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(Music plays)

RYAN BARTHOLOMEW:
Good morning! I'm Ryan Bartholomew postop thanks for being here we have another fantastic training lined up for you. Over the next few days you are going to go in-depth to one of our most in demand evidence-based therapies so you can bring it to your clinical practice using a wide range of clients. We have Caitlin here who's another one of my favorite PESI trainers and she always gets rave reviews when she teaches so we are looking forward to hearing from her.

Before begin just a few helpful reminders for you, if you have questions for Caitlin during the training, please go to www.pesi.com/DBT22 when you go to that site there's a place where you can type in your questions and submit and out through all three days Caitlin will have a special guest, me, to help answer your questions.

If you are looking for session materials, that's where you can find them where you launched into the session. Remember, if you have any questions about technical issues, CE credits or anything else, you can go to the FAQ tab in the portal is all because of good information there that can help you.

So let me kick this whole thing off with a quick introduction of Caitlin.

Katelyn Baxter-Musser is a licensed clinical social worker and is silent-- certified in dialectical therapy. She currently works in private practice were her areas of expertise include trauma, PTSD, depression anxiety, grief and relationship issues.

She incorporates DBT of her practice with adolescents and adults, and has facilitated DBT skills groups and used DBT individual therapy in private practice and works for several agencies. Her years of experience in these principles, have helped her class develop healthy coping skills, surpass traumas and to increase their ability to identify coping instructive emotions.

With that, Caitlin, I'm going to turn them over to you.

KATELYN BAXTER-MUSSER:
Alright, good morning. Thank you Ryan, I appreciate the introduction. Hello everybody, like Ryan said my name is Katelyn Baxter-Musser, I'm really excited to be here with you over the course of the next couple of days. We are just. . . we have so much information so we are going to dive in and get started.

If I can get my screen slides to move. There we go. I just wanted to give like a quick heads-up. There's a lot of material presented over the next three days over the course of the presentation. And so I ask is that we go to the material is that you are just aware of what your own professional standards, and boundaries include and that you use these materials such as practice in whatever your scope of service looks like.

Here is my information, if you need to reach me, if all of you all were to email me this week it would take me a minute to get back to everybody, so give me just a little bit of time, but I am in my office Monday through Wednesday, I do try to respond to everybody's emails when the email me any questions about DBT or about the presentation itself, and so just to give you a little bit more information on me, I have been working in the field for over 14 years, I am certified in DBT, as well as working with personality disorders as well. I am an EMDRIA consultant. So here I am in private practice, but I have been blessed over the course of my career to work at a lot of different places.

So I've worked on several Native American reservations, I've also worked for local agencies, both in Arizona and then in here in the state of Maine, and what I find and what I love about DBT is that I have been able to integrate the DBT skills into my work across the board. So I was actually introduced to DBT very early on in my clinical career. At my second internship when I was in graduate school and it was there that was exposed to all the skills that I really got to learn how DBT skills help clients.

Clients who are in crisis, clients that have experienced domestic violence, first responders, kid clients, adult clients, across the board, I find that you can take these DBT skills and then you can integrate them into your clinical work.

So I have found that DBT has really enhanced my clinical work I really hopeful that over the course of the next three days that you are able to find that as well.

So Ryan has given us a lot of the important information and there is just a couple of things that I'm going to run through. Just so that you know, I do do my best to make sure that I stick really on time with the presentations. With starting and ending, not just because you need the hours for CEOs, but also because I know specifically, during lunch breaks people try to schedule and see clients. So that being said, I am here on the East Coast, I will give you the central time for everything at the East Coast time, but if you are an in a different time zone than that, then just do the math.

We are going to break today for lunch at 11:50 AM and we will break until 1:00 PM central time. So that it is 12:50 PM to 2:00 PM sent Eastern time as we will follow that schedule for three days. We will end every day at 440 central which is 5:40 East Coast time and we will have two bricks in the afternoon. Sorry one break in the morning and one break in the afternoon.

So we will probably take our first morning break about 10:15 AM it's about a 15 minute break and that that's 11:15 AM East Coast time and then in the afternoon we will take a break about 2:45 PM central time.... So you will know when you can get up and stretch until your cup of coffee and if I am over that orbit like a minute or two right in the middle of some important information, then we will just wrap up

that information by will make sure that you get all of your time.

The only other thing that I wanted to mention is that when we start each morning, and when we are coming back from lunch, I do like to incorporate a mindfulness video, and these are about 3 to 5 minutes so if you hop on and you're running a couple of minutes late, just jump into the activity or practice your own mindfulness and over the course of this morning, we are going to talk a little bit more about mindfulness and why I incorporate this into the presentation.

So that's what you will know if you're coming back from lunch and there's all of a sudden a video on you will know it's happening.

So I know a lot of you are going to be moving forward with obtaining the DBT certification, I know when I did it just really enhanced my clinical career. And so here's the link so that you have it. I really found that it has been very beneficial and I really believe that you're going to find the same as well. I wanted you guys to have it right from the get-go as we start off this morning.

Alright. So the biggest question, as we dive into this material this morning, is generally why are we here? So what are we doing here? I kind of challenge you anyway to think for a second. So of all the various disorders that are in the DSM-V, what percentage of those disorders have some component of emotion dysregulation as part of the diagnostic criteria? So what percentage you all don't have to chime in and hit at the Q&A and after that, just kind of think to yourself, what would I guesstimate that that percentage would be disorders in the DSM-V that have some component of emotional dysregulation. The answer is about 75% mental health disorders in the DSM-V have some component of emotional dysregulation and the reason why I shared this is because if we know that 75% of the disorders that we might be seeing presenting in our own clinical practice have those components of emotional dysregulation, and at the end of the three days, trust me you will know if you don't already know, the DBT helps working with emotion dysregulation than what we know is that DBT can be very beneficial just across the board for so many of our clients.

So even if we are not currently working with somebody who has a diagnosis of borderline, and I think that that's really important to highlight, because even when I was first trained in DBT, early in my career, it was like oh this is what you use for borderline personality disorder, nobody, it took me a while but nobody actually sat me down and said, oh and, we can also use it for sexual trauma, we can use it for PTSD, we can also use it for depression and anxiety. And so, when I want to let you know is that DBT is highly effective in working with those clients who meet the diagnostic criteria for borderline personnel-- borderline personality disorder and also effective in working without a diagnosis as well.

So when we get to Friday, so the end of Friday, probably in the afternoon, I don't go through it specifically talk about diagnosis, but I do talk about how we can integrate DBT with specific populations and then, as we are going through each of the skills, I think you will start to understand, oh, this could be really help her for some of my clients, who are experiencing anxiety, for example. So we can talk about that.

So why are we here? First and foremost we want to learn and understand the theory, the rationale,

and where did DBT come from? How did Marshall --- we want to understand the various formats in which DBT can be offered to our clients. We will talk today and over the last -- next couple of days about using the approach and having DBT skills-based group. Other people may be familiar with those terms and other people may not. It's really important, and I appreciate what I go to trainings as well, that I can take what I've learned from the training and that is applicable to my practice in some way.

And so, we will start to talk about what DBT really looks like so that you can start to figure out how does this apply to my clinical practice, to what I'm doing? We are going to learn the components of DBT, and then like I said, we are going to figure out how can we integrate DPT into our own clinical work?

Alright. So what can you expect from the three days? Besides lots of fun, it is a lot of information, so don't get too overwhelmed, you have access to it for a little bit of time after, so you can go back and you can rewatch anything that you need to rewatch, but essentially over the course of the three days, what you can expect to leave with his understanding and learning what makes DBT DBT.

DBT is amazing because it is very practical, is very teachable, and it's very effective. And that's one of the reasons why I love DBT. So lots of commit you know you just don't have to be a Masters level clinician in order to be practicing DBT. When I was in the graduate program, when I was first trained in DBT but I'd worked with bachelors level students, I worked with case managers, nurses, psychiatrist, you know there's so many different people that are working with our client population, that can really benefit from these skills.

As we are learning about these skills over the course of the next three days, I'm actually going to challenge you to use and to practice some of the skills. And this is a really important piece with DBT. So when we actually practice the skills, it's just going to enhance how we present these skills to our clients, and how we integrate them into our own work. With our clients.

If we are not practicing the skills, and then the client comes in and they are really challenged with something, I do know they are really struggling, we might not really understand well why, this seems like such a skill, wisest client having issues integrating in this skill. We are actually parsing the skills ourselves, we can learn what the pitfalls are, with the struggles are, and those can really be teaching moments, that we can actually share with our clients most upward clinically appropriate and when they're helping to illustrate a point.

So for example, when I first was introduced to mindfulness, I was like what is this? I could not sit still for the life of me. There were so many thoughts in my head, all the time, and it was a really hard struggle. I am very much like a planner, a thinker, a type a person, a doer, as are to be able to sit and kind of quiet my mind and notice my thoughts was really tricky for me.

I have found that having that experience, because I started practicing mindfulness skills myself, was really healthy to be able to share with my clients and really validating. Because it's not just that we are going to teach a skill and that is going to click for a client. We are going to teach a skill and that client is good had to practice it and then they might struggle with it and that we have to help those clients

work through the struggles.

So in addition as we go through this, this presentation over the next three days, one of the things that I would encourage you to do, because trust me, I know I take (Indiscernible) to I know how easy it is to sit in a training at the new printer the PowerPoint or whatever and you put it in your file cabinet age don't think about it ever again and like six month later you likely as I took the training I should go back and look at that.

So we are going to the different modules, mindfulness, distillers, emotion regulation, which we will get into this afternoon and into tomorrow, just like star or highlight or make a note of this guilt that really jumps out at you, one that you're like yeah, this totally makes sense, I love this skill, this is going to be my new favorite Bible to tell you what to buy favorites as radical acceptance, but what I'd like you to do over the weekend and over the course of the three days, is to think about, how can I bring this skill into my clinical practice next week? So I certainly know we have this class that is we are going through our training we can sit back and we can identify and say, hey, this client would really benefit from this. So just make note of that and then challenge yourself to bring that into your session, or into your groups, or whatever the work is next week.

We will start with the foundations of DBT and develop an understanding of how to use DBT in our clinical practice, we will talk about what each of the DBT modules looks like, those foragers listed off, do not worry – you do not need to write them down you will have the memorized by the end of the three days.

We will talk about DBT skills, we will – on Friday, we will talk about suicidal behaviours, and a self harming behaviours, and like I said we will talk about using DBT with specific populations.

I give an overview. I cannot say I have tackled every single population in my presentation as the training has gone on, I have added more and more based upon the different attendees who have told me what they want to see, so to give you an overview of the various populations and how you can integrate DBT.

Then we'll talk about this very awesome component in DBT called the DBT consultation team and we will identify how you can form one in your own clinical practice, and one of the most important parts and think is the most important part of any presentation, we will talk about clinician burnout.

What does that look like and how can we combat that?

I should also mention that I really love resources. If you know me professionally, you know that about me. I'm always trying to look up resources. I love to share them with people and I recommend couple YouTube videos as we go to the next couple of days, but I wanted to highlight at the very end of your presentation, there is several slides with the different recommended readings that you can look at.

There is a lot of DBT material on the market. So, it is not an exhaustive list, it is one I found helpful or my clients have really helpful, and just because it is always asked in advance, I will share it now. I

believe it is the third day, the one I will go through in a second, when we are talking about DBT in our clinical practice I will share ideas on different apps you can use as well.

A lot of people like to figure out: how can I use different DBT apps to help facilitate my clinical work with clients?

Alright, so... that is what you can expect over the next three days. I hope you are really excited. It is going to be great. What we will start with this morning in true DBT fashion and go through and earning the different skills and how DBT is set up in practice, you will see why.

What we will do is start with a five-minute mindfulness activity. I have a video for you. What I invite you to do as we switch to the next slide is get into a comfortable position and allow yourself to explore this activity.

See how it works for you and you notice what some of your challenges are, and enjoying! My slide is not clicking over. Give me one second. It is not working. Here we go.

(Video plays)

SPEAKER:
A five-minute centering meditation. This quick and simple guided meditation is an easy exercise to help you centre yourself, and we gather your scattered energy and thoughts.

You can use it at any time, when you have been doing too much. Overthinking... and feeling emotionally out of bounds.

A soft chime will signal the end of this short exercise. Find a place and time where you will not be disturbed. It can be helpful to sit with bare feet on the floor.

But if this is too uncomfortable, or too cold, you may lay down.

Close your eyes and begin by breathing. Without stress. Until you settle into a natural pattern. And just listen to the soft sound of the wind. And breathe.

Focusing on the air passing in and out of your lungs.

...

Now, direct your awareness inward. To the area below your navel. And feel as if you are inhabiting that part of the body. This is the physical centre of the body. Known as the lower Dan Tian point.

Breathe into this area.

...

As you inhale, feel or imagine yourself pulling back all your scattered energies, those energies you need for yourself. And your own strength of mind. And body.

...

They are returning to you. Breathe normally, and naturally.

Let your mind just follow the rhythm of your breathing, without judgement.

...

(Chime)

KATELYN BAXTER-MUSSER:
Alright! Welcome back.

So, take a deep cleansing breath. If you are new to mindfulness, you might have had a similar experience. The first time I ever did mindfulness I was living in Scottsdale, Arizona and it was the homework for my graduate classes and I was lying on the floor in my living room and I remember thinking, "Oh my God, when will this be over? I have so much to do!" Wait a second, this is not the point of the activity."

If you just notice those thoughts and let them go welcome at this perfect timing. And what I like to do and what I've expressed this morning that mindfulness is a crucial aspect of DBT and elect to introduce it in different ways throughout the presentation.

If that mindless did not work for you, the next one might and it might not, it might be something different. There are some different ways we can incorporate mindfulness into our clinical work with clients. Quite frankly, also into our personal lives.

I will share a variety of different ones as we go to the next three days together of what that would look like and one of the questions I often get is: where do these mindfulness videos come from, or where can I get this information?

There are so many different resources online, I got a lot of videos from YouTube. This is from the honest guys based out of the UK and they are great and they have so much materials but are also scripts you can use.

The videos, when I'm doing a presentation like this, when I'm facilitating a DBT skills group and we are bringing in a mindless activity, oftentimes I find a script I can just read off of and share come and do the same thing in my individual sessions, as well. I use a combination of videos there, too.

Alright, I hope that helped invigorate you and centred you to the here and now for this morning with the

we will jump into the material.

What is DBT? DBT is a broad-based cognitive behavioural therapy treatment and it was originally developed for chronic suicidal people and people diagnosed with borderline personality disorder and the first population studied with DBT was women who met the criteria for borderline personality disorder, at a full program treatment of DBT, you will hear me talk about this – standard DBT over the next three days.

What that looks like is it has individual therapy, skills training in a group format, phone consultation, this is where when a client is struggling to generalize skills into their everyday life, they can reach out and talk to their clinician, they can get some places do three to five minutes, some places do five to 15 minutes, but you can get some support around generalizing those skills.

There is also this consultation team for the commission and we will talk a lot about the consultation team and the phone coaching on the third day.

And what's really great about DBT is it can be used with a variety of disorders including over and under control of emotions.

When we think about DBT and people who are really emotionally dysregulation, think of that outward expression of what emotion dysregulation looks like.

But when people are really over controlling their emotions, containing everything and holding everything in and not expressing a lot of emotions, having that over control of emotions is also a form of emotion dysregulation.

So, DBT is effective working with those plans, as well.

DBT is rooted in the development of mindfulness which is why mindfulness is so important. DBT, the mindfulness skill is really the foundational skill that all of the other skills are built off of.

And you will see as we go through the different modules, we start with mindfulness. We start with mindfulness because you need those skills in order to understand what the other skills are.

How to practice those other skills. We need to be practising mindfulness at the same time. That is why we start with mindfulness and it is so crucial to DBT.

So, it is also rooted in the emotion regulation skills. Adapting, interacting with people and the environment around them, and what we want clients to do is to be able to shift from using those maladaptive or impulsive behaviours and to instead learn how to integrate new skills that actually help them to modulate their emotions.

