Specific dialectical behaviour therapy (DBT) techniques for working with people who self-harm or are suicidal

This section describes DBT techniques *specifically* intended for adults who are actively self-harming or suicidal.

Effective delivery of this approach depends on its integration with the knowledge and skills set out in the full description of DBT set out in the competence framework for working with people with personality disorder and in the CBT competence framework (both can be accessed at: www.ucl.ac.uk/clinical-psychology/CORE/competence-frameworks).

Knowledge of the principles underpinning the structure of DBT interventions*

An ability to draw on knowledge that DBT techniques and strategies were developed specifically to help people who self-harm or are suicidal
An ability to draw on knowledge that there are five elements that characterise DBT interventions:
enhancing a person's skills
improving a person's motivation
generalising from the clinic to the natural environment
improving a therapist's motivation and adherence to the model
structuring the environment to reinforce more adaptive (skilful) behaviour
An ability to draw on knowledge that these elements are commonly delivered through:
weekly individual therapy
skills training groups
out-of-hours contact (e.g. access to out-of-hours telephone consultation)
weekly team consultation for staff
adjunctive groups/therapy or training that is compatible with DBT (e.g. family groups, couples therapy, training in behavioural principles for non-DBT staff members)
An ability to draw on knowledge that each person will have one primary therapist who oversees all components (modes) of treatment

* Described fully in the competence framework for working with individuals with personality disorder.

Knowledge of how DBT conceptualises self-harm and suicidal behaviours

An ability to draw on knowledge that self-harm and suicide are viewed as a way of coping with acute emotional suffering when a person is unable to access other (more constructive) coping strategies
An ability to draw on knowledge that these behaviours are viewed as learned responses to emotional suffering (whereby a pattern of escaping from distressing internal or external situations becomes negatively reinforced, and over time emerges as an automatic response)

An ability to draw on knowledge that both self-harm and suicidal behaviours are viewed as a form of 'problem-solving' aimed at relieving intense negative emotional arousal:
directly, by ending life through loss of consciousness
indirectly, by eliciting help from the environment
through negative reinforcement (e.g. experienced reduction in emotional pain, physiological effect of the body's natural painkillers)
through positive reinforcement (e.g. eliciting of help from the environment)
An ability to draw on knowledge that self-harm and suicidal behaviours are considered to emerge as a consequence of a number of interacting factors:
a lack of a stable sense of self-identity
a poor capacity to create and maintain stable relationships with others
a poor capacity for emotional regulation, including tolerating and experiencing distress
personal factors (such as relevant demographic and historical factors) and environmental factors (such as recent life changes, family and social contexts) that inhibit the development and deployment of more effective behavioural coping skills
An ability to draw on knowledge that DBT directly addresses these issues by:
skills training which aims to enhance the capacity for interpersonal effectiveness and for self-regulation (including mindfulness and emotion regulation) and tolerance of distress
structuring the treatment environment in a way that motivates and reinforces the appropriate use of the taught skills component
identifying and 'breaking-up' learned behavioural sequences that precede a person's dysfunctional behaviours, and removing reinforcers for those behaviours by using behavioural and solution analyses
structuring treatment to encourage the generalisation of new skills from therapy to application in everyday life
providing support and regular ongoing consultation for therapists treating people at high risk of suicide

Using DBT techniques in individual work to address the risk of life-threatening behaviours

An ability to track self-harm and suicidal behaviours through the use of diary cards
An ability to maintain a dialectical balance between validation and change in discussions of self-harm and suicidal behaviours
An ability to help a person develop and apply problem-solving skills through:
an ability to conduct a behavioural analysis of the self-harm or suicidal behaviour*
an ability to conduct a solution analysis of the self-harm or suicidal behaviour*
an ability to address self-harm or suicidal behaviour using appropriate DBT change procedures (e.g. contingency management *, exposure*, cognitive modification*, interpersonal effectiveness or coaching to make use of targeted application of skills training)
An ability for the therapist to make use of team consultations in order to maintain a non-judgemental, empathic and dialectical stance when discussing suicidal behaviours

* Described in the full DBT framework.

