3-2022

Anticipating Success within Mental Health Training

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School of Behavioral Health
in conjunction with the
Department of Counseling and Family Sciences

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Anticipating Success within Mental Health Training

by

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A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Marital and Family Therapy

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March 2022

Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree Doctor of Marital and Family Therapy.

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ACKNOWLEDGMENTS

I would like to first acknowledge my Lord and Savior; I know that he has opened the doors and has entrusted me with this opportunity that I am eternally grateful for. Thank you, Lord. I would like to thank my Chair Dr. Distelberg, thank you for your tenacious effort in equipping me to see this through from the beginning of this journey. I would like to acknowledge my inside committee member Dr. Ribadu for being such a huge believer in my program while being a true inspiration to my ability to innovate a program that could be successful. I would like to acknowledge Lisa Ciccarelli for being the example of what I want to be as a Leader, a Clinician, and a woman of God who has truly paved the way for me to reach a milestone in my career. Thank you, Lisa, for being such a great pillar of hope in this journey.

I would like to thank my mother, Paulette Joy Wozencroft for being the women of strength that has seen me through everything, I could not be more grateful. I would like to dedicate this moment to my father who passed Albert Patrick Wozencroft, to say, “We Did It” and I carry you in my spirit each day. I want to acknowledge Nadia Patricia Wozencroft for being the wind beneath my wings. I want to acknowledge Nicole Phelps for being a pivotal support to me in the darkest hours in this journey. I want to thank my fiancé Jacob Poulose for entering my life and your patience in seeing this through. I am grateful to my cohort in the mutual support throughout my Doctoral Program experience. Lastly, I want to acknowledge all the Physicians that were participants in my trainings, thank you for all that you do to serve patients and allowing me to serve you by providing the opportunity to share my program.

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ABBREVIATIONS

ABP	American Board of Pediatrics
ASWMHT	Anticipating Success Within Mental Health Training
DBT	dialectical behavior therapy
FST	family systems theory
GSE	General Self-Efficacy Scale
HIPAA	Health Insurance Portability and Accountability Act
PCP	primary care physicians
SPP	Self-Perception Profile for Adults
T1	Time 1 (the first measurement time point; pretraining)
T2	Time 2 (the second measurement time point; immediately posttraining)
T3	Time 3 (the third measurement time point; 1 month posttraining)

ABSTRACT OF THE DOCTORAL PROJECT

Anticipating Success within Mental Health Training

by

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Doctor of Marital and Family Therapy, Graduate Program in
Counseling and Family Sciences
Loma Linda University, March 2022
Dr. Brian Distelberg, Chairperson

The Anticipating Success within Mental Health Training (ASWMHT) provides a 2-day training that consumes two hours a day for a total of two days. This training provides emotion dysregulation techniques that can be done within 2-5 minutes of a patient and provider interaction. The skills promoted throughout this training will be Dialectical Behavioral Therapy informed, which is an evidence-based therapy that has been used in multiple health care facilities and targets severe depression, anxiety, substance abuse, suicidal, homicidal, and self-mutilation behaviors. The training focuses on equipping medical doctors who encounter the mental health population with the skills necessary to regulate the patients to a point that is necessary for assessments to be conducted.

This program can provide a more efficient way of assisting the patient, lessen the vulnerability of misdiagnosing from erratic dysregulated behavior versus the true mental status of a patient, and elevate confidence levels for providers to perform the necessary service to the patient population. The idea is to provide a more immediate solution to integration of behavioral health care and primary care. Considering the high demand for mental health facilities and providers this a short-term approach to a problem that will

require an expansion in facilities and providers. However, give important to equip doctors with skills that are instrumental in working with mental health population who contend with emotion-dysregulation. The primary goal for medical doctors attending Anticipating Success within Mental Health Training is for each participant to walk away feeling more confident and equipped in being able to facilitate practical implementable skills that will allow for an effective approach to service emotionally dysregulated mental health patients.

CHAPTER ONE

PROJECT PURPOSE

The Anticipating Success Within Mental Health Training (ASWMHT) is a 2-day training sequence that takes place for 2 hours each day, for a total of 4 hours. This training teaches participants techniques for de-escalating emotionally dysregulated patients that can be performed within the first 2–5 minutes of a patient–provider interaction. Throughout this study, "emotional dysregulation" is defined as:

> a core psychopathological factor in many other psychological disorders such as borderline personality disorder (BPD; Linehan, 1993; Schore, 2003), emotional trauma (Corrigan et al., 2011), attention deficit hyperactivity disorder (ADHD; Shaw et al., 2014), bipolar disorder (Van Rheenen et al., 2015), and anorexia and bulimia nervosa (Lavender et al., 2015). Emotion dysregulation has been demonstrated to mediate the link between child abuse/neglect and later depressive disorder (Crow et al., 2014), and also the link between cumulative adversity in lifetime and depressive symptoms (Abravanel and Sinha, 2015). (Guendelman et al., 2017)

The skills promoted throughout this training will be informed by dialectical behavior therapy (DBT), an evidence-based therapy that has been used in multiple health facilities and targets severe depression, anxiety, and substance abuse as well as suicidal, homicidal, and self-mutilation behaviors. This training will focus on equipping doctors with the skills necessary to regulate patients to a point where the doctors can conduct patient assessments. This program can give providers more efficient ways of assisting patients; lessen the chance that a patient will be misdiagnosed on the basis of erratic,

dysregulated behavior as opposed to their true mental health status; and elevate providers' confidence levels in performing necessary services for the mental health patient population. The goal of the program is to provide a more immediate solution to the integration of behavioral health care and primary care. Many studies demonstrate that having behavioral health professionals available to do the work of managing dysregulation would be ideal; however, the reality of this transition continues to be prolonged while emergency rooms are being flooded and physicians are being forced to make quick decisions with little support and skill.

Targeting resident physicians as the primary population to pilot this training can provide benefits that lessen the case load for more seasoned doctors, allowing them to attend to the higher acuity patients and to provide better preceptor services to residents who require more mentorship. This training program may also prove to be beneficial for other doctors, not just medical residents. The emergency room is a primary site of resident teaching, but because emotional dysregulation can be provoked in patients in diverse situations, providers in inpatient and outpatient care clinics could equally benefit from learning the skills covered in the training (Williams et al., 2004).

Dysregulation in patients can prolong the time it takes for health care providers to deliver necessary care. DBT-informed skills provide ways of managing dysregulation; they offer practical tools that can diminish opportunities for escalation, lessen the probability of patient resistance, promote better rapport, and allow providers to advance to an assessment of the primary issue that requires the doctor's attention (Landes et al., 2017).

This project provides physicians with training in techniques that will help them

create a more efficient workflow for the treatment of highly emotionally dysregulated patients within health care facilities. Mental health illness is an epidemic that continues to grow in our outpatient clinics, emergency rooms, urgent care centers, and other health care–related places of refuge. The widespread integration of mental health care within primary care facilities has been a necessary change rather than a voluntary one, and it has continued to affect health care systemically in terms of workflow and patient care. A known, ongoing debate within the health care field centers on how physicians—who are the frontline providers for mental health illness and who may have limited skills to execute mental health care—can best establish assessments and provide treatment according to patients' needs in an efficient manner that does not monopolize the limited time they have to assist other patients who also require their care (Tai-Seale et al., 2007).

Primary care physicians (PCPs) are experiencing high demands for their services in taking care of patients with severe mental illness; often these patients are highly emotionally dysregulated and require crisis management (Tai-Seale et al., 2007, p. 1872). The reality is that primary care doctors are the frontline providers for this population, and they are being bombarded with mental health illness in health care facilities. The mental health pandemic continues to present problems for our already overburdened health care system, which is hamstrung by a limited number of physicians, an overabundance of patient needs, limited staff support, limited time to spend with patients, and a prevalence of ill-equipped physicians tasked with managing patients' needs related to mental health. On average, primary care providers spend 13–24 minutes with any given patient, depending on the medical health care facility (Michas, 2019). The focus of this research is to prioritize the treatment of mental health illness by the physicians within this limited

time.

Emergency rooms are used to treat mental illness at a rate between 4% and 12% (Fleury et al., 2019). Patients coming into the emergency room are at a higher risk of return to the emergency department if they have a mental illness, and the chance that they will return becomes higher as the severity of their illness increases: Patients with mild mental illness have a 2.9% chance of returning, with a 12.1% chance for patients with moderate mental illness and a 22.6% chance for patients with severe mental illness (Niedzwiecki et al., 2018). Internal stimuli in response to the emotional dysregulation may cause verbal aggression and physical aggression, up to and including disassociation (GeneSight, 2018). Providers are often unable to engage with patients in such a state of dysregulation in ways that will allow them to conduct appropriate assessments.

Patients with personality disorders who are seen in primary care settings are often perceived as “difficult” patients by physicians. The character traits common to these disorders can provoke strong feelings from providers, which in turn can disrupt the patient—physician relationship. This can negatively affect the processes of diagnosing and managing the medical and psychiatric needs of the patients (Ward, 2004).

The combination of physicians’ limited time and the limited training that they receive in delivering effective and efficient care to dysregulated patients in crisis has continued to compromise patient care and has overwhelmed providers with a significant number of cases that require immediate attention (Tai-Seale et al., 2007, p. 1885). A major problem that has become more prevalent is the fact that “the root cause” of primary care providers’ deficiencies in this realm is their poor diagnostic skills and inadequate training in the realm of mental health as a whole (Smith et al., 2014). The limited training

provided through medical school and residency has not given physicians implementable skills that promote high standards of patient care in all of the diverse work environments in which physicians practice. PCPs are forced to contend with dysregulated patients in very limited amounts of time, which could contribute greatly to deficiencies in care, including misdiagnosis, inaccurate dosages, and higher recidivism rates to emergency departments upon discharge. For this reason, training that teaches physicians practical techniques can prepare them to work with the mental health illness population. Because the proposed training is accessible and relatively brief, it can be used immediately to assist physicians who are contending with this issue.

Physicians are struggling to meet the needs of this patient population because they are unable to devote adequate time to managing their dysregulation and assessing their needs in the midst of crisis. This hinders their ability to meet the needs of other patients while more and more cases flood the hospital doors, creating a plethora of patients with minimal time for providers to service such a high demand. PCPs need skills that can help them manage crises, including those posed by severe mental health illness. Often, mental health crises manifest in patients who are so escalated that they may be physically aggressive, patients who are emotionally dysregulated to the point that they are unable to sustain a conversation, and any other situation in which patients are difficult to assess as result of behavior or verbal aggression. To make the best use of doctors' time, working with highly dysregulated mental health patients would require techniques that can enable doctors to efficiently manage the different forms of crisis and thereby allow the treatment process to begin (Harris et al., 2019).

The shortage of providers contributes to patients' challenges with accessing care.

Psychiatrists are only seeing 15% of the population with mental illness, leaving the remaining 85% to seek care with primary care providers. PCPs' lack of experience and training prevents them from providing psychiatric consultations in a time-effective way, which backs up the workflow of the emergency room and other health care settings (Smith et al., 2014). A gap exists in the literature on how the limited time that physicians have translates into the quality of the care they can provide. Many studies identify causes of disruption for physicians outside of the inability to manage time, including assessing diagnoses inaccurately and prescribing inaccurate medication dosages. The literature is also limited on the effects that short-term trainings may have on applying DBT-informed skills in the area of emotional dysregulation.

Gaps in mental health education affect physicians' ability to assess and manage patients with mental health illnesses. Physicians need ways to treat mental health illness that they can operationalize while upholding a high-quality standard of care. A training that can be used in outpatient and inpatient settings to help physicians better treat patients at diverse levels of acuity can be a huge asset to all health care facilities, physicians, and patients. Practical, efficient, DBT-informed techniques to target disruptive areas of emotional dysregulation can allow physicians to better provide care for the chief complaint of the visit.

Providing a training that can bridge these gaps and equip providers with the skills necessary to solve this issue is the objective of ASWMHT.

Objectives

The first aim of this training is to teach physicians skills that can help them

efficiently and effectively manage dysregulated patients, thereby enhancing their ability to assess patients experiencing mental health illness within inpatient and outpatient health care facilities. The training will provide 4 hours of practice with DBT-informed crisis management skills that will help physicians manage emotionally dysregulated patients. Attending the training will improve physicians' ability to serve mental health patients, help them assess patients' needs effectively and efficiently, and enhance diagnosis accuracy. The training's brief length will make it relatively easy for doctors to attend without taking significant time out of their schedules. The training will be conducted online.

The second aim of the training is for physicians to be able to implement the skills they have learned immediately and for them to retain the skills through 1 month posttraining. Physicians should be able to use the skills taught in the mental health training on their own, which will prepare them to serve mental illness patients in moments of crisis and emotional dysregulation with an elevated level of self-confidence.

The third aim is to focus this training on physicians within any form of health care facility to demonstrate diversity in its effectiveness.

Significance

Providing physicians with skills that can help them stabilize crises among highly dysregulated patients will meet a number of needs. Physicians will be better able to effectively service patients in need, wait times for patients will decrease, recidivism as a result of inaccurate diagnosis or regression will decrease, and physicians will have more time available for other responsibilities. This training focuses on tools that doctors can

quickly implement to lessen the intensity of highly dysregulated and high-risk crisis patients. These tools will not only give physicians the ability to assess these patients but also free up more time for physicians to meet the needs of other patients who require care. This training is short and accessible online, so it is flexible and easy to access.

Emergency departments are at a higher risk of encountering aggressive patients who, if unmanaged, can contribute to a safety issue for staff and patients (Harwood, 2017). Ideally, a patient entering an emergency room will be assessed by a physician, but this cannot be accomplished if the patient cannot self-regulate enough to engage with the doctor.

Multiple studies have shown that integrative care is most effective within medical health care facilities, but the potential implementation of integrative care has been stymied and postponed by many roadblocks (Chin et al., 2000). Current limitations include the availability of staff that will support integration, limited training, incompatibility with the workflow of physicians, and the limited experience of behavioral health providers within medical health care facilities. These limits create a gap between effective care and implementation. Physicians continue to complain about their inability to treat mental health illness effectively, and they constantly have to contend with treating patients in areas that they feel are outside of their scope. Physicians say that they are not provided sufficient clinical training or experience throughout their academic career to provide adequate mental health care overall (Smith et al., 2014).

