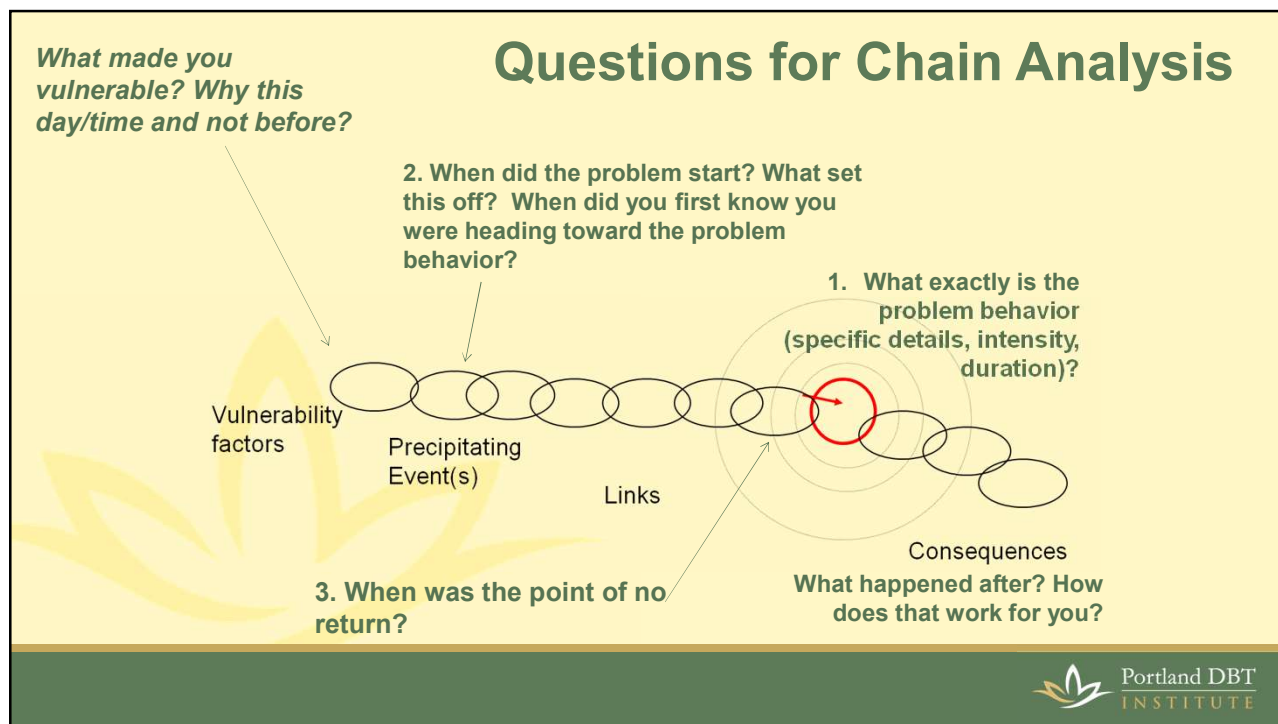
193

Identify Patterns Across Chains





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Insight Strategies

- Highlight clinically relevant variables.
- Observe & describe reoccurring patterns.
- Comment on implication(s) of behavior.

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Common BCA Problems

- Therapist superficial in assessment, over-simplifies problem and ease of solving it, and/or moves to solutions before understanding the problem
 - Lots of assumptions (vs. careful assessment)
 - Solution does not really fit the problem
- Void of:
 - Solution Analysis
 - Troubleshooting solution
 - Actual Practice (insight only)
 - Commitment
 - Intention
- Therapist forgets that T and C see “the problem” differently (C = suffering; T = target behavior)

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Chain Analysis: Beyond the Basics

“... many therapists don’t consider thoughts and urges to be modifiable or necessarily problematic. Therapists frequently have a sense of hopelessness about changing thoughts or urges or they are so focused on the fact that an accompanying behavior didn’t occur that they lose sight of the fact that thoughts may still be a problem.”

Rizvi, Chain Analysis in DBT, 2019



ISBN 9781462538904

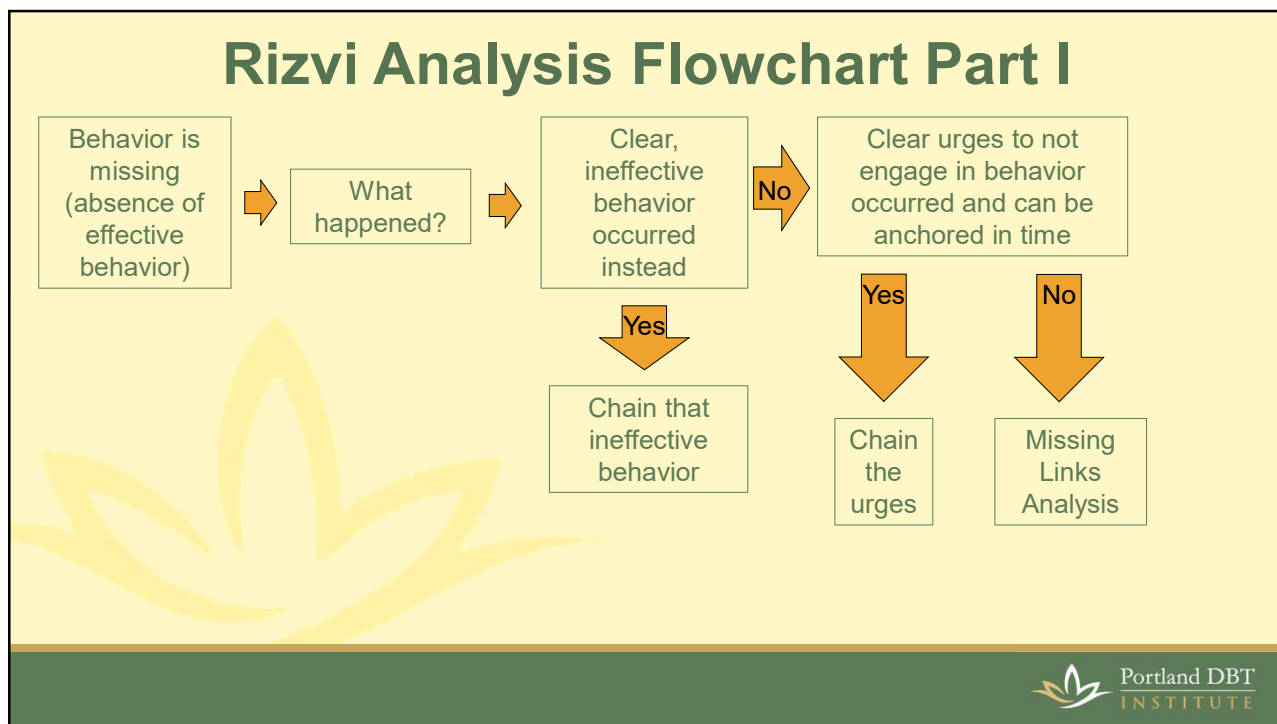
198

General Guidelines for Chains on Thoughts

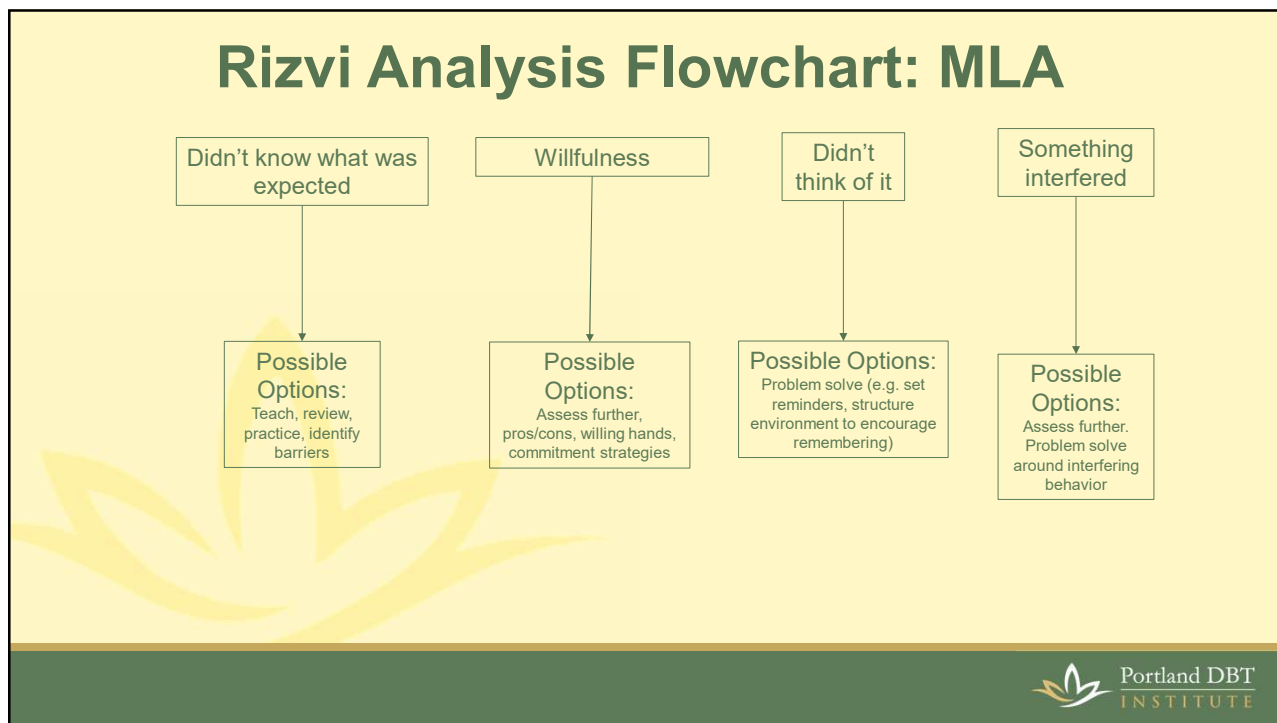
- Guideline 1: Use the target hierarchy
- Guideline 2: Behavior beats thoughts about that behavior
- Guideline 3: Patterns of thoughts are important for case conceptualization and may represent a core “problem”
- Guideline 4: Significant distress or negative consequences are associated with the thought

Missing Links Analysis

- Missing Links Analysis
 - Did I know what effective behavior was needed or expected?
 - Was I willing to do what was needed?
 - Did the thought of doing what was needed or expected enter my mind?
 - What got in the way of doing what was needed or expected right away?



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202

Break!



A slide with a yellow background and a red footer bar. The word "Break!" is centered in a bold, dark green font. Below it is a green lotus flower icon.