Consultation with people in and between sessions

An ability to set a person's expectations for how and when to use routine between-session coaching
An ability to respond to a suicidal act that has already occurred by:
assessing the medical lethality of the act
ensuring that the person receives medical attention
trying not to reinforce the behaviour through the therapist's response (e.g. by being clear that consultations will not take place immediately, but will be delayed by 24 hours)
conducting a behavioural chain and solution analysis at the next face-to-face session
An ability to respond to imminent self-harm or suicidal behaviour by:
determining the immediate risk of self-harm or suicide
removing (or instructing the person to remove) means
empathically reinforcing the idea that self-harm and suicide are not the solution
generating hopeful statements and alternative solutions
assessing whether the behaviour is a direct response to overwhelming negative emotional arousal or an indirect response that may function to elicit help from others
An ability to respond to a crisis in a manner that is congruent with the principles of DBT, for example:
focusing on the current emotion rather than the content of the crisis
identifying triggers to the crisis and arriving at a formulation of its development
helping the person to problem solve and identifying the skills they are implementing
reducing any risk factors in the environment
reducing any high-risk behaviours
developing a collaborative plan of action
assessing the potential for suicide throughout and again at the end of the interaction

Using consultation meetings for therapists to help maintain the therapeutic frame

An ability for the therapists to set an agenda for the consultation meeting that is consistent with the DBT hierarchy of targets, and so identifies:
the therapist's need for consultation around suicidal crises or other life-threatening behaviours
a person's behaviours that interfere with therapy (including absences and dropouts) as well as inadvertent therapist-behaviours that might adversely affect the treatment
team behaviours that might adversely affect treatment and burnout
a person's behaviours that are severe or escalating and interfere with their quality-of-life
areas where the therapist is working effectively
An ability for the therapist to use the consultation team to further their DBT training

Using consultation to help people interact with their environment effectively

An ability to identify problematic aspects of the environment that might increase the risk of repeated self-harm or suicidal behaviour
An ability to engage in a consultation with the person to enable them to interact with their environment more effectively (e.g. learning to communicate more effectively with family members, carers, significant others, friends and professionals)
An ability to use clinical judgement to decide when it is more appropriate to intervene in the environment to prevent substantial harm to the person (e.g. when they lack the abilities they need to learn and the situation is acute and potentially life-threatening)

Cognitive behavioural therapy (CBT)[1]

This section identifies CBT competences directly relevant to therapeutic work with people at risk of self-harm. It assumes that practitioners are familiar with CBT techniques as applied to work with people with depression and anxiety disorders and detailed in the CBT framework (accessed at www.ucl.ac.uk/CORE).

Knowledge of the cognitive model of suicidal acts

- An ability to draw on knowledge of psychological models that emphasise the role of overwhelming thoughts and feelings of hopelessness about oneself, the future and one's capacity to change one's circumstances for the better, a state of mind that has a number of potential determinants:
  - long-standing 'dispositional' factors that become more problematic in the presence of stress, such as:
    - impulsivity, particularly when combined with a tendency to respond to difficulties with aggression
    - a sense that others set high standards for the self, and that fulfilling these standards is a condition for being accepted
    - a restricted ability to apply problem-solving strategies that might ameliorate difficulties
    - a tendency to employ unhelpful ways of thinking (such as overgeneralisation, jumping to conclusions or all-or-nothing thinking) that in turn exacerbate distress
  - processes associated with mental health problems
    - long-standing and unhelpful ways of making sense of the world that become activated when trying to manage challenges, and which:
      - tend to shape unhelpful ways of thinking
      - increase the salience (and presence) of negative thoughts
  - processes associated with suicidal acts in which the person intends to die
    - entrapment combined with a long-standing sense of hopelessness about the future (a sense that the current situation cannot be changed and is intolerable), leading in turn to:
      - a capacity for 'rational' decision-making being inhibited by, for example, extreme distress, restlessness, racing thoughts and agitation
      - 'attentional narrowing' – a narrow focus on the present that precludes 'rational' thought and problem-solving
      - 'attentional fixation' in which suicide appears to be the only option, which in turn reinforces a sense of hopelessness
      - a downward spiral in which hopelessness and attentional fixation interact with a reduced capacity for problem-solving, and which further promotes suicidal intent

[1] Source: Wenzel A, Brown GK, Beck AT. Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications. Washington, DC: American Psychological Association; 2009.