Rationale

Multiple dilemmas arise in conjunction with primary care providers' attempts to

treat mental health illness with limited resources. The collaborative care approach has proved to be an effective way of managing mental health. In a review of 76 integrated primary care programs that aimed to be collaborative within a treatment team, nurses were most often tasked with the role of the behavioral health provider, often in hospital settings—only emphasizing the point that physicians are insufficiently trained in interventions that assist patients with mental health illness (Martin et al., 2014). In this review of multiple programs, IMPACT, Collaborative Care for Anxiety and Panic, and PRISM-E, which is derived from Wagner's Chronic Care Model, created their own sets of limitations of implementation. These programs did not have duplicable models or theoretical approaches that could be emulated within other facilities and among other providers (Martin et al., 2014).

The challenges that come with teaching and learning behavioral health therapy have created still other barriers. Cognitive behavioral therapy is a vastly used, evidence-based therapy that seems to be the default therapy referenced in studies related to treating mental health illness. One study revealed how challenging it is for physicians and nurses who learn these modalities to maintain the fidelity of the therapy tenets; these practitioners often are unable to conceptualize treatment from a more therapeutic perspective, which ultimately compromises any training being provided (Currid et al., 2011).

Compared to licensed behavioral health practitioners, providers who have had significantly less training with mental health populations are limited in the insights and techniques they can apply to the de-escalation of patients experiencing crisis and mental illness. The issue of power can also present tensions in a transition to collaborative care.

The Institute of Medicine and National Committee for Quality Assurance emphasized the importance of disengaging from power struggles by conceptualizing all members of the patient treatment team as equally important leaders, thus moving away from a physician-driven hierarchy of power and control.

The literature, however, lacks innovative ways to move forward and bridge the gap from the idea of collaborative care to evidence-based integration of care. Doing so would require steps that are feasible to implement in the here and now as opposed to attempting second-order change as a first step. This study will expand on effective ways to achieve immediate solutions to mental health care gaps. The training provided will equip physicians with techniques that are conducive to their work environments, easily implementable and retainable, transmissible through a short period of training, and informed by an evidence-based theoretical approach that translates to both diverse patient populations at all levels of acuity and diverse medical health care facilities.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

Mental health in the United States has become a huge issue and continues to grow. The U.S. health care system is being bombarded with high mental health patient counts in emergency rooms, clinics, and urgent care centers (American Hospital Association, 2019). PCPs are on the front lines of mental health care, "provid[ing] up to 74% of psychiatric care in the United States" (Abed Faghri et al., 2010, p. 18). Out of that percentage, 36% of care goes to those who are severely mentally ill (Chin et al., 2000). It is imperative that these physicians are prepared to meet patients' mental health needs, which have been evolving rapidly. Patients' access to care from psychiatrists is much lower because there are more PCPs than there are psychiatrists, positioning PCPs as the first contact in most cases for patients seeking mental health care.

According to Jones et al. (1989), "primary care physicians who are surveyed frequently report feeling pressed for time and inadequately trained and/or equipped to treat patients with psychiatric disorders" (p. 110). There are thus huge gaps both in the care available for patients with mental health illnesses and in the system that is in place for training PCPs, who contend with mental health illness the most. Since recruiting more psychiatrists is a solution that cannot alleviate the immediate need for more providers, helping physicians improve their ability to serve mental health patients would be the best realistic alternative. Providing mental health training that focuses on skills that help doctors treat patients who are emotionally dysregulated is the objective of this project.

There is a gap in access to behavioral health care globally (Luitel et al., 2017), and this gap causes many people to seek behavioral health care through PCPs (Abed

Faghri et al., 2010). PCPs often express feeling ill-equipped to handle severe mental illnesses, especially when patients with aggressive or emotional symptomatology show up in their appointment rooms. While the larger issue is the need to increase access to behavioral health care through more providers and behavioral health facilities, this is a long-term goal that cannot be accomplished in a short period of time (Luitel et al., 2017). As a more immediate approach that can act as a bridge toward the long-term goal, PCPs would benefit from this DBT-informed training, as it would help them meet the needs of their patients. Ultimately, this training will assist PCPs in helping their patients gain access to more robust, appropriate care.

Dialectical Behavior Therapy

DBT was developed in the 1980s by psychologist Marsha Linehan. DBT is a behavioral skills training that pulls from cognitive behavioral therapy and promotes specific skills derived from the therapy's major tenets (Huffman et al., 2003). The overall goal of DBT is to help patients change their maladaptive behaviors—that is, emotional, thought, and interpersonal patterns that provoke poor coping mechanisms and affect patients' life functioning (Ekdahl et al., 2016). Adopting a DBT-informed approach can equip doctors with the skills that they need to tend to patients who struggle with emotional dysregulation.

There are significant benefits to learning and implementing DBT-informed skills as a PCP because these skills are translatable within diverse health care settings and in treating common mental health diagnoses (Hoffman et al., 2005). DBT was originally developed for highly suicidal patients and those with borderline personality diagnoses. As

of 2015, however, thanks to continuous research and new, innovative ways of expanding this therapy since the 1980s, DBT had successfully treated oppositional defiant disorder in adolescents, attention-deficit/hyperactivity disorder, bulimia nervosa in women, binge-eating disorder in women, major depressive disorder, bipolar disorder, generalized anxiety disorder, and problem drinking (Neacsiu et al., 2014; Ramaiya et al., 2018). DBT has been proven to benefit a diverse population, including family members of individuals with borderline personality disorder, family members of suicide attempters, convicted offenders diagnosed with mental health disability, adolescents, adults, female victims of interpersonal violence, male victims of intimate partner violence, incarcerated women with a history of trauma, and correctional facility inmates (MacPherson et al., 2013; Moore et al., 2018).

DBT can also be used within different health care settings, from residential facilities to outpatient facilities, primary care clinics, hospital settings, and inpatient settings (MacPherson et al., 2013; Moore et al., 2018). DBT has traditionally been thought of as a yearlong treatment, however developments since the 1980s have expanded and diversified the treatment process so that it can vary based on the treatment setting. Linehan has modified the therapy into shorter intervals so that it can be applied in ways that are conducive to whatever setting a patient is in (MacPherson et al., 2013; Moore et al., 2018). As a PCP, it is important to learn techniques that can be easily implemented, that are based in concrete skills and therefore are straightforward to apply and understand, that serve a vast majority of common patient needs, and that can be used in diverse environments. Adopting DBT-informed skills can generate success in each of those areas.

DBT is being used in this training to provide PCPs with skills that can help them treat mental health illness, specifically when patients are emotionally escalated or present with emotional symptomatology (Ramaiya et al., 2018). DBT has been used in diverse environments to serve patients with diverse mental health illnesses (Ramaiya et al., 2018). This form of therapy incorporates teachable, practical skills, and significant experience is not required to use the different skills. Although there has not been a significant amount of direct research on the benefits of DBT-informed skills training for PCPs, limited research has shown how families seeking to support their family members in maintaining their recovery have benefited from using DBT-informed skills with their loved ones. Multiple trials have considered the use of DBT within families who struggle with severe mental health illness in certain family members (Ekdahl et al., 2016; Hoffman et al., 2005). Families have learned the DBT model so that they are able to engage in DBT skills in their home environment. The training discussed here adopts and transforms this concept: PCPs take on the role of family members, while the patients showing up for their appointments are analogous to the loved ones struggling with mental illness.

In these trials, DBT-informed training proved to be an effective and efficient way to help families guide their loved ones through their mental health challenges in the moment; the objective of the training discussed here is for PCPs to be able to do similar work with patients in health care settings (Ekdahl et al., 2016; Hoffman et al., 2005). ASWMHT aims to provide PCPs with teachable, easily accessible skills through brief modular training. Given that PCPs already have experience with patient care, less intensive training will be required to give PCPs the skills they need to be an effective

bridge to providers who can provide more extensive, appropriate care.

In recent studies, DBT skills have been used by providers such as nurses and have proved to be effective with patients (Huffman et al., 2003). Training in validation, dialectical thinking, behavioral interventions, and DBT skills has improved relations between nurses and patients, and practicing validation has helped both staff and patients feel mutually supported and understood (Hoffman et al., 2005). Implementing this training has increased patients' compliance with treatment recommendations, and their receptiveness to limit setting. Being able to set limits with certain patients gives providers more bandwidth to contend with the more challenging patients (Hoffman et al., 2005). Dialectical thinking gives providers and patients a better understanding of how opposites can exist simultaneously, which allows for better communication and insight into working through dichotomous thinking in patient care. This can help providers to communicate and patients to understand that, despite patients' emotional struggles, they will need to change their behavior. Providers and patients can thus build rapport, as both acknowledge what is currently happening with the patient and simultaneously help the patient understand the need for change. Behavioral interventions can help eradicate behaviors that interfere with treatment while providing better structure and boundaries for caregivers (Hoffman et al., 2005). Lastly, teaching DBT skills can help patients with their own distress tolerance and emotion regulation, which in turn can improve their communication with caregivers in the service of better meeting own their needs and building better rapport (Hoffman et al., 2005).

DBT's common goal is to help each patient live a more fulfilling life. Part of achieving this involves addressing behaviors that may interfere with this mission,

including but not limited to high-risk, debilitating behaviors. This form of therapy is a collaborative approach that requires the participation of both patient and provider. It is also support-oriented and seeks to help patients focus on their strengths to build self-confidence. DBT takes a systems approach in that it acknowledges that all things are interconnected and that change is not only constant, but inevitable.

DBT emphasizes that opposites can be integrated to help with "empathetic approaches towards others, becoming more responsive rather than reactive, and becoming more adaptable and resilient" (Horne, 2021). An example of the integration of opposites could be: "I voted Democrat, and I also see that Republicans have some good points on certain issues." Another example would be: "A person can be violent and compassionate." DBT aligns well with the patient and PCP relationship specific to the objectives of this proposed training. Patient care, specifically when a patient is emotionally dysregulated, can be challenging for both the patient and the PCP. DBT was intentionally chosen as a therapeutic modality for ASWMHT because it focuses on providing skills that facilitate patient care through the building of empathy, adaptability, and resilience.

DBT skills training includes four modules: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Each of the modules provides teachable skills that can be utilized in day-to-day practice and easily implemented immediately after training. Mindfulness is the foundational skill in DBT. Mindfulness originally derived from Buddhist practice. However, even though DBT is influenced by Eastern spiritual traditions, it does not teach any form of religion or spirituality. Mindfulness skills are focused on helping patients practice awareness of their

environment using the five senses: touch, taste, sight, smell, and sound. Mindfulness helps patients practice acceptance in moments of discomfort. This approach is meant to help patients concentrate on what is happening in the present by focusing on doing one thing at a time.

Mindfulness exercises are meant to help patients manage intense emotions that promote reactivity, which increases emotional dysregulation. In the realm of patient care, it is imperative to provide PCPs with mindfulness skills that can help patients who are experiencing emotional dysregulation lessen the intensity of their emotions and become more present. De-escalating patients will in turn help physicians provide comprehensive, effective, and efficient assessments that are accurate to patients' needs. Helping patients become more oriented to their immediate needs provides physicians with the information they need to provide a high standard of care. It also lessens the likelihood of misdiagnosis and poor adherence to treatment recommendations because it avoids the potential negative impact of poor patient–doctor rapport in the event that a visit were to persist with an escalated, emotionally dysregulated patient.

Interpersonal effectiveness skills focus on adaptive communication between the patient and PCP. These skills give physicians tools to ask for what they need, ways to say "no," and strategies for contending with conflict that presents itself in the visit. These skills promote respect toward self and others through listening empathetically, using validation, and boundary-setting. Working within diverse health care facilities with mental health patients of diverse levels of acuity requires interpersonal adaptability and flexibility. When physicians must engage an escalated patient in a time-sensitive visit, it can be both time-consuming and challenging to provide an accurate assessment if the

physician does not have effective tools and techniques to gather the information necessary. Specific interpersonal skills help doctors keep in mind quick ways to help patients feel more understood, allowing more opportunities for resistance to subside. These skills can allow the physician to provide uninterrupted service, which can improve the rapport between physician and patient. If a patient is unable to de-escalate, a visit may require additional staff involvement, thus requiring a delay in service. Conflict resolution skills and a more validating and empathetic approach can not only maintain confidence within the patient–physician relationship but also enhance patients' adherence to treatment recommendations beyond the visit.

Distress tolerance skills are meant to help patients tolerate the moment and accept what cannot be changed in any given moment, including such things as deaths, illness, and other extenuating circumstances that are outside of one's control. Patients experiencing distress due to these circumstances may come in to visits highly agitated and find it challenging to articulate their needs. The focus of these skills is to help patients refrain from judgment of the circumstances and accept the associated distress rather than fight against reality. Distress tolerance skills allow physicians to begin to help patients move forward in a more effective and progressive way rather than staying stuck in the dysregulation. Patients in this state tend to perseverate about things that cannot be changed, which only intensifies their agitation and stagnates their chances of moving forward by meeting their more immediate needs during the visit. Often, patients who experience this agitated state struggle to do or are unwilling to do what is effective, which results in further resistance and agitation. This directly impacts patient care through high levels of resistance and often oppositional behavior, which is manifested through

symptomatology of emotional dysregulation. Such situations with challenging patients can require additional time to handle, which can delay assessments and other forms of care. Distress tolerance skills include crisis survival skills that enable physicians to provide guidance to patients who are experiencing painful situations that are provoking intense emotional dysregulation. The skills will help patients lessen the intensity of their emotions so that they can exercise willingness to engage in the visit and adhere to the treatment recommendations that are being provided for their care.