203

Day Three

Chain role plays (Ted/Margo)



A slide with a yellow background and a red footer bar. The text "Day Three" is centered in a bold, dark green font. Below it is the text "Chain role plays (Ted/Margo)" in a dark green font. At the bottom is a green lotus flower icon.

204

Day Three

End of Day

- Homework for tomorrow
- Housekeeping
- Closeout



205

Day Four

Mindfulness

Homework Debrief/Discussion



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Day Four

Chain analysis follow up




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Understanding and insight into a behavior is unlikely to change it.

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Standard Problem Solving
Used in DBT

Behavioral Analysis
Insight
Solution Analysis
Skills Training
Contingency Management
Exposure
Cognitive Modification
Didactic
Orientation
Commitment




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Solution Analysis Strategies

- Identify goals, needs, desires.
- Generate solutions
- Evaluate solutions
- Choose solution to implement
- Troubleshoot the solution
 - Identify where it will break down, not work.
 - Then solve that problem.



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Task Analysis: From Goals to Solutions

Identify specific behaviors required to skillfully achieve a goal; break it down into specific steps or components.

1. Identify desired behavior/outcomes
2. Identify required behaviors to achieve outcomes
3. Identify behaviors necessary for adapting to obstacles along the way.

211

Task Analysis: Finding the Information You Need

1. Models

- Identify people who have met the goal, have the behavior.
- In social environment, books, films

2. Psychology

212

Options for Responding to Problems

1. Solve the problem
2. Change emotional reaction to the problem
3. Tolerate/accept the problem
4. Stay miserable

213

Skills Training Procedures

Skills acquisition
Skills strengthening
Skills generalization

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Skills Acquisition Procedures

- Instruct
- Model
 - Therapist models
 - Self-involving modeling
 - Demonstrating; role-playing
 - Self-disclosure modeling
 - Participant modeling
 - Models in social environment, books, media, stories

215

Skills Strengthening Procedures

- Rehearse behavior
 - Describe new behavior
 - Covert rehearsal
 - Role playing
 - Staging a practice
- Reinforce new skills
 - Natural
 - Arbitrary

216

Skills **Generalization** Procedures

It is your responsibility to ensure that your client can use the new skill in all relevant contexts.



217

Skills **Generalization** Procedures

- Program generalization
 - Relate in-session behavior to outside life.
 - Troubleshoot obstacles that may interfere with transfer.
- Consult to C in between sessions.
- Provide audio recordings of sessions to review *in vivo*.
- Assign C homework that involves behavioral rehearsal.
- Change the environment
 - Community reinforcement approach



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Contingency Management

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Contingency Management

- Positive reinforcement
- Negative reinforcement
- Extinction
- Punishment

220

Manage Contingencies Well

- Reinforce target-relevant adaptive behavior (clinically relevant behaviors)
 - Immediate vs. delayed
 - Continuous vs. intermittent } How do you decide which to use when?
- Extinguish target-relevant maladaptive behaviors
 - Find an alternative response to reinforce
 - Soothe
- Provide aversive consequences *with care*.
 - Withdraw warmth
 - Correction/Over-correction
 - Vacation from therapy
 - Termination as a last resort } In collaboration with consultation team.

221

Use Contingency Management Strategically

- Assess the potency of consequences.
- Pay attention to satiation.
- All things being equal, select natural over arbitrary consequences; if arbitrary reinforcers *are* used, transition them to natural.
- Shape new behaviors.



222

Observe Your Own Limits

- Be mindful of and monitor your limits.
- Be honest to C and team about your limits.
- Strategically extend your limits, if needed, and temporarily.
- Be consistent and firm with respect to your limits.
- Soothe, validate, & problem-solve when your limits cause your client anguish or frustration.

223

Correct/Overcorrect

Start correction/over correction:

What was the harm of the behavior and how can you go about correcting it?

Some ideas: a letter of apology, making commitments and following through and repairing what was damaged, or completing a project that has been created by staff.

224

Egregious Behaviors Protocol

A special application of contingency management

225

Egregious Behavior Protocol (EBP) Steps

1. Programming stops until EBP is completed.
2. Resident undertakes work on BCA
 - Uses worksheet
 - Works on it alone for 2 hours
3. Resident presents to staff, including solutions generated.
 - Resident practices skills with staff
 - Resident makes commitment to use
4. Staff evaluates BCA/EBP. If acceptable, signs off.
5. Resident resumes regular programming.
6. Behavioral analysis is covered in detail in next counseling session.
7. Target behaviors (to decrease and increase) are identified and added to the youth's treatment plan.

226

Exposure Principles, Procedures & Therapy

227

Working with Classically Conditioned Responses

- Change the Cue
 - Problem solving (get rid of the cue)
 - Stimulus Control (modify presentation of the cue)
- Change the Response to the Cue
 - Non-reinforced exposure
 - Response prevention
 - Opposite Action


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Exposure Principles in a Nutshell

Cue Exposure

Response Prevention

Opposite Action




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Exposure Principles

- Orient:
 - Will feel worse before feeling better; validate how difficult it is; distinguish between masking emotions and changing emotional expression.
- Provide non-reinforced exposure:
 - Present & do not remove the cue.
- Block action tendencies & use of safety cues associated with the problem emotion:
 - Leaving topic or session when emotion increases; using drugs before session).



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Exposure Principles

- Block expressive tendencies associated with the problem emotion
 - Client experiences intense shame, so slumps in chair, avoids making contact.
 - Clients yells at and verbally attacks therapist when T encourages continued engagement with the stimulus.
- Enhance control over aversive events using Opposite Action
 - Reinforce using skills
 - Improving Quality of Life

231

Cognitive Modification

232

Clarify Contingencies

- **Clarify current contingencies**
 - Highlight consequences as they occur
 - Use self-involving self-disclosure
- **Clarify future contingencies in life**
 - Provide realistic, accurate information
- **Clarify future contingencies in therapy**
 - Highlight/observe your own limits.

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Clarify Restructuring

- **Teach cognitive self-observations**
 - Self monitoring
- **Identify and confront maladaptive or erroneous cognitive content and style**

Cognitive distortions, irrational beliefs; interpretations without checking the facts.
- **Generate alternative adaptive cognitive content and style**
- **Develop guidelines for when to trust perception and when to suspect myopic/inaccurate cognitions**
 - Highlight/observe your own limits.

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Basis for Cognitive Restructuring

- **Empirical Evidence**
 - Develop experiments to evaluate accuracy of beliefs.
- **Logical consistency**
 - Examine beliefs for logical consistency/inconsistency.
- **Consistency with true beliefs (i.e., Wise Mind)**
 - *Is this belief what I believe when I am calm and in Wise Mind?*
- **Effectiveness**
 - Is it effective for me to hold this belief?

235

Didactics, Orienting, & Commitment

236

Didactic Strategies

- Provide facts
- Give reading materials
- Give information and resources to family members

237

Orienting Strategies

Communicate treatment plan, rationale, & approach so C can make an informed decision & fully collaborate.

- **Role Induction**
 - Describe the general task
 - Link rationale/necessity to C's goals
 - Link to specific expectations/behaviors required by C.
- **Rehearse new expectations**

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Commitment Strategies

pp. 284-291

- Selling commitment: evaluating the pros and cons
- Playing the devil's advocate
- Foot-in-door and door-in-the-face techniques
- Connecting present commitment to prior commitments
- Highlighting freedom to choose and absence of alternatives
- Shaping

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Break!



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Day Four

Case Conceptualization



241

Myth: “DBT doesn’t treat the real/underlying problem”

- Associated myths:
 - DBT is not depth therapy
 - DBT does not treat underlying causes
 - DBT only changes surface behaviors
 - DBT only focuses on symptoms
 - DBT doesn’t focus on the therapeutic relationship
- Synthesis:
 - Additional work needs to be done to ensure folks in DBT improve functioning as well as symptom improvement
 - A better therapeutic relationship helps with all aspects of treatment

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Journal of Consulting and Clinical Psychology
2012, Vol. 80, No. 1, 66-77

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0022-006X/11/\$12.00 DOI: 10.1037/a0026113

Treatment Differences in the Therapeutic Relationship and Introject During a 2-Year Randomized Controlled Trial of Dialectical Behavior Therapy Versus Nonbehavioral Psychotherapy Experts for Borderline Personality Disorder

Jamie D. Bedics
California Lutheran University

David C. Atkins, Katherine A. Comtois, and
Marsha M. Linehan
University of Washington

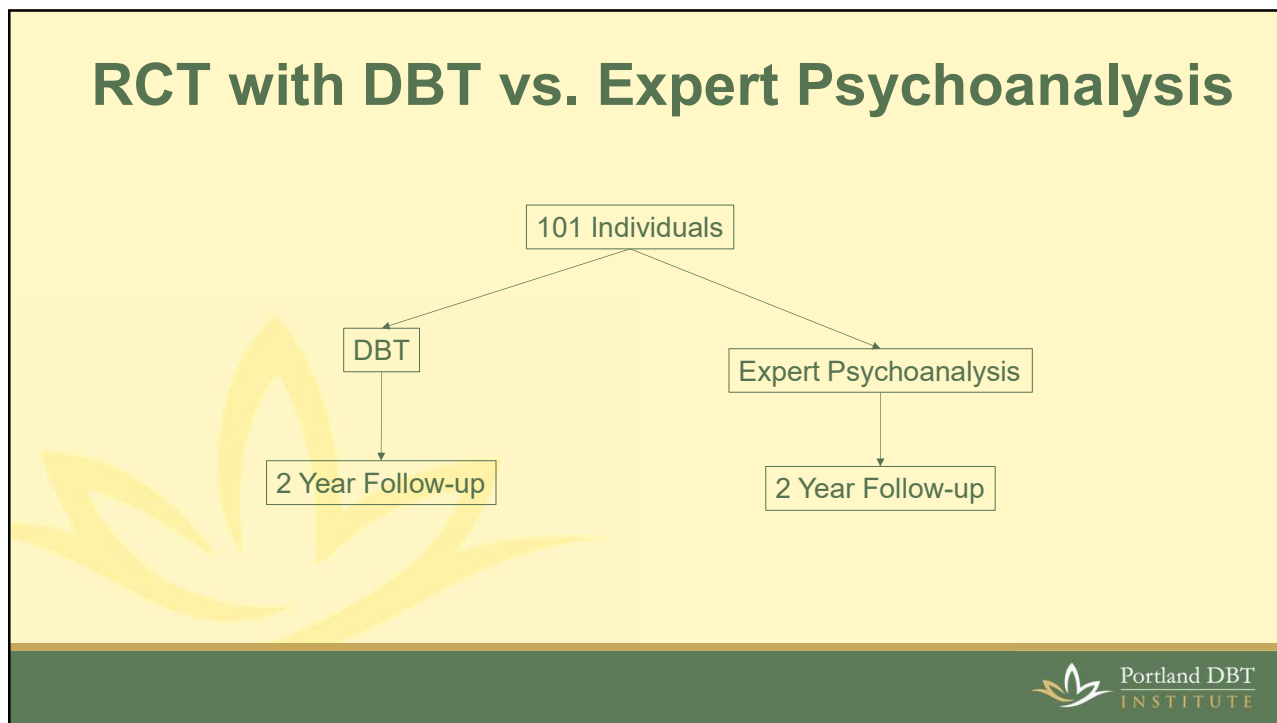
Objective: The present study explored the role of the therapeutic relationship and introject during the course of dialectical behavior therapy (DBT; Linehan, 1993) for the treatment of borderline personality disorder. **Method:** Women meeting *DSM-IV* criteria for borderline personality disorder ($N = 101$) were randomized to receive DBT or community treatment by experts. The Structural Analysis of Social Behavior (Benjamin, 1974) was used to measure both the therapeutic relationship and introject. **Results:** Relative to community treatment by experts, DBT participants reported the development of a more positive introject, including significantly greater self-affirmation, self-love, self-protection, and less self-attack, during the course of treatment and 1-year follow-up. The therapeutic relationship did not have an independent effect on intrapsychic or symptomatic outcome but did interact with treatment. DBT participants who perceived their therapist as affirming and protecting reported less frequent occurrences of nonsuicidal self-injury. **Conclusions:** The study showed positive intrapsychic change during DBT and emphasized the importance of affirmation and control in the therapeutic relationship. Results are discussed in the context of understanding the mechanisms of change in DBT.