Overarching principles

An ability to draw on knowledge that CBT for suicide prevention assumes that during suicidal crises a person:
lacks appropriate cognitive, behavioural and affective coping strategies
finds it difficult to use previously learned helpful coping skills
may try to cope by using coping skills that are unhelpful and exacerbate difficulties
does not make use of available resources
An ability to draw on knowledge that the primary goal of cognitive therapy for suicide prevention is to reduce the likelihood of future suicidal acts by helping a person to:
acquire more adaptive coping strategies
develop cognitive 'tools' to identify reasons for living and instil hope
improve problem-solving skills
increase constructive activities that bring a sense of pleasure and/or achievement
increase connection with social support networks
increase take-up of adjunctive interventions

Identifying when the focus of treatment should be on suicide prevention

An ability to draw on knowledge that a focus on suicide prevention is appropriate when a person:
reports substantial increases in suicidal ideation
makes a suicide attempt during the course of treatment
is taken on immediately following a suicidal crisis

Establishing the therapeutic frame for work with people in suicidal crisis

An ability to draw on knowledge that the entire intervention rests upon a good therapeutic alliance, in which the therapist's stance is explicitly warm, empathetic, collaborative and non-judgemental
An ability to draw on knowledge that the therapist will need to maintain a consistent and constructive stance even when a person is unresponsive or interacts in an unhelpful way
An ability to manage discussions about the limits of confidentiality sensitively and directly, holding in mind the particular concerns of this user group and the information-sharing issues that may arise
An ability to discuss the scope of the intervention and to make clear that the primary goal of treatment is to prevent a future suicidal act
An ability to explain how therapy for suicide prevention fits with longer-term interventions that address longer-term difficulties (as a person becomes better able to manage the immediate suicidal crisis)
An ability to hold in mind that because a person is experiencing high levels of distress, they will find it hard to attend to and retain information, and so descriptions of the limits of confidentiality, consent and treatment structure should usually be supplemented by written materials (if required, with multiple repetitions of the content)
An ability to acknowledge the likelihood that a person will be distressed and to help them identify strategies that they can use to manage distress during or immediately after the session

An ability to instil hope using a variety of direct and indirect methods, including:
conveying a sense of hope about the potential benefits of treatment (based upon the evidence base and previous successes)
engaging in ‘Socratic dialogue’ around negative thoughts about the treatment
examining the costs and benefits of trying out a more hopeful approach (e.g. the potential benefit of more active problem-solving versus apathy and inaction)

Ability to manage barriers to engagement in people in suicidal crisis

An ability to draw on knowledge that it is appropriate for clinicians or case managers to actively assist a person in getting to (and staying in) therapy
An ability to address concerns about adverse consequences of disclosing suicidal thoughts (e.g. involuntary hospitalisation)
An ability to draw on knowledge of the common barriers to engagement, including:
disadvantaged economic circumstances
a chaotic lifestyle
negative attitudes towards treatment
severe psychiatric disturbance
substance misuse
shame about suicidal crises
concern about stigma
culturally based negative beliefs about mental health services
An ability to make use of a range of clinical strategies to address barriers to engagement, such as:
working with a person to identify, and so plan for, obstacles to engagement
using Socratic questioning to identify and address negative beliefs that may interfere with engagement
problem-solving practical issues, such as forgetting about appointments or lack of finance for transport

Ability to conduct a comprehensive risk assessment

An ability to draw on knowledge that in an outpatient setting the aims of a comprehensive risk assessment are to:
identify the risk and protective factors that can help to estimate a person’s risk of suicide
identify co-occurring psychiatric and medical disorders that may contribute to suicidal behaviour
determine the most appropriate level of care (e.g. inpatient or outpatient treatment)
identify which risk factors are likely to be modifiable with treatment
An ability to draw on knowledge that talking about suicide does not increase the likelihood of suicide attempts, and so adopt an open and frank stance to discussion
An ability to help a person manage the potential distress associated with discussing difficult topics by:
ensuring that they understand the rationale for the assessment questions
discussing how they might like to manage distress, both during and after the interview (e.g. during the session: take a break or use relaxation to manage negative emotional reactions; after the session: plan positive activities afterwards, use social support)
acknowledging and helping a person to manage their distress if this becomes overwhelming