Emotion regulation in DBT provides techniques that teach patients how to identify and experience their emotions in a way that does not cause feelings that are overwhelming. Emotion regulation skills are meant to avoid triggers that catalyze impulsive behaviors. The skills are meant to help lessen the intensity of emotions in the moment and to deter escalation. Often, emotional dysregulation is accompanied by false perceptions that can lead to irrational decisions and judgment. This is very impactful on the patient–physician relationship when providing care, building rapport, and establishing willingness for compliance.

Emotion regulation skills provide physicians with an opportunity to utilize simple approaches that can improve interactions when emotionally dysregulated patients are struggling. Emotion regulation skills target impulses related to mood swings, somatoform disorders such as chronic pain from medical conditions, self-harm and/or suicidal behaviors, rumination of intrusive thinking patterns, and poor self-control.

Emotion regulation skills can provide practical ways to contend with emotion-based perspectives that are not based in facts to help patients gain a more grounded perspective of their treatment. This approach works well within the short stints of time

that fit within the workflow of patient visits. These skills help refocus the patient away from impulsive urges and toward the here and now, with grounding approaches that also enrich the patient–physician rapport. Emotion regulation skills are meant to help patients feel more in control of their emotions and to empower them to articulate their needs more effectively, which benefits the provider seeking to serve the patient and the patient seeking the care that they need.

According to Hodges et al. (2001), "primary care research showed that primary care physicians already felt strongly that they should care for the emotional needs of their patients" (p. 2). Overall, the skills focus on "acceptance skills which are demonstrated through mindfulness and distress tolerance, while the change skills are demonstrated through emotion regulation and interpersonal skills" (Eist, 2015, p. 2).

Family Systems Theory

Systems theory sees symptomatology as a part of a system and not isolated to the person experiencing the symptoms (Fiese et al., 2019). Repeated patterns of interaction within the family perpetuate the symptoms of any one family member (Bortz et al., 2019). Systems theory focuses on a circular causality that interlocks one person's behavioral issue with the behaviors of others within the family system. This concept facilitates the identification of repetitive patterns of behavior that uphold problematic interactions within the family unit.

Family systems theory (FST) operates on two assumptions: first, that individuals can't refrain from communicating, and second, that individuals are continuously trying to define the nature of their relationships with others (Bortz et al., 2019). In essence, FST

looks at how the behavior of one person in the system affects the others involved in the system; that is, it monitors how their actions manifest within other members of the system. The interactional patterns that exist between family members allow the therapist to see the family unit as a mutually causative system that engages in complementary communication that reinforces problematic behaviors. As a family therapist, seeking out rules that uphold the behaviors within the system will help promote interventions that can change the rules, which, in turn, will affect the patterns of interaction, making the symptomatic behaviors futile (Pinkus, 2006). The objective of FST is to break up patterns that promote maladaptive behaviors and replace them with adaptive behaviors. The emphasis of change focuses on the system and not the individual.

ASWMHT DBT-Informed Training

ASWMHT seeks to improve patient care overall by encouraging adaptive interactional patterns among the PCPs from whom patients are receiving care. Studies have indicated that PCPs struggle with unstructured clinical interviews, and incomplete interviews can lead to underdiagnoses of mental health illness (Abed Faghri et al., 2010). The training is meant to equip and empower PCPs with the skills they need to de-escalate emotionally dysregulated mental health patients, in turn allowing them to treat patients more accurately and permitting more effective, efficient intermediate care until the patients are able to see the appropriate care provider. The interactional patterns between PCPs and these patients reflect a systemic dynamic that is affected by both verbal and nonverbal communication. Mental health patients who are dysregulated struggle to communicate effectively. A strategy based on systems theory can allow the PCP to be the

changing agent and disrupt maladaptive interactional patterns that may escalate emotional dysregulation. In order to provide enhanced care for patients, it is crucial that PCPs stay focused on what is being presented in the moment and navigate the barriers that threaten to get in the way of effective assessments. In turn, PCPs can feel more empowered to work with the mental health population effectively and efficiently, acting as a temporary solution to the bigger issue of the lack of providers and treatment facilities for mental health patients. Equipped with the interventions taught through training, PCPs will be in a position to spearhead systemic changes within the patient–doctor relationship.

ASWMHT aims to take an FST-inspired approach to the issue of PCPs receiving an influx of mental health patients due to a general lack of resources and available psychiatrists. As a temporary, more immediate way to address this problem until more resources are available, providing PCPs with training will enable them to act as a bridge for mental health patients and will help them contend productively with patients' emotional dysregulation. Looking at this issue from a systemic approach, providing DBT-informed skills to PCPs through a brief training can help them provide sufficient, in-the-moment care before patients can get to more appropriate providers. Without the training, PCPs may feel inadequate to serve the mental health patients they receive, affecting their confidence. This dynamic could result in misdiagnosis, which may cause patients to experience regressive symptoms and increases their likelihood of recidivism (Abed Faghri et al., 2010). These circumstances would continue to cause frustration among patients and PCPs, creating an environment lacking trust and validation that would affect patient care, communication, rapport building, and rates of adherence to providers' recommendations. Overall, patient and provider interactions would be affected

negatively. Interactions between patients and PCPs thus demonstrate circular causality (Abed Faghri et al., 2010). An emotionally dysregulated patient who shows up to see a PCP is directly affected if that PCP lacks the skill to provide appropriate patient care in their interaction. A poor result from this interaction can disrupt the patient's experience in the form of misdiagnosis risk and disengagement from the treatment process. These outcomes can further result in distrust of primary care providers, rapport loss, and a high likelihood of recidivism. This system, in essence, is a stable negative feedback loop.

Providing ASWMHT to PCPs can shift this negative feedback loop into a positive feedback loop and promote a more adaptive interactional pattern. Giving PCPs the skills they need to de-escalate and assist mental health patients in moments of distress can help them improve their interactions with patients through positive engagement, higher levels of confidence, and enhanced rapport. There is little research to indicate this as an evidence-based claim, which may act as a limitation related to whether DBT-informed training can actually achieve these proposed changes. Hypothetically, this process could shift the system into a positive feedback loop.

A combined DBT–FST approach has proved to be effective in situations of caring for family members in the home who struggle with mental health illness. The concept of teaching DBT skills to families mirrors the proposed approach to training PCPs to care for their patients. In DBT–FST, interventions are implemented that incorporate acceptance and change techniques. According to DBT–FST, there are four focal points in this treatment process: skills training, application of skills to the environment, balancing and treating the therapist, and enhancing the motivation of the patient, which is done through individual therapy (Hoffman et al., 1999). Skill building is accomplished through

instruction and practice. Skills are discussed among the family members and with the therapist so that the family can gain better insight into application of the skills in vivo. In providing family members with skills, the DBT treatment has been implemented within a family system effectively.

This DBT-informed skill-building process can be adapted to the patient–physician dynamic. This framework functions in the same way that the DBT-informed training would, with the idea that training would be focused on specific skills that pinpoint techniques that can help physicians contend with emotional dysregulation and the immediate needs of patients with mental health illness. This DBT–FST model of treatment and the skills it provides have been proven effective among families as a whole (Hoffman et al., 2005)

CHAPTER THREE

LITERATURE REVIEW

PCPs Are the Main Doctors Seen for Mental Health Reasons

Mental health continues to be a prominent problem in the U.S. health care system. According to the National Institute of Mental Health (2021), 1 in 5 U.S. adults experiences mental illness each year, approximately 5.2% of U.S. adults experience serious mental illness, and an estimated 49.5% of U.S. youth aged 13–18 experience a mental health disorder each year.

Many studies have pointed out physicians' lack of confidence in their own ability to treat mental illness accurately due to their lack of training (Smith et al., 2014), but the fact is that "primary care physicians provide up to 74% of psychiatric care in this country" (Chin et al., 2000, p. 412). This reality raises the question of how equipped PCPs actually are to contend with this demand. Training has been identified as a pertinent and much needed provision for physicians in their day-to-day practice in medical care facilities, yet the accessibility, demands on time, and focal points of such training all can be huge barriers to physician participation (Ross et al., 2015). Dedicating significant time out of one's day to long hours of training—which may take days to provide a full understanding of mental health and to cover the specific intricacies of meeting the needs of mentally ill patients—is untenable for the function and role of most PCPs due to preexisting demands on their time and the systemic effects of their presence in their work environment (Solomon, 2008).

Contending with the service lost due to training participation, providing the

appropriate staff to conduct the training, and finding the facilities to host a secure training are all factors that require financial resources and that must be addressed. These challenges make facilitating any long-term training that removes physicians from their roles for long spans of time problematic (Harris et al., 2019). Rather than seeking out an expansive approach that delivers time-consuming training to PCPs, a better approach would be a more direct one that focuses on specific, teachable skills that are easy to adopt in practice. A short training that does not demand much time, operates on an accessible online platform, and is cost-effective (in that it requires very little change and only one trained facilitator) would sufficiently navigate the aforementioned barriers.

PCPs are the frontline workers for mental health patients (Ross et al., 2015), and their lack of training in this area has proved to have negative ramifications for patient care, with systemic impacts (Harris et al., 2019; Jones et al., 1989). The cycle of mental health patients with minimal accessibility to psychiatrists continues to necessitate the ongoing demand for PCPs to service patients (Ross et al., 2015). Providing training that focuses on skills to address symptomatology and emotional dysregulation is a temporary fix. The ultimate, long-term goal would be to have more providers and behavioral health facilities, but in the interim, being able to provide a training that can facilitate a more immediate approach—enabling PCPs to provide services that will assist patients immediately until they can be seen by the appropriate provider—is the objective. The focus on providing DBT-informed skills training to address emotional dysregulation and symptomatology will provide PCPs with accessible techniques that they can use in interactions with their patients.

Currently, PCPs are bombarded with mental health patients that have

heterogeneous mental health issues with various symptomatology, including emotional dysregulation (Harris et al., 2019). Rather than taking a generalized stance and delivering an abundance of information related to mental health diagnoses and the use of assessments, this training will teach PCPs through a relatively specific lens, in a way that will help them navigate patient care productively and accurately, how to de-escalate patients who present with emotional dysregulation and diverse symptomatology (Halpern, 2007). Doctors struggle with treating mental health patients before they can secure care with the appropriate providers (Halpern, 2007). The DBT-informed skills are meant to act as quick methods that allow for de-escalation and address diverse symptomatology.

Organizing the deficits within the patient–physician interaction allows for a more intricate approach that targets specific areas of improvement; not only can it promote better diagnoses, make patient–provider interactions more efficient, and enhance the alliance between patient and provider, but it is also practical, immediate, and effective in its objective (Halpern, 2007; Platonova & Shewchuk, 2015). Assessments, which are a crucial part of any visit with a provider, dictate treatment plans and are crucial to patient care. Inaccuracies in the assessment can create a snowball effect of negative ramifications related to the patient's care. Focusing on barriers to assessments and figuring out the sources of deficiencies can help indicate the most productive areas of emphasis within training.

Approaches that help providers interact with challenging mental health patients must begin with communicating and building rapport. Mental health issues can present with diverse symptoms, which may also create barriers in providing care to this

population. Provider training that focuses solely on symptom identification has proven to be ineffective, as indicated by continued deficiencies in patient–provider interactions. Engagement with mental health patients requires skills that allow for immediate de-escalation of a patient's emotional dysregulation as well as rapport building, primarily in order to conduct the next steps of the triage approach. Due to the limited mental health resources available, mental health patients require a bridge of treatment that allows them to maintain stability until they can be seen by the appropriate providers. Because the demands on the time of any physician are considerable, the initial assessment offers the best opportunity to gain an understanding of what needs to be treated. Often, mental health patients struggle with emotional dysregulation, which is an escalated state in which patients are debilitated in their ability to think clearly and communicate and are highly reactive, both physically and verbally (Harris et al., 2019).

Physicians' lack of training has left many patients with mental illness symptoms undertreated (Ross et al., 2015). There is limited research that has identified specific target areas in which it would be best for PCPs to train, since the primary focus overall is to continue to train in symptom recognition for diagnostic purposes and to work toward integrative care with mental health practitioners, which will require a significant amount of implementation time. There has been limited research addressing the idea of training PCPs with techniques that focus on emotion regulation and symptomatology.

Rather than providing a broad training, the idea is to start from a more practical place that can effect change more immediately. Teaching specific skills that apply to physicians' daily interactions with distressed mental health patients provides great advantages to the both the patient and the physician, and it can reduce patient recidivism

rates. This is an innovative way to immediately put tools in the hands of physicians that can de-escalate patients, allowing physicians to conduct assessments and perform any other needed services that catalyzed the visit. Treating patients effectively starts with understanding the patient through interpersonal engagement, and being able to receive as much information as possible while maintaining a de-escalated interaction can better the overall experience for the patient and physician (Platonova & Shewchuk, 2015).

Lack of Mental Health Training for PCPs

A national survey of the didactic and clinical hours provided in primary care/internal medicine residencies concluded that the amount of mental health training provided to residents is insufficient. This survey indicated that residents received mental health training for a total of 99 hours, with 69.5 hours going toward clinicals and an additional 29.8 hours dedicated to didactics, during their 3-year residency training (Chin et al., 2000). According to the survey, approximately 7 out of 10 residents felt that the training was insufficient. This approach does not address the physicians that are currently practicing and contending with mental health patients; it instead attempts to prepare up-and-coming physicians. In addition, the insufficient training in residency leaves physicians highly vulnerable to rendering misdiagnoses. Patients in turn experience a higher risk of worsened symptoms because of this deficient system of mental health care. Mental health care training for PCPs is often concentrated on diagnosing patients accurately to determine the appropriate course of medication and referral. This generalized approach to an entire population that contends with dual diagnoses and comorbidities has been determined to exacerbate the mental health crisis. The average

amount of time dedicated to mental health in medical school is 30 hours of didactic training and approximately 20 hours of clinical training (Smith et al., 2014). Again, while teaching new doctors can affect the future, it neglects the issues affecting bombarded physicians now. Many approaches to mental health training are based on a linear logic that does not consider workflow, time management, the accessibility of training, and to what extent the training should focus on any one area of mental health (Davis et al., 2019).