Regulate those emotions in an effective way. So they are able to express their needs and get their needs met, so they can do that in a crisis and this is what DBT is doing.

Why would I choose DBT and want to bring DBT into my clinical practice? DBT, I will say it and I will say it again, it is applicable across diverse settings and population.

I have used DBT with kids individually, I have used DBT with adolescents, I used to run a DBT skills group for adolescents when I worked on one of the reservations I worked on, I've done skills group for clients with trauma as well, there are so many different populations of people you can integrate DBT skills with. That's what makes it so beneficial.

There are a variety of different therapeutic interventions. DBT is not just all mindfulness. DBT is not just the four modules, DBT is also a chain analyses, DBT is also phone coaching, DBT is also the consultation team for the clinician.

DBT has a lot of therapeutic interventions that help support the client, as well as the clinician in this process. DBT is a really teachable and practical thing.

I already said, there are so many different DBT resources on the market. There is a lot of different workbooks. So, what I would recommend that you do, is it you find what works for you.

What translates for you in terms of understanding the skills in the material and also what works for your clients. I have a lot of different DBT books, I have a lot of books in my office and a lot of those are DBT books, and what I have done over the course of time is taking different skills and worksheets that I liked, the formatting and the ways the skills are explained, and across the board no matter what resource you are using, the worksheets are presented in a way that is teachable and practical it makes so much sense.

They are not oversimplified or complicated, or just right. I think that's what really works for clients. These are not skills that are super complicated, you do not have to over intellectualize everything, these are skills that are very practical and the client can take these skills and they can translate them right away into their everyday lives.

Like I said this morning it's available to all levels of conditions, if you're a nurse, case manager, if you are a teacher in a school, DBT skills are utterly effective at helping people when they are struggling with emotion dysregulation.

So I think one of the reasons why people are so drawn to DBT is because, you know, we can integrate it easily into our clinical work, it has benefits for our clients, and that we can see pretty quickly, and that it is also, you know, very teachable what we are doing that.

So the ultimate goal of DBT is to help increase resilience, and to build a life experienced is work living, through helping individuals change, behaviorally, emotionally, cognitively, and interpersonally, so changing all of those various patterns that cause problems in their everyday life. So what DVD does is that it really stresses the importance of learning a new set of skills that replace those skills that are our clients currently have that are not working for them and ultimately with the problem is is that those

skills are causing albums and how they function in everyday life. So the skills are aimed at teaching how to change what is, and also how to accept what is at the same time.

So we can't change if first we don't accept that change needs to happen. This is the DBT skill radical acceptance. When I used to lead support groups for men who had expense trauma, ISA talk about radical acceptance and I will never forget, you will learn by the end of the presentation, that is a very end, when I say goodbye as I was leaving intercession and to go to the Reds, one of the guys said to me you know Caitlin, when you die one day, you know what your gravestone is just going to say radically except and I just chuckled because he was like you know you love that skill come you talk about it all the time, and I do. I think Randall Cole acceptance can be very very changing, life-changing. Marshall in hand, for those of you that are like how do I accept something how do I just accept it? How do I do that that centrally difficult. We are going to talk more about radical acceptance of what it is, a little bit this morning or this afternoon, and also again only get to distress tolerance skills, but a really good analogy, one that I find works well in explaining radical acceptance to any of my clients, has been that you know if you're driving on the side of the road, and you get a flat tire, if you don't accept that your tire is flat, then you're not going to be able to change your tire. So, you can sit there and you can suffer on the side of the road, and I used to live in Arizona, in 90° weather or hundred and 20° weather or you can accept that the tire is flat and then you are actually able to change the tire and what happens when you do that, is that you start to relieve some of that suffering and some of what is keeping you sad.

So really offers this class this idea of this middle path, so this balance between emotional and rational well-being. So how do we reach that path? So we are going to, through the course of the next few days, when we are together, we'll talk about how each of these skills actually help get clients to that place where they are able to you know, build that life worth living. So, I really like a lot of visuals, and one of those people that finds the visuals artist very helpful, you know sticking in my head so I really like this idea of DBT being like a roadmap for clients. So, what happens is that when clients come into our office, they often command with what I call, a trauma backpack, it could be an anxiety backpack, it could be a depression backpack, but in this backpack, is all the stuff that they carry with them each day. So maybe all their trauma, all their negative life experiences, and in this backpack they have all of these really unhealthy coping skills, that they used to cope with all of the stuff that is stored in there.

So it could be help self harming behavior, it could be suicidal thoughts and behaviors, it could look like shame, and embarrassment. And so what happens is that each day of our clients lives, they carried his backpack everywhere they go, and they are constantly feeling the weight of this backpack, and what happens that with all that stuff that they are carrying, is that as they fill that happiness,-- feel that heaviness, they cannot take that backpack off so in an effort to deal with all of that, they are either not coping, or they are just using the usual coping skills. So when they are faced with challenges in their life, the user usual way of coping and even if they have a moment of brief relief, what ends up happening is that it brings back this continued misery and suffering so think for example, someone that's all terms they have a trigger they self harm, there's an experience of relief from that, and then, that feeling of shame or guilt's surface and they get triggered again. So this is what often brings clients here into our sessions, they don't actually really want to engage in these behaviors, people don't love living in a state of constant misery. But, with this backpack on the don't really have any other way to

live so this is how I view DBT and where I think DBT comes in. So what DBT does is that it teaches clients a new way of coping with whatever is in that backpack. So we help them learn in a practice skills and we encourage clients and we are going to challenge client as well. We are going to challenge them to use the skills even when things are really difficult.

So first we do, and again this highlights the importance of mindfulness, is that we teach client the skills of mindfulness. We teach clients how to be in this present moment. So when clients are faced with a challenge that they have in their lives, rather than just reacting to it, through the use of mindfulness, they are able to pause, they are able to go into awareness of what is coming up for them in this moment. And then without awareness, comes the ability to choose how to respond versus just reacting.

So for clients over time, they develop this new set of coping skills, so they are faced with a challenge, or distressing situation, something is triggered but they pause, they practice mindfulness and then mindfulness helps them to choose what skill, what new skill are they going to use? What means of coping can be used to respond to everything that is not backpack? In overtime what DBT really does is as we are replacing these maladaptive coping skills with new coping skills, the weight of that backpack starts to left, because we're not constantly adding to it. There's not all these triggers everyday, there's not discontinued suffering, because we really started to access these skills and use the skills you know in facing these data challenges that we have.

So clients are able to lighten up with this backpack doesn't shift and how they experience life and how they approach their everyday life, and rather than just participating in life, and responding to it, they are actually able to start to feel more confident, and they are participating with awareness. They are participating without reaction, but with conscious awareness about what is happening and what skills do I want to use and how do I get to that place where I'm actually being able to build a life worth living. What is that actually look like for me? We are going to define what a life worth living looks like in a couple of slides, because attic is really important for us to understand what are we helping clients build towards?

So this is the map that we are walking with clients so we are walking from this place of shifting from usual coping skills with continued misery, to this place where clients are able to build a life worth living through the development of the DBT skills. So through the use of mindfulness and coping skills as well.

So, another way that I really conceptualize DBT, so again for those of you that are little bit more visual like me but I think this does help out is kind of like a trace of the top of the tree, the ultimate goal is a life worth living in the trunk of that tree is the assumptions, principles and strategies that DBT is based off of.

And then under that, we and rooted everything that DVT is rooted in, as the skills developed. So this is the four core skill sets that really support a life of recovery for clients. Zero mindfulness skills, to discuss Trenton -- distress tolerance skills and your and personal effectiveness skills.

We are going to start with identifying what a life worth living looks like, and I think that you know this really helps us to understand what are we helping clients get to and I'm not just sure if any of you are ever familiar with this term before, it might be something new in my not. What happens is that clients show up to our office, right? And I don't know anybody that just like escapes into therapy other like hey Caitlin, I'm so excited to be here, that's not how that usually happens.

People are usually like I'm here, I'm suffering, some of my clients don't even necessarily want to be here, right? And I mean, they are just this is miserable, I've gone to 12 different therapist before, and nothing is ever going to get better, they are really hopeless, they really stuck, so our clients commend and they feel demoralized, oftentimes they feel confusion about themselves, and the world around them, a lot of our clients feel abandoned, they feel really useless, and empty, I just did 70 the other day that I was chatting with, and we were in a session they just looked at me and said, you know, I have two people, the people that the world sees and then I'm dead inside. Who I am inside is not at all who that person is that everybody else sees. I can turn it on but really I just feeling dead inside.

Really that chronic sense of emptiness. And a lot of our clients feel like they live on this intense roller coaster of emotions. And I think that is true for a lot of people who struggle with emotion dysregulation and certainly that is true as well, for clients who meet the criteria for board line personality disorder. And we'll talk about that in a couple of sites will so, why would we want to help clients build a life worth living question marks the first and foremost, it gives clients hope, so when we are working with clients, it gives clients an idea of what can something other than this look like?

What are my dreams? What my goals? For a lot of clients sometimes they've been stuck in this misery for so long that they have not even allowed themselves to think what those dreams and goals are for them.

So, when we are talking about clients with building a life worth living, it really helps you and your client to know, what to prioritize in your treatment. Carmack if clients commend, as often they do and they are struggling with multiple things at one time, you know it certainly can be a challenge, clinically, to say, well where are we going to start? I had this happened the other day, somebody came in for an intake and they were like, there's this, this and this, by the way I don't want to focus on this, and I'm like well where do we want to start? What does like I actually asked the client when you felt happiness? What are your goals in life, what is look like to have a life worth living? And that wasn't a thought a client had had in a really long time. But through identifying you know how can we get to this life worth living, client was able to say, here is actually where I need to focus. This is what is just consuming me every day of my life. So really helps us to get clear about goals and dreams that our clients have, and helps us to decide where we are going to focus our clinical treatment with clients, and, when we are practicing for the DBT model, what we want to be focusing on is the thoughts, the behaviors and the feelings that just interfere most with the clients ability to create a life worth living. It's good to be really hard to build a life worth living, if all of that stuff is getting in our way.

Another reason why we help clients you know build a life worth living is because it helps to keep clients going. Therapy is not always an easy process. I'm sure many of you are sitting there and you're like yes, sometimes it's just really difficult.

Is out when therapy gets really really rocky things are difficult, it can really be a challenge for clients to continue to show up to sessions. And it can challenge our patients, as clinicians as well. Because sometimes change and progress is much slower than we anticipated that it was going to be.

But also for our clients, that change is really super scary. People will often say to me, you know I don't know who I am without the self harming. I've self term since I was 14 years old. I don't even know what it would look like to have this cultural place that so that change can be really scary for clients. So when we have worked with clients to identify and to build a life worth living, then, clients are able to see what their goals are, were able to remind clients of their dreams, and that can help in a way as well to engage clients, and keep them moving forward, to ultimately what they are trying to reach.

Here we go. Sometimes my screen does not want to move for me.

So, how do we define a life worth living? As we are talking about a life worth living, I want to challenge you to think about what does a life worth living look like? Not just for clients, but how do you define them, as well?

It is important to practice the DBT skills. If you're not practising the skills and have not conceptualized what a life worth living has looked like, it might be hard to sit with clients who are struggling with this idea of building a life worth living.

What does it look like for us, and our clients? Interestingly enough, DBT has this – what is the word I'm looking for? Not stigma, there is this idea around DBT that DBT is a treatment that keeps people alive.

DBT is a treatment that stops people from killing themselves. (Unknown Name), which he says is, "DBT is not just about helping to keep you alive, DBT is at the core of helping clients to actually build a life worth living."

We are going beyond keeping you alive. One of the great things about DBT is that helps people to identify what are the challenges in their everyday life?

Is it interpersonal relationships? Is it they want to develop long-lasting relationships, but these relationships seem to just kind of blow up and get destroyed really quickly?

So, what we do is clients as we identify a life worth living, we identify what those struggles are. Maybe a client wants to have employment that they really love and enjoy. We are identifying that is their goal and how can we help you get there?

Clients are really only able to do this work through accepting the limitations, whether they are relationship imperfections, or emotional limitations, we have to first radically accept where we are at in order to move forward and change.

DBT, like I said, is based upon this notion that everybody actually has the capability within them,

believe it or not, have a life worth living full-time I'm sure you have sat with clients who have felt pretty hopeless and would disagree with you but what Marshall (Unknown Name) has says, "There might be constraints on what your life can look like, but there are no constraints on whether your life is worth living."

"There may be constraints on what your life can look like, but there are no constraints on with your life is worth living."

DBT is at the foundation of a way of escaping life of misery and learning new coping skills and being able to build a life worth living.

But I just want to be really honest with you and you are like, "This is my it and am bringing it into session next week," this will go great, it sounded so easy, living a life worth living is really super hard. Especially for clients who have been suffering with so much misery.

When I start to talk with clients and we start to explore how to build a life worth living, they are usually such beautiful sessions for clients.

Painful because people really recognize where they are at and that is part of this acceptance. Here is where I am. But really eye-opening and like, "Here is where I want to be."

Clients need to dream and imagine something other than the reality they are currently living in. This can be really scary and difficult for our clients to do.

A lot of clients might have grown up in an invalidating environment. In this invalidating environment, they were trying to survive and in that constant state of flight, fright, freeze, and this leads to clients mistrusting their own internal experiences and we will talk about invalidating environments later today.

When clients are in these invalidating environments, clients have received these messages whether directly or indirectly, what they were thinking, what they were feeling, what they wanted from life, those things are all wrong.

Let's fast-forward, the client is an adult, you are asking a client like, "Let's build a life worth living" clients might not trust themselves and feel like it safer them to have a dream or a goal for something that benefits them to be able to try to achieve something they want.

Clients are trying to make it day by day. For a lot of clients, it can be hard to sometimes look at this bigger picture and expand a little bit. There just every day trying to make it through. Living every day in that misery, or living in that suffering.

And also, it really requires a belief that change is possible. I find that it's hard for some of the clients and clients who have been in and out of therapy, in and out of therapy, and they just do – they feel like they are suffering and stuck in some way. And there is this idea of like, "This is who I am – it will always be this. Nothing will ever change in my life." Building a life worth living requires -- this belief that

change is possible.

This can help your client get to this idea. What are your goals for therapy? That's one of the best questions we can ask people. What are your goals for therapy?

This is helpful when somebody comes in and they give you all of this information and you in your head start to clinically conceptualize it and we can go here, here, here, and you ask their clients what their goals are and you can start where the client wanted to, and you can add your clinical two cents like, I'm noticing XYZ.

I will define what a life worth living looks like with client and what defines that, what would that look like for you?

And this is one of my favourite questions. I do not know why, I feel like Joy is such an underrated emotion. We are not talking about it enough.

But what brings you joy? So many of our clients have not felt joy and they are so scared to allow themselves to sit in that because it's like, "When is the next bad thing going to happen?"

That is a great way to move clients into this idea of what does a life worth living with like even if they have not experienced joy in a long time. If you ask a client that and they express that, you can validate that and be them with the client and acknowledge they have not felt joy for a really long time, but what would it look like if they did? What would be different about their life?

So, I have some questions here and ways you can work with clients to help clients get to this place and idea of reaching a life worth living.

Listing two goals you can set to help you reach a life worth living, what are three achievable steps that you can work towards to meeting your goal? I think this is really important because it super easy to be like, "Here is my goal." I cannot think of a good one off the top of my head, and that goal is this big.

If you and the client never identify what the steps are like, how is it going? And they are like, "That goal is going nowhere." Putting it into achievable steps, we are able to break it down so they are able to achieve that goal.

I like to do that work with clients because sometimes people will give me a step and that's really big and we need to have micro steps before that and it's good dialogue to have the client.

What are the behaviours, thoughts, or emotions that interfere with you achieving your goal? This will be key because it will help you as the clinician identified what are the skills this client is meeting?

It varies with the client that walks in the door, the reason I'm pointing this out here is if a client comes in and we are talking about a life worth living and identifying what are the things that get in the way of them achieving that goal, and they start to talk about relationships at home, relationships at work,

maybe not having friends or having a lot of unhealthy relationships they cannot and in their lifetime and that is a light bulb moment for me.