<https://doi.org/10.1037/a0026113>



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Results

- The Introject in psychoanalysis refers to an individual’s self-appraisal, and is a key element used when researching psychoanalysis
- “Individuals assigned to DBT reported significantly greater increases in introject affiliation including self-affirmation, self-love, self-protection and greater decreases in self-attack during the course of treatment and 1-year follow-up”
- “DBT participants who perceived their therapist as affirming and protecting reported less frequent occurrences of non suicidal self-injury”

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Behaviour Research and Therapy 142 (2021) 103874

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Relationship to CBT outcome and dropout of decision support tools of the written case formulation, list of treatment goals and plot of symptom scores

Vael Gates^a, Megan Hsiao^b, Garret G. Zieve^a, Rebecca Courry^b, Jacqueline B. Persons^{b,a,*}

^a University of California, Berkeley, USA
^b Oakland Cognitive Behavior Therapy Center, USA

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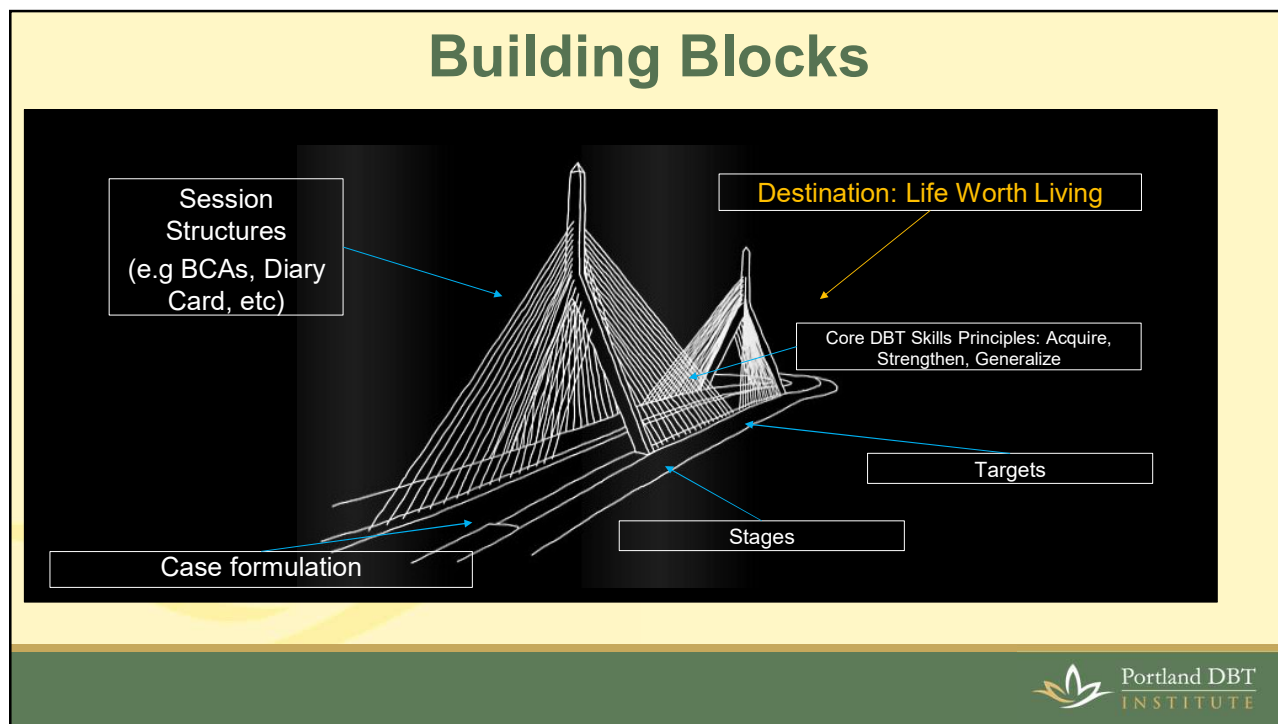
Keywords:
Outcome
Dropout
Case formulation
Decision support
Measurement-based care

ABSTRACT

Many patients who receive cognitive behavior therapy (CBT) for mood and anxiety disorders fail to respond or drop out of treatment. We tested the hypotheses that therapist use of each of three decision support tools, a *written case formulation*, a *list of treatment goals*, and a *plot of symptom scores*, was associated with improved outcome and reduced dropout in naturalistic CBT provided to B45 patients in a private practice setting. We conducted regression analyses to test the hypotheses that the presence of each tool in the clinical record was

<https://doi.org/10.1016/j.brat.2021.103874>

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In both Stage I and II, DBT is principle-based and ideographic.

Case formulation is key!

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Case Formulation is Key in DBT

- “a set of hypotheses about the causes, precipitants, and maintaining influences of a person’s difficulties that helps you to translate general treatment protocols into an individualized treatment plan”



Koerner, K. (2011). *Doing Dialectical Behavior Therapy: A Practical Guide*.

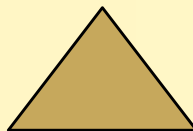
ISBN 9781462502325



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The Overarching Treatment Planning Dialectic

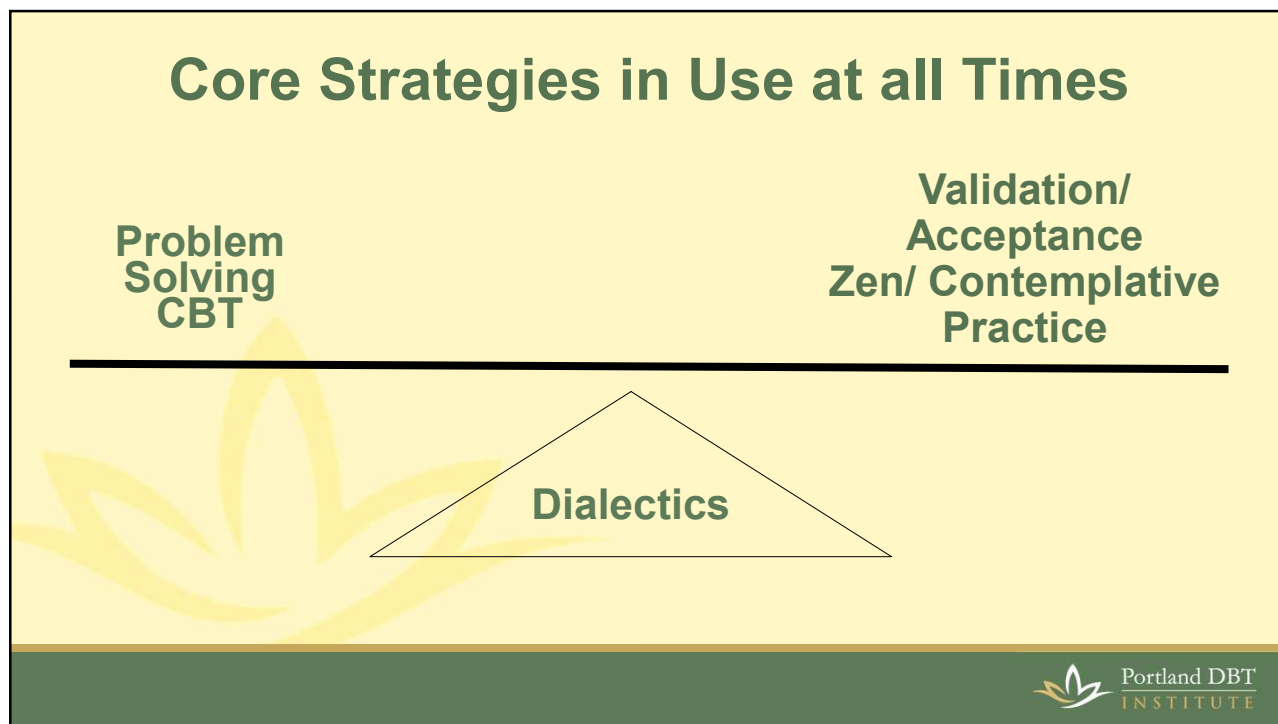
**Decrease
Stage 1
Target
Behaviors**



**Build a Life
Worth Living**



250



251

Getting Specific With Our Clients about their Goals

- What does your client want/desire the most that will make it worth the hell they will have to go through to give up their primary target behavior?
- What are their ultimate Wise Mind goals?
- And what else?



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Translating Goals into Behavioral Targets

- What are the steps that need to be taken to achieve these goals?
- What behaviors have to INCREASE?
- What behaviors have to DECREASE?
- What else needs to change contextually in the individual's life?