An ability to assess potential risk factors, including:
suicidal ideation and behaviours that are linked to suicidal intent
psychiatric and medical conditions (including any psychiatric history)
psychological vulnerabilities (e.g. hopelessness)
psychosocial vulnerabilities (e.g. recent loss, experiences of discrimination)
An ability to work with a person to identify cognitions that focus on suicide (including the content, duration, frequency and intensity of suicidal thinking, and the level of intent to die)
currently
at the worst time in the past
An ability to work with a person to identify behaviours (both currently and in the past) that relate to suicidal intent (e.g. preparing a will, writing a note, saying goodbye to significant others, acquiring the means to end life)
An ability to discuss with a person the specific characteristics of suicide attempts (e.g. level of intent to die, the function of the attempt, whether precautions against discovery were taken), and use this to estimate the likelihood of future acts
An ability to help a person identify protective factors that may be associated with a decreased risk of suicide, such as:
attitudes or beliefs (e.g. hopefulness, reasons for living, a wish to live), a belief that suicide is immoral
a sense that it may be possible to manage the problem area associated with the suicidal crisis
a supportive social network
a sense of their importance to others
a fear of death, of dying or of suicide
An ability to judge the level of care required, guided by the presence and strength of risk and protective factors, and to evaluate the need for:
inpatient versus outpatient treatment
additional follow-up meetings to assess and manage ongoing risk
referral to other agencies
obtaining more information from other sources
informing other clinicians or agencies of the level of risk
informing family members, carers and significant others of the level of risk

Ability to develop a safety plan

An ability to draw on knowledge that ‘no suicide’ contracts (in which a person promises not to attempt suicide) have not been shown to reduce risk and may obscure a person’s true risk status if they contribute to a sense of shame and withholding of information
An ability to work with a person to develop a safety plan (a written list of prioritised coping strategies and resources that they agree to apply, or to contact during a suicidal crisis)
An ability to ensure that items in the safety plan are developed in close collaboration with a person, are phrased in their own words and relate to their individual circumstances
An ability to ensure that the safety plan includes:
recognising warning signs that precede a suicidal crisis
identifying coping strategies that can be used without contacting another person
contacting members of a person’s social network (family members, carers or significant others)
contacting mental health professionals or agencies
An ability to ensure that the safety plan includes steps which can be implemented in sequence (progressing to the next step if the previous step does not resolve the crisis):
recognising warning signs (including ‘automatic’ thoughts, images, thinking styles, moods or behaviours)

using coping strategies, reviewing these in the light of what a person has learned in therapy (e.g. using distracting activities early in treatment and using skills learned during treatment at later stages)
contacting family members, carers, significant others or friends (which may include making a prioritised list and deciding on the type of contact or disclosures that a person might make to different individuals)
contacting professionals and agencies (including treating clinicians, on-call clinicians, 24-hour emergency treatment facilities and other local or national support services)
An ability to discuss the degree of access to lethal methods and agree reduction of access to these methods
An ability to assess the likelihood of using completed safety plans and to collaboratively construct strategies to overcome obstacles

Ability to construct a cognitive behavioural formulation of a recent suicidal crisis

An ability to obtain a detailed narrative description of the crisis
An ability to construct a timeline incorporating the activating event, cognitions, emotions and behavioural responses
An ability to identify core and intermediate beliefs associated with the suicidal crisis
An ability to identify dispositional vulnerability factors (such as impulsivity, deficits in problem-solving, information-processing biases)
An ability to assess suicide-relevant cognitive processes such as attentional fixation, automatic thoughts related to unbearability, and suicide-relevant environmental cues
An ability to develop an individualised formulation based upon the cognitive model of suicidal acts
An ability to create an individualised treatment plan based upon the assessment and formulation, focusing on the specific skill deficits and dysfunctional beliefs that will need to be modified to prevent a further suicidal crisis

Intervention skills

Establishing the priorities for intervention

An ability to establish the rationale for a primary focus on suicide prevention over other issues that may be more chronic but less related to immediate triggers for suicidality
An ability to work with a person to establish treatment goals relevant to the suicidal crisis, including work on specific life problems, negative beliefs and skills deficits
An ability to link a person with other relevant services, if related issues need to be addressed (e.g. to manage psychiatric or medical needs)
An ability to use the formulation and treatment goals to identify the specific cognitive and behavioural interventions most likely to prevent a future suicidal act