I will say, OK, we need to start with interpersonal effectiveness skills. It is hopeful to start with your mindfulness skills first, but we would start with our interpersonal effectiveness skills, or if a client comes in in constant state of crisis, and we are meeting on an individual setting and they are in individual student crisis, we need stabilization before moving on to some of that other work.

We need to list three transport that can help clients achieve a life worth living, and how will your life be different? That is important because it's easy for people to sit back and say, OK, people can sit back and say here is what my life worth living looks like and that is what the goal looks like, I want my clients to attach to that.

How is that going to feel for you when you are waking up every day and that is the life you are living? Usually clients are like, "That is going to feel amazing." How can we get there? It is good to help clients attach that on an emotional level as well so they know what they are working towards and how that will help them feel.

You can ask clients what their goals are for you can use the word priorities, whatever language works for your client, if clients are struggling, here is a list of some ideas and various areas that you can help clients focus on to identify.

You can do goals for each of these sections if you want to, Patterson, he has a DBT expanded skills book, and in his book he has a worksheet where there is space to work through each of these areas. With clients.

That's why I say, different manuals will contribute different things to your DBT work. This is specifically from Patterson. Some of these goals would be: what are your emotional health and mental health looking like? What are your goals for your mental and emotional health? Are there school and educational goals? Are there employment goals? Financial goals?

This causes somewhat stress. With the cost of living, I know where you are at, I have paid more money in my life than I ever have for a tank of gas.

Talking to clients about when we are goading that life worth living what do those financial goals look like for them? Relationships with friends and family, a lot of clients struggle with those.

Just as important is the relationship we have with ourselves. We will talk a little bit later about having and maintaining self-respect and validating ourselves versus invalidating ourselves.

What are our hobbies and interests? So often I hear people that have these hobbies and interests and they just are like, I cannot do that. I do not want to take time away from my kids on the weekend, or this barrier, or that barrier, and we can identify with clients: what are workable ways to go and to start to achieve and meet those hobbies and interests?

I talk about this on Friday, but I will share this now. One of my interests and hobbies is yoga and I definitely think that helps me live in a and building a life worth living.

I was at Panera bread with my good friends who is a clinician in the state of Maine and we are chatting and she's like, how is it going? Maybe need to destress a little and practising yoga. I have three little ones at home. I have no time for that. The babies are busy.

I do not have an extra hour in my day full I will never forget and she looks at me and calls me Arizona and she's like, "Arizona, is it not real yoga if you only do it for 15 minutes?

I remember sitting there and laughing and I'm like, you are right. I do not know why this has to be an hour to make this happen.

It is still yoga. That is me participated in an hobby and interest in the something that helps to fulfil me to maintain a life worth living and helps balance my stress.

When we are going to these goals that is a great example of an achievable – all goal somebody has put identifying achievable goals or helping clients figure out – (Static) when the sun is rising at 5 AM, I am not a morning person and that's never happening.

Figure out a different way to do it. Spirituality goals, as well. I do want to take a moment and although I believe it comes out later in the presentation, just in case I gloss over it, part of when we are teaching DBT skills with clients, there is a lot of different ways we can teach these skills.

Part of doing that is sharing like, it's OK to share some of our experiences with our clients. DBT allows for that. I want to stress the importance of it when we are illustrating up (Indiscernible) and sharing a personal story with the client, you need to ask yourself if it's about you or the client.

We do not go into super, super deep stuff but that example I shared with you and throughout the presentation are usually things I will share when I'm leading a group or individual session, but that example is an example I've used with clients and talking about how to build this goal, but how are we getting stuck? What is holding us back from that life worth living?

It's a simple example and easy example and does not delve too much into my personal information and used as a teaching point. I find when we are sharing pieces like that, those are really teachable moments for clients and it normalizes the humanity, and all of our lives.

It also helps people recognize we are humans as therapists and struggle sometimes, too. It validates clients in their own process of trying to move through and stumble sometimes through the skills. I will end up mentioning that again. I do think it is important to highlight as you are going through these three days and as you start to integrate DBT skills, think about those little teaching points that you can use.

I do not pretend to wake up every day when I'm teaching mindfulness and like, the first time I tried this, I was a guru and it fit. What am I doing laying on my floor here? And in facilitating a group and a chat with clients about that, and they're like, yeah! I felt the same way, too. And my thoughts were bombarding me. So stories are hopeful and beneficial in our clinical practice.

I want to share these life-changing moments. It's easy to go through these three days and not have anything to connect with so I really wish that I had like closing videos of some clients to share with you, maybe one day, if I get good at videography skills I will start to do that. I don't but I do have some quotes from clients about how DBT has impacted them and how DBT has changed their lives and I want to share these with you because I think these really communicate hopefulness and I also think that it helps us to see how helpful DBT skills are for clients.\So, one kind of mine usually said

(Reads)

So this really integrates or really stresses a really good point. It really stresses a good point with the DBT skills which is that, ever skill is not working, that doesn't mean that you are a failure. That doesn't mean that you are getting an F in DBT skills group, maybe we need to use our distress tolerant skills before we use our emotional relationship skills. Or even our stress tolerance goes before we set a boundary with somebody so there's different skills that we can use at different times.

So it's OK if the skills are not working, there's other skills that we can use. Another client said

(Reads)

That was just so beautiful and those sessions closed with those clients. And I'm in control of my life right now, versus my impulsivity and emotions controlling me. I am sure that you are sitting here thinking yes, I had someone in the caseload that had that exact same struggle, right? Their emotions run their everyday lives.

So for our clients to be able to have control over that, to be able to use that mindfulness skill, and really pause and consciously really choose how to respond, that is so powerful. And, another client said "My life is worth living, I owe that that to DBT, that was a highly suicidal client and lots of hopelessness and did lots of amazing work. So, I want to share a quick story... What my hope is for the youth at the end of the three days.

Early in my career when I was working and living in Arizona, I worked for an agency that specialized in working with victims of domestic violence and sexual assault and other forms of trauma. As so, I was an individual clinician and as well, I did a skills group and they also facilitated a support group over the time that I was there I did a men's only support group and a women's only support group and I had a client in my support group and this client was not a fan of me. Which is totally fine, that happens, we don't always drive and connect with everyone, they were just not a fan of me we are both like East Coast people, I don't know, maybe were both just little bit stubborn or something. So the way that the services worked there, the services were grant funded and were free so there was a waitlist. So, pretty

much whatever clinician opened up as a clinician that you got, if that timeframe worked for you. And so, it just so happened that this client who was really not a fan of me, I had a spot in my caseload open up, our case manager called, offered them the spot, they were not overjoyed, and the case manager told me about this later and just kind of gave me a heads up, the client had actually asked if they could see someone else, they did not want to work with me, and she was like, you know, it's going to be months, Caitlin has his opening, you can take it you can leave it but when you try it for a couple of sessions, and see how it goes, and then if ultimately decided doesn't work you can transfer. So OK, so the client and I started working together, and I deftly took some time to establish a therapeutic alliance and rapport, and over the time that we were together, which was for about two years, we did DBT and then when stabilization was reached, we actually integrated the NCR processing as well. And so, the client will be initially met, met the criteria for borderline personality disorder, and I will what I will let you know is that when we ended the meeting, this client did amazing work. Like amazing work so did DBT skills group, went to support group was doing individual work with me, DBT and trauma processing in MDR, and to commit when the client finally left our session, like the client stuck in it with me, we ended up having some amazing therapeutic relationship, they did so much amazing work, it was really them I was just blessed to be there. And they no longer met the criteria for borderline personality disorder. They had this whole new skill set that they were able to carry with them out into the world, and it had shifted every aspect of their life, like their emotions didn't run them, they were able to really acknowledge their emotions, and know what they were feeling, they were able to choose how they interacted in these interpersonal relationships, they were having family relationships, completely shifted right because they had boundaries. And they ended relationships that were distrustful.

It was probably one of the most beautiful like you have to list of top 10 amazing clinical moments and clinical situations, and that is on my list. It was just a really amazing process. So anyway, the point of the story is this.

The very last day of my session with a client I had no idea but this was back when Justin Timberlake sexy back was like the song of the century so the client actually, on her very last day, played Justin to black "Sexy back" Danced, danced, this is amazing, danced out my office door, down the hall, then out the door and it was like an atrium style, it was open as soon as he opened the door, on the second floor, danced all the way down, down the stairs and out to the parking lot, and, just danced away from session like from her last session playing sexy back and I will never ever forget that. So, I'll call those clinical successes, you might call them clinical successes I call them sexy back moments now, in honor of that amazing client the progress that they made and so what I hope for you over the course of the next three days, and as you start to integrate DBT into your clinical work, is that you have some of those sexy back moments, because even with the clients that are the most challenging, it is entirely possible, so, alright we are going to get into the foundation of DBT, but I just wanted to share that with you. And let you know my hope for you, as you continue your DBT work and after your done meeting.

So, we have a little bit to go until our first break,

We are going to talk now about where does DBT come from, how is DBT founded? And what is that look like? And this is really important for us to know when we are working with clients who struggle with emotions regulation, you know how does this come about and how does DBT help?

So I think most of us know that DBT was developed in the 1980s by Marshall Lenihan, she was at the University of Washington in Seattle. And so she was using CBT in order to help clients who were suicidal and self harming. And what she recognized was that CBT skills were just not enough to help his clients. So using her knowledge of CBT and then other forms of treatments, that were already developed, she really brought together this series of skills that were able to meet the needs of those clients that were highly suicidal.

And now today, it is one of the most clinically proven methods in therapy. And so, even expanding from what we knew in the 80s when this was really, 80s and 90s when this was very therapeutical and validated to use with DBT, what we know now is that anyone who is struggling with regular eating emotions, can really benefit from these DBT skills that are being taught. So I'm using these DBT skills with people of trauma history, people that have self esteem problems, people that have relationship issues, I'm using these skills all the time. Actually had, even yesterday, I do returning client come back it was our first session, and I have met with this client priestly, so our intake was a little bit different this time, of knowing the history, but we immediately were able to talk about radical acceptance is a skill, so you are really able to take a lot of these skills come and integrate them I think for probably most of the clients on your caseload.

So what Marshall Lenihan Newcomen when she was able to see in the work that she was doing, was that a purely behavioral perspective, people could learn new behaviors, people could change how they act and this would have a top-down effect, on actually altering their emotions, but what she recognized that suicidal people have tried to change their behaviors, over and over and over again. There was still feeling suicidal. And so, thus, the only way really to actually begin to facilitate change was to acknowledge that their behaviors, so those thoughts and those feelings and those urges made sense. Given the fact that this given their situation.

So I just want to say that again. So she really started to do is acknowledge that these behaviors made sense, given the situation, so given the amount of pain and suffering and misery that this person was experience and, so she brought together different skills from CBT, other modalities including mindfulness. Actually formulated DBT. And as you already know, radical acceptance is my favorite skill. So, this actually is one of my favorite quotes, this accurately represent what we know today to be radically acceptance or radical acceptance. So acceptance of life, as it is, not as it is supposed to be, and then the need to change despite that reality, and because of it. That is really that skill of radical acceptance post so, for those of you that don't know, many many years ago, Marshall Lenihan Exley talked about her own experiences in her own history she does have a memoir out, it came out I'm deftly recommended I think it's a great read, it came out I want to say maybe two years ago, life is a blur because of the COBIT -- COVID in the pandemic. And I believe is a Redbook I can picture it, I think is at my house. But it's called building a life worth living, I think that's the exact title.

I should have it on the resource page but you'll be able to find it on Amazon. So she talks about her own expenses and so commit years ago she cannot and she talked about how around the age of 17, she actually entered into a clinic with cuts all over her body, she has cigarette burns, she was actually kept in a seclusion room for a while because she had these never ending urges that she was going to

hurt herself, she was going to die.

At the time, borderline personality disorder actually wasn't even a diagnosis. And so she was actually diagnosed with skits for Enya, she was heavily medicated, I think like a lot of people in those situations, she was treated with ECT, she was in the hospital for a little over two years.

So flash boarded 1967 she had this epiphany while she was praying that actually led to her going to graduate school. When she was in graduate school that she got to started to do clinical work and then really the foundation of DBT began.

So several years ago, she came out and she talked about how her own experiences and her own, you know, diagnosis of borderline personality disorder and she says, you know honestly I didn't realize at the time I was dealing with myself, but I suppose it is true that I developed a therapy for all the things that I needed for so many years, and never got.

And where I think that this is really powerful and the reason that I share this with you. So many of my clients that meet the criteria for borderline personality disorder really feel really helpless about that diagnosis. So I will likely share with clients this about Marshall and Lenihan for them to see that there is somebody who has those same experiences as them, and here's this person and here is what their life looks like now. Here's what they were able to do and here's how they practice the skills. That for so many clients is often that they can really attach to and really provides hope because they've had so many people walk in the door and is like say to me tell me how you know that this is whatever the therapeutic modality is Tommy how you know that's going to work for me. And it's not often that we get to sit back and say well the person that developed also really met all this criteria so this didn't just have straight from an individual – my intellectual perspective this came from felt re-perspective about what was going on with that person. So I think that is really inspiring for clients to

Alright. So, it's important to touch base a little bit on borderline personality disorder. I'm not going to give us the whole like DSM review here, I'll just highlight the criteria and will talk a little bit about all of them, but DPT was originally developed for people with borderline personality disorder so I do feel and do no actually I should say, that some of us that are in this presentation today, might solely work with clients that meet the criteria for Berlin personality disorder so I think it's really important for us to review that as well as I know in my own clinical practice, I see clients who have borderline personality disorder as well. So again, DBT can be used with borderline personality disorder and with clients that don't meet that criteria.

The term, borderline was developed with the creation of the DSM three so that was in the late 1970s, but it was really meant at the time, to describe clients who were on the border commit between psychotic and neurotic disorders. So there's this kind of catchall term for those clients. And over time this actually isn't or really doesn't click or make sense anymore but I will say is that over time, there has been a push a little bit in the field commit actually try and get the name of borderline personality disorder changed, to kinda shift how we identify the symptom cluster so that for example, one suggestion has been emotionally unstable personality disorder. And part of the reason why I think that there has been this push for this, part of the reason why I would say a lot of our clients come in and

they just feel so hopeless when they had this diagnosis, is that there's often really this stigma attached to borderline personality disorder, and what it actually means to have borderline personality disorder.

I've deftly found that I often find that sometimes it is a little bit overused and diagnosed, and that had just been my personal experience. We are good to talk in a couple of slides about how DBT overlaps with other mental health diagnosis, like PTSD, and even what looks more like of a complex PTSD and so I think sometimes when people walk in, and clients are really emotionally dis-regulated, or there is somebody who's in crisis often on, it can sometimes get lumped into this personality disorder agnosia so it's really important, because of the weights that the diagnosis carries with it, it would really making sure that we are doing a really sound clinical assessment of people, prior to just putting this label on it.

I will say my least favourite thing right now is diagnosing based on social media. I have clients come in and will be like, "I just saw this video and I totally have this personality disorder." I'm like, or did you see that video? And they will list one of the streaming services or social media services.

I am like (Laughs) Show me the video. Clients will show me and there will be clinical information missing. Let's be mindful when we are looking at our diagnoses and making sure we are doing a thorough, thorough assessment.

Do not get me wrong, there are some great videos out there as well, but I found there is a self diagnosing trend that frightens me a little bit in my field.

The other thing I will say about borderline personality disorder and this happened to me a few months ago and I think this is something that reinforces the stigma, I was in conversation with a friend of mine and somebody who is not in the mental health field.

They were talking about somebody else and they were like, "She is so borderline." I was a bit taken back. I stood there and went to the criteria of BPD in my head and I was like, "She is not. She is an emotional person, but not borderline."

I think sometimes this diagnoses can become this catchall term to describe people. Not even people in our field that are continuing the stigma associated with BPD, it is people outside of our field and it becomes this term to describe people who are more emotionally intense or are struggling, so, I just want to say the overall point here is just to be cautious when we are diagnosing any personality disorder.