The idea that there is a need for training is not so much the issue; questions of how best to facilitate the training and which target areas to focus on are more significant concerns. Approaches to the lack of training do not always consider the whole experience of physicians: They may not consider how physicians' interactions with patients differ in different settings or how different environments will determine the severity levels of the patients who are seen, the prevalence of different diagnoses, and the systemic support that physicians have. Harris et al. (2019) noted that "the American Board of Pediatrics (ABP) released the pediatric entrustable professional activities in 2013, which highlighted the need for the pediatrician to demonstrate the ability to assess and manage patients with common behavioral and mental health issues" (p. 4). It is no surprise that doctors who are most likely to treat mental health patients are not adequately equipped to serve this population (Harris et al., 2019).

Various studies have indicated the need for residents entering their careers as physicians to be more adequately trained in mental health (McMillan et al., 2017). There are limited studies, however, that identify how specific tools in the realm of de-escalation can best be directed toward dysregulated mental health patients. Thus, few studies can be

used to validate these specific elements of the communication process between physician and patient. Some call for physician education to restore a focus on mental health, seeing this as a potentially great contribution to the needs of society (Smith et al., 2014).

Given the many reviews that demonstrate the need for more effective mental health training, the question becomes: How is it that we continue to contend with high levels of unseen or misdiagnosed patients and with physicians' continued complaints of feeling ill-equipped? Accessibility, stakeholder cooperation, and time are all crucial factors in being able to solve these problems (Davis et al., 2019). Providing training in basic, practical techniques that can easily fit into the lives of physicians while also effecting change is the objective of ASWMHT. Effectively navigating challenges within patient–physician interactions in moments of patient escalation would require physicians to have immediately implementable skills that enable supportive, effective communication and rapport building (Platonova & Shewchuk, 2015).

Working with mental health illness presents issues related to communication that affect patients' willingness to engage in treatment (Silverman et al., 2005). The importance of the therapeutic alliance rapport as it relates to compliance is often overlooked in common training approaches (Platonova & Shewchuk, 2015). Wait times for psychiatric care continue to be problematic. Therefore, being able to bridge the gap temporarily can be a step in the right direction as mental health facilities hire more providers and evolve to meet the needs of the mental health population. Considering how providers can best acquire information in situations where patients are dysregulated can affect the workflow of patient care greatly (Harris et al., 2019).

Similar Programs That Exist and What Is Missing From These Programs

The available literature related to training meant to help PCPs in their interactions with mental health patients is restrictive and limiting. While there are DBT-related programs in which providers teach this form of therapy to patients to help them self-regulate, very few programs offer training for the sole purpose of equipping doctors with these skills for themselves to use as they treat mental health patients. However, some programs take a similar approach to DBT-informed training: They focus on providing skills to people who interact with individuals struggling with mental health who may be subject to emotional dysregulation and symptomatology.

Multiple trials have explored the concept of teaching family members and hospital providers DBT skills, and these programs have proven to be effective in building rapport through validation, maintaining compliance with treatment plans, and creating a higher quality of engagement through effective communication (Rathus et al., 2015).

Families with loved ones who suffer from mental health illness were given an opportunity through DBT programs to learn skills focused on distress tolerance, emotion regulation at different severity levels, and communication skills in the midst of emotionally heighted situations. Teaching family members tools that are adaptable to their home environment has helped them engage with their afflicted family members in ways that promote connectedness and acceptance (Wilks et al., 2016). Families can feel more empowered in their ability to be a supportive part of the recovery process.

In other trials, nurses in a hospital setting were trained to use DBT skills in their interactions with patients. The patients involved in the trial were not restricted to those with mental health illness, but the trial focused on challenging patients who were reactive and

noncompliant. These trials demonstrated improvement in provider–patient interactions (Rathus et al., 2015; Hoffman et al., 1999). The DBT skills that were taught focused on validation, communication skills, and emotion regulation. Teaching providers these skills lessened nurses' vulnerability to emotional reactivity toward challenging patients, created more opportunities for positive engagement with emotionally dysregulated patients, and facilitated more effective communication that led to better patient care compliance (Hoffman et al., 1999).

Learning specific DBT skills focused on interactional experiences within a family system or working environment proved effective in bettering relationships both between family members in the home and between care providers and their patients in health care facilities (Hoffman et al., 1999; Wilks et al., 2016). DBT proved to be most effective in relation to patient care in the specific areas of limit setting, moving through dichotomous thinking patterns, and validation (Hoffman et al., 1999). Specific behavioral interventions accompanied each of these categories, and the overall approach both promoted more understanding within the patient–provider relationship and protected healthy boundaries to reinforce treatment recommendations (Hoffman et al., 1999). Not only did this approach benefit patients in their experience, but providers also reported feeling that a sense of mutual support had developed within the culture of their work environment. The benefits grew beyond patient to provider and spread throughout the work environment, creating a positive culture that integrated the DBT skills into how medical care providers interacted among each other (Hoffman et al., 1999).

There have so far not been studies that have elaborated on how the teaching of DBT skills affected the family dynamic within households that participated in the DBT program.

The studies available only highlight the training's positive effects relative to the challenges of contending with family members with mental health illness without any skills to help navigate the recovery process in the home.

Most trainings that are currently being researched relate to integrative care that combines the work of PCPs and mental health professionals. These trainings offer onsite instruction that incorporates psychiatry and gives medical students and residents more exposure to patients with mental health illness. A nationwide survey was conducted to assess medical students' perceptions of a consultation-liaison psychiatry clerkship rotation. This clerkship enabled students to work with psychiatric specialists who coached and mentored students as they developed their skills. The survey revealed that "82% of participants recommended this clerkship to other students, seeing this program as beneficial" (Meyer et al., 2018).

Staffing needs and time restraints are barriers to providing a level of training that is consistent with providers' needs. Current programming does not address the skills that practicing PCPs need now. The chronic deficit of providers, specifically psychiatrists and general medicine physicians, makes engaging these professionals in capacities outside of patient care a huge challenge. Programs that provide an enhanced level of training on mental illness care continue to be problematic in their implementation, as numerous barriers related to staffing and time constraints continue to stagnate this approach (Davis et al., 2019). Most of these additional training programs focus on assessment measures and skills related to diagnosing patients accurately. While these approaches have been seen as effective, the time required to attend such trainings varies.

Because of the numerous factors that can get in the way, the approach taken by

the consultation-liaison psychiatry clerkship rotation is limited in the extent to which it can be utilized to effect replicable, sustainable change. This approach has yet to be implemented in a way that has meaningfully affected the mental health epidemic or remedied the continuous deficiencies that PCPs still face. This program, much like many others following the model of on-the-job training, gave insight into how effective it could be to pay more focused attention to mental illness alongside staff who have experience; the program enhanced both the knowledge base of the students and their confidence levels in being able to offer a high level of care to their patients. As mentioned previously, 82% of participants found this approach to be effective (Radhakrishnan et al., 2019).

The Ontario College of Family Physicians received government funding to provide a collaborative mentoring program that aimed to help physicians develop competence in the area of mental health; this program proved to be effective (Radhakrishnan et al., 2019). This approach aligns with other programs that rely on physician-to-physician mentorship to teach enhanced skills in the realm of mental health. Many programs that have attempted and successfully trained other physicians feature a liaison and on-the-job training for multiple days. The issues, however, continue to remain the same: The staffing and funding resources are not sustainable enough to engage this as the ideal approach in tending to deficiencies in mental health education. While this approach addresses training for doctors in the future, it does not address how doctors can access training now in any easily implementable capacity.

Additional programs from North Africa, specifically Tunisia, offered a training called the Mental Health Gap Action Program. In this program, nonspecialists provided

mental health–based training, which was ruled to be effective in developing physicians' ability to work with this population (Spagnolo et al., 2020). This idea lends itself seamlessly to engaging professionals outside of the realm of physicians and inviting others to offer trainings. Despite the numerous programs that have implemented more training in mental health treatment—with results that demonstrate effectiveness in improving participants' knowledge bases, interest levels, accuracy, and confidence levels—there has been little change. There are many people that support the idea of additional training, such as professors and students, yet resources and time continue to be barriers (Davis et al., 2019).

The number of supporters who act as stakeholders and influence funding for these trainings continues to be limited, considering the lack of providers to draw from to actually implement these trainings in addition to the limited interest in providing additional mental health care standards for medical students. Countless trials have been evaluated and continue to demonstrate that better physician training produces positive results in terms of enhanced patient care. The problem also affects the heightened cost of health care, as high recidivism rates from poor care often result in the use of emergency rooms rather than the use of social service clinics that can be more effective and less costly (Gabel, 2010). A lack of adequate training for up-and-coming physicians will only exacerbate the issue by putting PCPs in positions where they need to use on-the-spot training with this population, which increases the likelihood of mistakes and runs an even higher risk of spawning return visits, damaging trust within the patient–provider relationship, and jeopardizing patients' willingness to follow recommendations (Meyer et al., 2018).

How My Program Is Different

Enhancing mental health care training for providers can take a significant amount of time, depending on the degree of depth that training programs choose to require. Programs may range from weeks to months of training, a length of time that continues to prevent training from becoming standard practice among PCPs. While learning about symptomatology for mental health patients is vital, there are various ways to seek this information independently, and technology and alternative resources are available that can help guide diagnoses.

However, interactions between mental health patients and PCPs offer physicians opportunities to use practical techniques for managing emotional dysregulation and other symptoms. The DBT-informed skills training program was developed to teach effective, practical, accessible, and time-efficient skills that can be easily implemented immediately after learning about them through manuals. The DBT-informed training program consists of two 2-hour sessions that are taught online, which is both more accessible and more feasible for physicians to incorporate in their demanding schedules.

This short-term training lessens the demands of time and coverage on PCPs, making it easier for them to attend. The skills are taught through a manual that provides specific instructions for implementation. The manuals are easily reproducible, allowing this training to be duplicated in other departments and providing ample opportunities to spread techniques that target emotional dysregulation and symptomatology. De-escalating patients promotes more effective patient–provider communication, allowing patients and providers to relay higher-quality information and build better alliances (Platonova & Shewchuk, 2015). This can equate to increased compliance with

recommendations. A significant number of patients that are discharged from PCP visits do not follow up with the PCP's recommendations (Papageorgiou et al., 2017). Although there are no studies showing that better patient compliance will necessarily follow from this training, there are studies that correlate increased compliance with a supportive alliance between patient and provider.

The skills taught in this training will not only help with de-escalation but also provide opportunities for providers to engage with patients in a more grounded state; providers will learn to demonstrate their willingness to help patients work through difficulties in a way that can further the patient–provider alliance and encourage patients to comply with recommendations. These skills can be applied in any area of practice, which is a great aspect of this training program. Even though the target for this training is the care of emotionally dysregulated mental health patients, these skills can improve patient care in other areas, too. De-escalation skills can be helpful at any level of dysregulation, and they can be used in personal life circumstances; with family, friends, or coworkers; and in any other situation that involves interactions with people. Emotional escalation is a part of the human experience and therefore makes these skills viable and valuable in life as a whole.

Providing these skills can elevate PCPs' confidence. PCPs become more willing to engage with patients when they have a better grasp of how to navigate disruptive behaviors that may get in the way of facilitating any form of treatment. Research has demonstrated that PCPs' level of confidence in working with the mental health population has suffered (Abed Faghri et al., 2010). The idea of having to serve a population with which they have had deficient training has given PCPs a level of

discomfort and insecurity with being able to facilitate adequate care. PCPs must often serve people who struggle with mental health illness and experience heightened emotional states, which only seems to further providers' feelings of vulnerability and insecurity with their skills. Giving PCPs opportunities to develop skills will empower them to interact with these patients more freely, knowing that if they come across challenging patients, these are skills that can help them.

Confidence levels can further complicate physicians' ability to serve, with possible avoidant behaviors, disengagement, and invalidation polluting the interaction between patient and physician. Providing a practical, easily implementable solution may not only improve the relationship between patient and physician but also boost physicians' sense of their own ability level, which can in turn affect the engagement of the visit in a positive way (Harris et al., 2019). The idea of this approach is to teach time-sensitive, practical techniques that can be immediately implemented. PCPs are in high demand when it comes to the patient-to-provider ratio. This is also true when it comes to the mental health population.

Psychiatrists are less likely to see the mental health population as frequently as PCPs for two reasons. One reason is that the number of psychiatrists as compared with PCPs is significantly deficient (Abed Faghri et al., 2010). Second, PCPs are most likely to see these patients because they are more financially and physically accessible than psychiatrists (Abed Faghri et al., 2010). Creating a program that focuses on more immediate needs and that can address the problem now can be a huge benefit in that it gives physicians more autonomy over their interactions with patients; physicians will feel better equipped to handle mental health patients' abundant needs until they can be seen

by the appropriate provider. A 4-hour training that does not require additional physicians to facilitate, that is manualized, that is accessible online, and that is practical in its focus on physician–patient interaction meets physicians' needs in all areas where other programs lack.

The DBT-informed training program also addresses culture. Patients of some cultural backgrounds—Asian American patients, for instance—may experience more somatic symptoms resulting from psychological distress, and these symptoms often result in PCP visits. Although these visits really stem from mental health illness, stigma and culture play a role when patients determine which type of provider they should see. Asian cultures in general tend to carry stigma related to mental health, which only perpetuates underutilization of therapy and premature discharges (Leong & Kalibatseva, 2011). Among diverse ethnic and racial minority groups, furthermore, there is significant distrust in the mental health system (Leong & Kalibatseva, 2011). Providing a training that not only focuses on diagnostic needs but also expands into cultural sensitivity satisfies an additional cultural competency component that often seems to be missing in other trainings. The DBT-informed training program can be instrumental in providing a more holistic approach, as it equips physicians for their interactions with mental health patients of diverse cultures and ethnicities.

DBT has been modified to provide a culturally sensitive intervention that was effective among and embraced by women in Nepal; this therapy included modalities related to emotion regulation and mindfulness, but other aspects of this model posed challenges with respect to navigating the language barriers (Ramaiya et al., 2017).