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Hierarchically Arrange Behavioral Targets

Overall & Within
a category

- Imminent Life Threatening Behaviors
- Therapy Interfering Behaviors
- **Quality of Life Interfering Behaviors**

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Case formulation in Stage I and II DBT

- Includes hierarchy of targets (based on client goals, severity of problem, functional relationships between problems)
- Guided by behavioral, biosocial, and dialectical theories
- Interventions pull from DBT skills, behavioral interventions, acceptance-based strategies, dialectical strategies

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Formal Case Formulation

Comprehensive account of all relevant goals, problem behaviors, and treatment plan; include:

- Client goals/problems
- Role of biosocial theory
- Stage of treatment
- Targets
- Controlling variables
- Treatment plan/solution analysis
- Outcome measures

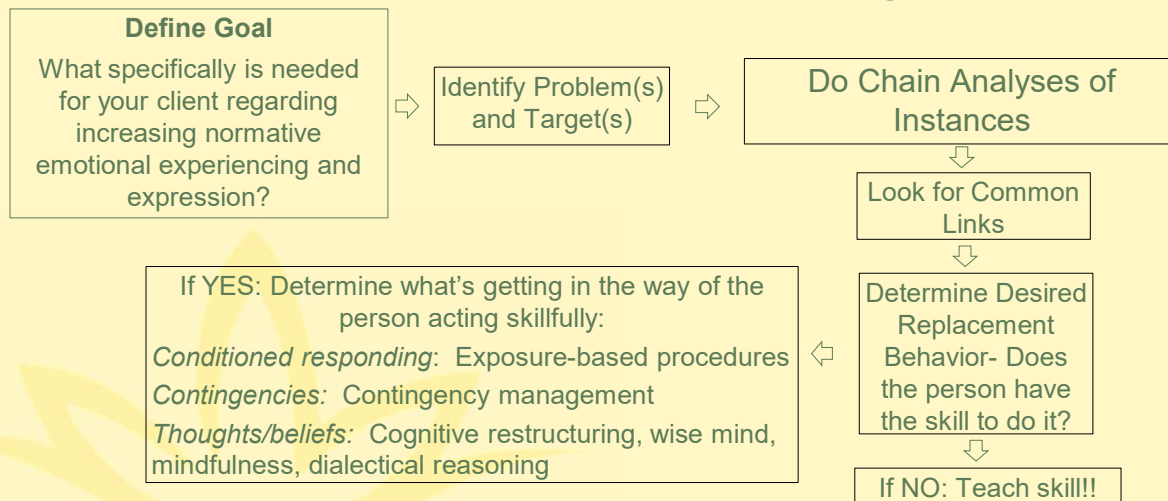
256

Orienting and Commitment

- Presenting case formulation
- Integrating biosocial theory, emphasizing the ways in which emotional sensitivity and invalidation relate to targets
- Importance of validation in this conversation (really recognizing the degree of current emotional suffering)
- Orienting and commitment to *willingness* to have emotional experiences
- Orienting and commitment to overall treatment tasks and individual tasks as they arise (from mini formulations)

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Mini Formulation: Step by Step



258

Behaviors that can function as **emotional avoidance** (and also increase suffering):

- Non-suicidal self-injury
- Substance use
- Dissociative behavior
- Eating disordered behavior
- Secondary emotions
- Judgments
- Intentional suppression
- Restriction of life activities
- Facial expressions/body posture
- Therapy interfering behavior

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Lunch!



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Day Four


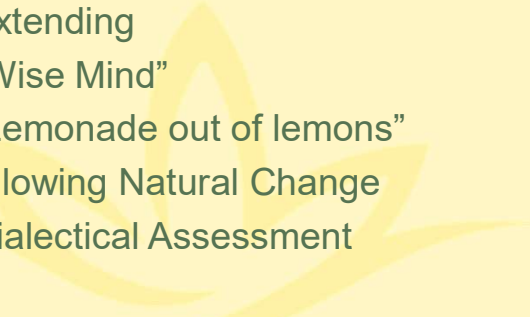
Dialectical Strategies and Stylistic Strategies



261

Dialectical Strategies

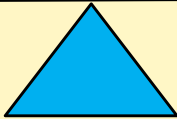
- Balances treatment strategies
- Entering the paradox
- Metaphor
- Devil's advocate
- Extending
- "Wise Mind"
- "Lemonade out of lemons"
- Allowing Natural Change
- Dialectical Assessment




262

Stylistic Strategies

Define *how* we apply all treatment strategies

Irreverent  Warm, Reciprocal



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Irreverent Communication

- Reframing communication in an unorthodox, off-beat manner.
- Plunging in where angels fear to tread.
- Using a confrontational tone.
- Calling client's bluff.
- Oscillating intensity
- Expressing omnipotence and impotence.




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Reciprocal Communication

- **Responsive**
 - Staying awake
 - Taking Cs agenda seriously
 - Responding to the “manifest” (vs. latent) content of C’s communication
- **Self-Disclosure**
 - Orients C to T’s use of personal disclosure
 - Self-Involving Self-Disclosure
 - Personal disclosure
- **Warm engagement**
- **Genuineness**

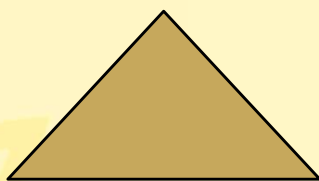


265


Consultation Strategies vs. Intervening in Environment

Consultation to the Client

Environmental Intervention



Consultation to the Therapist



266

When to Intervene in the Environment

Intervene in the environment when the short term gain is worth the long term loss in learning.

267

Conditions Mandating Environmental Intervention

- When C is unable to act on his/her own behalf and the outcome is very important.
- When the environment is intransigent & high in power.
- To save C's life or avoid substantial risk to others.
- When it is the humane thing to do & will cause no harm.
- When C is a minor.

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Environmental Intervention Strategies

- Provide information to others independent of C.
- Advocate for C.
- Enter C's environment to provide assistance, as is needed.



269

Consultation to the Patient

The DBT therapist's primary role is to consult to C about how to effectively manage his/her environment (e.g., social, professional, personal), and *not to consult to the environment about how to manage the client.*



270

Consultation to the Patient Strategies

- Orient C and network to this approach.
- Consult to C about how to manage other professionals
- Consult to C about how to manage others within his/her environment.

271

Corollaries of Consultation to the Patient

- Give other professionals generic information about DBT and the therapy program.
- Do not discuss C or C's treatment without C present (except on the team or in supervision).
- Within the team, share information as needed while honoring spirit of this strategy.
- Do not tell other professionals how to treat C.
- Teach C how to act as his/her own agent.
- Do not intervene or solve problems for C with other professionals.
- No not defend other professionals.

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Day Four

Skills Crash Course



273

Break!



274

DBT Skills Training 101

Basics for Running an
Effective DBT Skills Class



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Rule #1

**Structure Up Your DBT
Skills Training Class &
Stick to It**

(even if you don't want to).

276

DBT Skills Training TARGETS

- DECREASE behaviors likely to **destroy** therapy.
- INCREASE skills acquisition & strengthening
 - Mindfulness, Emotion Regulation, Interpersonal Effectiveness, Distress Tolerance
 - Self-Management
- DECREASE therapy-interfering behaviors

(Question: How is this similar to/different from DBT standard targets for Stage 1 clients? What is the rationale?)

277

Practical Issues to Consider

- Co-leader Selection
- Individual vs. Group Format
- Open vs. Closed Group
- Treatment Module Cycle
- Order of Modules
- Heterogeneous vs. Homogeneous Group
- Role of Individual Therapy & Therapist in Skills Training

278

Scheduling/Planning Group

- Plan to have 2 rotations through skills
 - Six months each rotation x 2 rotations = 1 year!
- One Module = 8 weeks total
 - Two weeks of mindfulness
 - Six weeks of primary topic (ER, IPE, DT)
- Open group to new members the first 4 weeks of a new module, then close for 4 weeks.
- Know/communicate clearly end of group date.

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Tips for Starting a DBT Skills Training Group

- Individual therapist first orients C to mode & purpose and introduces C to group leader.
- Group leader meets with C individually before starting gets group-specific commitments from C using DBT Commitment Strategies
 - Come to group on time, every week.
 - Do homework between sessions
 - Be solid citizen as member of the group
 - Orients C to four-miss rule.
- Orients C to group logistics: location, time/date, structure of group

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Rule #2

Prevent problems by establishing & maintaining group norms & expectations early on.

- Show up on time; communicate when you can't.
- Do assigned homework.
- Act with kindness & compassion toward others.
- *Use your skills often throughout the day, and every day.*

281

Tips for Starting a DBT Skills Training Group

- Encourage norm of alerting group of absence/tardiness
- Structure environment to promote skills training targets
- Give members a skills training notebook with extra homework sheets
- Have loaner notebooks, pens and pencils in the classroom

282

Tips for Starting a DBT Skills Training Group

- For therapists, group begins 15 minutes before start time, 15 minutes after group ends, and breaks.
- Establish group norm for functional behavior early on
- Manage group tone proactively
- Consider technology tools to augment
 - DBT Coaching App, DBT Skills Online Training, MML (and others) videos, DBT-RU, etc.



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Standard DBT Skills Training Group Format (2.5 hours)

- **Getting Started** (5 minutes)
- **Homework Review** (60 minutes)
- **Break** (10-15 minutes)
- **Didactic/New Teaching** (60 minutes)
- **Homework Assignment/Wind Down** (10-15 minutes)



284

Getting Session Started

- Account for/track down members who are not yet present.
- Call missing members and coach attendance (typically co-leader)
- Do and debrief mindfulness exercise.



285

Structuring Homework Review

- Review homework assigned last week.
- Ask for a volunteer to start.
- Set pace so that each member more or less gets same amount of time.
- Look for opportunities to highlight other skills member used, reinforce skills use, and teach/highlight self-management strategies applied.
- Therapists and other members provide feedback to further strengthen behavior or practice



286

Effectively Manage the Group Break

Overarching Goal

- To facilitate emotion regulation before moving onto next (didactic) portion.
- To discuss topics with specific member that are not easily addressed in the whole group.

287

Tips for Delivering Didactic

- Weave in self-management
- Balance focused discipline with ease of pace (e.g., a fancy dinner party).
- Speak (**indirectly**) to C's dysfunctional patterns &/or problems.
- Make **explicit** how the skill is relevant to C's problems & how it will help C get a **life worth living**.

288

Tips for Assigning Homework

- Assign one (max two) **doable** more extensive homework that will strengthen the new skill.
- Clearly and explicitly define the homework; write homework on board. If using handout, go over the handout with group.
- After assignment given, ask/address questions about the assignment.
- Identify/address barriers that may interfere with completing assigned homework.

Group Wind Down Function

To ensure that clients are sufficiently emotionally regulated before leaving group.