It is definitely something that sticks with people and they carry with them. Throughout their time in therapy services. And to share a really quick story with you, I had a client who actually really experienced this stigma of BPD happen and I was in private practice, and this person called me.

I did my intakes, my screening before, and made sure I was a good clinical fit and the person came in and during the intake we were talking and I asked if they had any previous mental health treatment and what was working and the person has said, "I was diagnosed with borderline personality disorder."

And I was like, that did not come up in our initial conversation. I mentioned it to the person and they said, "I had called a bunch of therapists in private practice and left voicemails, and all of those voicemails I mentioned I had BPD and nobody called me back." I thought it was borderline personality disorder and I decided not to tell you. I was like, "OK, noted."

I'm not necessarily saying it was not false, but there is the stigma of working with people with borderline personality disorder and what that means. We need to be cautious and we do not want to continue that stigma, as well.

It turned out the person did not meet the criteria for BPD. That specific client, it was more of a PTSD, complex PTSD case. I'm not quite sure what happened at the previous agency there were at.

They were at an agency where you needed a diagnosis of BPD to get into a specific skills group. I do not know if that is what happened. If the diagnosis kind of fit and we put them there so the person could get skills. I'm not quite sure.

No judgement. We are doing the best we can when we are making these clinical judgements and assessments. There is no judgement there. In case you are wondering about that client.

Another stigma I have actually seen that I have experienced first-hand in the field is this idea that men do not have BPD.

A long time ago when I was doing crisis work, I was doing these overnight crisis calls and went to a call for a male client who met the criteria for borderline personality disorder and have the diagnoses and when I came back the next day to work and I was staffing with my supervisor, my supervisor's response to me at the time was, "That'll be the only male you will ever see in your career with BPD." That's it! I was thinking to myself like, I'm really young right now! I have a long way to go. There is nowhere that can be the only person I will see with BPD that is male.

I think there is a stigma that men do not have BPD. I have found that again, that is not something that is true, but one of the stigmas that are attached is very, very rare. It is diagnosed more in females than males but it's one of those stigmas to think about that are present. That we are up against working with BPD.

OK. My slides are not... my slides are not moving! I guess we will talk about borderline personality disorder all day. Here we go.

Sorry, guys. This is why I'm a therapist and not somebody who does tech. Here we go. There you go, I got it.

OK, thank you for your patience with that. Computers give me a little bit of anxiety.

So, what is borderline personality disorder? Borderline personality disorder is a pervasive pattern of

instability in interpersonal relationships, self image and effect. It is marked by impulsivity beginning early adulthood and present in a variety of contexts and indicated by five or more of the following: five or more of these.

Here is the criteria. I will read them out loud and we will go back and go through them. Fear of abandonment, unstable relationships, unclear or shifting self image, impulsive, self-destructive behaviours, self-harm, as well, extreme emotional swings, chronic feelings of emptiness, explosive anger, and feeling suspicious or out of touch with reality.

In order for someone to meet the criteria of borderline personality disorder they need to meet five out of these nine. The fear of abandonment – let's talk about that.

People with BPD are often really terrified of being abandoned or left alone. What happens is these triggers of abandonment whether they are real or imagined really trigger this very intense emotional response.

So, what we see in our client is they will cling to these relationships and they will beg and start fights with their partner, they might track the partners movements, they might physically block a person from trying to leave the room because they cannot tolerate that feeling of abandonment.

What happens is this has the opposite effect. This pull to get this other person in actually really pushes the other person further away.

Unstable relationships, people with borderline personality disorder tend to have relationships that are really intense and short-lived. I view it like this tornado for a lot of clients. They tornado into these relationships and tornado out of them, and they tornado in and they tornado out is huge and a really big tornado because a lot has happened to make this person go from loving this person quickly to feeling completely disappointed, and this person is the worst person in the world and they never want to speak with them again or see them again.

There is no middle ground in these relationships. A person is either all good or all bad. They are either perfect for them or horrible and the worst person in the world. There is no middle ground.

There is an unclear or shifting self-image. What this means is clients that have a borderline personality disorder typically have this unstable sense of self, and sometimes they might feel really great about themselves and often times are stuck in self-loathing and hatred. They do not necessarily have an idea of who they are or what they want in life.

Now you can see by building a life worth living would be so helpful for these clients to give them an idea of where they want to go, and what does the future look like?

Impulsive and self-destructive behaviours. This and the self-harm, and suicidal behaviours are a part of the big highlights that most people know come with the right here of meeting a diagnosis for BPD.

These impulsive and self-destructive behaviours is any sort of behaviour that somebody engages in that is harmful, these can be sensation seeking behaviours, this part right here we will talk about does not necessarily include a self-harm.

This is gambling, spending money on somebody cannot afford to spend, driving recklessly, shoplifting, I've worked with clients to engage in really risky sexual behaviours, substance use, as well.

These are risk behaviours that make clients feel really good in the moment but ultimately the experience hurt. That roadmap I showed you this morning they have a challenge with her usual way of coping, brief relief and continued misery.

We are very familiar as clinicians with self-harm and suicidality and deliberate self-harm is a very common in many people who meet the criteria for BPD, as well as thinking about suicide, making suicidal gestures or threats, and actually carrying out suicide attempts.

We will talk about suicidality and self-harm on the last day. I do want to specify self-harm is not just cutting, self-harm is any act you are actually hurting yourself whether it is banging your head against the wall, burning yourself with cigarettes, hurting yourself in some sort of physical way.

And then extreme emotional swings. These are unstable emotions, moods that people have, one moment I should say somebody feels really happy and the next moment they are completely miserable.

These little things that you or I might be able to brush off our shoulders and move on with, these can trigger an intense emotional response and that is where that person goes into this tornado of emotions or a tailspin, if you will.

These mood swings are very intense, but they tend to pass very quickly. They might last a few minutes or a few hours, this is not something that usually lasts several days, you would see with the diagnosis of bipolar disorder.

That is important to note because we will talk in a couple of slides of some of the disorders that can look very similar. These are the tedious little criteria that we need to tease out.

And chronic feelings of emptiness. People who meet the criteria for BPT often talk about feeling extremely empty. As if there is some sort of hole or void inside of them. They may feel like they are nothing or nobody, they may feel complete worthless, and ultimately, nothing is satisfied.

People are in these relationships and get in and they love this person really intensely and it's all really quick, and something starts to go wrong in the relationship and their chronic feelings of emptiness because nothing is really satisfied get triggered, the relationships ends in turmoil and they get into another relationship. They are looking to fill that void and it could be with food, sex, true intimate relationships, as well.

And explosive anger. People who meet the criteria for BPD might struggle with having short fuse, they cannot control themselves, they might yell or throw things, they become completely consumed by their anger. It is a quick response.

And feeling suspicious or out of touch with reality. People with BPD often struggle with a sense of paranoia, or suspicious thoughts about other people's motives.

People with BPD may experience dissociation. When they are in these moments of high stress they lose touch with reality and have that really foggy feeling or feeling of as though they are outside of their body.

So, for those clients that have and meet the criteria for borderline personality disorder, they often come in and like I said before, they feel like they are living in and on this roller coaster.

Some of the statements you might hear clients say that help you recognize a client is or may be struggling with BPD would be that, "I often feel empty, my emotions shift really quickly, my relationships are really intense but they end really quickly or they feel very unstable." You will often hear people talk about the self-harm, or suicidality, as well.

(Unknown Name) talks about people who meet the criteria for borderline personality disorder. That it is like living in a world where you are just covered in third-degree burns all over your body. It is a really raw, continually raw experience for those clients.

Just imagine what that would feel like. Everything hurts, everything is painful. And that's what it feels like for a lot of our clients. So the struggle for someone with this disorder is that they have problems containing relationships yet tend to be really social they actually create great relationships and they cannot tolerate being alone.

And so what we often see in our offices or these printed behaviors to try and avoid abandonment which actually leads to an increase in anxiety, and intense emotional mood swings, chronic suicidality, as well as self harming behaviors.

Is a really great book, sore and looking over here because I want to get the title of it, I believe I have it on the resource page, it is called "Clinical assessment and diagnosis and social work practice" By Corcoran and Walsh and has a blue cover. But their citation is here on the slide. They have a really great questionnaire and there, that you could look at that helps in assessing for borderline personality disorder so it doesn't have every single diagnosis in the DSM but it has a great summary of PPE and has a great list of questions. . . so what is happening just for those that like to hear about what is happening internally for clients to, what's happening on a physiological level, so we know that our amygdala governs our emotions, this helps us focus on getting our basic needs met, so security, and survivor, we have our free prefrontal cortex and that is online to help us with these higher-level issues. But in some situations, the amygdala just doesn't can indicate well but the front of our brain. At that part of our brain is a part of our brain that determines how we are able to respond.

So what's happening is that for these clients that have really pervasive emotional write dysregulation and borderline personality disorder is actually respond with a higher level of emotional intensity and the front of their brain cannot go and reduce that emotional intensity in these moments.

So it's like your amygdala is back here you got your prefrontal cortex appear and it's a one-way road. So your amygdala is saying, I need to respond on a 0 to 10 scale of my emotional, I need to be at a 10, your prefrontal cortex, even though it's like trying to assess the situation camera this looks like a three, I don't need to be at a 10 I need to be at a three, it's a one-way street so your prefrontal cortex cannot go back and commit to Kate that to your amygdala, and that flight/fight freeze system is activated and you are already responding in that level of emotional intensity.

I like the visual of the one-way road that has been very helpful at talking about their responding with this high level of emotional intensity.

People with Borden -- waterline personality disorder is really good at reading the emotions of others what happens is that they tend to misread neutral faces, as anger, or criticism for example, and then they respond to those nonverbal messages. So if you don't already know this, which I'm sure you already do, we are communicating with one another and we have a series, I'm telling you maybe I'm standing like this, my arms are crossed and I'm like looking over the side and I'm like got a little but of attitude, but I'm telling you, know everything is fine we are totally fine I'm not at you at all. We're good. Are you really going to believe what I'm saying? No you're not going to believe that you're going to believe all of my nonverbal cues.

So what happens is that people with borderline personality disorder, they respond to those nonverbal messages and like any of us would, in those nonverbal messages can trigger an intense emotional reaction.

So in that situation, that would be valid because the person is committed getting to you nonverbally is accurate. They are actually upset with you.

But with people with borderline personality disorder they are misreading cues so when you have a neutral phase that isn't like coming in oh, it's like fine OK, and you generally need that, they might interpret that as anger or criticism.

So I think it's just really important for us to know and I will share a quick example with you about how interpretation looks like and the awareness that we need to have with clinicians. This does not involve a client that met the criteria for Berlin personality disorder and a client that had a trauma history, a severe trauma history, it was a male client and I was in a session one day, and the client shared some information with me, and the client communal, share this really intense and very powerful story this was not my first rodeo with trauma, but it was like really hard story to hear. And the client said you're the first person I've ever told us to, I never share this experience with anybody, and even looking back at it now, I know how difficult it was for the client to share.

But I will be really super honest with you, I was sitting in the session, just trying not to vomit. And the

story that the client was sharing was very difficult for me to hear, as a woman, and I'm not going to go into super specifics but it would all make sense, it was very difficult to hear, and I was like literally just trying not to vomit.

So I sat there in the session, I really thought that I was doing such a great job, I was doing a terrible job I sat there in the session and I would just like you know looking at the client, I do very neutral face on, I was literally just trying not to open my mouth, and I was trying to do my best so I left that session and I was like, oh my, I went to my supervisor, I did some clinical Constitution rounded because it was like hey I just listened to a really difficult trauma story and it just really resonating with me. So I processed it with my clinician sorry not my clinician with my coordinator, and that we talked about how the session went, and you know I was like yeah, I really did not give a ton of feedback to the client and I didn't feel so great about it.

So the next week the client came in and the class identity no Caitlin, magister spec this client so much for being able to say this, I told you something that was so traumatic, something that I've never shared with anybody else, and all you did was just sit there. Like that's all you did.

And I was like, I just owned it I said yeah, that's it all I did and can I just be really honest with you and the clay was like ask about I said to the client that was a really difficult story for me to hear, as a female, I said and quite honestly, I was just trying to not to vomit. I wasn't really trying, I don't often have the physiological response in a session, I wasn't trying to look as though I wasn't believing in you, or I wasn't offering you validation this is what was going on in my brain and actually it was just this really beatable and powerful clinical moment because the client would experience that trauma felt like my emotional and my physiological response was so validating. It was such a grotesque situation, that they were like That actually hearing that it triggered something in me that validated that experience that was actually a grotesque situation.

So not exactly working with someone with BPT but really recognizing that our clients are really noticing our nonverbal communication combats we just need to be aware of that as therapist. So we are going to talk a little bit about this afternoon about validation looks like and what it does look like and how we can integrate that into our session. I think it supported to share these stories with you because even as I sit here with you and I train on BPT, I had these clinical fumbles, right question mark in my moments with clients we all have them. And their great expanses as we continue to grow as clinicians.

Women with borderline personality disorder is more likely to present with comorbid disorders. And men are more likely to present with comorbid substance use disorders. Other disorders that we often see presenting would be mood disorders, most common being bipolar disorder, we also see anxiety, most common being panic disorder and then substance use disorders as well.

Just give me some general statistics, even of the term borderline is thrown around like we could just describe any person walking to the store that makes us frustrated, as borderline. 1.2 per 6% of the general population are actually affected. So this looks like 10% of those clients who seek outpatient services, 20% of those patients seek out inpatient services and 10% of those who meet this criteria do commit suicide.

So we will talk on day three about how do we work with this population, how do we also work with suicidality because we are going to be presented with that and working with that.

People with borderline personality disorder, as a suicide rate that's 15 times harder sorry 50 times higher than the general population so that it's really important when you're working with those clients as well.

So I did want to share two different graphics that I have just found to be so helpful in my clinical practice, the citations so you can read here as well, so, there is I think some of what our struggle is sometimes diagnosed bird line personality disorder is is overlap that it has with other diagnoses. So here we can see this idea of I know complex PTSD was like tossed into the ring for the DSM-V, and we talk a lot about it so it's important to really mention to it should say. So this overlap between PTSD, complex PTSD and borderline personality disorder. So the client that actually did not meet the criteria for board line personality disorder, they more met the criteria for complex PTSD, that was more that presentation.. . . So PTSD, in case you are not familiar with working at quick summary is just experiencing something that is a life-threatening problem, with the experiencing problems with trying to avoid either memories or triggers of memories come experiencing a sense of threat, a hypervigilant site-- state, there's a vulnerability to startle as well.

And then we have those borderline personality disorder sometimes so this, like I've said, is suicidal gestures and behaviors, threats, deliver self harm, and really what this is is that is people's response to this severe and pervasive emotion dysregulation.

The sense of feeling really out of control. So, borderline personality disorder is a personality disorder and there are two main criteria that are really important here.

So the relationship functioning and the sense of self, so people with borderline personality disorder often have these problems in relationships, this idea that they become very unstable quickly, is very quick forcibly to become all good or all bad. And then there's this frantic sense of abandonment. And others that not that stable sense of self and identity that we talked a bit as well.

's overlapping, when you have this other presentation of complex PTSD, these symptoms have to do with emotional regulation problems, and also, a sense of badness so those are there's that personality disorder symptoms, so these people often struggle with emotion dysregulation as well.

So if you're like me in your private practice and you take insurance or you're working in an agency and you're taking insurance, you have to diagnose, that is that how cookie crumbles, and so I just it's important when your diagnosis, we are just cautious a little bit about it and we are looking at at this full-spectrum of symptoms, but you can see the overlap here.

So it's easy to get lost and what is the most accurate diagnosis. This is where the clinical supervision is really great there as well to kind of staff with others.

This is another way expanded diagram but this actually shows this kind of overlap between different symptoms, and I thought it was really interested and important for us to come again, see there are so many of the symptom medical relapse of here we have the PTSD core symptoms, we have the complex PTSD or disorders of extreme stress, not otherwise specified, that is in that bigger circle right there in the medial-- middle, as well as major depressive disorder.