Given ongoing research on ways to adjust and modify therapies to accommodate

culture and ethnicity, DBT was chosen as the model to influence ASWMHT. The training's practicality in terms of skill use, time efficiency, and cultural sensitivity are significant benefits that make it effective not only in the acquisition of techniques but also in terms of its flexibility for use among diverse providers such as nurses, therapists, and physicians.

The question of high demand for an insufficient number of providers raises the issue of time. In the state of California, the average PCP visit has lasted "13 to 24 minutes with patients for at least the past three decades" (Dugdale, 1999). The chronic deficit in providers continues to pressure physicians to meet patients' needs in the most time-efficient way possible, which affects visit times.

Often, physicians must consider the amount of time spent with each patient. Ideally, physicians would find ways to give more attention to the patients who require it based on the presenting issues. Providing tools that de-escalate circumstances in a practical way so that physicians can reach the goal of treatment faster will not only benefit the doctor and the patient but also create more opportunities for physicians to meet the needs of more people more effectively. In general, time demands are different for dysregulated patients than they are for patients who are not dysregulated. Giving physicians tools to de-escalate patients will allow them to use their time with these patients more effectively, rather than using their time in an inefficient de-escalation process or seeking out other providers to assist, such as nurses or physicians in other disciplines. Doing so would strain resources and take them away from other patient care responsibilities. The workflow would be affected immediately and could affect other levels of care with a trickle-down effect.

DBT has been an effective therapeutic model for individuals with severe mental illness and has been adapted for all levels of severity and diverse diagnoses. The DBT-informed skills taught in the training provide an effective approach that will be beneficial to physicians in targeting the patients that they are the most likely to see in a health care facility. The skills taught have proved to be effective in significant research related to high-risk patients. The skills can be used in diverse clinical settings and among patients with diverse diagnoses that are likely to appear in any given medical facility.

Overall, teaching DBT-informed skills is an immediate approach to providing PCPs with techniques that they can use to improve their patient care on an interpersonal level right away. The skills have been identified as teachable, effective, and efficient, as they have been practiced and duplicated across disciplines and derive from a DBT model that has been taught to many and practiced with many licensed mental health practitioners.

Limits to My Program

This study has a number of limitations related to the limited number of participants. The participants were all former medical students of St. George's University who now practice in a variety of specialties as resident physicians. In future research, trainings should include a wider range of participants to explore the effectiveness of the training. The training was promoted as voluntary, which could have affected the results and influenced interest level in the training. Few studies have been done on the effects of a 4-hour training on specific skills that relate specifically to mental health illness and emotion regulation.

The literature does point out the effectiveness of training for PCPs in the realm of diagnostics for the mental health patient population. Some trainings help PCPs focus on what to look for as they assess mental health patients. This feature of patient care has been addressed through multiple techniques, including assessments that patients take as a way to help physicians maintain their workflow and gauge symptoms that patients may not feel compelled to share or even know how to explain. These assessment tools are seen as cost-effective, immediately implementable in a way that does not disrupt physicians' workflow, evidence-based, and easily trackable.

This training program will require effort, willingness, and an adjustment phase to begin to implement new ways of engaging with patients. These techniques may seem more taxing compared to assessment tools, since the latter do not require much interaction between a PCP and a patient. Culturally, there are gaps in the proposed training; although DBT-informed skills are considered implementable in culturally responsive ways, additional training outside of the 4 hours would be required to demonstrate how to consider patient culture in more depth. This training is primarily focused on skill building and not as much on how to modify this approach to suit the needs of diverse cultures.

The literature is limited in its designation of studies that focus on the barriers to PCP care for mental health patients. The focus of the literature is not so much on PCPs' deficiency in terms of lack of skills as it is on the necessity of training PCPs in mental health illnesses and accurate detection. Understanding the criteria for diagnosis is not the only issue; being able to navigate reactivity and emotional dysregulation is also key, since being able to communicate effectively can assist in the diagnosis process and may

allow providers to differentiate between an isolated moment of dysregulation versus the dysregulation being part of the diagnosis as a whole. Based on the literature, providing more information about diagnostics in addition to onsite training with a psychiatrist is an effective way to improve PCP care. The provided training will be implemented by a licensed clinician with specific experience with emotionally dysregulated patients, which does not encompass the lens of a PCP. This could also be seen as a barrier in terms of how this training would pertain to PCPs' experiences, given the different scopes of practice.

CHAPTER FOUR

METHODOLOGY

This chapter describes the research methodology used for this dissertation. The research focused on social and behavioral science methods. This section discusses the research approach, data collection process, sample selection, and process of analysis. It discusses the different forms of interventions that were utilized in the study and includes sample questions from multiple surveys used for this project in addition to a logic model (Figure 1).

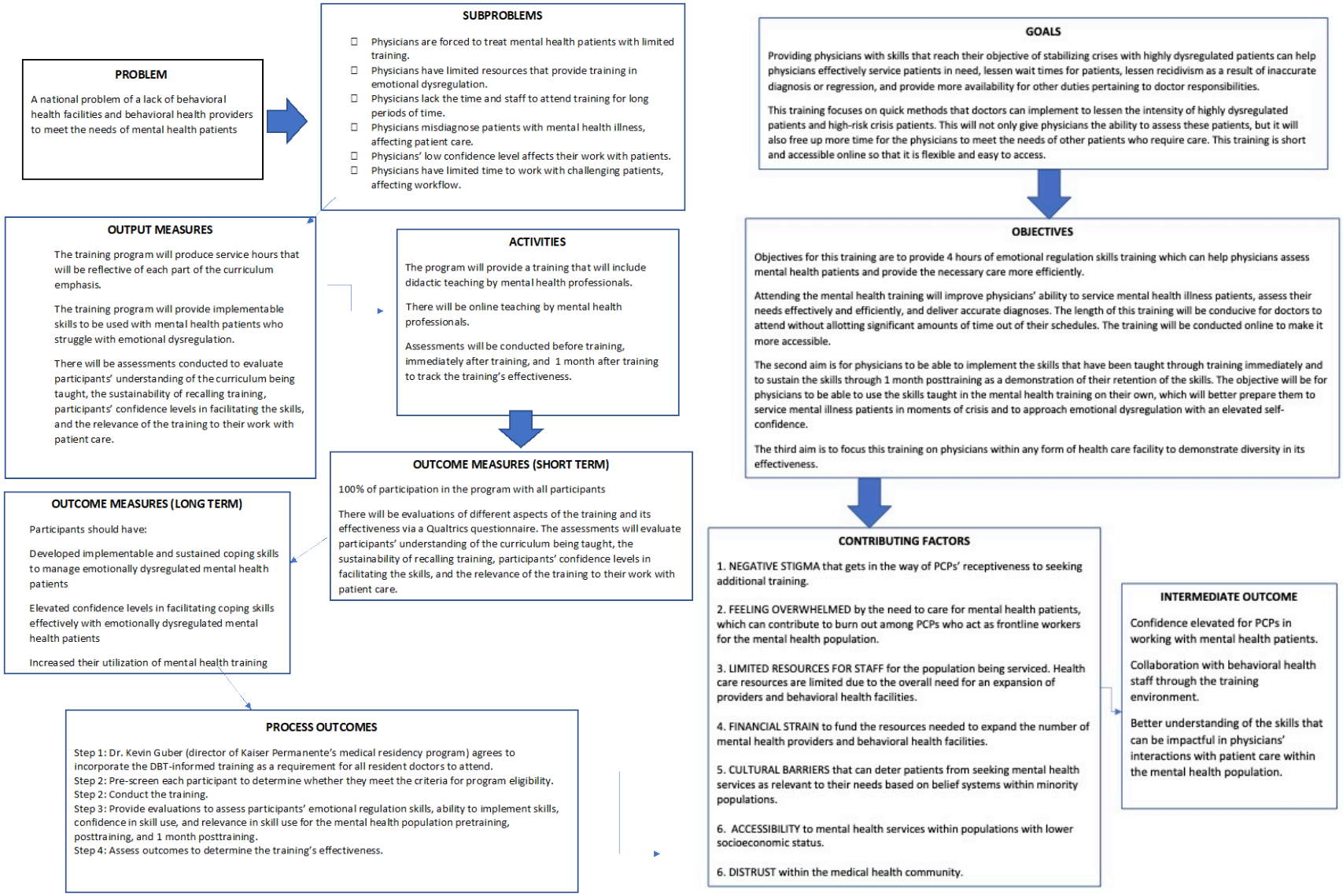

Figure 1. Logic Model.

Study Information

All training was conducted online. Inclusion criteria for this study included healthy adults, male or female, between the ages of 18 and 40. Speaking, reading, and writing proficiency in the English language was required of all participants.

All participants were former medical students at St. George's University, and all were working with patients in a medical health care facility in a resident physician capacity at the time of the study. Exclusion criteria included medical residents not working with patients who suffer from mental health illness. The training was specifically designed to aid physicians who provide care for patients contending with mental health illness within a medical health care facility.

Subject Recruitment and Screening

The number of subjects was calibrated given an expected attrition rate to result in a sample size of 6 individuals ranging from 18 to 40 years old. In this study, a final sample size of 6 was achieved. The target study population was family medicine physicians who speak English as their primary language. This was a voluntary training designated for resident physicians to complete online. All descriptions of consent precautions regarding subject rights and welfare were included in the informed consent document.

Informed Consent Process

A specific description of the informed consent process included: who; how; training; when; where; considerations; privacy and time for decision-making/discussion;

consent capacity determination (who and how); the methods of subject identification and randomization, including the coding system and subject randomization/group selection processes used; privacy of medical and research records information/medical records; medical release forms; and a Health Insurance Portability and Accountability Act (HIPAA) compliance/authorization form.

Study Design

The purpose of this study was to evaluate the efficacy of DBT-informed skills training on each participant. The study's objective was to assess whether the skills training better equipped the participants to work with emotionally dysregulated mental health patients. The study aimed to determine whether the training could help physicians conduct assessments and other necessary duties more efficiently and effectively, and it assessed whether the training enabled physicians to better interact with their emotionally dysregulated patients, thus reducing the risk of misdiagnosis and enhancing physicians' confidence levels.

The training was conducted for a total of 4 hours. The subjects were provided with surveys before training (T1), immediately after training (T2), and 1 month after training (T3) to assess their confidence levels related to the training and their perceived ability to implement the skills within their health care facility and in their own interactions with patients.

All data were collected through an online forum. The data collected was stored in a locked cabinet within an office that required key entry. All subjects were former medical students at St. George's University who now practice in a variety of specialties

as resident physicians. Consent was obtained through an online platform administered by April Wozencroft.

Objectives

Aim 1

Aim 1 of this training is to teach DBT-informed skills that can help physicians manage dysregulated mental health patients more efficiently and effectively than they were able to prior to the training.

Hypothesis

Hypothesis: Providing DBT-informed skills training can help physicians interact with emotionally dysregulated mental health patients in order to perform treatment more efficiently and accurately than they were able to prior to the training.

Hypothesis: Attending the ASWMHT will improve physicians' confidence in their ability to assess the needs of and service patients with mental health illness.

Aim 2

Aim 2 of this training is for physicians to be able to implement the skills addressed in training 1 month after the training as a demonstration of their retention of these skills.

Hypothesis

Hypothesis: Physicians will be able to use the skills taught in the mental health training on their own, which will better prepare them to service mental illness in emotionally dysregulated patients up to a month after the training.

Procedures and Research Interventions

The skills being evaluated were newly acquired DBT-informed skills targeting treatment for emotionally dysregulated patients who suffer from mental health illness. All data were collected via Qualtrics. The three assessments provided were administered at three different stages (T1, T2, and T3) and were distributed through an online platform.

Dr. Jacob Poulose (physician who oversees medical residents from St. George's University) provided via email the names and corresponding email addresses of current resident physicians who agreed to attend the training. Dr. Poulose asked residents to participate in the provided DBT-informed skills training course, which was developed and led by doctoral student April Wozencroft. At the start of this training, participants underwent the informed consent process and were asked to voluntarily participate in the evaluation of the training. This was a voluntary training. Resident physicians from all medical specialties were able to participate.

Participants were provided an online consent document prior to beginning the initial online survey. There were a total of three time point measurements: pre (T1), post (T2), and 1 month after (T3) the DBT-informed skills training course. All surveys were provided to each participant via email. The T1 survey was provided 30 minutes prior to the start of the training. The T2 survey was provided at the end of training. The surveys at

each time point were estimated to take no more than 30 minutes to complete. A phone call was made to each participant a week prior to T3 to remind participants to check their email for the last survey. Please see Appendix C for the script that was used.

All data was stored electronically on a laptop. The laptop was stored in an office that required key entry. The laptop was protected using a required passcode to access any data and was accessible to April Wozencroft. All data was collected through Qualtrics, which has protected access and encrypted the data. April Wozencroft was the only person with access to identifiable information, and after the data was collected, it was downloaded from Qualtrics and de-identified, and the online Qualtrics file was deleted.

The training schedule is included in Appendix D. On the first day of training, the facilitator first welcomed each resident and performed a short 10-minute check-in to confirm the names of all attending the training. An agenda was displayed on a shared screen for all residents to see what topics would be covered in the first session. The facilitator then reviewed the different DBT-informed skills, which took no more than 50 minutes. Residents were free to ask questions through the first part of the lecture for clarity purposes. After the skills lecture and a 10-minute break, the training transitioned into role playing specific scenarios of patients who were emotionally dysregulated with mental health illness; this discussion helped residents see how each skill can be mobilized in these kinds of circumstances.

This part of training required resident participation. Each resident was given a number matching them with a partner and indicated whether they would play the patient role or the doctor role. The facilitator observed residents' demonstrations and provided feedback. After the resident demonstrations, the facilitator pointed out specific things to

consider when enforcing the skills and offered an open forum for residents to ask any additional questions related to what was taught. At the end of the class, the facilitator provided contact information in the event that residents wanted to ask additional questions after the training.

