

## Outpatient Dialectical Behaviour Therapy



*Mental healthcare : for people, not for profit*



# Introduction

The Tuke Centre provides outpatient Dialectical Behaviour Therapy (DBT) delivered in collaboration with The Retreat, York. This handbook will tell you who this service can help and what it offers.

DBT is a psychological therapy developed by Marsha Linehan at the University of Washington, USA. It brings together well-established elements of behaviour and cognitive therapy in a clear framework.

DBT is helpful for clients who are chronically suicidal or repeatedly self-harm, together with difficulties coping with life, impulsivity and feeling out of control, particularly with emotions and relationships. Research carried out over 25 years supports this, and shows consistent results of improvement in self-management skills in relationships, emotions and impulses. This offers people increased probability of safety and a sustained life, a life which can be more fulfilling and rewarding.

People experiencing these difficulties repeatedly come into contact with services including Psychiatry, Accident and Emergency departments, and Social Services. Their difficulties often feel overwhelming, both to professionals and themselves. This can lead to difficulties in keeping relationships with helpers and on agreeing on the best way forward.

The DBT team at The Tuke Centre help people recognise and address some or all of the following:

- **Suicidal and self-harming behaviours:** repeated suicide threats and attempts, cutting, burning or other physical self-harm.
- **Relationships:** intense unstable relationships, fear of being abandoned, trouble keeping relationships.
- **Impulsiveness:** acting in ways likely to cause harm such as drinking, drug taking, binge eating, shoplifting, reckless driving, or impulsive behaviour ruled by mood.
- **Confusion about self:** confused or absent sense of self, feeling empty, evil or non-existent, feeling that the self, others or the environment are somewhat unreal, changed or threatening.
- **Unstable moods:** extreme emotional sensitivity, mood swings, problems with anger.



## Understanding how these patterns develop

DBT combines psychological, biological and social knowledge to understand how people develop these difficult patterns of feelings and behaviour. Each person's unique temperament influences the way he or she responds to experiences, and this in turn affects the ways in which that individual copes with events while growing up.

Some people are more emotionally sensitive than others at birth, through a combination of temperament and biology. If a sensitive child then grows up in a setting where relationships with carers are unpredictable and abusive, the child's experiences and emotions may be dismissed, punished or rejected. As a result the child may grow up having difficulties in making sense of their experiences and dealing with their emotional reactions to events.

In damaging environments (whether a family, children's home, religious cult, or perhaps a boarding school), the child may not be helped to learn ways of handling his or her feelings, nor develop the skills needed to solve life's problems and handle relationships. The child is unable to develop a reliable feeling that other people understand and share their experiences.

Against this background the individual tries to develop ways of coping. Impulsive behaviour, including suicide attempts and other forms of self-harm, become highly effective although maladaptive ways of regulating emotion. However, they can bring relief from anxiety and other intense painful feelings (including intrusive memories and flashbacks to abusive situations in the past) or may act to release the individual from feeling totally numbed and empty.

## What is Dialectical Behaviour Therapy?

DBT focuses on these patterns of behaviour and difficulties. Research shows it can help reduce suicidal behaviour and increase quality of life.

Therapy first focuses on reducing suicidal behaviours and self-harm. The client and therapist work together to do this by developing a detailed understanding of behaviours, thoughts and feelings that lead to feeling out of control. The client learns new coping skills to use in place of self-harm and is helped to take steps towards a better quality of life. Therapy only moves on to emotionally processing the past when the client has learned to regulate intense emotions and is better at solving day-to-day problems. This way the client is better equipped to deal with memories of painful past events without being overwhelmed or having to resort to self-harm.

The term "Dialectical" is an important part of DBT making it different from other forms of cognitive and behaviour therapy. Dialectics means balancing opposites in order to move towards change, in the form of a new balance or synthesis. This is a repeated process that proceeds in stages. There are many dialectics or opposing forces that may be addressed in DBT, the most central being the dialectic of acceptance and change.

In DBT, clients learn to accept themselves and their world more fully as they are in the moment (as a radical acceptance that things are as they are), while at the same time recognising the need to change, and that everything in life is constantly changing. DBT brings together Eastern psychological and spiritual practices, mostly Zen, with Western approaches to therapy. DBT tries to balance acceptance of pain and the intolerable aspects of life, with active coaching towards change.



# DBT in practice in four parts

## Introduction

There are four parts to the DBT outpatient service. The individual and group sessions described below work in tandem and it is a requirement that clients attend both regularly otherwise the therapy will not be effective.