You can see where everything starts to line up, in all these different order for lapse this affect a gross regulation, this this functional impairment, very consistent with BPD... To give us this idea of their Sony Center medical relapse.

And on that cluster of personality disorders, most of that time when I'm working with clinicians and were talking about diagnosis of personality disorder, is pretty easy to differentiate commit like narcissism versus antisocial behaving where I see people sometimes get a little bit like stock from which one is it is that both are there traits of both? What is happening here? Is that borderline personality diagnosis with a history on personality diagnosis. So just to give you a quick review.

Antisocial personality disorder people lack remorse and empathy and there's an inability to maintain attachments. We have narcissistic personality disorder which is the exaggerated thoughts of self-importance and self absorption, we have BPD which we have discussed about and impulsivity and instability in interpersonal relationships and self image and emotion dysregulation, with histrionic personality disorder which is excessive emotionality and attention seeking behaviors. So I think that attention seeking behaviors like that is sometimes what throws people off with the clinical presentation. But like I said, it could be one, it could be both, it could be BPD with trace of histrionic personality disorder as well, so there's just when we are thinking about conceptualizing diagnosis, these are some of the diagnosis that I found the people kind of get hurt up around. The other one is bipolar versus borderline.

One of the main differences you can see is those extreme emotional, intense emotional shifts and mood swings that happen for borderline personality disorder, those last longer than people who have bipolar disorder.

That can be one of the key features. I had an argument with an inpatient psychiatrist, and I had worked with the client for a long time and really felt like the client met the criteria for bipolar disorder.

And the client was in a state of crisis, inpatient, and met with the psychiatrist for the clients report for like 25 minutes, the psychiatrist did this assessment and the psychiatrist was like, "You have borderline personality disorder." And they said, "That is not what my clinician thinks." We have been trying to get them a psychiatrist anyways. We have been looking at a bipolar tag diagnosis. And they said, it's borderline.

Yes, the client was in a state of crisis and the psychiatrist was seeing them in this moment, and is the biggest things was that depressed mood state and feeling of emptiness and hopelessness, that had been a really expanded amount of time and it was not these quick shifts that were happening.

I do find this one can be really tricky for people to tease apart. I will not go through all of the symptoms but on the bipolar spectrum, have depressive symptoms like having a depressed mood, insomnia, hypersomnia, suicidal ideation switch we see in the borderline personality diagnosis, as well, one of the issues my client was having is my client had not slept in days upon days.

Those manic and hypomanic symptoms kicked in, a lot of energy, there is high risk taking behaviours, pressured speech and this flight of ideas.

In borderline spectrum we see that excessive self-criticism, those chronic feelings of emptiness, and those suicidal gestures and behaviours at high risk taking behaviours and we see that impulsivity, and that pervasive shame. It can be difficult to tease that apart.

It is about making sure that we do comprehensive assessments. And I'm always cautious when I'm diagnosing anything in general, but personality disorders as well.

So, (Unknown Name) has this emotional reaction cycle talking about this shift that the intense ability, this quick ability to shift that somebody who meets the criteria for borderline personality disorder has.

So, we will walk through this and other is a diagram that shows it as well. Just so you understand what's happening for your client, the client has a minute where everything seems fine and the next minute going well and the next minute something has happened.

It could be something internal or something that is actually external, often, not all the time it is probably something that seemingly seems like a small issue or is not a big deal.

For the person with BPD, this actually is a really big deal. It has triggered something in them like this hurt or rejection or shame. You have this painful event that leads to this intense emotional response, and others resist.

The people they are surmounted with our like, wait a minute. This is not a big deal. And they think what they are doing is helping the person by letting them know to not worry about this, do not stress, no big deal. This is not a big deal.

But what ends up happening is they are actually invalidating that emotional response that the person with BPD has. What happens when they feel invalidated is the emotional response escalates.

The key and the trick here is if the person, the secondary person here in this example steps three here. If they stopped and validated that person's BPD, yeah, that must feel like a really big deal for you. Whatever that validation might look like.

Somebody agreed with them and the cycle would stop and the person would be able to calm down. That resistance they feel where somebody is like, it is no big deal, do not worry about it. It triggers a fear of abandonment.

What happens is the client we are staying with BPD, there all or nothing kicks in and they become very black or white and the idea that the person they are in the situation engaged with can have both negative and positive qualities and goes out the window, the person is all negative, or all positive. They are all bad or all good.

And ultimately the relationship is doomed. That is how clients feel in the moments that the relationship is doomed. The survival mechanism is activated, that response kicks in, and here is where we start to see some threatening statements even of suicide and of self-harm.

The next step in this process and the cycle is that the other people in this situation become really confused. The person on the receiving end of this is caught little bit off guard.

Whether they fight back, or whether they tell the other person they are overreacting, or even if they withdraw, they are further reinforcing these fears that have been ignited and there is this intense emotional response coming from that person.

The person with BPD feels even more validated in their emotional response.

And removed that self-harm and dissociation phase. Fully believing here that the relationship is over and fully doomed and the feelings of abandonment are quickly activated. Now our clients are overwhelmed by these really intense feelings.

For many of our clients, what do they turn to when they are really overwhelmed? They turned to self harming behaviours. They might cut themselves, they might burn themselves, or engage in these high risk-taking behaviours or go out and drive really fast and go out drinking, or spend all their money, and what happens is at this point, this behaviour actually provides that momentary relief.

But really, it is just a form of self protection. It is a self defence mechanism to detach from others, and even from themselves. And then this leads eventually to another painful response.

Now after I'm done self harming and I have that brief sense of relief, what bubbles backup? My embarrassment, my shame, my guilt over self harming, and what state does that put the client in at that point? In a state of misery.

Let me show that to you... here is an actual example of it. In a different way. The painful emotional response, others resist, fears are ignited, others become confused and the self harming and dissociation and the cycle continues.

I think this is super important and helpful because when you look at the behaviours and you can centralize it like the cycle you will wonder why clients are so stuck, they do not have the skills to get them out of the cycle.

DBT gives the client the skills to stop this cycle from happening. I have shared a lot about stigma around borderline personality disorder and to wrap it up before we move on to the goals and concepts

of DBT, but I would say is it is important when diagnosing a personality disorder because that diagnosis can follow a client for a really long time.

Unfortunately, I definitely have seen it impact treatment that clients get or providers do not want to work with somebody because they might have that diagnosis, we all have clinical limits. Just something to think about.

What you want to do is we want to remember that personality disorders really represent an ingrained pattern of interacting with others. When something comes into our office and is what I find to be really helpful in my work, I am not just looking at what is the current situation, that is happening for the client.

Obviously, I'm looking at that as well. I'm looking beyond the presenting issue and look into a clients interpersonal history. If a client does meet the criteria for BPD, you are going to see these patterns that are playing out in your current session have been playing out over the course of the client lifetime.

They have many examples of these really self-destructive behaviours, or in stable relationships. That is why I think we are diagnosing for BPD, that is one of the things that helps us. Has that pattern been there and been pervasive over the course of this person's lifetime? For some clients, it has not been. If that is your only interaction with them, there might be flavors of a potential personality disorder and I shift to PTSD, and other of those complex PTSD, for example, but diagnosis of posttraumatic stress disorder and those trauma related diagnoses at that point.

So, we have a couple more minutes before we will head out to our first break. We will shift before break to talk about the general concepts, and ideas of DBT.

So, what is really important to gain from the slide right here... as a DBT therapist, we need to be working really hard, as a DBT therapist we need to be working pretty hard to understand the world our client comes from.

We will talk about the levels of validation and how we can do that. We need to be validating our clients and acknowledging our clients. We need to acknowledge their feelings, thoughts, and behaviours, and acknowledge these behaviours make sense given the current situation.

That is what we talked about this morning when Marshall (Unknown Name) was developing Dialectical Behavior Therapy is this idea that behaviours make sense given the situation and we need to accept that.

Even if it is scary to do with clients who are actively suicidal, we need to accept that in order to make change.

The focus of DBT is on the need to learn skills to replace behaviours that do not work. We will talk about over the course of the next couple of days what those goals are.

We need to address the problems that cause difficulties in how we function in life. We will have an accepting, nonjudgmental and validating approach to our clients. DBT skills take a really eclectic approach.

You might find as you are going through the DBT skills, this seems familiar. Maybe you have been exposed to this before, DBT polls form a lot of different modalities.

It is dialectical and comes from the Biosocial Theory which we will talk about when we come back from break. The easiest way to remember this and I will say this in a couple of slides: safety first.
DBT addresses safety issues and therapy interfering behaviours before anything else. On Friday, we will talk about interfering behaviours for the clinician and the client.

Safety issues. We are not going to be able to sit there and do interpersonal effectiveness goes with the client in our office who is in crisis and feeling suicidal. We need to be addressing those safety issues first. We will talk about the different stages of DBT therapy when we get back from break to help you understand, OK, how do I conceptualize where my client is at and were in a meeting?

DBT integrates a couple of really great resources. Diary parchment chain analyses, I love them both and we will talk about them on the third date or afternoon on the second data coming on where they are at.

Those are really great skills to help clients attract skill used themselves and help to determine any treatment priorities and assess for progress that is happening with the client. Which is fantastic.

For so many of clients, they are often in it and do not see their progress, when you are able to go back and say this is the chain analysis we have done and our DBT diary, and here is the physical proof of the progress they have made, totally empowering! I totally love it.

The goals of DBT entities are broken down by module. These would be to live in the moment, the mindfulness skills. When to be able to regular emotions, your emotion regulation skills. We need to be able to develop coping mechanisms for stress and those would be your distressed tolerance skills and improve interpersonal relations of this as well.

In order to meet all of these goals with DBT, clients will learn a variety of different skills and they will teach people how to change those unwanted behaviours and emotions, and how to change what is coming up for them, and how to set boundaries, how to end destructive relationships.

The things that are happening in their everyday lives that cause the misery and constant distress and at the same time, this is where some of the other work comes in. The mindfulness work comes in. It will teach people how to live in the moment and how to accept what is and what is happening, one we push against that moment and reality, that is when we get stuck in the suffering.

Over the course of DBT therapy, if you're wondering what to expect and what clients can expect, clients can expect to experience a greater stability in behaviours, moods, and a sense of self image,

and also to have a greater sense of control over their self harming impulses, as well.

I do not know about you, but if I was not present in, I'd be like, sign me up for that! I know my clients need that and they certainly do. We can give that declined in a really teachable way and it's really so empowering. One of the questions I get is the difference between DBT versus CBT. I get this question from clients, DBT and CBT are different.

DPT adds mindfulness and acceptance techniques which we will talk about. DPT takes the judgement out of CBT. So rather than thinking that my thinking is wrong, or I'm labelling something as a distortion, what clients do in DBT is that they acknowledge that there is a problem, and they do this with acceptance rather than judgement. And then they are able to find skills and use them to interact with their environment in a more balanced way.

DBT is administered with treatment stages and priorities. Cognitive therapy is actually more protocol driven. So in CBT if I'm expressing a panic attack, then there actually is a protocol for that panic attack, right? With psychoeducation, and abdominal breathing etc. DBT is a behaviourally focused treatment which allows the therapy to be more flexible.

Other key features include using more intensive/specific self-monitoring exercises. DBT does have an openness to spirituality. So stop mentioned on the slide where you saw it talked about the living goals with Patterson, in Eric Hammond's manual, she has some expanded handouts on spirituality as well. So if you have a client who is looking for this as well, DBT has a space where you can incorporate this into counselling, which clients find to be very very helpful.

DBT uses therapist self-disclosure. I talked a little about this earlier. You just have to ask yourself… (Laughs) I'm going to repeat this because it is important, if we are sharing with the client, is this little story about us? Or is it about the client and will it benefit the client? If it is to benefit us, we need to find our own therapist and paper our own sessions. Right? So we are just using appropriate self-disclosure to help teach a point to clients.

For example, I gave my yoga example. In terms of the building the life worth living goals. But there are examples you can use. The reason why I want to say this here and now is that, as you actually start to practice the DBT skills yourself one of the benefits to doing that is that you get these little stories to use with clients. These little things that are teaching points. These teaching points are so important because they can help with client through the points of their having.

There is a focus on therapy interfering behaviours. Therapy interfering behaviours or anything with the get in the way of client progress. So if a client shows up later session, it could be a clinician shows up late to session, the client is constantly missing an appointment… So we will talk about those on the third as well.

It focuses on emotions over cognitions. So if we are looking at the approaches that Marshall developed, then there are these focuses on cognitions. In the expanded (unknown name) clinical manual, he does have some additional modules. And we will talk a little bit about what those modules

look like, he actually includes a module that is focused on cognitive aspect as well.

So if you want to kind of… When we talk with the structure of what DBT looks like, this will make sense, but if you want to pull in there are some resources for that in his manual.

And of course a major factor of DBT are the dialects as well. I just wanted you to know that DBT is a behaviourally focused treatment. So the lands that we use as a clinician with DBT, is that the character six of bipolar disorder are really a pattern of learned behaviours, and what we have to do is to help clients identify triggers of behaviours, and figure out what is maintaining these behaviours as well.

If you're like me and you like to break things down conceptually, behavioural components of DBT look like your distress tolerance, emotion regulation and interpersonal effectiveness skills.

Now we're going to talk about theories that comprise DBT. The biosocial model, mindfulness practice, and mindfulness dialects as well.

Emotion dysregulation and the biosocial theory of DBT, the Biosocial Theory is really what drives the DBT. This is one of those pieces of foundational work that we are going to be looking at to help understand why clients are the way that they are. You know, what has contributed to clients expressing these symptoms that they have.

Linehan talks about this model of emotions. And so, her construct of emotions that she has is really broad, and it includes a broad chemistry of the motions, and includes physiology of emotions. It talks about our facial and muscle reactions. I mean… Emotions are a whole body experience, but for so many of our clients… There so like, the emotion is so overwhelming for them, that they may not even realize that there is a whole body expense happening for them as they're stuck in this really intense emotion.

Emotions are patterned responses to our internal and external environment that are brief, involuntary, and like I said they are a full system, with interacting subsystems that happen as well.

So we have thought processes to get linked with our emotions, and the DPT model really emphasizes that there is emotional vulnerability to cues that clients have. So class with emotional dysregulation have predisposed emotional dysregulation, and we will talk with us after, maybe in the next couple of slides or after break.

As they have these internal expenses, or external expenses that happen that are these prompting events to these emotions that are occurring. And then there is this interpretation,

So they make an interpretation of whatever this trigger is, whatever this Q is. Neurological responses can happen. And for many of my clients, they do not even realize a shift is happening in them until they go from 0 to 60, right? There during that shift, there could have been a moment when we used mindfulness notice that coming up for us, then pause and use a distress tolerance skill for symbol. But

for many clients once the weight comes, shoot it is going to crush over them.

And what many people have is a verbal and nonverbal way of expressing their emotional reactions and their actions. So the key here is, is by modifying any component of the emotional systems we can change the function of the entire system.

When I talk with clients about the model of emotion and I share that with them, that by just modifying any component we can share this whole reaction, clients are amazed that they are actually are able to have that much control over their emotions. Now… I'm not saying that that is easy to do! But the development of emotional regulation skills certainly does help in that process.

Emotion dysregulation is really just the inability to change or regulate emotional cues, experiences, actions, verbal response, or nonverbal expressions. When this occurs over a wide variety of emotions it is known as pervasive emotion dysregulation. It is linked with the inability to regulate intense emotional responses.

75% of the mental illness in the December have a component of emotion dysregulation, so it is linked to a variety of mental disorders. Eating disorders, trauma, substance use disorders just to name a few.

Emotional dysregulation is a pre-temperament that someone has, where an individual is born more emotionally sensitive. Not all people that are more sensitive develop a bipolar, that is not what you're saying, but we are saying how the impact of the environment can… Like when you are more sensitive, and when you are paired with and invalidating environment, this can likely lead to the development of borderline personality disorder.

Characteristics of emotion dysregulation, identified by an excess of painful emotional expenses. Inability to regulate intense arousal. So if we have a client with a zero 250 scale, there is this an ability to completely regulate that arousal that is occurring for them. When clients are struggling with emotional dysregulation, they have a hard time turning away those emotional cues.