On the second day of the training, the facilitator conducted a check-in to address any concerns, questions, or comments before delving into the training. An agenda was shared on the screen to disclose what would be covered for the day. The first hour of training was designated for lecture, and the following hour was used for resident demonstrations. Each resident kept the same number from the previous day's session to identify who their role-playing partners were. The facilitator had a list of the residents' numbers if they could not remember who their partners were. As each resident engaged in the demonstrations, the facilitator observed and intervened when necessary to ensure that the relevant concepts and skills were being performed accurately. This also gave residents an opportunity to clarify the aspects of each skill that they found most challenging as they attempted to facilitate the skills in the mock scenarios.

At the end of class, the facilitator thanked each participant for their willingness to attend the training and allowed for the additional time to be a forum for feedback, questions, or concerns that the facilitator could address before the end of training.

Once the training was over, a survey was emailed immediately to all participants. Each resident was asked to follow the same protocol as they did for the first survey. Each resident was informed that a phone call would be initiated 3 weeks after the training to remind participants to complete the last stage of the assessment from the training. Each resident was emailed the last survey 1 month after the training. A script was provided for

any follow-up phone call.

Data Collection

An adapted version of the General Self-Efficacy Scale (GSE; see Appendix B) was used to address two domains in the planned analysis at T1, T2, and T3. The two domains being evaluated were participants' knowledge of skills and implementation of skills in treating emotionally dysregulated patients who suffer from mental health illness. The modified GSE included a total of 10 questions based on a Likert scale ranging from 1 to 6 (where 1 = *strongly agree*, 2 = *somewhat agree*, 3 = *neither agree or disagree*, 4 = *somewhat disagree*, 5 = *strongly disagree*, and 6 = *decline to answer*). Once the numbers from each question were added up, the score determined whether participants perceived themselves to have a high skill level, moderate skill level, or low skill level in their ability to treat emotionally dysregulated patients with mental health illness.

An adapted version of the Self-Perception Profile for Adults (SPP; see Appendix B) was used to identify residents' confidence levels in treating emotionally dysregulated patients suffering from mental health illness, with measurements taken at the same three intervals of T1, T2, and T3. The outcome was measured by one survey with a total of six questions, using a Likert scale ranging from 1 to 5 (where 1 = *extremely adequate*, 2 = *somewhat adequate*, 3 = *neither adequate nor inadequate*, 4 = *somewhat inadequate*, and 5 = *extremely inadequate*). Once the numbers from each question were added up, the score determined whether participants had a high confidence level, moderate confidence level, or low confidence level in their ability to treat emotionally dysregulated patients with mental health illness.

Data Analysis

Analysis of the responses was conducted at each time point (T1, T2, and T3). Once the data from all time points were analyzed collectively, an interpretation of the content identified the underlying meaning of the responses. All participants who had submitted missing data were contacted via phone to complete any missing components of the surveys. Subscores and total scores for measurements were calculated. Descriptive statistics were examined and a univariate analysis was performed for the purpose of addressing the study hypotheses.

Risk and injury were addressed, and participants were informed that during the training there may be risk for fatigue and/or discomfort related to questions being asked about skill levels, engagement with peers, and engagement with the facilitator. Participants were informed that they may experience boredom and emotional stress from being observed. Additionally, participants were informed that any breach of confidentiality would constitute a potential risk for all participants.

The larger benefit of the study was to enhance care for emotionally dysregulated patients who battle with mental illness by equipping physicians with techniques that enable them to assess patients and provide optimal treatment. This training was provided for better engagement with patients, to enhance the confidence level of doctors serving this population, and to confront the barriers that get in the way of optimizing doctors' time without jeopardizing best practices in patient care.

If the training is successful, doctors could benefit from the training in different medical health care facilities. Providing a curriculum that can be followed by other mental health care providers could allow the training to be conducted by other providers,

which would provide exposure to the training on a wider scale.

Confidentiality

Participants could terminate their participation at any time if they chose to quit the evaluation. All records and research materials that identified participants were kept confidential. Any published documents resulting from this study will not disclose participants' identities without their permission. Information identifying participants was only available to the study personnel. No paper documents were used. All data was collected through Qualtrics, which has protected access and encrypted the data. April Wozencroft was the only person with access to the identifiable information, and once the data was collected, it was downloaded from Qualtrics and de-identified, and the online Qualtrics file was deleted.

CHAPTER FIVE

RESULTS

In this chapter, the results of the analyses conducted for this study are presented and discussed. Data were collected from a total of six resident physicians who had completed medical school at St. George's University. All six residents completed the training and were asked to complete two assessments, the adapted GSE and the adapted SPP, at three time points (T1, T2, and T3). These assessments were used to measure participants' knowledge of skills used to manage emotionally dysregulated patients with mental health illness in a health care setting, their perceived ability to implement those skills, and their level of confidence with implementing these skills within a medical health care facility.

Five out of the six participants (83%) completed the GSE at all three time points. Four out of the six participants (67%) completed the SPP at T1 and T3, whereas all six participants (100%) completed the SPP at T2.

This chapter includes an initial series of descriptive statistics followed by the GSE and SPP results. These latter analyses consist of analyses of variance (ANOVAs) examining the mean change in survey items across this study's three time points. In addition to one-way ANOVAs, Levene's tests of the equality of variances (an assumption of the one-way ANOVA) were conducted, and Brown–Forsythe ANOVAs were planned in cases where this assumption was violated. Pairwise comparisons were also conducted in all cases where the ANOVA was found to achieve statistical significance, with Tukey's HSD used when the assumption of the equality of variances was not violated, and the Games–Howell test used in all other cases. These results are summarized and

interpreted here.

Descriptive Statistics

Initially, a series of descriptive statistics were conducted on these data. As these analyses were focused on change over time, means and standard deviations by time point are presented in Table 1. While differences were found to be notable in some cases, the results of the statistical tests reported in the following sections determined whether these mean differences differed significantly over time.

The GSE was coded to indicate that higher values were associated with greater disagreement. Means within this study are indicative of the average responses to each of the questions in the GSE survey. A decrease in the means indicates an increase in agreement to the GSE questions over time. Small to moderate mean differences across time were evident with respect to GSE Questions 3, 6, 7, 8, and 10. These findings reveal minimal differences in participants' average responses from T1 to T2 and T3. These five questions specifically addressed participants' ability to identify skills that they could utilize with emotionally escalated patients suffering from mental health illness, how these skills can be used for time management and assessment purposes, and how these skills can be used with other patients who do not suffer from mental health illness. Overall, the means show only slight differences in participants' agreement with these questions over time.

Larger differences in mean values across time points are found in the remaining GSE items of Questions 1, 2, 4, 5, and 9 (see Table 1). In these latter questions, with the exception of Question 9, substantial decreases in the mean values were found across time.

These findings reveal larger differences in participants' average responses from T1 to T2 and T3. Questions 1, 2, 4, and 5 focus on participants' ability to recall training that they have attended that helps with skill building for emotionally dysregulated patients with mental health illness and their ability to identify and implement skills effectively to de-escalate emotionally dysregulated mental health patients on their own. Lastly, Question 5 identifies whether participants have attended a training that has helped them with skills to manage emotionally dysregulated patients who struggle with mental health illness. Overall, the means demonstrate a larger increase in agreement to these questions over time.

Regarding Question 9, the mean was found to substantially decrease from T1 to T2 and then to substantially increase from T2 to T3. "Rebound" effects were also found in relation to some of these questions, whereby the mean was first found to substantially decrease from T1 to T2 and then to increase slightly between T2 and T3. Responses to Question 9 indicated an increase of agreement that participants do not need additional training for working with emotionally dysregulated patients who suffer from mental health illness from T1 to T2 (posttraining). However, the mean increased from T2 to T3, showing a decrease in agreement to this question.

The SPP was coded to indicate that higher values were associated with a greater degree of inadequacy. A decrease in means thus indicates an increase in adequacy over time. With respect to SPP, small to moderate differences in mean values were evident in Question 4, with larger differences found in the remaining five questions and the most substantial change found in Question 3. In Question 4, the small to moderate mean differences indicate that physicians' sense of adequacy in utilizing skills that will help

with assessing emotionally dysregulated patients only changed minimally over time. Question 3 demonstrates the largest increase in sense of adequacy; this question addressed physicians' belief that having training in skills to manage emotionally dysregulated patients who suffer from mental health illness would help the assessment process within the work environment. In all questions, means were found to decrease over time, while a rebound effect was found in some questions, again where the mean first substantially decreased from T1 to T2 and then increased slightly from T2 to T3. This suggests that physicians' sense of adequacy increased slightly in all questions at 1 month posttraining. The overall decrease in mean values from pretraining to both posttraining surveys in the five questions mentioned demonstrates how physicians' sense of their own inadequacy decreased over time in identifying and implementing skills within their work environment targeting emotionally dysregulated mental health patients.

With regard to both sets of questions, no patterns were evident when comparing standard deviations either across time or when comparing different questions. This includes no clear pattern of standard deviations either increasing or decreasing over time and no clear pattern when comparing the magnitude of these standard deviations between questions.

Table 1. Means and Standard Deviations by Time Point.

Measure	T1 Mean (*SD*)	T2 Mean (*SD*)	T3 Mean (*SD*)
GSE			
Question 1: I have effective skills to manage mental health patients who struggle with emotion regulation.	4.000 (.707)	2.000 (1.225)	2.000 (.000)
Question 2: I can implement effective skills that will enable me to treat emotionally dysregulated patients within the allotted time I have to see patients where I work.	3.800 (1.095)	1.800 (1.304)	2.400 (2.387)
Question 3: I can identify skills that I can think of utilizing with an emotionally escalated patient who suffers from mental health illness on my own.	2.600 (.548)	1.600 (1.342)	2.000 (.000)
Question 4: I can identify and implement skills effectively with an emotionally escalated patient who suffers from mental health illness on my own.	4.400 (.894)	2.000 (.707)	2.400 (.548)
Question 5: I can identify specific training that I have attended that has helped me with skills to help manage effectively emotionally dysregulated patients who struggle with mental health.	4.000 (1.225)	1.800 (1.304)	1.800 (.837)
Question 6: I think that having training to help manage emotionally dysregulated mental health patients would be beneficial to me where I work.	1.800 (1.304)	1.200 (.447)	1.400 (.894)
Question 7: Acquiring emotion regulation skills for mental health patients will help me in my assessment process.	1.400 (.548)	1.200 (.447)	1.400 (.548)
Question 8: I feel that learning skills for emotionally dysregulated patients will help with other patients who do not suffer from mental health illness.	1.600 (.548)	1.400 (.894)	1.200 (.447)
Question 9: I feel that I do not need any additional training to manage mental health patients who present as emotionally dysregulated.	4.600 (.894)	2.600 (1.517)	3.800 (1.643)
SPP			
Question 1: As a physician I feel that I am adequately trained to manage emotionally dysregulated patients who suffer from mental health illness.	4.500 (.577)	2.667 (1.211)	2.750 (.957)
Question 2: As a physician I feel confident that I am able to perform my assessment effectively in the allotted time where I work for emotionally dysregulated patients who suffer from mental health illness.	4.000 (.816)	2.500 (.548)	3.000 (.816)
Question 3: As a physician I think that having training on skills to manage emotional dysregulation in mental health patients will help with my assessment process within my work environment.	3.000 (1.826)	1.333 (.516)	1.786 (1.251)
Question 4: As a physician I feel confident that I know of effective skills that will de-escalate emotionally dysregulated patients who suffer from mental health illness in order for me to assess patients accurately in my work environment.	3.250 (1.258)	2.333 (1.366)	2.500 (.577)
Question 5: As a physician I feel confident that I know of effective skills and can implement these skills that will de-escalate emotionally dysregulated patients who suffer from mental health illness in order for me to assess patients accurately in my work environment.	3.750 (.957)	2.667 (1.033)	2.250 (.500)

GSE Results

A series of one-way ANOVAs was conducted in order to determine whether significant mean differences were present between the 10 GSE survey questions on the basis of time point (T1, T2, and T3). One-way ANOVAs were conducted as opposed to repeated measures ANOVAs because, while this study incorporated a repeated measures method, a variable uniquely identifying participants across all three time points was not included in these data. This precluded the use of a repeated measures test, and instead, one-way ANOVAs were applied to these data.

For all ANOVAs, Levene's tests of the homogeneity of variances were conducted in order to test this important assumption of the one-way ANOVA. In addition, the Brown–Forsythe ANOVA was planned instead of the one-way ANOVA in cases where this assumption was violated, as the one-way ANOVA assumes the equality of variances. In addition, the Brown–Forsythe ANOVA was preferred over Welch's ANOVA, another appropriate choice when the assumption of the equality of variances has been violated, due to the very small sample sizes associated with each group. The results of the Levene's test also determined, when the ANOVA was found to achieve statistical significance, whether Tukey's HSD, which assumes the equality of variance, or the Games–Howell test, which does not, was used in the pairwise comparisons. On the basis of the results found in these analyses, it was found that there was no case where the Brown–Forsythe ANOVA needed to be used instead of the one-way ANOVA.

First, the results of the Levene's tests conducted found statistical significance in the cases of Question 3, Levene's $F(2, 12) = 5.236$, $p < .05$, and Question 9, Levene's $F(2, 12) = 4.148$, $p < .05$. The results of the ANOVAs conducted found significance in

three cases: Question 1 (“I have effective skills to manage mental health patients who struggle with emotion regulation.”), $F(2, 12) = 10.000$, $p < .01$; Question 4 (“I can identify and implement skills effectively with an emotionally escalated patient who suffers from mental health illness on my own.”), $F(2, 12) = 15.500$, $p < .001$; and Question 5 (“I can identify specific training that I have attended that has helped me with skills to help manage effectively emotionally dysregulated patients who struggle with mental health.”), $F(2, 12) = 6.205$, $p < .05$. In all three cases, means were found to significantly decrease over time, which relates to a significant increase in agreement with these statements over time.

Welch’s ANOVA was conducted in the two cases where Levene’s test indicated that the assumption of the equality of variances was violated, Questions 3 and 9, with these two Welch’s ANOVAs failing to achieve statistical significance. With respect to Questions 1, 4, and 5, as Levene’s test was not significant in any of these three cases, the one-way ANOVA was applied, and Tukey’s HSD was used for the pairwise comparisons.