## 1. Individual Psychotherapy

In individual work, the client and therapist agree a working contract and agree what would constitute the client dropping out of therapy. This includes persistent non attendance at either these sessions or the skills group. When they are committed to working together, they meet for one hour each week, and collaboratively identify problem behaviours. We expect clients to keep a diary card between sessions and be willing to discuss the areas targeted for change, and the skills used which enabled them to cope or change their behavioural responses. The goal is to reduce the need to use old self-defeating behavioural patterns and learn more effective strategies to cope with distress, frightening impulses and challenges. This includes exposure to situations that may evoke problematic negative emotions and thought processes. Therapist and client work together to develop plans to enable clients to become used to coping in such situations through challenging thoughts, and using skills to reduce the impact of powerful emotions.

## 2. Skills Training

DBT states that people who suffer from emotional problems want to manage their lives in a different way but often lack the skills or knowledge to do so. However, it is difficult to learn these skills in individual therapy that looks at deeper issues more intensely. So we provide separate skills training in a weekly small group. The group reviews homework from last week, learns new skills and sets homework for the coming week. Skills training targets problems with four modules:

- 1. Mindfulness:** this skill helps the client gain control of his or her mind rather than be controlled by his or her mind. This can reduce impulsive behaviours and help develop an awareness of a sense of self.
- 2. Interpersonal effectiveness:** this skill helps the client cope with conflicts; ask for what he or she wants and to say no. It also helps build self-respect and helps develop respect for others.
- 3. Emotional regulation:** this skill helps the client gain control over emotions through developing understanding of them, decreasing the vulnerability factors likely to put them in touch with negative emotions, and helps increase contact with positive emotions.
- 4. Distress tolerance:** this skill helps the client tolerate distress and get through a crisis without self-harm or self-defeating behaviours. This reduces impulsive behaviours previously used to tolerate or avoid emotional pain.

## 3. Telephone Consultation

Telephone contact is an additional service of this programme. It offers the client a goal-orientated intervention to facilitate the shaping of required behaviour and to reduce the unwanted behaviour. Telephone contact is limited to a maximum of one hour per week and is



dependent on the availability of the individual therapist, i.e. when he/she is on duty. Therapists will endeavour to call back any client contacting them within the working day.

The client and therapist agree on the frequency of telephone contact, and how it takes place. Contact between sessions helps to coach and support the client to use skills to handle situations which might otherwise end in self-harm or other unhelpful behaviour.

Telephone contact is brief, and not used in place of individual therapy, or for chit chat. Telephone contact is dealt with in a specific way, particular to the present moment. Skills coaching delivered in the moment such as this, helps the client feel empowered, enables them to use skills used in different situations, and can help to maintain and reinforce behavioural change. For example, a client who has difficulty asking for help directly might use suicide attempts as a cry for help. When such a client telephones for help this is evidence of their ability to change dysfunctional patterns. Clients are expected to call before they are in the grip of a crisis. Telephone contact is not for crisis management. Clients in crisis are expected to contact their GP or appropriate CMHT/Crisis Team.

Phone calls can also increase connection and communication between therapist and client and sometimes help address any imbalance in power, when conflicts arise.

When a telephone call occurs during, or following an incident of self-harm, therapists follow a structure to assess risk, gain commitment from the client to stay safe until the next therapy session, and end contact for 24 hours. If the client cannot commit to staying safe, and refuses to remove the means of suicide, this is identified as being beyond the therapist's limits. The therapist will contact the crisis team and ambulance services to ensure the client's safety. Following this, the therapist will end telephone contact with the client for a limited period of 24 hours but planned individual and skills sessions will go ahead as planned.

Telephone contact in these situations is guided by behavioural and shaping principles. The action taken by the therapist is governed by how dangerous, or potentially dangerous the incident is, and the client's ability to keep safe.

#### **4. Weekly Therapist Consultation Meetings**

This is a weekly meeting attended by all members of the team where the therapists aim to consult to the client. This may mean reviewing skill use or problem solving behaviour, or addressing potential therapist burnout through team discussion and peer supervision. This is an important part of treatment as it can improve fidelity to the treatment model as well as constant active therapeutic thought about the clients in the service by the whole team.

## **Evaluation**

We evaluate how effective our treatment is. This means we need clients to complete questionnaires as part of their initial assessment and at intervals throughout therapy. Clients also may be asked to consent to audio or video taping of sessions for research and training purposes. All material is kept in strictest confidentiality at The Tuke Centre. Clients can ask questions and raise any concerns about this at assessment.

DBT requires much commitment from both clients and therapists, but it provides an exciting and challenging opportunity for clients to move forward in their lives. People who have taken



part in skills training are very positive about this approach. They say that DBT offers understanding and support, together with the means to make changes in their lives.