- Process wind-down by offering observation about themselves, one another, the leader, or the group as a whole.
- Lead clients through relaxation, visualization, meditation, or breathing exercise.

Rule #3

All problems that arise are
grist for the mill & simply
problems to solve.

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Day Four


End of Day

- Homework for tomorrow
- Housekeeping
- Closeout




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Day Five
Mindfulness
Homework Debrief/Discussion

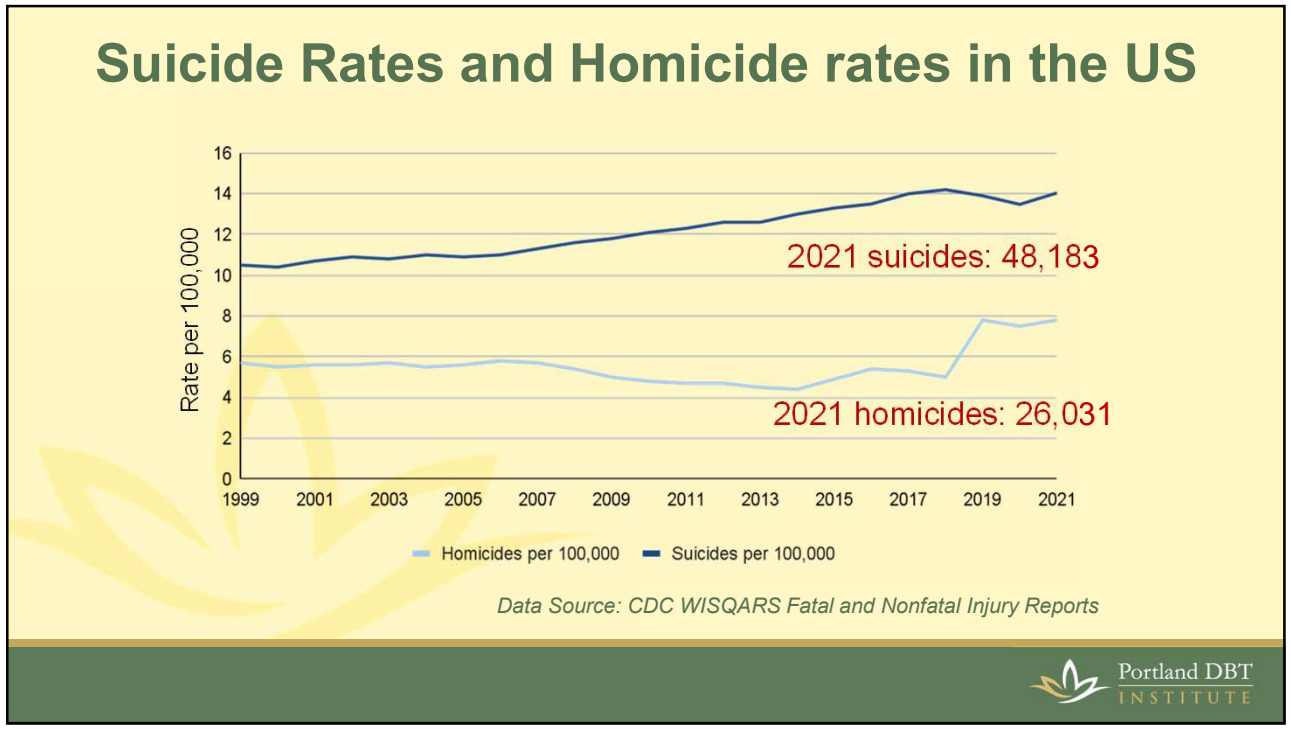


293

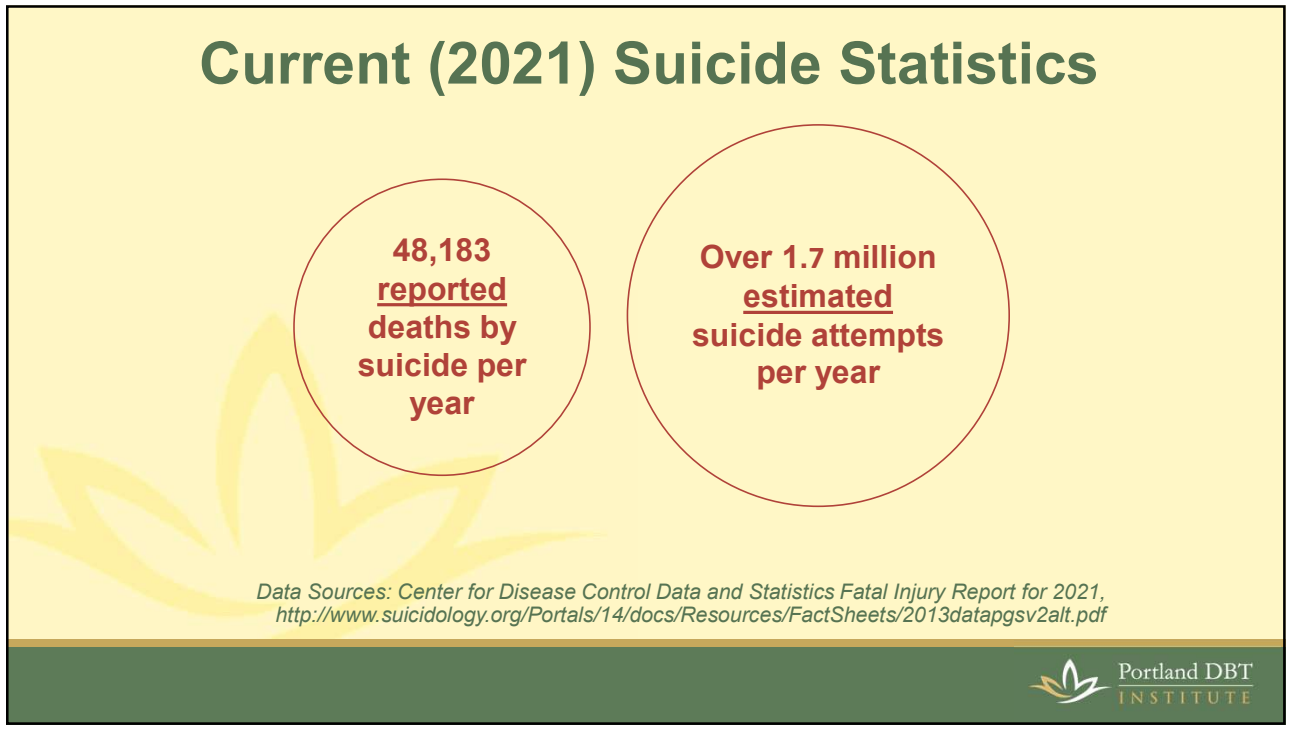
Day Five
Suicide Assessment & Suicide
Imminent Risk Protocol