Adapting standard session structure

- An ability to adapt session structure relevant to meet the needs of people in suicidal crisis, such as:
  - ensuring that agenda-setting prioritises the issues that both therapist and person agree are the most life-threatening
  - assisting a person who may have difficulty with establishing a focus (due to distress or difficulty organising thoughts) by taking a more active lead in making suggestions informed by the case conceptualisation
  - using a 'mood check' to identify changes in suicide-relevant symptoms (such as suicidal ideation, sleep disturbance, fatigue, adherence to other relevant treatments (e.g. for substance misuse))
  - assisting visibly agitated patients by practising an emotional regulation strategy (such as controlled breathing or progressive muscle relaxation) at the start of the session
  - focusing homework assignments on a concrete, manageable task that a person can accomplish (and avoiding complex tasks that may be difficult to implement in distress)
  - ensuring that there is time at the end of each session to discuss a person's reactions to session content, recognising and responding to any negative cognitions, and establishing plans for specific self-soothing activities or follow-up arrangements if suicidality has increased

Applying behavioural techniques

- An ability to help a person generate and plan activities for pleasure and/or mastery that can be easily accomplished (as a stand-alone task, rather than as part of activity scheduling)
- An ability to help a person to challenge negative beliefs about others using interpersonal behavioural experiments
- An ability to help a person make more effective use of their social support networks or develop new relationships
- An ability to help a person enhance their communication and social skills
- An ability to help a person access relevant adjunctive services, by working with them to identify difficulties with engagement and develop strategies that address them

Applying emotion regulation techniques

- An ability to draw on knowledge of the rationale for using self-soothing strategies (aimed at preventing the onset of attentional fixation and heightened physiological arousal or decreasing its intensity in a non-harmful way)
- An ability to help a person apply individualised strategies to help them self-soothe based on their own preferences, such as:
  - physical strategies that help decrease physiological arousal, for example:
    - vigorous activity
    - progressive muscle relaxation
    - controlled breathing
  - cognitive strategies that shift attention and decrease the intensity of distressing emotions (and so make it easier to manage situations that a person needs to cope with), such as:
    - distraction techniques (e.g. recalling positive memories, focusing on neutral or positive environmental stimuli, engaging in an absorbing activity)
  - sensory strategies that would be likely to induce a soothed response, such as:

smell (e.g. candles, coffee beans, aromatherapy oils), sound (e.g. music), touch (e.g. warm bath, hot shower, self-massage)

Ability to apply cognitive techniques focused on the acute management of suicide impulses and behaviour

Knowledge

An ability to draw on knowledge that cognitive work for suicide prevention is focused on decreasing the risk of future suicidal acts (leaving other targets for continuation phase work)
An ability to draw on knowledge that cognitive work in suicide prevention should be congruent with the level of distress and stage in treatment. As such, it may be:
more concerned to help a person de-centre from thoughts when they are highly distressed and/or earlier in the work, using techniques that are easier to grasp (e.g. empathetic prompts to step back from extreme thinking as a 'final verdict', Socratic dialogue to help identify alternative responses)
using cognitive techniques when a person is calmer/later in the work (e.g. addressing thinking biases, using thought records)
less concerned at first with belief change (which might be difficult to achieve when a person is highly distressed)
more concerned at first with empathetic engagement and use of the therapeutic relationship to help a person to stay in treatment and consider alternatives
adapted when distress level is lower, to include more complex techniques (e.g. continua, positive data logs, behavioural experiments)
An ability to draw on knowledge that the aim of cognitive techniques in the acute suicide prevention phase is to:
identify a person's beliefs and understand the manner in which they influence automatic thoughts, emotional reactions and behavioural responses
help a person regularly assess the strength of these beliefs and modify them as needed