The results of the pairwise comparisons found nearly identical results when comparing Questions 1 and 4. First, with regard to Question 1, a significantly higher mean was found at T1 as compared with T2 and T3, with a mean difference of 2.000 found in both cases. This result indicates a significant decrease from T1 to T2, with this significant difference being maintained at T3. A similar result was found when examining Question 4. Here, a significant mean decrease was found from T1 to T2 (mean difference of 2.400), and from T1 to T3 (mean difference of 2.000). This result also indicates a significant mean decrease from T1 to T2, which is maintained at T3. Finally, the pairwise comparisons found in relation to Question 5 indicated a mean response that

was significantly higher at T1 as compared with both T2 and T3. Specifically, this mean was found to be 2.200 higher at T1 as compared with both T2 and T3. The following figures present graphs of the means associated with these three significant ANOVAs.

First, Figure 2 presents the means associated with Question 1. As presented in the descriptive data, the mean was found to substantially decrease from T1 to T2 and remain constant from T2 to T3.

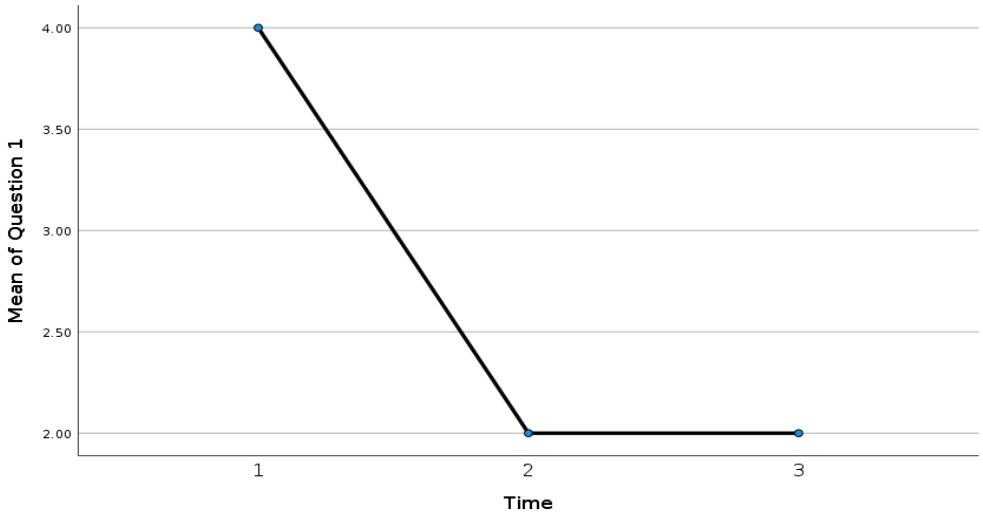

Figure 2. GSE: Mean of Question 1.

Next, Figure 3 presents the means for Question 4. The mean was found to sharply decrease from T1 to T2 and then to increase slightly between T2 and T3.

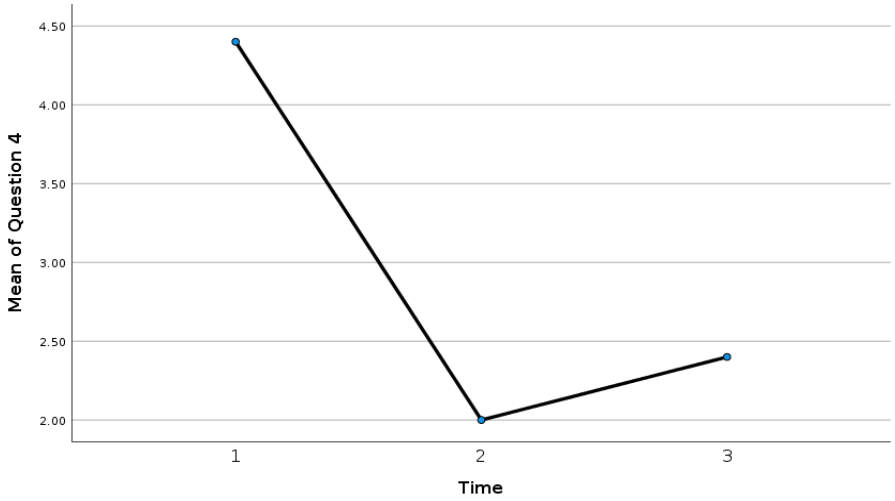

Figure 3. GSE: Mean of Question 4.

Finally, Figure 4 presents the means associated with Question 5. The mean on this question was found to decrease sharply from T1 to T2 and then to remain constant between T2 and T3.

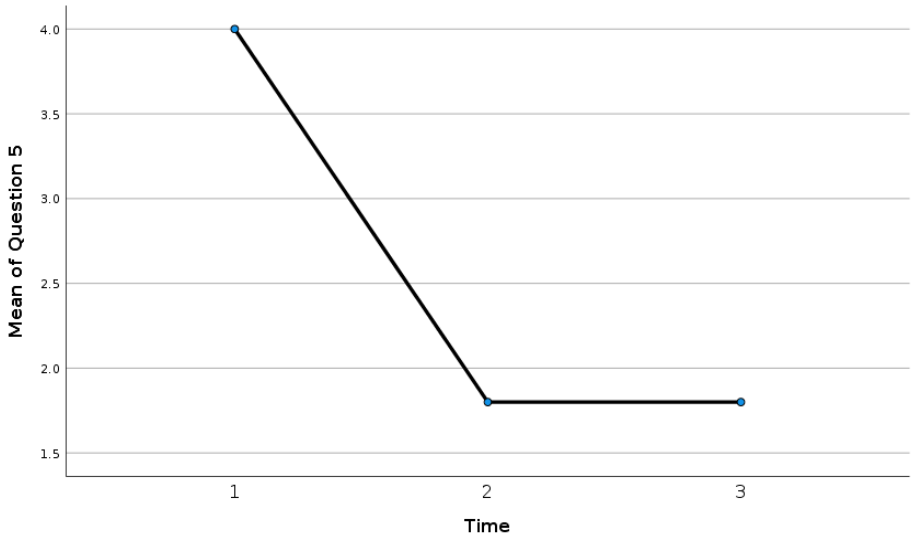

Figure 4. GSE: Mean of Question 5.

Among these questions that will be discussed demonstrate three major trends despite the data demonstrating no statistically significant differences. The first major trend, which includes two subtrends, involves Questions 2, 3, and 9. These three questions show a decrease in the mean value from T1 to T3, and these same questions demonstrate a decrease in mean value from T1 to T2. Questions 2, 3, and 9 also all show an increase in mean value from T2 to T3.

The second major trend pairwise was found between Questions 7 and 10. Question 7 has the same mean value at T1 and T3, and Question 10 also has the same mean value at T1 and T3.

The third trend pairwise was found between Questions 6 and 7. Both Questions 6 and 7 show a decrease in mean from T1 to T2 and show an increase in mean from T2 to T3. For full results, see Table 2.

Table 2. GSE Results.

Variable	*n*	*M*	*SD*	*SE*	95% CI for *M*		Min.	Max.
					LL	*UL*		
Question 1: I have effective skills to manage mental health patients who struggle with emotion regulation.								
T1	5	4.000	0.707	0.316	3.122	4.878	3.000	5.000
T2	5	2.000	1.225	0.548	0.479	3.521	1.000	4.000
T3	5	2.000	0.000	0.000	2.000	2.000	2.000	2.000
Total	15	2.667	1.234	0.319	1.983	3.350	1.000	5.000
Question 2: I can implement effective skills that will enable me to treat emotionally dysregulated patients within the allotted time I have to see patients where I work.								
T1	5	3.800	1.095	0.490	2.440	5.160	2.000	5.000
T2	5	1.800	1.304	0.583	0.181	3.419	1.000	4.000
T3	5	2.400	0.548	0.245	1.720	3.080	2.000	3.000
Total	15	2.667	1.291	0.333	1.952	3.382	1.000	5.000
Question 3: I can identify skills that I can think of utilizing with an emotionally escalated patient who suffers from mental health illness on my own.								
T1	5	2.600	0.548	0.245	1.920	3.280	2.000	3.000
T2	5	1.600	1.342	0.600	-0.066	3.266	1.000	4.000
T3	5	2.000	0.000	0.000	2.000	2.000	2.000	2.000
Total	15	2.067	0.884	0.228	1.577	2.556	1.000	4.000
Question 4: I can identify and implement skills effectively with an emotionally escalated patient who suffers from mental health illness on my own.								
T1	5	4.400	0.894	0.400	3.289	5.511	3.000	5.000
T2	5	2.000	0.707	0.316	1.122	2.878	1.000	3.000
T3	5	2.400	0.548	0.245	1.720	3.080	2.000	3.000
Total	15	2.933	1.280	0.330	2.225	3.642	1.000	5.000
Question 5: I can identify specific training that I have attended that has helped me with skills to help manage effectively emotionally dysregulated patients who struggle with mental health.								
T1	5	4.000	1.225	0.548	2.479	5.521	2.000	5.000
T2	5	1.800	1.304	0.583	0.181	3.419	1.000	4.000
T3	5	1.800	0.837	0.374	0.761	2.839	1.000	3.000
Total	15	2.533	1.506	0.389	1.700	3.367	1.000	5.000
Question 6: I think that having training to help manage emotionally dysregulated mental health patients would be beneficial to me where I work.								
T1	5	1.800	1.304	0.583	0.181	3.419	1.000	4.000
T2	5	1.200	0.447	0.200	0.645	1.755	1.000	2.000
T3	5	1.400	0.894	0.400	0.289	2.511	1.000	3.000
Total	15	1.467	0.915	0.236	0.960	1.974	1.000	4.000
Question 7: Acquiring emotion regulation skills for mental health patients will help me in my assessment process.								
T1	5	1.400	0.548	0.245	0.720	2.080	1.000	2.000
T2	5	1.200	0.447	0.200	0.645	1.755	1.000	2.000
T3	5	1.400	0.548	0.245	0.720	2.080	1.000	2.000
Total	15	1.333	0.488	0.126	1.063	1.604	1.000	2.000
Question 8: I feel that learning skills for emotionally dysregulated patients will help with other patients who do not suffer from mental health illness.								
T1	5	1.600	0.548	0.245	0.920	2.280	1.000	2.000
T2	5	1.400	0.894	0.400	0.289	2.511	1.000	3.000
T3	5	1.200	0.447	0.200	0.645	1.755	1.000	2.000
Total	15	1.400	0.632	0.163	1.050	1.750	1.000	3.000
Question 9: I feel that I do not need any additional training to manage mental health patients who present as emotionally dysregulated.								
T1	5	4.600	0.894	0.400	3.489	5.711	3.000	5.000
T2	5	2.600	1.517	0.678	0.717	4.483	1.000	4.000
T3	5	3.800	1.643	0.735	1.760	5.840	2.000	5.000
Total	15	3.667	1.543	0.398	2.812	4.521	1.000	5.000
Question 10: I feel that having skills that manage emotional dysregulation with mental health patients would be an effective way to assist with time management for patient visits								
T1	5	1.200	0.447	0.200	0.645	1.755	1.000	2.000
T2	5	1.600	0.894	0.400	0.489	2.711	1.000	3.000
T3	5	1.200	0.447	0.200	0.645	1.755	1.000	2.000
Total	15	1.333	0.617	0.159	0.992	1.675	1.000	3.000

SPP Results

The same methods were used when analyzing the SPP data. First, the results of the Levene's tests for the homogeneity of variances only found significance in relation to Question 3, Levene's $F(2, 11) = 13.856$, $p < .01$. For this question, Welch's ANOVA was used, which failed to achieve statistical significance. With regard to the remaining one-way ANOVAs, significance was indicated in relation to the ANOVA conducted with Question 1 ("As a physician I feel that I am adequately trained to manage emotionally dysregulated patients who suffer from mental health illness."), $F(2, 11) = 4.602$, $p < .05$, and Question 2 ("As a physician I feel confident that I am able to perform my assessment effectively in the allotted time where I work for emotionally dysregulated patients who suffer from mental health illness."), $F(2, 11) = 5.429$, $p < .05$. In both cases, means were found to significantly decrease over time, which relates to a significantly higher level of stated adequacy over time. As Levene's test was not significant in either of these cases, the one-way ANOVA was used, along with Tukey's HSD for the pairwise comparisons.

Regarding Question 1, a significantly higher mean was found at T1 as compared with T2 (mean difference of 1.833), and with respect to Question 2, a significantly higher mean was found at T1 as compared with T2 (mean difference of 1.500). Figures illustrating the means over time in relation to these two questions are presented below.

First, regarding Question 1, Figure 5 illustrates a sharp drop in the mean score between T1 and T2, with a very slight increase between T2 and T3.

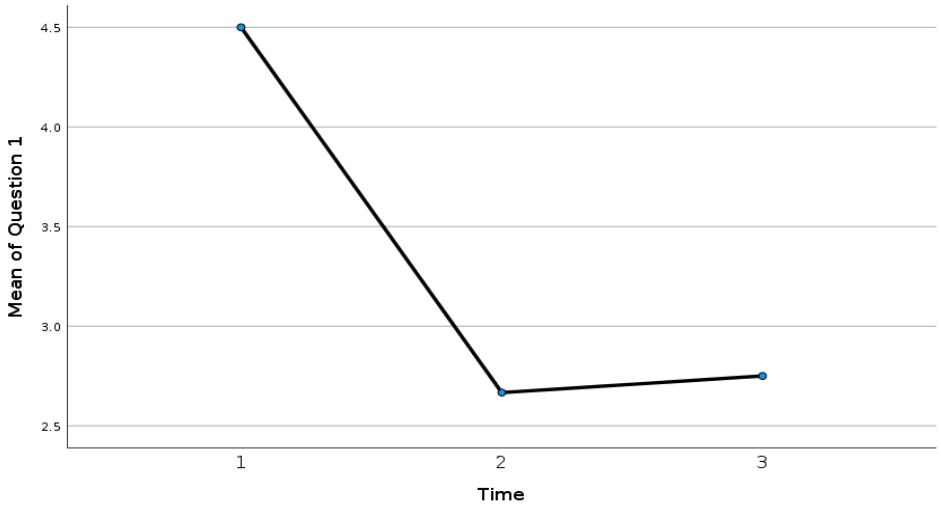

Figure 5. SPP: Mean of Question 1

Next, Figure 6 presents the mean score for Question 2 between T1 and T3. As shown, a large decrease in the mean was evident between T1 and T2, with a much smaller, but still moderate, increase indicated between T2 and T3.