So they actually keep engaging in those emotional cues. When there are these cognitive distortions that happen as well. There are impulse control problems that come up for clients. It was happening on a biological system, is that there are failures in information processing systems occurring. They have a fight flight or freeze, they are fully activated and they are outside of their window of tolerance. So even if we give people factual information in that moment, they are not going to internalize that. That will not sink in, because they are just trying to survive in that moment and they are just responding.

It is when you're stressed skills would be very helpful for somebody. We back up a little bit, when a client is really struggling as they are engaged in one of these really intense emotional arousals, if they are not able to access motion Galatians goes, you can use those to the stress skills. Then once a client is able to come down a bit, then they will be able to access their emotion regulation skills. There's also a tendency to breathe during emotional stress for situations as well.

Those who struggle with emotional regulars, that of our time regulating their emotions. Well... That is obvious and I did not mean to say that again. What I mean is that it is really hard for them to identify their emotions. So people will often come into session, and they do not really know why they're feeling the way that they are feeling and they're not even sure how to label the emotion they're having, but they know that they are in it and they feel all of it and it feels overwhelming.

People often struggle with identifying what are the different emotions. Because sometimes there are primary and secondary emotional responses, so there is sometimes happening for clients.
More than one thing.

DBT's modality that we can use with clients who percent with over control of emotions and suppression. I had a client who came in and was angry all the time. Angry. Nothing else, but totally everything was identified as anger. But it was all so contained. And it was so suppressed, and even physically on your sing with the client you could feel how much had fully contained and suppressed all of this anger, but they still fully felt it because this is all they were feeling. And so DBT, emotion regulation skills were so important, because as we started to understand this client's emotional vocabulary, the client was able to divide they were actually all these other emotions they were having! That it was not just anger.

So what happens with clients that have an over control emotions, is that they actually have difficulties with effective communication. It is 11:14AM East Coast time, I'm so sorry! I should have previous to that. It is something 15 wherever you are… But we're going to take a 15 minute break.

Will come back at 1030 central time, which is 1130 East Coast time. I will see you guys back here in a couple of minutes! If you have any questions please feel free to cement them -- submit them and hope we can get to them. Thanks! -- 10:30 AM central time, 11:30 AM East Coast time.

(BREAK)

RYAN BARTHOLOMEW:
Hey, guys welcome back. Lots of great questions have been coming in for Katelyn. To those in a second. Just want to take a quick moment to encourage you to check out that chat feature. There's lots of information there answering any questions. Schedule for breaks, when recordings are available, any questions about certification, where you can grab materials and download them. Make sure you keep an eye on that chat feature because often times it's got what you're looking for.

With that let's move forward to some of the content questions that we've got. The first of those is how do you explain DBT for first-time new clients, and can you define dialectics for us?

KATELYN BAXTER-MUSSER:
I will save dialectics for that part. What was the first part of that question? How do I describe DBT to my clients?

RYAN BARTHOLOMEW:

How do you explain DBT for the first time?

KATELYN BAXTER-MUSSER:
When clients come in and I am first talking about what is DBT and I am introducing it to client on just say, hey there is this therapeutic modality that was developed that is skills-based, it's really practical. It's easy to start to integrate. These are skills we can start here today in our individual sessions and you can walk out the door and we can identify skills you can start up lacquers. I'll talk with client to let them know what the different modules are and how each one can help them. And usually clients will be like, yeah that sounds great. I would love to be able to regulate my emotions, or I would love to have better interpersonal relationships. You don't say quite like that but they have that sort of response and it gets that sort of buy-in.

I introduce it like that, but what I want to highlight is that for client that walks in that is new to me or we haven't been doing DBT work at and they are in a state of crisis and I present the distress tolerance skills specifically, because those are our crisis survival skills, all talk about these are skills that right now can help us in this moment tolerate this distress, trigger, crisis.

I will sit down with clients and break up the worksheets and go through how clients identify what skills to use. I want to highlight that you can do that with the distress tolerance skills as a standalone, but that's also generally how I introduced DBT. I let clients know the successes that people have with DBT, and for those clients that are really stuck that have been through a lot of clinicians I will actually use that story that I shared this morning about Marcia Linehan.

That's provided clients with a lot of hopefulness because they can really connect to that. You feel this immediate buy into DBT because it was developed by someone was actually experiencing what they've experienced.

RYAN BARTHOLOMEW:
That's great, perfect. We will try to get through as many of these as we can. 10 or 15 minutes. This person indicated that I often find clients are ready to jump into learning skills to help resolve their struggles. They are hesitant to engage in the mindfulness module. How can I better present the importance and necessity of mindfulness to these clients.

KATELYN BAXTER-MUSSER:
I either think that sometimes clients walk in and they think mindfulness is just like Wu. Or when we first responder clients they walk in and they're just like Ireland. Mindfulness, have heard about that.

I just really educate clients on provide a lot of psychoeducation on what mindfulness is. I tried to use examples that will stick with the client. By the client is heavily into sports and I'm like, listen. Imagine that DBT is all of the plays, the skills that you are making on the field, right?

You can do that if you don't have the football. Guess what? Mindfulness is the football. It's what helps you do all of the other things. I let them know mindfulness is the foundation. If we can figure out where we are at in a pause we are going to be up to use the other skills appropriately because we are going

to be reacting versus thinking about where we are at.

RYAN BARTHOLOMEW:
Next up, how do you explore identifying a life worth living things when you're working with child.

KATELYN BAXTER-MUSSER:
I think with any of the DBT skills you have to shift things if you are working with kids, and make it more developmentally appropriate. We might not call it, you can change the name you don't have to call it a life worth living. You can say what are our life goals? Usually with kids they are not taking about when they are 60. When there even in their 30s. There think about what is life like when I'm 10.

I take it way down. Try and figure out, and I find most kids it's about who they want to be as a person and how they want to feel in reaction to the world around them. Those are the goals that we kinda focus on.

RYAN BARTHOLOMEW:
Excellent. Could you speak to implementing DBT skills for a client with autism or who is maybe on the spectrum?

KATELYN BAXTER-MUSSER:
Yes I could. I'm gonna take up my phone because I want to read this correctly. That is not a group of clients that I specialize in working with. There should be two resources in the resource section. One of the books is escaping my head right now, but the other one I want to recommend is called, and it's in the resources, 'Neurodivergent Friendly Workbook of DBT Skills'.

There's another one there as well that are listed. I would take that material and that material is really great, and it is specifically geared towards that population, so formulated a little bit differently. There is DBT books and information out there on how to work with that population. Both any of the DBT skills I think it's important that you are meeting a client where they are at developmentally, and so there's to phone but in adults I've worked with-- definitely been adults I've worked with to pull out that material because it's formulated in a different way and maybe it's a little bit more simple 5 to meet the needs of the client. There's definitely resources out there and hopefully that helps.

RYAN BARTHOLOMEW:
Hopefully our team caught that.

KATELYN BAXTER-MUSSER:
It's in the recommended reading at the end.

RYAN BARTHOLOMEW:
Remember, you can get a hold of a PDF of all the materials. On the resources page. Go to where you launch the program and you will be able to download that stuff.

This individual asks, how do you consistently work with the client with DBT when they only see all

good or all bad?

KATELYN BAXTER-MUSSER:
I think that's a lot of clients that have BPD. When we are working with those clients we are starting to work, talk and educate those clients on what dialectics look like. And how we can live in a world where two opposing viewpoints can be true. How we can actually when we are living in that space of all good or all bad we create these really intense emotional reactions for ourselves, right? We go from loving and overvaluing somebody to hating that person, and like I said, never want to see them again.

I say what if there can be an in between? I say to them, what does that middleground even look like? You can have a relationship with somebody, or maybe sometimes they upset you but that doesn't mean the relationship has to end because we have skills to help us manage conflict in relationships. If it's obviously healthy relationship. Helping clients recognize the benefits of finding that middleground and that takes a lot of psychoeducation initially.

RYAN BARTHOLOMEW:
We have a few more that are all borderline personality disorder. This individual pointed out that the criteria for BPD sound similar to what many adolescents experience. I'm wondering if teams are typically diagnosed.

KATELYN BAXTER-MUSSER:
Not typically. I wouldn't diagnose them, and I believe the DSM says the same thing. You don't diagnose personality disorders before the age of 18. People are still developing and formulating. Their personalities are still developing and formulate them. You wouldn't diagnose that before the age of 18, and I instill pretty cautious.-- Am still precautions. I usually don't diagnose in my first session with the client. I want to work through and make sure I'm getting a full, comprehensive assessment and feel for the client before I put the diagnoses out there.

RYAN BARTHOLOMEW:
Great. Can you speak about more of your differential diagnosis process when considering the client you might meet the criteria for BPD.

KATELYN BAXTER-MUSSER:
I think it's just a process of really getting an assessment of what is currently happening in this client's life, and then what I do is I sit down with that client over the course of several sessions and try and identify where are these patterns coming from.

Has this been a pervasive pattern, sorry, my eye is watering. Is there a more recent trauma that has occurred? Really trying to help clients identify has this been going on for a long time. The reason why that's really important is because clients can walk in with some of the symptoms and have experienced a recent trauma and it can be more of a posttraumatic stress reaction versus borderline personality disorder.

I think the key is seeing those patterns play out over the course of the person's life. Asking lots of

questions is important. Some he wants to know the name of that book again. The book I recommended with the questionnaire. Want to make sure I get it right and keep looking over there. 'The Clinical Assessment and Diagnosis in Social Work Practice' they have a great questionnaire to go through about BPD when you're diagnosing it that I found to be helpful.

RYAN BARTHOLOMEW:
Perfect. Probably time for a couple of more. It's a question regarding emotional reaction cycle. They ask, how do we validate without creating a cycle constantly having to validate each time?

KATELYN BAXTER-MUSSER:
That's a really good question. I'm trying to think of how I want to go about answering that one. I worked with clients before who, their partner, is somebody who meets the criteria for borderline personality disorder. We talked about that need for validation. This person asking the cycle. I also think that the responsibility to shift is on the person who is having that experience.

It's I think the way you create where you don't have to constantly be validating is that the person with the borderline personality disorder diagnosis is doing their own work, is in a skills group, learning DBT skills and putting those into practice so that eventually they get to a place where they are able to validate themselves, or they don't need outside external validation of others to know that their internal experiences are accurate, or that they are able to get to a place where they are able to use their mindfulness skills and pause and say where my on the emotional intensity scale? Recognize their own needs first so that shift occurs from being externally focused on those needs being met to the person able to internally meet their needs. That's the work returned to constantly do with clients.

I let clients know just because we're learning skills doesn't mean everyone in your life is learning skills all of a sudden so we have to be responsible for learning the skills for ourselves.

RYAN BARTHOLOMEW:
One last one. And then let you die back in. What do you see as the differences between BBT and ACT.

KATELYN BAXTER-MUSSER:
They stem from a similar tradition, behavioral tradition. They both have this emphasis on acceptance and mindfulness. The underlying differences I would say is DBT skills-based. There's a lot of psychoeducation that takes place in DBT, and DBT stems from what we are about to talk about in a couple of slides that bio social perspective.

How does somebody, what we are going to talk about is, how do our clients, what has contributed to them having this severe emotional dysregulation. That's one of the defining features of DBT is that Biosocial Theory.

RYAN BARTHOLOMEW:
Sounds great. I will jump back out after the lunch break and we will do this again.

KATELYN BAXTER-MUSSER:
Thanks. All right, everybody we are back.

You all are doing fantastic. Those were great questions. Hopefully we answer those questions. If you need a little bit more submit something in. I will certainly do my best to get back to you right after lunch. We've got three days together so we've got time to figure it out.

Let's talk a little bit about emotional vulnerability. It's important for us to know what kind of motion dysregulation look like in our clients because I said before it's not always that really external strobe emotions, it's also that over control of emotions.

What are the things that contribute to emotional dysregulation? Where does the stem from? I think it's easy to look at it and say that's emotional dysregulation, those are intense emotions. But why is the client actually having these responses? Emotion dysregulation is produced by two different things. Emotional vulnerability, and then there's these inadequate regulation skills and we will talk about how there's an overlap between the two.

The first characteristic of emotional vulnerability is that there's a high negative affectivity as a baseline.

So, you and I might respond to on that 0 to 10 scale, where 10 is the most and zero is none, what might be a generally an average person responds at like a three or four to something, that person that is struggling with this emotional vulnerability has their threshold much higher. They are going to respond at a higher level than somebody else would. So, that high negative affectivity is the baseline.

What we would react to Ed like a three some veils might react to at an eight. These clients tend to typically react to things that others might not even react to at all. What happens is it takes clients longer to get back to baseline.

A quick example of what I show my clients when we are talking about emotional vulnerability. And I love… I have a whiteboard over here, and I'm always doing things for clients (Laughs) But my artwork is not the best. So bear with here.

What we have one we are talking about this idea of returning to baseline, is let's say that we have two people, OK? I have these two lines right here that represent to people. These two lines, and they are both reacting to the same situation. What happens is there is a trigger and that situation happens.

I don't like the word normal, so I'm not going to use that word. The average person, let's say a person that does not struggle with emotional vulnerability is going to have an emotional reaction that looks like one of two things: a jigger happens and they are able to come right down, or trigger happens, and there is some distress, but then they are able to come down and regulate.

Now let's talk about clients who struggle with emotional vulnerability. In the same situation, their time up is higher. And I found with clients as they start to come down, they are not even fully down yet, but

they are sensitive and the experiences another trigger, and when the experiences that trigger they go back up. And it is this… Kind of slow process of returning to baseline. So depending on the triggers, they may not even get back to baseline.

It takes a really long time, as you can see with this line here, so it takes a regular time to get there. I will draw out for clients what baseline looks like, and for clients is can be validating because they will think that this is what the expense. They will go, "Yes! That I stay stuck in this state of misery."

The end up trying to frantically search the area for information to judge what their response should be. There is an increased sensitivity to emotional stimuli. These clients have an intense response to emotional stimuli, and in this intense response these clients do not have emotional vocab that we do.

So maybe they did not develop it growing up, it was never aired for them in their caregivers, or maybe they did not get any foundation. If you are never validated, so if your internal experiences and emotions are never validated, and you never really learn the tools to manage your emotions. So their relationship with their emotions is one of mistrust, right? Because their emotions lead to a lot of misery, so they do not trust themselves, and they do not really trust their emotions and emotional reactions to expenses as well.

There are responses in the nervous system for those who are more predisposed to emotional vulnerably. Although exact differences cannot be pinpointed, the theories are that this could be related to genetics, it could be related to early trauma, and actually could be related to trauma in utero as well!

So experiencing neglect as an infant. These things can lead to damage to the nervous system and emotional vulnerability as well.

Kind of ask yourself as you are sitting there: what does emotion dysregulation look like and our clients? When someone walks into your session and they feel helpless, that is palpable. You can feel that with them as you sit with them. More are they gushing with emotions? With one flying out over the next? Or does it look like anger? So you have to ask yourself what this looks like and it will look different for every client.

Clients really struggle because their highly emotional, highly sensitive, and while we need to do and what they really need is to help them figure out, "How do I regulate in a world that mostly regulates around me but I'm not regulated?" That is what we are helping clients do as they develop these emotional regulation skills.

A lot of people who suffer from emotion dysregulation suffer from having no sense of who they are, they feel empty, feel disconnected or worthless. That ability to regulate their emotions really impacts their development of their sense of self. And what that leads to... That can lead to depression, to self-hate, to feelings of worthlessness.

So when someone deals with high levels of emotion dysregulation, they view themselves to the sons

of worthlessness. And it makes sense then why our client would feel so hopeless. This is where DBT skills come in, because through the use of DBT skills and through the use of learning how to regulate our emotions and practice mindfulness, we can actually start to shift and clients can start to shift how they think about themselves and how they view themselves.

So that way they are no longer living in this world they feel everyone else is regulating and they cannot, they start to feel that they can regulate to. Hey, I can participate in a way that my needs will be met, and I can set a boundary. It is really empowering work for clients that takes place.