## We offer support to clients, therapists and other services by .....

- Providing a clinical programme for a number of people at a moderate risk who self-injure. It is ideal for people in the transition between inpatient care and community living.
- Seeing episodes of increased risk from time to time, as part of a passing period and attempting to support clients through these.
- Offering consultation, advice and support to colleagues who support the DBT outpatient service and other outside services when needed, this could include meetings with services to review a client's progress on the programme.
- Conducting assessments to advise teams on treatment and risk management plans.
- Providing staff training and staff development programmes to improve the level of skill present in staff teams to respond effectively to clients using this service.
- Liaising with other service networks, CMHTs, Eating Disorder Services, MDTs, PD Services, etc to enable the DBT team to address the complex needs of those using this service.

## Treatment philosophy ..... we believe .....

- Clients are doing the best they can and want to improve.
- Although clients may not be responsible for, or have caused all their problems, they do have a responsibility for the choices they make about solving them now and in the future.
- Change is facilitated by increasing client's motivation. Change is also supported by the therapist's ability to recognise the client's strengths and to draw on these to help the client establish a life free of self-defeating behaviours.
- Clients will need to learn new behaviours in all relevant contexts and generalise skills in as many areas as possible.
- The most caring thing a therapist can do is to help clients change in ways that bring them closer to their ultimate goals
- A variety of treatment approaches can play a valuable role in the care of individuals with treatment resistant emotional problems. Our programme uses a whole systems approach which combines medical and social treatments. The DBT team consults among themselves and work with clients on a "consultation to the client basis" to....
  1. Identify relevant social activities and educational or employment opportunities that may enhance skills acquisition and self-esteem.



2. Identify and exercise caution in the use of possible contra indicatory therapies such as any psychological approaches that may clash or conflict with DBT and confuse the client.
  3. Empower the client to act as a self-advocate in dealing with care teams, interviews, voluntary organisations etc, to include other services in their care.
  4. Involvement from the key therapist may also occur in dealing with other teams or organisations, but only when there is a large skills deficit or if the environment is too powerful or discriminatory. We do not have contact with families or carers, this is the role of the CPA Care Co-ordinator or GP.
- Clients have rights to make choices that are detrimental to their health and well-being. However, society also has rights and responsibilities to protect individuals from harm. Although we will not actively exclude people who self-harm, there is an expectation that clients will identify self-harm as a problem, understand it more and work towards reducing and stopping it. Our objective is ethical, and we shall take steps to protect individuals from self-harm and discrimination.
  - Clients have rights to choose not to engage in therapy. Where clients are unable to commit themselves to giving up suicide as a option, or are a risk to others, we develop and implement a risk management plan. This may, for example, involve the clients referring themselves or the team referring clients to inpatient care. It is essential for clients to maintain contact with a Care Co-ordinator who will not be a member of the outpatient team.

## Considering DBT as an option

Here are some things to consider if you are wondering about talking to your doctor or psychiatrist about this therapy option, or if you are a professional considering this treatment for one of your clients.

### **DBT is suitable for people:**

- Meeting diagnostic criteria (DSM IV) for Personality Disorder
- Who have treatment resistant depression
- Who have problems with impulsivity, and bulimia
- With continuing deliberate self-harm and/or parasuicidal behaviour
- With ability to control hostility/aggression towards others
- Who show evidence of commitment to therapy
- Who are male or female, aged between 18 and 65
- With eating disorders with Body Mass Index above 17
- With an active Care Co-ordinator - this is a requirement before acceptance onto the programme. This can be their GP



## **DBT is not suitable for people:**

- With active psychosis
- Without ability to control hostility/aggression towards others
- With eating disorder with Body Mass Index below 17
- With prolonged and persistent high risk of suicide

## **The Team**

### **All members of the team are DBT trained**

Dr Julia Coakes, Clinical Psychologist & Service Lead

Dr Gill Smith, Consultant Psychiatrist

Dan Round, RMN, Psychotherapist

Sally Paybody, RMN, Nurse Therapist

## **How to access DBT**

Please ring us if you wish to refer someone for standard DBT, or if you want to discuss whether a referral would be appropriate.

We accept referrals from a member of the client's clinical team, ideally from their GP or Psychiatrist.

Please send referrals to The Tuke Centre. It helps speed up assessment and admission to the programme if appropriate arrangements for funding are already in place. We do not accept referrals without written confirmation of appropriate funding arrangements.

The referral information needs to include:

1. Initial referral letter from GP or Psychiatrist.
2. Contact details of the Care Co-ordinator and Responsible Clinician. If you do not have these we would ask your GP to act as care Co-ordinator and write to us confirming this.
3. Details of current problems and presentations.
4. Details of previous admissions and interventions in the community.
5. Present medication.
6. Client's personal history and demographic information.
7. Present risk assessment and management documentation, including arrangements for crisis management while therapy is ongoing.