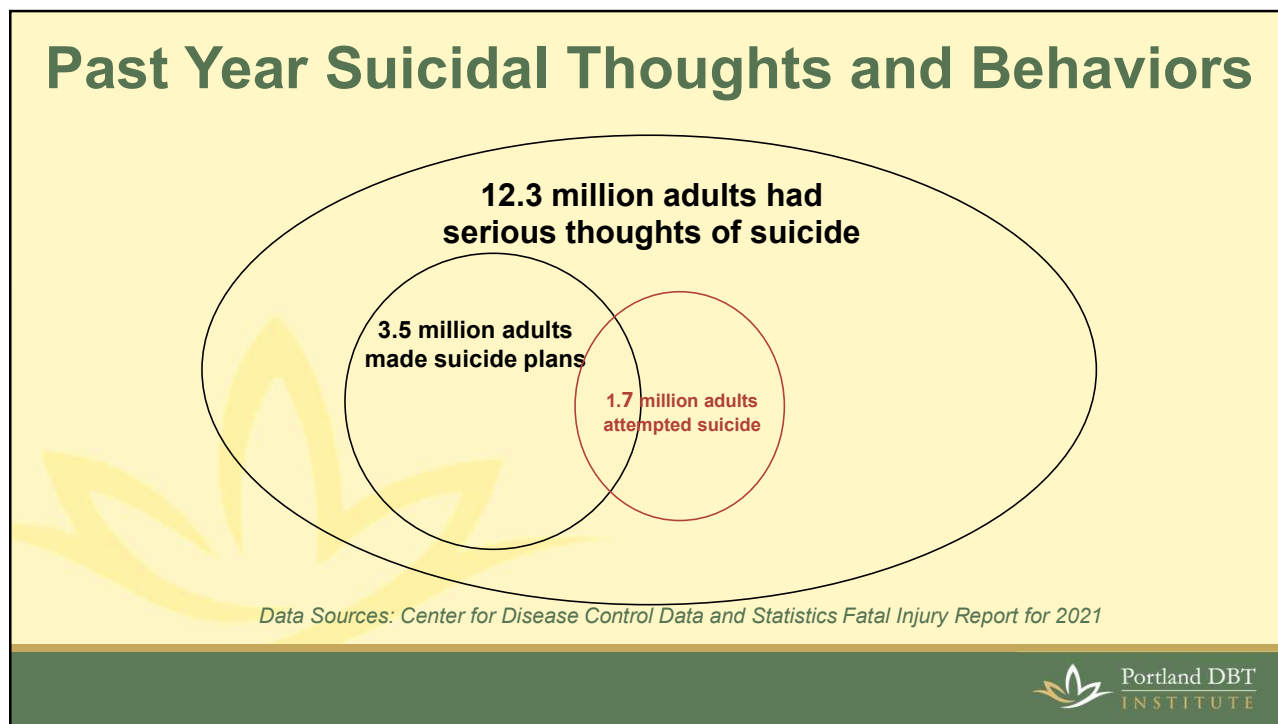
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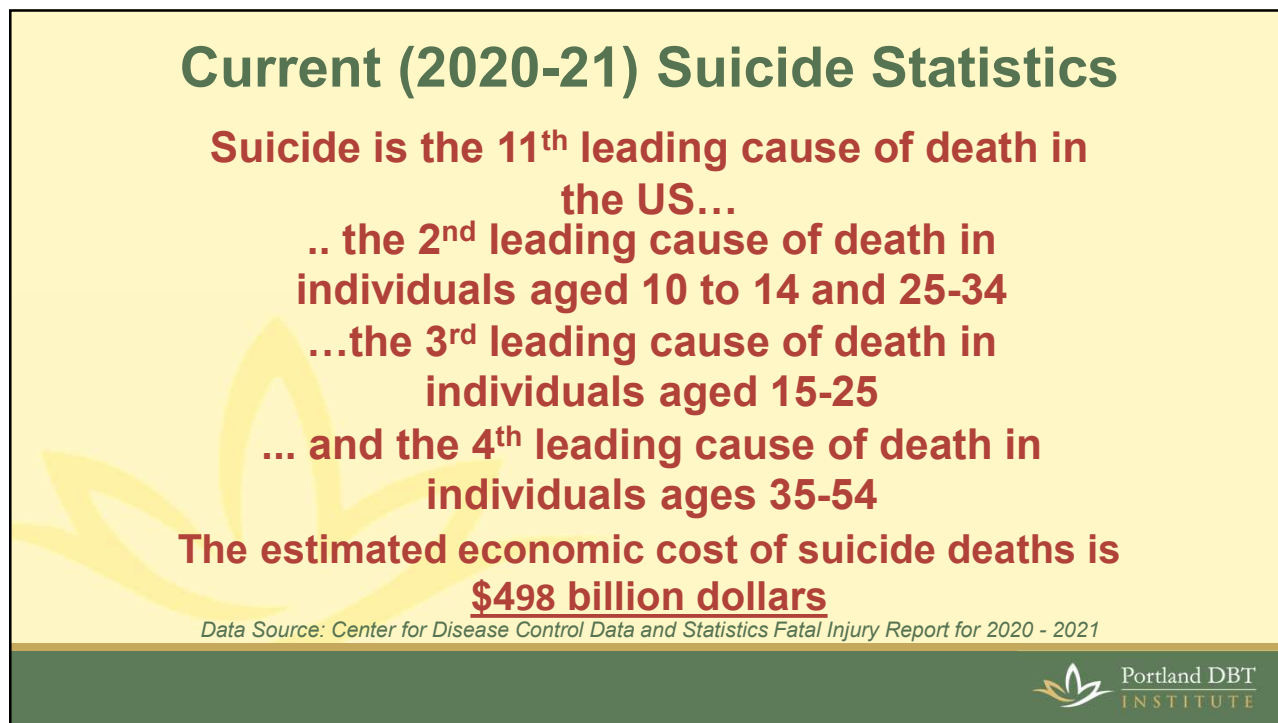
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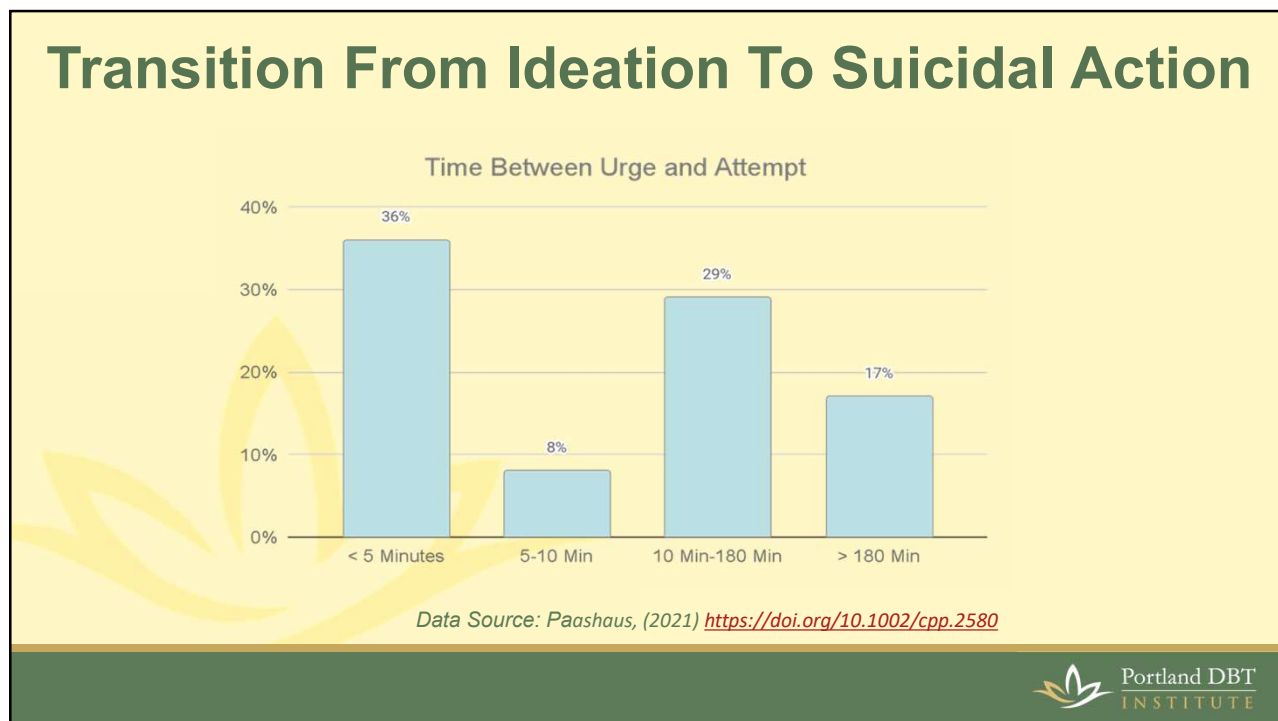


298

Suicide and Borderline Personality Disorder

- Between **8-10% mortality** (Paris, 2019, <https://doi.org/10.3390/medicina55060223>)
- Close to **50 times greater** than general population (CDC, 2016)
- Histories of suicide attempts in population reported **as high as 73%** (Soloff et al, 2000, <https://doi.org/10.1176/appi.ajp.157.4.601>; Söderholm et al, 2020, <https://doi.org/10.3389/fpsy.2020.00290>)
- One study reported suicide attempts in BPD population at **60%**, with **90%** of those with comorbid BPD and BD attempting suicide (Söderholm et al, 2020, <https://doi.org/10.3389/fpsy.2020.00290>)


Risk Factors for Suicide



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General Risk Factors

- **Family discord/domestic violence**
 - In justice or child welfare setting (APA, 2003; National Strategy for Suicide Prevention, 2012; Ruch et al, 2021, <https://doi.org/10.1001/jamanetworkopen.2021.15683>)
- **Environmental Characteristics**
 - Life changes - losses, disrupted relationships, discharge from psychiatric hospital within 6 – 12 months (Linehan, 1993, 2014; Chung et al, 2017, <https://doi.org/10.1001/jamapsychiatry.2017.1044>)
- **Social Support**
 - Unemployed, single, less available family, limited social support network (Linehan, 1993, 2014; Roelfs & Shor, 2023, <https://psycnet.apa.org/doi/10.1027/0227-5910/a000908>)
 - Perceived Burdensomeness/Thwarted Belongingness (Interpersonal Theory of Suicide (Chu et al, 2017)
- **Access to lethal methods/Capability for Suicide**
 - Leading methods in USA are firearms, suffocation/hanging, and poisoning (CDC, 2017)



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Social Factors Related to Long Term Risk For Suicide

- Modeling
 - Family history of suicide (Linehan, 1994, 2014; CDC, 2022)
 - High profile suicide publicity
 - Family history of mental illness or substance use (APA, 2003; Capuzzi et al, 2020, <https://doi.org/10.1016/bs.acc.2019.11.005>)
- Cultural or religious beliefs about death or suicide

303

Medical Factors Related to Long Term Risk For Suicide

- Somatic- Poor health, low pain tolerance.
- Serotonergic system abnormality (Chesin & Stanley, 2013, <https://doi.org/10.1111/bdi.12092>; <https://doi.org/10.4088/jcp.13m08398>)
- Major Medical conditions (National Strategy for suicide prevention, 2012; Ahmedani, 2017, <https://doi.org/10.1017%2FS2045796020000529>)

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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, 2010, <https://pubmed.ncbi.nlm.nih.gov/20816034/>; Cassells et al, 2005, <https://doi.org/10.1027/0227-5910.26.2.53>; Galynker et al., 2017, <https://doi.org/10.1002/da.22559>; Galynker, Yaseen & Briggs, 2014, <https://psycnet.apa.org/doi/10.3928/00485713-20140908-07>; Linehan 1993, 2014)

305

What Increases Risk For Adolescents?

- Exposure to interpersonal violence, bullying, sexual/physical abuse, alcohol and drug use, family problems/peer conflicts, comorbid psychiatric disorders, previous suicide attempts (Brent 2010, 2013; King, Arango, & Foster, 2017, <https://doi.org/10.1016/j.copsyc.2017.08.037>; Carballo et al, 2020, <https://doi.org/10.1007/s00787-018-01270-9>).
- Cannabis use slightly elevates risk of depression and suicidal ideation but elevates risk of suicide three times that of non-users (Gobbi et al, 2019, [doi:10.1001/jamapsychiatry.2018.4500](https://doi.org/10.1001/jamapsychiatry.2018.4500); Han et al, 2021, <https://doi.org/10.1001%2Fjamanetworkopen.2021.13025>).

306

Family History and Risk

- Family history of suicidal behavior increases suicide risk even after controlling for diagnosis.
- Suicidal behaviors are transmitted within families.
- Suicidal ideation is not transmitted in families- it is linked to depression specifically.

Brent (2010, <https://doi.org/10.1016/j.jaac.2009.10.008>; 2013, <https://doi.org/10.1016/j.jaac.2013.09.009>), O'Reilly et al, (2020, <https://psycnet.apa.org/doi/10.1037/abn0000512>)

307

Sleep and Risk of Suicide

- Insomnia in past week predicts a 5-6 times increase in risk for adults even after controlling for mood disorder severity Brent (2010, <https://doi.org/10.1016/j.jaac.2009.10.008>; 2013, <https://doi.org/10.1016/j.jaac.2013.09.009>), Hedström et al, (2021, <https://doi.org/10.1093/sleep/zsaa245>).
- Difficulty sleeping predicts self-harm in adolescents.
- Insomnia negatively moderates treatment response to antidepressants.
- Association between social media exposure and suicide in teens is mediated by bullying and sleep disruption (Sedgwick, Epstein, Dutta, & Ougrin, 2019, <https://doi.org/10.1097%2FYCO.0000000000000547>).