Just to give you an idea of how each of the modules help with emotional regulation. Our modules help to address problems with emotion regulation recognizing, labelling, describing it now to do with emotion. Interpersonal effectiveness skills how to address patterns of behavioural regulation and help us let go of unhealthy relationships.

When we are working with emotion dysregulation, it is really important that we also have an understanding of what does emotion regulation look like? It is not enough to just say," I want you to be emotionally regulated", to a client. Emotion regulation is the ability to inhibit impulsive behaviour they to either strong positive warning of emotions. We also want to go to organize ourselves for coordinated action to meet an external goal. Right? So we want the ability to not just necessarily act in a mood dependent way when necessary.

So we can actually work with clients to get them to a place where they can regulate their emotions. But at first it will be a very conscious effort. Clients will have to try really hard, they will have to really be thinking about it and really be conscious of what skills they are using and how to implement skills.

What will happen over time is that skills will eventually become automatic. So those new skills will replace those maladaptive coping skills, and when that happens for clients, right? When this happens over time with practice, they will not have to think about as much because this will just be there new way of interacting with the world around them.

When I talk about this, it is not just about regulating negative emotions, now what it actually means is that we really want to increase our positive emotions as well. I think that is really important, because so many of our clients cannot have more cannot hold onto when they feel those really positive emotions.

We want to be able to self soothe strong emotional responses, and refocus attention regardless of the presence of strong emotion.

The people that we are currently working with probably have a real hard time tolerating the emotions they are expansion, and often cannot even label origin for the emotion, why they are feeling it, or understand how to effectively expressive. It is through the use of emotion regulation skills that we can help clients start to understand their emotions, to be able to label them and to come to a place where they can regulate those emotions.

That is just so empowering for our clients! Because I have been living in a world where they feel completely dysregulated and run by their emotions for such a long time.

The Biosocial Theory was developed by Linehan to understand how emotion dysregulation develops. Because I think it is really important for us as clinicians, as we practice DBT to understand what even causes emotion dysregulation.

This is great work we can do with clients, the development of emotional dysregulation disorders occurs often in very invalidating environments. Biosocial Theory is based on the idea that at the core, suicidality and BPD are disorders of emotion dysregulation.

Borderline personality is the result of a serious dysregulation of the effective system. So here's a little equation for you to help you remember it: biologically-based emotional sensitivity+ invalidating environment= chronic emotion dysregulation and then leads to dysfunctional response patterns in emotionally difficult situations.

So then out of that emotion dysregulation, we have dysfunctional response patterns. We know that it is a combination of biological on abilities and environment, that can definitely impact the development of bipolar disorder, and the ability of someone being able to regulate their emotions.

What we also know is that people with bipolar disorder have really intense and long-lasting emotional responses, even to small stimuli, so people with bipolar disorder for example are really intended to any sort of emotional rejection such as disapproval for example, because they have been living in this world and they have grown up in a very invalidating environment. When you grow up in a very invalidating environment you and you cannot trust yourself or your inner experiences, so what do you do? You look at everyone else to try to understand what is going on, and you become a really high tuned to any signs of rejection or abandonment for example.

I think most of us are pretty familiar with the ACE's study. If you want to Google your ACE's? I think it is always interesting to see. I did not send out a link where you connection get the ACE quiz, the questionnaire because there are so many available online.

Just as a quick little review of the ACE's, the original phase of the ACE study was done from 1995 to 1997, and there were more than 5000 participants. These parts Vince went under a standard physical examination, and then the completely confidential survey. On this survey there were questions about childhood maltreatment and family dysregulation, and on how sties and behaviours. So this information was all combined with a result of their physical information, and it based the formula for this study.

What you can see here, is that the invalidating environment, the impact of that is really validated by this study. Because we know that adverse childhood experiences such as trauma and invalidating environments can have and really do have long lasting impacts on the people we see every day in our offices!

I like to take a minute to talk about what invalidating garments are, and what those look like. This is a place where there is a tendency to deny, respond unpredictably, extremely, radically and/or inappropriately to a child's private experiences. This means that the caregiver, and this could be a parent, or someone raising them, but a primary caregiver or someone who they are exposed to a lot in life, they do not respond to their emotions with understanding. So what happens is that the child's private experiences, their physical sensations and thoughts, everything they think to know to be true in the world, I mean for them it feels true, but they are told that it is wrong.

We're going to go over invalidating statements. In an invalidating environment, there are judgements, telling each other and correct, minimizing motions, punishing the child for talking about their thoughts feelings, and even ignoring their experiences are how invalidations take place. They have this expectation is that the child should be able to control and regulate their emotions, which we know is not possible! These skills take time to develop, and children do not have the resources yet to do all this yet right? So they look to their caregivers to validate their experiences and help them regulate these difficult emotions.

But in some of these environments, the caregivers and up over simplifying the ease of problem-solving. So imagine when that is done to you! It makes you feel like, "Oh. Well I feel like maybe I just overreact, because this person over here is just telling me it is easy and I should just deal with it."

Children are often punished for coming to getting their experiences, and the other side of that is when the caregiver only responds when there is an emotional display that the child displays, and the needs go unmet. On the roof of their house when they're about to jump.

That was when the caregiver started to pay attention though was then in that moment. What does that do? It reinforces that your needs can only get met when they are extreme emotional display.

These invalidating environments teach kids that there are two ways to manage their emotions. You either stuff them down and do communicate, don't tell people at all, or you have to communicate in these extreme ways.

The caregivers really failed to provide the support that these highly emotional children need to learn how to manage these intense emotions.

What ends up happening is that the individual, for example in the situation or person who has borderline personality disorder, they learn to mistrust and fear their emotions. They don't ever really learn how to manage them. What Marshall Linehan said is that a client with borderline personality disorder, and I like this example, is like a car with a really powerful emotional engine but they are completely lacking the brakes.

I'll say it one more times you get the visual. A client with BPD is like a car with a really powerful emotional engine, they are completely lacking breaks. I think right there puts a nice little bow on what does emotion dysregulation look like?

So, what are some of those things that our clients have heard before in their environment? So, if clients have an emotion and clients are told no you shouldn't feel that way that doesn't actually ever help.

One time, and I will tell you this only ever happened one time in my relationship with my husband because I was not a happy camper. One time something was happening, I'm known to be a bit fiery. My husband is from Arizona so he's very West Coast mentality, and I'm very East Coast mentality, it's a good balance.

My husband turned around and told me to chill out. I remember that just lit my fire right there. I remember looking at him and I was like, "When in history has anyone ever been told to chill out actually work?" It doesn't work. I'm furious even more now. My husband and I had a good laugh about it and we still laugh about it to this day. What ends up happening, and I know it's a bit of a silly example, that when you're told you shouldn't feel a certain weight actually just increases your sense of anger or frustration and your sense of helplessness.

These environments that our clients grow up in, right? These kids communicate any problem that you experience is really easy to solve, but you just don't feel it or you stuff it, or you don't show it.

The problem is in this environment problem solving skills for emotions and emotion regulating skills are never taught. Clients never learn the ability to self regulate, so the ability to help myself feel better doesn't exist for those clients and that leads to a sense of failure, self judgment. I should be able to, but why can't I?

Some of the statements that our clients here might be like oh you must be hormonal. You are just being dramatic. That's when I hear a lot and the clients meet the criteria for borderline personality disorder, hearing from other people in their lives, being told to just let it go. Shake it off. Being told boys don't cry.

That's extremely invalidating. Or just snap out of it. Just get over it.

I don't have it embedded into the presentation, but when you are sitting back on your lunch break and thinking DBT is clearly amazing and you're like, man I wish this was five days instead of three days. Just kidding, I can't talk that long. When you're sitting thinking you want to learn more about what invalidation looks like there's a great video on YouTube called the still face experiment. It's out of UMass Boston. It will say that on the side of the YouTube.

I'm sure many of you remember it for graduate school. It's really cool to watch this little video and see it play out, but in summary for right now what happens is that babies come around the age of one, are asked to sit in front of their mother who is engaging with them. What the researchers do after the mother has engaged with the baby a little bit the researchers asked the mother not to respond to the baby. It's really interesting to see what happens when the mother stops responding.

As the mother stops responding you see the baby actually start to go through a series of responses. At

first the baby will start to maybe make a noise to call out to their mom. And then the baby starts to point and they are used to their mother following their face and looking at with her pointing to. And then the baby is trying to reach out, and this the reaching out and the mothers not responding back to them you can see their distress escalating. What happens is that they actually start to lose their body posture even as their emotions, dysregulation increases.

Obviously this experiment ends after a few minutes and I think it's just a couple of minutes, like two or so, the mother re-engages and the baby is able to reregulate.

What really sticks out to me is what Doctor Edward, who talks about this in the video states is, he calls the good, the bad and the ugly. I want to share this with you because I think the clients we are working with our living and the ugly. That's what they grew up in.

He states that the good is like the normal stuff that happens with our kids. The everyday stuff. The bad is where something bad is happening but then the baby is actually able to overcome it. But the ugly is where the child isn't given any chance to ever get back to the good and they are constantly stuck in that bad situation. That's really what our clients are stuck in.

When I watched this video I often think the lack of response that the mother is giving the baby, even though this is just an experiment, that's the kind of response our client has probably gotten often over the course of their lifetime from their caregivers, from the people they were looking for help and support from. They were met with nothing, or invalidation, hurt, pain or minimization.

That's a really painful way to grow up. That's the ugly.

When our clients are never given a chance to move beyond the ugly that's the only way they know to relate and interact with the world. Again, their behaviors that bring them to our office make sense. So, I want to give you kind of an example of one time where I saw this validation occur, and I will straight out let you know that this is just like, I'm going to take it just for what it is as an example. I don't know the people and so it's just like an observation that occurred.

One day I was in graduate school, so you know I had my critical thinking cap on. Sitting at the dog park in Arizona and there's myself and my dog. The dog park is really big. There's two people across the dog park and one of, the dog they are there with lungs to one of the women, and then a family of four walks in. There's a boy who's older than the little girl, or under the age of 10 and a mom and dad.

There's three dogs in the dog park. My dog is doing something. The family's dog decides it needs water and they have these bubblers, water fountains in the dog park for the dog to drink out of. The dad and the daughter decide they're going to walk across, and the sun stays back with the mom.

We are sitting and I'm just kind of watching. Mom hasn't been super active the whole time, but that's fine, sitting relaxing or whatever. The little boy decides that he is going to go and meet his sister and his dad over on the other side of the dog park. He runs across the dog park. I can imagine all of you are like, "That's a bad idea." Yes it is.

As he is running across the dog park the dog that belongs to the other woman sitting with her friend, that woman's dog runs out and just, probably as tall as the kid, the dog is jumping. He jumps on the kid, right on the kids chest. The dog jumps. It's meant to be playful but totally knocks the kid back. He falls good lately over.

The woman whose dog it is stands up because she's clearly nervous that she's about to be screamed at. I'm watching this whole thing like what is happening right now? The point of my story and what really sticks out is what happens next. That's why had to lay the context for you.

The child looked back at their mother in that moment who had just been knocked over by the dog and they are on the ground at the dog park and looks back to their mom who is sitting two seats away from me and the mother looks at the child and the mother just looks away from the child. I'll never forget that. I'm not trying to pass any judgment on what was happening because I don't know, but on the surface level as an example here was an experience that this kid had and even at nine turned to their mom for something and got nothing. What did the kid have to do? Even if he was really scared of that moment they were alone in the middle of the dog park. Dad didn't see what happened. They got themselves up and continued on their way walking.

Just an example of kind of like what that invalidation can even really look like. That always stuck out with me because that kid really turned for something and got nothing.

We are going to talk a little bit more about the impact of the environment. Our environment obviously has a major impact on how we learn how to regulate or not regulate our emotions. Some of the examples I can give you, positive experience would be a parent responding in a restorative way--supportive way to kids emotional needs. That will help a child learn how to regulate and that their feelings are valid and they will see what emotional regulation skills look like.

A negative example would be witnessing an abusive relationship as well. The good news is that is that research supports the idea that our ability to regulate emotions actually changes across our lifespan and improves with age.

The reason why I really like this study is because, I mean I am, if I wasn't a therapist I would have gone and been like an astrophysicist. I love science. I love the research. I love the why behind stuff. When somebody does research like this to me that super fascinating and cool. I like to have this research to say to clients, there's actually research that supports it doesn't have to be like this forever. We can actually learn and DBT is evidence-based. There's so much research backing DBT working for various populations that we can actually learn how to regulate our emotions and that change can happen for you. You don't have to live like this forever.

That is really inspiring for clients. I have some clients that come in and they're just heavily intellectual and so quite honestly they want to hear that research-based information. I try not to let clients sit in a place where the over intellectualizing stay for too long. But is hopeful for some of those clients were stuck in that to really say, okay that is, there is more to this and it can actually change, that research

validates it.

This is not necessarily a part of DBT but I promised you and love resources and so I'm going to share it because, and I should say, when I practice DBT in my practice now is a private practice commissioner there are some clients where we are super strict on how we are running DBT. I have other clients were not as strict, that doesn't make it less DBT but we'll talk about some of those variations probably this afternoon.

One thing I've incorporated before, it's kind of like a nice segue after the ACEs study is this resilience questionnaire. The ability to recover from or adjust easily to a misfortune. This questionnaire is through the American College of pediatrics. It's more of a teaching tool. Each question reflects introspection, or encourages introspection and reflection, and to just give you an example like the question would be, I believed that life is what you make of it. Definitely true, probably true, not sure, probably not true, definitely not true. What I like about this question, is that I can get a general sense about iLife that they think is worth living, or life in general. And it opens up some interesting dialogue.

It opens up dialogue around feelings of hopelessness, but also feelings of hope for those clients. And when we start to say that life is what you make of it, how do we make up that living? If you can believe in it, how can these skills help you? Just skills to incorporate in your practice.

Biological influences can include but are not limited to any impact on healthy brain development, and genetics as well. The environment tends to be particularly focused and placed on caregivers and parents. But I do also want to say that I have worked with clients, I have worked with a couple of kids who are crazy talented athletes. And in that they have had a lot of exposure for example to a coach who is really critical and highly negative. So taking that into account when working with clients with emotional dysregulation, I know that we tend to focus on caretakers, but I also noticed that the impact of a highly critical coach puts a detrimental role for kids and adolescents I have worked with. So keep that in mind!

The high negative effect as a baseline. Sensitivity to emotional stimuli, intense response to emotional simile, and then so return to emotional baseline. We have an environment with a tendency to invalidate emotions, and environment with an inability to model appropriate expression of emotions. There are interaction styles that reinforce the escalation of emotions. So when I told you about that client that was having a response, having a response, with no reaction, then when the client was on the roof, now there was a response. So it encourages them to this behaviour, because that was how the tension was gone. So we will talk about poor fit between child temperament and parenting style of caregiver in the next couple of slides.

A child who meets these biological and emotional vulnerability, paired with this type of an environment may be at risk for developing borderline personal disorder. Or at least developing some set of emotional regulation disorder. Something I want to point out, is that it is not so simple, you may have a child with emotion dysregulation who is in a well matched environment, where they receive validation and love and ultimately what ends up happening in the environment is that they do not develop, photo in, so the environment and actions of the parents do impact the child.

We look at dialectic thinking and Biosocial Theory, it is not all the person or all the environment but rather that our clients behaviours are a natural reaction that occur in response to environmental reinforcers to take place over time.

Once we look at it from this lens, a backup. Their needs are met, their needs are met as a kid when they have these emotional reactions. For example with a client that stepped out on the roof, they had in that moment showed an extreme response and then that need got met. So that skill became adaptive in that moment for that client because that still work for them, it got there need met. But later on in life, it is more obvious that it is a maladaptive skill to get our needs met, because people in relationships we are in may not respond in the same way.

Or if we have a client who jumps to an extreme emotional response, and then the partner there with sis, but the situation does not meet that intensity" So they do not know what to do that or how to handle. If our mental reinforcements that take place over time could situations where clients create skills to cope with and invalidated or neglectful environment that they are growing up in, but these skills do not translate into adult relationships well and so we see these maladaptive skills play out over and over.