The Tuke Centre checks the referral for entry criteria and suitability for the outpatient programme. The DBT consultation team then offers an assessment for prospective clients for the DBT outpatient programme, or alternative therapy options are offered if it looks as if this programme is not appropriate.



Following a suitable assessment a treatment plan is agreed and the client enters the DBT programme.

## Treatment Costs

**This DBT programme starts from £288 per week.**

This includes:

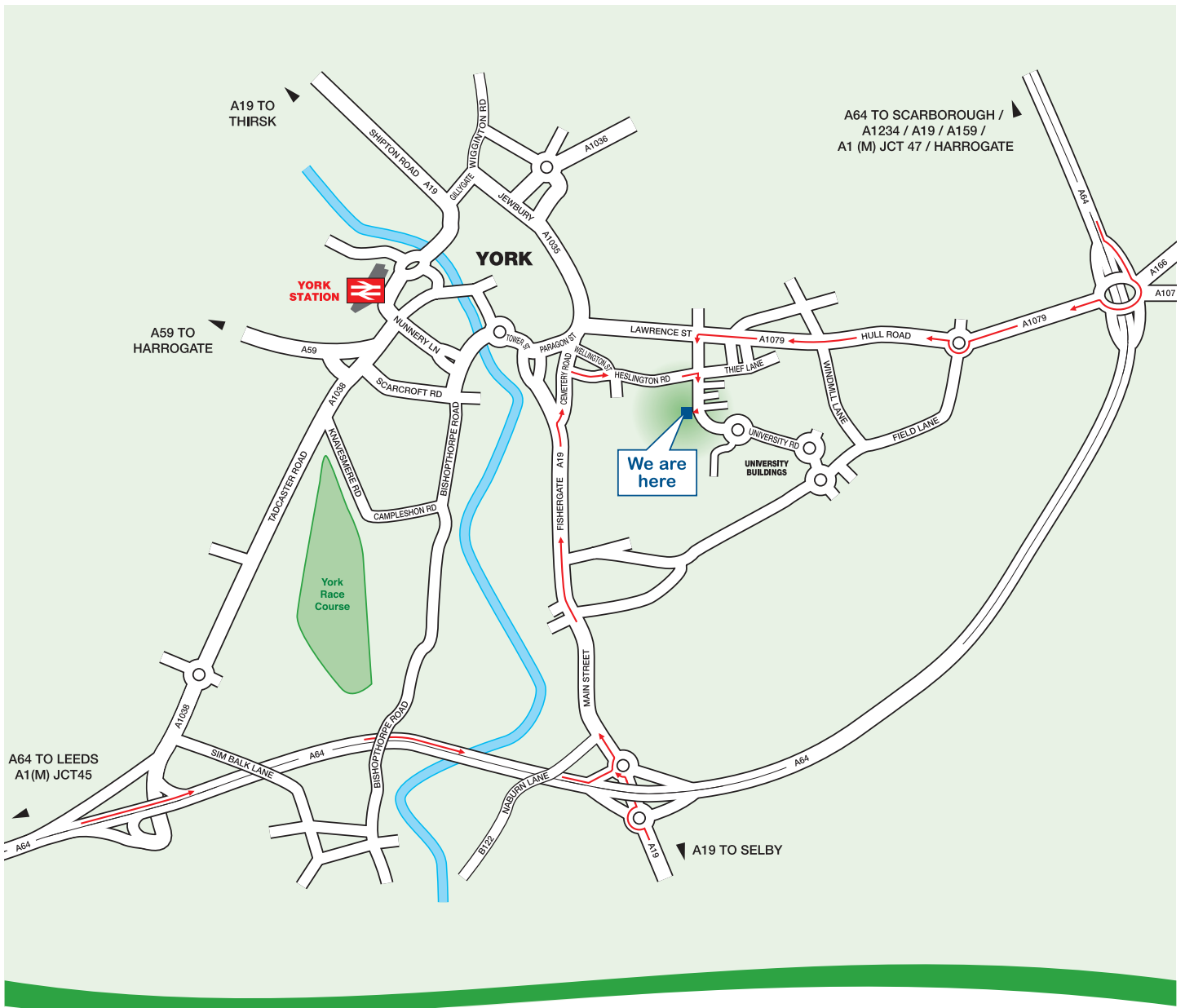
- One hour of individual Dialectical Behaviour Psychotherapy weekly
- Two hours of Skills Group Training weekly
- Individual phone contact and support, up to one hour per week
- Liaison with local professionals

## Further Information

For further information please contact Julia Coakes at The Tuke Centre on 01904 430370, e-mail [info@thetukecentre.org.uk](mailto:info@thetukecentre.org.uk) .







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