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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.
- More work is needed in the area of suicide prediction.
- **Know the risk factors, and know your patients better- suicide is the ultimate attempt to solve a real problem which is causing profound suffering.**
 - 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, <http://dx.doi.org/10.1037/bul0000084>

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Stigma

Definitions proposed by Goffman, 1963, (ISBN: 9780671622442) as well as Phelan et al, 2008 (DOI: [10.1016/j.socscimed.2008.03.022](https://doi.org/10.1016/j.socscimed.2008.03.022))

“Keep people down”
exploitation and domination



“Keep people away”
avoidance of disease




“Keep people in”
Enforcement of social norms



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“Keep people down”

- Judgment and stigma towards individuals experiencing suicidality is related to:
 - Higher rates of suicide
 - Increased mental health issues
 - Increased functional impairment (Mayer et al, 2020, DOI: 10.1111/sltb.12617; Sheehan et al, 2017; DOI: [10.1027/0227-5910/a000413](https://doi.org/10.1027/0227-5910/a000413).)
- Similarly, higher amounts of invalidation (being told your behaviors are not understandable) on a personal or systemic level may serve to perpetuate and increase emotion dysregulation and in turn, shame/suicidality (Fruzzetti, Shenk, & Hoffman, 2005; <https://doi.org/10.1017/S0954579405050479>; Fruzzetti and Worrall, 2020; DOI: [10.1093/acprof:oso/9780195380170.003.0005](https://doi.org/10.1093/acprof:oso/9780195380170.003.0005))



311


Normalization

“liberal or accepting attitudes towards suicide in general”
Oexle et al (2022). doi: [10.1017/S2045796022000610](https://doi.org/10.1017/S2045796022000610)

Stigma:
Attitudes towards people

↑
versus
↓

Normalization:
Attitudes towards behaviors




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Goal: Decrease problematic and inaccurate attitudes towards people with suicidal behavior/histories


- Increase validation (e.g. Linehan, 2014, p155-156, ISBN 9781462516995) across systems
- Increase access to accurate information around suicide
 - Suicidal ideation is more common than people may think- an estimated 13.2 million adults reported ideation in 2022 (<https://www.cdc.gov/suicide/facts/index.html>)
 - Up to one third of adolescents in the US report making a suicide plan (Gaylor et al, 2021, DOI: <http://dx.doi.org/10.15585/mmwr.su7201a6>)
 - The Literacy of Suicide Scale suicide (Calear et al, 2022, doi: 10.1027/0227-5910/a000798)
- Decriminalization suicidal behavior and increase health care access (WHO Policy Brief on the health aspects of decriminalization of suicide and suicide attempts, ISBN 9789240078796)



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Literacy of Suicide Scale

| | |
|---|--|
| <ul style="list-style-type: none">• Most people who suicide are younger than 30 (False)• A time of high suicide risk in depression is at the time when the person begins to improve (True)• There is a strong relationship between alcoholism and suicide (True)• Most people who suicide don't make future plans (False)• Most people who attempt suicide fail to kill themselves (True)• A person who suicides is mentally ill (False)• People who talk about suicide rarely kill themselves (False)• People who want to attempt suicide can change their mind quickly (True)• Men are more likely to suicide than women (True)• Motives and causes of suicide are readily established (False)• People who are anxious or agitated have a higher risk of suicide (True)• A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted (True)• Media coverage of suicide will inevitably encourage other people to attempt suicide (False)• If assessed by a psychiatrist, everyone who suicides would be diagnosed as depressed (False) | <ul style="list-style-type: none">• Talking about suicide always increases the risk of suicide (False)• Not all people who attempt suicide plan their attempt in advance (True)• People with relationship problems or financial problems have a higher risk of suicide (True)• A suicidal person will always be suicidal and entertain thoughts of suicide (False)• Those who attempt suicide do so only to manipulate others and attract attention to themselves (False)• Very few people have thoughts about suicide (False)• Most people who suicide are psychotic (False)• Seeing a psychiatrist or psychologist can help prevent someone from suicide (True)• If you asked someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt (False)• Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves (False)• People who have thoughts about suicide should not tell others about it (False)• Only experts can help people who want to suicide (False) |
|---|--|




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Goal: Decrease normalization of suicidal behavior

Limit access to methods
(Florentine & Crane, 2010, DOI: 10.1016/j.socscimed.2010.01.029)

- Reduce/limit/restrict lethal means access
 - <https://www.hsph.harvard.edu/means-matter/lethal-means-counseling/>
 - <https://sprc.org/effective-prevention/a-comprehensive-approach-to-suicide-prevention/reduce-access-to-means-of-suicide/>
 - <https://www.samhsa.gov/blog/lethal-means-safety-suicide-prevention>
 - <https://vimeo.com/176189702>
- Reduce cognitive availability of suicide as a solution
 - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9970321/>
 - <https://stacks.cdc.gov/view/cdc/22163>
 - <https://afsp.org/safereporting/>
 - <https://theactionalliance.org/messaging/entertainment-messaging/national-recommendations>



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Lethal Means Management

- The time between thinking of suicide and suicide attempts is short- 73% of the time it's less than one hour (Simon et al, 2001; DOI: [10.1521/suli.32.1.5.49.24212](https://doi.org/10.1521/suli.32.1.5.49.24212).)
- States which lowered the age of handgun purchase from 21 to 18 experienced increased suicide deaths in adolescents equivalent to 344 extra suicides per state (Raifman et al, 2020; doi: <https://doi.org/10.1136/bmj.m2436>)
- Parents can be trained in lethal means restriction (King, Arango, & Foster 2018; DOI: 10.1016/j.copsyc.2017.08.037)

317

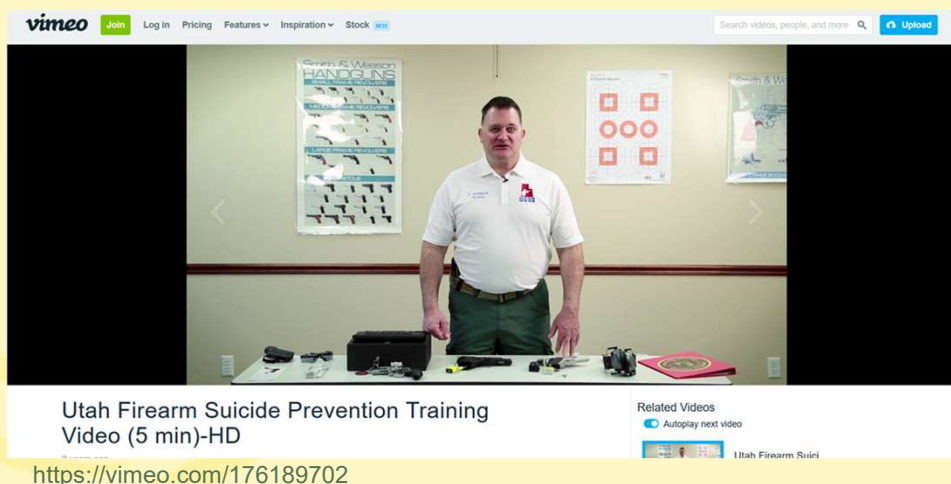
Counseling on Lethal Means Access

- 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, DOI: 10.1037/a0025051)

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Utah Firearm Safety Prevention Training



319

Goal: Increase/create social norms helpful to reduction of suicide

Hospitalization for suicidal ideation is not supported by the evidence

- Psychiatric hospitalization for suicidal ideation may increase the likelihood of death by suicide (Ciesielski & Rizvi, 2020, <https://doi.org/10.1111/cpsp.12332>; Chung et al, 2017, DOI: [10.1136/bmjopen-2018-023883](https://doi.org/10.1136/bmjopen-2018-023883), Coyle, Linehan, & Shaver, 2018, DOI: [10.1037/ccp0000275](https://doi.org/10.1037/ccp0000275))
- When looking at adolescents, this finding was more pronounced for adolescents with chronic suicidality (Czyz, Berona, & King, 2016; DOI: [10.1176/appi.ps.201400252](https://doi.org/10.1176/appi.ps.201400252))
 - “Hospitalization may act as an unintended reinforcement of self-harmful behaviors”.
 - “Hospitalization may disrupt the positive aspects of some suicidal adolescents’ lives”.
 - “Hospitalization may also unintentionally exacerbate hopelessness (failed outpatient treatment) or contribute to an identity as an “ill” person”.

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Goal: Increase/create social norms helpful to reduction of suicide

Significant Variation Exists in Risk Reduction for Hospitalization for Suicide Attempts

- For some patients, hospitalization after a suicide attempt reduces future risk, but not for all patients (Ross et al, 2024, DOI: [10.1001/jamapsychiatry.2023.3994](https://doi.org/10.1001/jamapsychiatry.2023.3994))
 - Future risk of suicide was reduced when the suicide attempt was within 1-day of hospital admission
 - “for patients with suicidality other than in the immediate aftermath of an SA, hospitalization is not a justifiable default approach, as hospitalization is associated with an increased risk of subsequent SAs in 20.0% to 40.0% of patients and decreased risk in another 20.0%to 40.0%”

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Goal: Increase/create social norms helpful to reduction of suicide

- Engage in policy and social change to amplify voices and disseminate information
 - Look for opportunities to serve on county and state boards
 - Give testimony on local/state/national policy initiatives
 - Join professional organizations which support your values
 - “Vote with your feet”- support organizations/companies (CE and otherwise) which support these values
- Educate your communities around these issues
- Publish and disseminate
 - Barlow D. H. (2010). Negative effects from psychological treatments: a perspective. *The American psychologist*, 65(1), 13–20. <https://doi.org/10.1037/a0015643>
- Find supports and communities which assist in these endeavors

322

Traditional Pitfalls in Documentation

If it isn't written down, it didn't happen"- Thomas Gutheil, MD

- Patient records are an enduring document which may be used by future providers, as well as in legal proceedings.
- Avoid the temptation to use "lazy" language, stock phrases, judgmental language, and things you would not want to have read on a stand in court.
- Be familiar with generally accepted medical/legal standards for documentation.

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Risk Benefit Notes

- Whenever a moderate to high risk event is occurring, and you are using your own (and your colleagues!) clinical judgment to not hospitalize the client.
- In these situations, a risk benefit note is needed so anyone reviewing the chart can understand your justification for not hospitalizing.

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What is in Risk Benefit Notes?