Application of cognitive techniques

An ability to help a person to challenge suicide-relevant core beliefs, particularly around themes of hopelessness and 'unbearability', by using:
Socratic dialogue
imagery techniques (e.g. creating positive images of the future)
behavioural experiments (e.g. using self-soothing to challenge ideas that distress is unbearable)
An ability to help a person identify and draw upon 'reasons for living' in times of crisis by creating a written list or alternative reminders (such as a physical or electronic 'hope kit' containing items that serve as reminders of life goals, family, carers, friends, etc).
An ability to help a person construct 'coping cards' to help them manage suicide-relevant cognitions and which include:
alternatives to suicide-relevant negative automatic thoughts and beliefs
evidence that refutes a core belief
personalised coping strategies relevant to suicidal crisis
statements that motivate them to take steps to reach goals or practise adaptive coping skills
An ability to adapt problem solving for people at risk of suicide by helping them to:

- select key problems relevant to suicidal crises
- challenge negative cognitions that may interfere with generating alternative solutions
- consider both short-term and long-term consequences of potential solutions, and the manner in which their actions might affect the lives of others as well as themselves
- use cognitive rehearsal to imagine a number of proposed solutions and their effects
- anticipate and plan for potential obstacles
- evaluate how well the problem-solving went and modify solutions if necessary

Ability to identify when a person is ready to move on from a focus on suicide prevention

- An ability to work with a person to identify when they are ready to move on from a focus on suicide prevention, as indicated (for example) when:
  - they no longer report any desire to die by suicide (they may still have thoughts, but without the intent)
  - most of the issues that triggered their recent suicidal crisis have been addressed
  - acute symptom severity has diminished (e.g. as shown by reductions on outcome measures)
  - they have demonstrated that they have acquired skills for coping with future distress or crises

Ability to implement a relapse prevention protocol based on guided imagery

- An ability to prepare a person for guided imagery exercises by:
  - discussing the rationale for using guided imagery as the vehicle for the relapse prevention:
    - that it can help people experience material in a more immediate and impactful way, making it a more accurate indicator of their progress
  - reviewing the treatment plan and safety plan resulting from the intervention
  - discussing how negative emotional reactions to the imagery task can be managed (e.g. taking a break, using a ‘stopping word’ to discontinue the task (e.g. ‘enough’), empathising with the thoughts and feelings that were experienced)
  - providing opportunities for discussion of any concerns patients may have and how they can be addressed (e.g. anxiety about experiencing painful emotions, deterioration of mood if they revisit the details of the crisis)
- An ability to use guided imagery techniques to:
  - review the recent suicidal crisis by helping a person to:
    - generate a vivid image of the relevant situation
    - describe (in the present tense) the sequence of events that led up to the suicidal crisis
    - identify the key thoughts, emotions, behaviours and circumstances that were most relevant to the suicidal crisis
  - rehearse the use of coping skills in the recent crisis by:
    - prompting a person to generate a vivid image of the relevant situation
    - helping a person describe (in the present tense) the sequence of events that led up to the suicidal crisis
    - prompting a person to describe applying the coping strategies and adaptive responses that they have learned in treatment to the key activating events
    - asking a person to rate the resulting degree of suicidal thoughts to determine whether the coping strategy helped to decrease the suicidal thoughts and impulses

obtaining feedback from a person about their confidence about implementing these strategies in a future suicidal crisis
rehearse the use of coping skills in a future suicidal crisis by helping a person to:
describe (in the present tense) the sequence of events that may lead to a future suicidal crisis
identify the key thoughts, emotions, behaviours and circumstances that were most relevant to the suicidal crisis
describe possible coping strategies and adaptive responses to the key activating events
An ability to help a person identify the specific changes they have made in the course of the intervention and plan the ways they can make use of relevant coping strategies in the future
An ability to review current suicidal ideation in a person following the completion of the relapse prevention protocol, and to help them to use the safety plan to generate specific management strategies that they will implement following the session
An ability to help a person to identify potential setbacks following the end of the intervention and consider adaptive responses to potential negative automatic thoughts about these
An ability to make use of scheduled follow-up sessions, where appropriate, to assist a person in identifying automatic thoughts in response to the imagery exercise and help them to generate adaptive responses

Planning additional treatment

An ability to judge whether continuation of therapy is appropriate and to discuss with a person how this will be done, for example if therapy will continue:
with the same therapist, negotiating a new treatment contract so as to separate a focus on suicide from a new focus on long-standing issues
if with a new agency or therapist, supporting this transition by identifying how and when this will be done