This is great DPT comes into play, because we can replace the skills with other skills. Clients have natural responses to their environmental reinforcers because their basic needs have gone unmet or were ultimately invalidated. Ultimately clients leave that situation having no idea how to regulate their emotions. So they just keep using them over and over again.

When a hand proposes that there are actually types of films that increase the risk of development of borderline personality disorder. Like I said, we have to kind of take into account... I mentioned a coach, but there are also clergy! So elders in a church, or grandparents can be another example. So please keep in mind these constructs!

With family constructs of DBT, I had the situation where there was this kid and they were so colourful… I mean so colourful, and so artistic, and both of their parents were engineers and very mathematically orientated. And there was such a major disconnect between the two of them, because their parents did not express emotions in the same way their kids did, and so they could always felt emotionally invalidated by their parents whose responses to motions always felt cold like, "That's fine. Get over it, or just do not think about it." So being in that situation, or being a kid who is creative but growing up in a home where creativity is not validated.

We have a disorganized family here. Caregivers come with their own history as well. So when we are with this family, there are barriers in the home that prevent a validating environment from forming. This could be addiction problems, mental health issues, these could be problems like the parents did not grow up in a validating environment themselves.

And so what happens is when you have this really emotionally sensitive child, it can actually cause the family unit to become even more overwhelmed and stressed. So for example, when you have a child

who experiences a high level of anxiety and you have a parent who does not recognize this anxiety, or they view their anxiety as not real, this invalidates the child and thus that invalidates their experiences.

Also in this category though our abusive homes. And I think it is very important for me to highlight that experiencing abuse does not equal borderline personality disorder! It does not necessarily mean that someone will develop BPD, so I did want to put that out there for you to keep in mind.

Coaches, clergy, babysitters, anyone who is exposed to that child a lot and who can invalidate that child's experiences. We have a perfect family listed here. Where expressing negative emotion is a no go. I have worked with clients who have grown up in homes.

I worked with a client that said, "From a very young age, I distantly remember that I had to look perfect, I had to act perfect. And I remember I did not have tantrums, or emotional outbursts as a baby. I remember not being able to have those things- that was just not allowed." And they actually brought in pictures from childhood, when they were really young like as a toddler.

And they even pointed out that there was no look of happiness on their face in any of the photos. In they said that this is how they felt all the time, that they just had to be there and be perfect, and stand and not react, so they could not show how they were actually feeling. That could lead to the development of borderline personality as well.

And even if it does not lead to the development of borderline personality, it certainly leads to the development of some form of trauma! Right? Because what you learn in that experience is that it is not safe to express your emotions and so you have to keep everything neat in a safe little box, but that is humanly impossible! You know? At some point that little box is going to become really full.

So those are the types of family contracts that can lead to the development of borderline personality disorder. I want to talk a little bit about emotion dysregulation interconnection with clients, I think this is really important!

I'm going to take a side road here, and topical about about poly vagal theory, and then we'll talk about how it ties into Linehan's work and this idea up regulation with clients. Which is so important for us as therapist to know when working with clients, what that looks like.

I'm in my office three days a week with a super full caseload, and so I know it is not super easy all the time. If you have stuff going on, to just sit in our sessions. Or for client comes in and is very dis-regulated, it can be difficult to exhibit that.

When a client comes in and sits down, and we are not in touch with ourselves and we already speculated. Right? So maybe we are this regulated because we have our own stuff going on, or we're despite elated because our client is suicidal and we are worried they may kill themselves and that makes us nervous. So what we then start to do are just throw skills at the client, right?

Go skills will just bounce off, they will not stick. So this is where our connection in the space comes in,

where we can help our clients flow down, and we can awfully of them if we are in a regulated state help them to regulate, and the real work can occur. What I think is so powerful about the job that we do is that we may be the first person or only person in their lives that they are actually safe to coagulate with.

And I think that is huge! That when we are sitting with clients, that is what we are teaching clients to do. They maybe have not learned to coagulate with anybody else, and it is very very powerful.

I love poly vehicle theory left back I love radical acceptance, I love polyvagal theory, and DBT, those might be my top three in my career. (unknown name)... I got a flyer with her an email and it is amazing. I have brought her into my work, and I find it to be really help will, because it helps me bring this work while I'm doing school-based work with clients.

A lot of my clients need this awareness. So (Reads) "When clinicians can get the body in a state of trust and safety, it creates the ability for client and clinician to co-regulate each other; thus exercising resilience." This is when they can really learn DBT skills, they get encouragement and they actually feel safe and hopeful to take these skills into their daily work.

If you have a client who is experiencing a lot of shame I have found I really been able to integrate Polyvagal Theory into my DBT work seamlessly. I really love how it works together.

It's really giving a client and understanding of how their emotional system, how their whole system I should say actually is responding to triggers in the environment.

Polyvagal Theory explains the how and the why clients move to this continuous cycle of mobilization, disconnection and engagement. What it talks about is the autonomic nervous system shapes our experiences and interactions for safety. And then it actually impacts our ability to connect.

So we have experiences like, for example with trauma, it impacts how our nervous symptom response the environment around us. These survival skills that we actually use in childhood then become these autonomic response patterns, and those are the skills we are targeting in DBT, those are the skills, the survivor skills that our client have developed as we are trying to replace the DBT skills.

In our work with clients with emotional dysregulation the impact here is that in the movement through their nervous system as our clients move to their CERT-- through their nervous system it's more extreme. If that emotional sensitivity and vulnerability. This can really be seen through their lack of ability to regulate emotions, as well as manage relationships.

Through the Polyvagal Theory we are able to understand that mental wellness comes from a really flux level nervous system, and that mental illness comes from a really rigid nervous system.

Again, for your weekend viewing pleasure there is a YouTube video from PsychAlive. I would go to YouTube and look that up. Doctor Stephen Porges, what is Polyvagal Theory. He does a four-minute video. He explains the nervous system and what that looks like. If you are looking to get just a little bit,

I could do a whole presentation on that but that's not what we're here for today. I want to give you the highlight looking for low bit more information that videos helpful in understanding what Polyvagal Theory is and why at some point to the work that we do.

Our physiological state we are in actually creates our psychological story. The system, our nervous system that we have is moving between this drive to survive in this longing to connect. I think that's so true for everybody, especially our client to meet the criteria for borderline personality disorder.

Our autonomic nervous system is constantly reading the environment around us and sending out, searching for cues. Searching for cues of safety, but also searching for cues of danger.

So, how we interact with the world actually starts with our autonomic state. And then our story that we have is shaped from that state. Like we've already talked about, people with borderline personality disorder often misread facial cues and emotions. So, what happens is you miss you read those facial cues and emotions you are shaping a story from that state.

It's happening from such a physiological level the clients might not be aware that it's happening.

We know the trauma impacts the development of a regulated autonomic nervous system. What ends up doing is it replaces patterns of connection with patterns of protection. So, Polyvagal Theory teaches us, I'm sorry what that teaches us, that trauma teaches us is that co-regulation is dangerous, and so with polyvagal teaches us as we can co-regulate or reactivate.

Trauma and those embodying experiences teach us that self-regulation is inadequate. What Polyvagal Theory helps us do is to create new possibilities, or to reinforce habitual response patterns that we are having.

I really think the Polyvagal Theory helps us to understand the how and the why our clients experience emotional dysregulation and what brings them into our office. Where I think this all ties and even with our window of tolerances we want our clients to be able to safely observe and tolerate their range of experiences.

The window of tolerance offers clients a way to ensure that clients are not exceeding more than what they can handle. Ensure you have had a lot of clients, they come in sometimes they are definitely not in their tolerance. They might be in a state of crisis. When they are in that state of crisis and they are out of their window of tolerance we might need to use our distress tolerance skills to bring us back to that optimal arousal zone.

When people are in their window of tolerance, when people are in the optimal arousal zone then people are able to feel more stable, they feel more regulated. They feel more present.

When they are outside of that zone they are likely to feel just regulated and even triggered. This is a way to conceptualize what we want to help our clients do. We want to help our clients said for you later the DBT skills through mindfulness, stress tolerance and emotional regulation.

When we are practicing using those skills then clients are able to stay or bring themselves back to that window of tolerance.

So, when we are in the optimal arousal zone, in our window of tolerance, our social engagement system is activated, and what happens is this is really intrinsically self calming.

For example, if we are being chased by a dog hyperarousal system is after-- activated because we need to survive. We turn the corner we can slow down, our heart rate rests and cortisol decreases and we can come back down to that optimal arousal zone. The window of tolerance.

Optimal arousal zone helps us to prevent from being hijacked with what's going on with other responses that are happening to us as well though when we are responding to things within our window of tolerance we are practicing mindfulness.

We are able to observe and describe what is happening when we respond to that, but a lot of our clients have a very small, small window of tolerance. They don't spend a lot of time sitting in that window of tolerance at all.

So, where this ties back in, really talks about co-regulation. Polyvagal Theory gives us a good understanding of what coregulation looks like with our clients. Whatman enhances is that effective and healthy interpersonal relationships rely on first, a stable sense of self, and the ability to express emotions in a healthy way, and then the ability to tolerate and regulate distressing emotions or painful stimuli.

Without the capabilities of learning the skills and healthy co-regulation, it makes sense that some many of the people we work with experienced chaotic relationships.

This is why co-regulation is so important. So many of the points we work with have just never experienced healthy relationships that they are able to co-regulate off of. They constantly have in this place where they feel fearful and where they don't feel safe.

And so when we are working with clients we might be like, I said, that first person that it's safe to co-regulate with. When people are in that place of being able to help co-regulate they are able to learn skills. They are able to implement those skills. Generalize those skills, take those skills out of your session and out of your office into the everyday life.

Were going to talk about, if you're like me and you like some research I've got some stuff for you here. I'm not going to go super crazy with so much to go over for the next few days, but I think it's important to give you the evidence-based, the factual pieces of information that support why DBT would work so well in your conical practice.

DBT is an evidence-based approach. It's been found to be effective in working with borderline personality disorder. In fact, in terms of working with women who have borderline personality disorder

DBT is really the only well-established treatment. It's well validated and supported by lots of randomized controlled studies.

It works really well with suicidal adolescents as well as college students. It works really well with clients who've experienced PTSD as a result of childhood sexual abuse, and it works with eating disorders, especially those that are comorbid with substance use disorders as well.

DBT also works really well with drug dependence, comorbid with borderline personality disorder. Eating disorders just alone, so you don't necessarily have to have a substance abuse component, but just in general working with eating disorders. I don't have a ton of slides on it but on the last day we will talk a little bit about integrating DBT into that working with it looks like.

And then it works and is really evidence-based in terms of working with anxiety and depression as well.

As a stand-alone treatment without any co-occurring individual therapy, and this is different than the standard DBT approach, I just want to say that.

When you have a standard DBT approach the client is engaged in the group, individual therapy, and then you got your phone consultation with your DBT consultation team.

What we're talking about here is just DBT skills. So, this is just a skills-based group. Listen, I don't know where you are at, all of you, right? There's so many of us here together today. But if you are looking to add something to your practice DBT skills group would be the way to go.

Let me tell you, I'm here in Maine, Maine is like a small town. Everybody per he much knows everybody, it's an interesting place, but it's a big state. During COVID there was just a couple of places that did DBT skills groups. When COVID happened one of the places that's a little bit further from me, which is a little bit more up north, they took their skills group and went up line and started offering it and telehealth format and it has taken off.

We've added more groups, we've added more times. They have wait lists. You can actually run a standalone skills group for DBT, and if you're looking at some of your practice, at least I can only speak for my area, but you would be full in a heartbeat.

I thing a lot of other people would probably validate that as well.

When you are using DBT as a standalone group has been found to be effective with working with depression, anger, emotion dysregulation, affective instability, eating disorders and ADHD as well.

We'll talk a little bit about a standalone group and what that will look like later today, and probably later in the next couple of days.

DBT with borderline personality disorder. DBT has been found to reduce the frequency and severity of

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That is a life-threatening behavior and that is of your treatment target. The higher targets we are going to talk about that is one of your top treatment priorities.

That's what I love about DBT is that it just provides this roadmap to be able to focus on that. I think often times, sometimes as clinicians were scared to focus on suicidality, were scared what's going to happen if we do that with our clients.

Those clients who receive DBT there is actually a decrease in suicide attempts by 50%. ER visits for suicidality with 51% less, and there was a decrease in inpatient visits for suicidality as well.

As a standalone DBT has been found to be effective in reducing PTSD symptoms, depression as well as interpersonal problems for women. And with men and women DBT has been effective, found to be effective with introducing aggression, impulsivity, reducing any intimate partner violence potential as well as anger expression.

DBT has also been found to be really effective when working with nonsuicidal self injury behavior. In DBT these nonsuicidal self injury behaviors are viewed as responses to unbearable emotional suffering. We don't shame the client for having these, we are not blaming the client for having these. What we are saying is these behaviors, though they may be dysfunctional, they are really a highly effective emotionally regulation strategy. It's a maladaptive strategy and causing the clients pain, like emotional pain, but what's happening for clients is that through the use of DBT there is a reduction in the self harming behaviors. There is a reduction in suicidality as well for

There's a reduction in therapy interfering debate-- behaviors, decreasing quality of life interfering behaviors as well for its theorized that these behaviors are all introduced or eliminated as a different range of factors that happen. There's the acquisition of new skills applicable across various areas so they don't have the need to use these maladaptive coping skills every-- anymore because now they have a new skill set. Also the use of the acceptance skills, right? The use of radical acceptance and dialects. Being able to accept life's difficulties and not living all the time in that state but being able to find and reach a middle ground as well. TBT has been found to reduce eating disordered behaviours through skills development, specifically emotion regulation skills. Emotion regulation skills have been found to be the most effective in working with individuals with eating disorders.

In terms of the structure of DBT, and implications on outcomes. There is really a lot of politics around stop… Where some people think it has to be the standard DBT approach, and others think it does not have to be the standard DBT approach. There is a wide variety in how DBT can be offered which I think is amazing.

The way I am currently operating in my private practice, I have facilitated the beauty groups before, I'm

currently not operating that because I have my own individual clients. What I'm doing is I'm offering my clients out to be DBT group, and that group knows that I am a certified DBT therapist. Because I am trained in DBT, that client is then able to meet with me and attend the group, and I have seen this work for a lot of different places.

In terms of individual versus group, should a client go to individual versus group sessions? No significant differences in terms of suicide attempts, and SSI occurrence, number of hospitalizations, emergency consultations. What I want you to grasp from that is that offering DBT is helpful for our clients. So if we cannot get our clients into DPT group, we can get them into a group and they can express a benefit.

I think this is powerful, I used to work on Native American reservations, there are probably some of you on this call that live in rural areas that did not have as much access… While while I was in Phoenix, you could get so much access because there were so many different options. So I think it does depend on where you're at, you can incorporate DBT into an individual or group setting.

The research has found that standard DBT versus others has a higher retention rate. I think there's probably a lot of different reasons for why that is, but a standard DBT group because it is combining all of the components that we will talk about, the requirements of the program are different and it helps clients I guess stay in the DBT program and worker.

DBT has been studied and found to be effective with people from diverse backgrounds in terms of age, gender, sexual orientation, and race ethnicity. So I think it is all about looking at your client population, if you're thinking of running a group and to think about what DBT skills you are going to bring in for those clients, and how those DBT skills will meet the needs of your clients.

We know DBT can work for a variety of populations. There are 70 different races out there, that if you have a really specific question, like the person earlier who asked for help with DBT for someone who may have an Autism Spectrum Disorder diagnosis, there are resources out there, you do not have to re-create the wheel.
If you love research this is where you can find more information, I have included a link.
There is a lot of research on DBT available through that website, and if you would like to explore more you can figure out what the best route is to go.

It is 12:45PM my time. I think now we will break for lunch. You'll be back at 1 o'clock Central time, 2 o'clock Eastern central time. So this gives you an hour for lunch.

Thank you guys! You've been great, see you in a bit.

(Break)

(Music plays)