- An accurate, complete assessment of risk
- Risk factors current present vs. historically present
- Factors which may lower the risk of death
- How information was obtained (e.g. in person, phone, collaterals, etc)
- Pros/cons of utilizing emergency/hospital services
- Notes about any consultations obtained
- A summary of how the relevant information has lead to the decision not to hospitalize

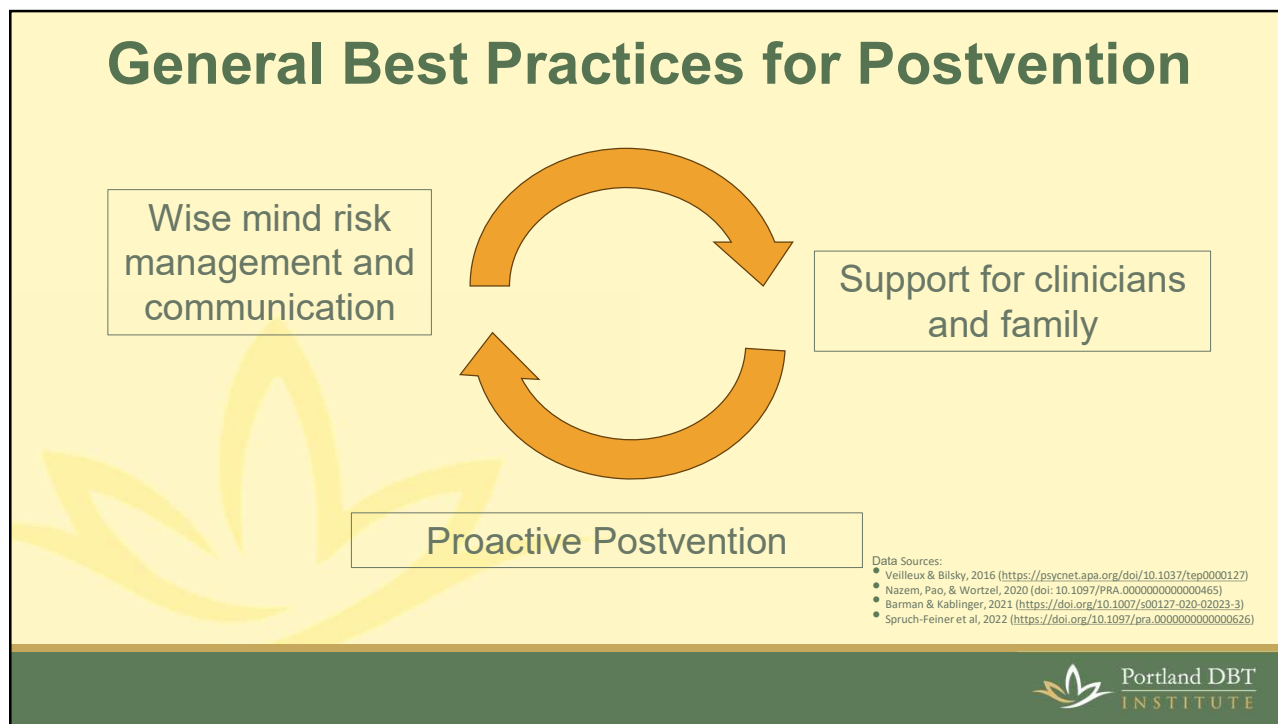
325

One Example: LRAMP

Linehan Risk Assessment and Management Protocol

- Protocol to reduce anxiety about malpractice lawsuits for assessors and providers.
- Standardized protocol to manage suicide risk during clinical research assessments that could be documented and applied by blinded assessors
- Generic crisis protocol that guide good clinical care across treatment conditions

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Proactive Postvention

- **Get trained on best practices**
 - Use of interventions/documentation which are gold standard for high risk patients (e.g. CAMS, DBT, CBT-SP, etc)
 - Avoid interventions which do not have robust support for suicidal clients
- Create suicide postvention preparation plan
 - Contact info for team/liability carriers
 - Coping statements
- Cope ahead
 - Effective and comprehensive assessment
 - Full documentation using best practices for clinical documentation
- Discuss fears and concerns with team


Data Sources:

- Nazem, Pao, & Wortzel, 2020 (<https://doi.org/10.1097/PRA.0000000000000465>)
- Barman & Kablinger, 2021 (<https://doi.org/10.1007/s00127-020-02023-3>)
- Spruch-Feiner et al, 2022 (<https://doi.org/10.1097/prs.0000000000000626>)

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Break!



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Day Five
Consultation Team



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DBT Consultation Team

A community of clinicians treating a community of clients

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Function of DBT Consultation Team

Function

To enhance therapists' motivation and capabilities to effectively treat DBT clients & to stay within the frame.



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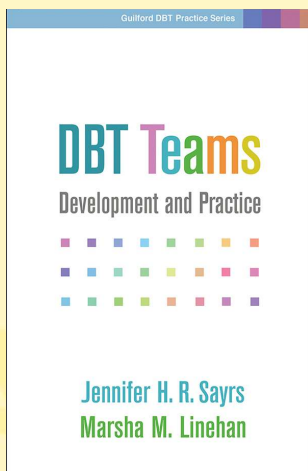
332

Team Agreements

- To accept a dialectical philosophy.
- To consult with C on how to interact with other therapists and not to tell other therapists how to interact with C.
- Consistency of therapists with one another (even with same C) is not necessary or expected.
- Therapists are to observe their own limits without fear of judgmental reactions from other consultation team members.
- To search for non-pejorative, phenomenological empathic interpretation of C's behavior.
- Therapists are fallible.

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Resource



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DBT Consultation Team BASICS

- Team leader vs. meeting leader vs. no leader.
- Roles
- Logistics
 - Who should attend?
 - How often should you meet?
- Depth vs. breadth
- How do we bring on new people to team?

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DBT Consultation Team BASICS

- Strategies for Consulting
 - Determine what specifically T needs (e.g., help figuring out the treatment plan, needs validation/emotional support).
 - Define and assess the problem behaviorally.
 - Once there is agreement on the problem, treat it using the same DBT strategies, principles used with clients (e.g., problem-solving, validation, acceptance).
 - Be mindful of time.

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DBT Consultation Team BEYOND the Basics

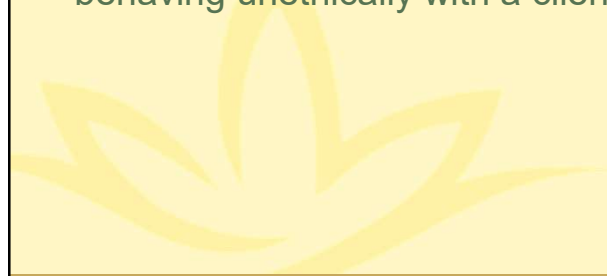
- Look for & address “Elephants in the Room”.
- Know your team mates’ Clinically Relevant Behaviors (CRBs)
- Take an active approach doing those activities that nurture and help maintain capacity for honesty & intimacy on your team.



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DBT Consultation Team BEYOND the Basics


- When is the problem one that must be addressed individually by the clinician (vs. in team)?
- What do you do when a client is not improving (or is deteriorating), but your colleague is not seeking help?
- What do you do if you have reason to believe your colleague is behaving unethically with a client and/or is impaired?



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Consultation-to-the-Therapist Strategies

- Meet to confer on treatment.
- Keep supervision and consultation agreements.
- Cheerlead each other.
- Provide dialectical balance.



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Therapist Characteristics

Oriented to Change


Oriented to Acceptance

Non-Moving Centeredness

Benevolent Demanding


Nurturing

Compassionate Flexibility



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Lunch!



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Closing out (for now)!

- Next Steps (as teams)
- Commitments (as teams)
- Homework!
 - Individual Assignment Sheets to go team lead
 - Team leads send sheets to our training team email (training@pdbti.org)
 - You get a thing!
 - For people doing CITI II- we will be in touch!
- Being in touch

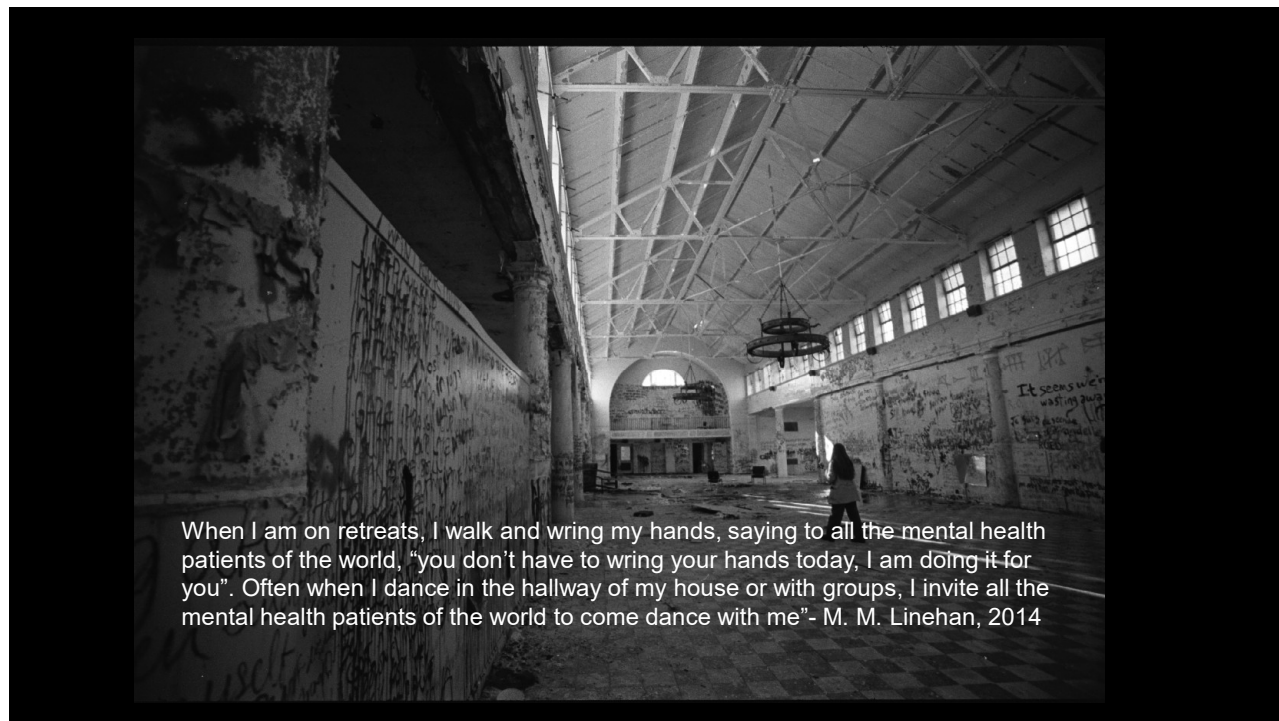


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Stay in Touch

- Clearinghouses for info:
 - <https://dbt-lbc.org/> (Certification and certified therapists/programs)
 - <https://behavioraltech.org/> (General resources)
- Add yourself to DBT-L:
 - Go to <https://www.pdbti.org/dbt-l/>
- Andy White Contact information:
 - awhite@pdbti.org, 503.290.3281
- Ashley Maliken Contact information:
 - amaliken@pdbti.org, 503.290.3277

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