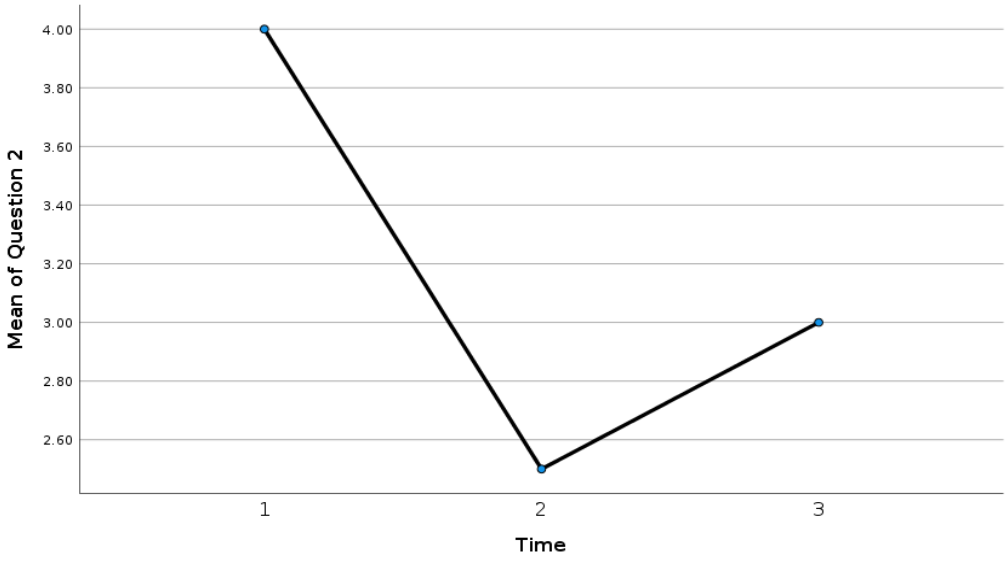

Figure 6. SPP: Mean of Question 2

Among these questions that will be discussed demonstrate two major trends despite the data demonstrating no significant statistical differences. The first major trend pairwise was found between Questions 3 and 4. Both questions show a decrease in mean from T1 to T2 and increase in mean from T2 to T3. The second major trend pairwise was found between Questions 5 and 6. These questions show a decrease in mean from T1 to T2 and from T2 to T3. Overall, Questions 5 and 6 demonstrate a tendency to have a decreasing mean over all three time points. For full results, see Table 3.

Table 3. SPP Results

Variable	*M*	*SD*	*SE*	95% CI for *M*		Min.	Max.
				LL	*UL*		
Question 1: As a physician I feel that I am adequately trained to manage emotionally dysregulated patients who suffer from mental health illness.							
T1	4.500	0.577	0.289	3.581	5.419	4.000	5.000
T2	2.667	1.211	0.494	1.396	3.938	2.000	5.000
T3	2.750	0.957	0.479	1.227	4.273	2.000	4.000
Total	3.214	1.251	0.334	2.492	3.937	2.000	5.000
Question 2: As a physician I feel confident that I am able to perform my assessment effectively in the allotted time where I work for emotionally dysregulated patients who suffer from mental health illness.							
T1	4.000	0.816	0.408	2.701	5.299	3.000	5.000
T2	2.500	0.548	0.224	1.925	3.075	2.000	3.000
T3	3.000	0.816	0.408	1.701	4.299	2.000	4.000
Total	3.071	0.917	0.245	2.542	3.601	2.000	5.000
Question 3: As a physician I think that having training on skills to manage emotional dysregulation in mental health patients will help with my assessment process within my work environment.							
T1	3.000	1.826	0.913	0.095	5.905	1.000	5.000
T2	1.333	0.516	0.211	0.791	1.875	1.000	2.000
T3	1.250	0.500	0.250	0.454	2.046	1.000	2.000
Total	1.786	1.251	0.334	1.063	2.508	1.000	5.000
Question 4: As a physician I feel confident that I know of effective skills that will de-escalate emotionally dysregulated patients who suffer from mental health illness in order for me to assess patients accurately in my work environment.							
T1	3.250	1.258	0.629	1.248	5.252	2.000	5.000
T2	2.333	1.366	0.558	0.900	3.767	1.000	4.000
T3	2.500	0.577	0.289	1.581	3.419	2.000	3.000
Total	2.643	1.151	0.308	1.978	3.307	1.000	5.000
Question 5: As a physician I feel confident that I know of effective skills and can implement these skills that will de-escalate emotionally dysregulated patients who suffer from mental health illness in order for me to assess patients accurately in my work environment.							
T1	3.750	0.957	0.479	2.227	5.273	3.000	5.000
T2	2.667	1.033	0.422	1.583	3.751	2.000	4.000
T3	2.250	0.500	0.250	1.454	3.046	2.000	3.000
Total	2.857	1.027	0.275	2.264	3.450	2.000	5.000
Question 6: As a physician I am confident that I have I have access to training to assist in skill building for effective skills to use for the purposes of de-escalating emotionally dysregulated mental health patients.							
T1	3.000	1.155	0.577	1.163	4.837	2.000	4.000
T2	1.833	0.983	0.401	0.802	2.865	1.000	3.000
T3	1.750	0.957	0.479	0.227	3.273	1.000	3.000
Total	2.143	1.099	0.294	1.508	2.778	1.000	4.000

Summary

The results presented in this chapter indicate significant changes over time in five cases in total, with three of these relating to GSE and the remaining two cases relating to SPP. All GSE questions were coded such that a higher value was associated with greater disagreement, while with regard to SPP questions, a higher value was associated with a greater degree of inadequacy. With regard to GSE questions, these three significant results all indicated a significant shift in the direction of agreement from pretraining to posttraining. In addition, both significant results related to SPP indicate a significant change in the direction of adequacy when moving from pretraining to posttraining. While the majority of these results did not indicate statistical significance, this can be attributed to the low statistical power present due to the very small sample size included in this study. These results do suggest a substantial positive effect, as indicated by these significant results comparing pretraining to posttraining means. The following chapter will discuss these results in relation to previous literature and theory as well as the limitations of this study, possibilities for future research, implications, and conclusions.

CHAPTER SIX

SUMMARY AND APPLICATION

The goal of the ASWMHT program is to provide a temporary, immediate solution that addresses the gap in mental health care faced by emotionally dysregulated patients who are seen by PCPs before they can be seen by more appropriate providers. Resolving this issue fully will require an expansion of mental health care facilities and providers, but this solution is time-consuming and does not address the immediate needs of the mental health population. Therefore, a temporary solution that can be implemented immediately is needed.

The DBT-informed skills taught within the ASWMHT training offer providers practical tools for managing emotional dysregulation. These tools can help providers diminish opportunities for escalation, lessen the probability of patient resistance, promote better rapport, and advance to an assessment of the primary issue that requires attention (Landes et al., 2017).

Goals

The first aim of this training was to teach physicians skills that can help them efficiently and effectively manage dysregulated patients, thereby enhancing their ability to assess patients experiencing mental health illness within inpatient and outpatient health care settings.

The second aim of the training was for physicians to be able to implement the skills they have learned immediately and for them to retain the skills through 1 month after training. Physicians should be able to use the skills on their own, which will prepare

them to serve mental illness patients in moments of crisis and emotional dysregulation with an elevated level of self-confidence.

The third aim was to focus this training on physicians within any form of health care facility to demonstrate diversity in its effectiveness.

Results

ASWMHT has not only provided participants with implementable skills that enhance their knowledge but also enhanced physicians' confidence in working with mental health patients with symptoms of emotional dysregulation. As demonstrated in five cases, this training has proved effective toward all three aims.

SPP

An adapted SPP was used to identify residents' confidence levels in treating emotionally dysregulated patients suffering from mental health illness, with measurements taken at the three intervals of pretraining, posttraining, and 1 month posttraining.

For both Question 1 ("As a physician I feel that I am adequately trained to manage emotionally dysregulated patients who suffer from mental health illness."), and Question 2 ("As a physician I feel confident that I am able to perform my assessment effectively in the allotted time where I work for emotionally dysregulated patients who suffer from mental health illness."), mean responses were found to significantly decrease over time, which relates to a significantly higher level of stated adequacy over time.

GSE

An adapted version of the GSE was used to address two domains in the planned analysis at the same three intervals. The two domains being evaluated were participants' knowledge of skills and their perceived ability to implement skills.

The results of the ANOVAs conducted found significance in three cases: Question 1 ("I have effective skills to manage mental health patients who struggle with emotion regulation."), Question 4 ("I can identify and implement skills effectively with an emotionally escalated patient who suffers from mental health illness on my own."), and Question 5 ("I can identify specific training that I have attended that has helped me with skills to help manage effectively emotionally dysregulated patients who struggle with mental health."). In all three cases, means were found to significantly decrease over time, which relates to a significant increase in agreement over time.

Limits

Due to the small sample size of this study, there is not sufficient statistical power to extrapolate the statistical analysis to a larger population (Faber & Fonseca, 2014). Continuing research that expands the number of training participants would facilitate better statistical analysis that could be used to assess an overall population and could provide a better understanding of the effectiveness of this training. In addition, providing a clear definition of emotional dysregulation on each of the assessments would have ensured a common understanding of what was meant by each question.

In the literature, there are a number of perspectives on what needs to be addressed with regard to mental health and what specific areas or methods training should cover. In

many studies, there is an emphasis on learning a specific modality, such as cognitive behavioral therapy; others emphasize working with other mental health providers in more of a collaboration; and some focus on interactional strategies such as communication skills and rapport building. Focusing training on a modality such as DBT-informed skills is an innovative way to incorporate communication skills, crisis management skills, and skills for managing symptomatology that impedes assessments into one program. Training in DBT-informed skills thus bridges the gaps and covers all areas that may potentially be problematic, ultimately providing a more immediate, temporary solution in response to the need for more mental health facilities and providers. Not many studies have focused on skills for handling emotional dysregulation and the effect of DBT-focused skills training on physicians' interactions with mental health patients.

The ASWMHT training operates on the assumption that emotional dysregulation in mental health patients catalyzes misdiagnosis, longer visits, and diminished confidence among providers who have underdeveloped skill sets to effectively address mental health issues. In order to determine whether this assumption is true or false, more research will be required that targets how emotional dysregulation impacts the physician–patient interaction. Such research could focus on developing a needs assessment that would (a) identify specific barriers that prevent physicians from feeling equipped to serve this population and (b) allow physicians to articulate how emotionally dysregulated patients affect their work.

In addition, to address physicians' gap in knowledge about how emotional dysregulation affects the patient–provider relationship and care, I have provided a DBT-informed learning tool that details specific scenarios scaling from mild to severe

symptomatology that will help physicians identify how DBT-informed skills can translate to diverse situations. The scenarios in this tool exemplify common scenarios that physicians face in medical health facilities (Appendix E).

A decision tree (Appendix F) is also provided to help physicians gain a more comprehensive perspective on how decisions are made with respect to emotionally dysregulated patients. Through a series of questions, the decision tree shows how decisions are made by physicians equipped with DBT-informed skills and how ill-equipped physicians with underdeveloped skills will need more time with these patients, resulting ultimately in delays of care.

These two learning tools are meant to help physicians compare how they would handle these scenarios without the skills provided in the training with how they would handle these scenarios after the training. These learning tools allow for a more in-depth look at the specificity of the training and the potential effectiveness of this approach.

This training provides specific skills that are meant to be practical and easily implemented. This training is manualized to provide structure to the facilitator, allowing individuals who are not licensed marriage/family therapists to easily facilitate trainings. This opens the possibility for other types of providers to facilitate training, increasing the feasibility of offering more trainings without the strain of pulling physicians away from their duties to conduct the trainings. In terms of time, limiting the length of the training to 4 hours was meant to make it more accessible than time-consuming all-day or multiday trainings. However, the literature is limited in its discussion of the comparative effects of shorter trainings versus longer trainings in the realm of skill building focused on mental health illness and emotion regulation. To provide better insight into the impact of training

length, further research may be needed that provides multiple trainings and allows for a more comprehensive comparison of the amount of time dedicated to emotion regulation.

DBT

In the DBT-informed training, emotion regulation skills, interpersonal effectiveness skills, mindfulness, and distress tolerance skills were discussed in terms of specific areas within the physician–patient relationship. Although the use of DBT has been considered in diverse studies, there are limited studies that assess how these skills operate in the physician–patient relationship with respect to patients' emotional dysregulation. Expanded research is needed to investigate the effectiveness of this type of training in more depth.

Additionally, providing an assessment that identified participants' areas of interest in relation to emotionally dysregulated mental health patients would have given the facilitator better insight into which areas of the training to emphasize in order to best meet the needs of the audience. This form of assessment would be distributed before any training to give the facilitator ample time to prepare a more customized training.

Systems Theory

A strategy based on systems theory can allow PCPs to be change agents that disrupt maladaptive interactional patterns that may escalate emotional dysregulation. In order to provide enhanced care for patients, it is crucial that PCPs stay focused on what is being presented in the moment and navigate the barriers that threaten to get in the way of effective assessments. In turn, PCPs can feel more empowered to work with the mental

health population effectively and efficiently, acting as a temporary solution to the bigger issue of the lack of providers and treatment facilities for mental health patients. Equipped with the interventions taught through training, PCPs will be in a position to spearhead systemic changes within the patient–doctor relationship.

Providing ASWMHT to PCPs can promote a more adaptive interactional pattern. Giving PCPs the skills they need to de-escalate and assist mental health patients in moments of distress can help them improve their interactions with patients through positive engagement, higher levels of confidence, and enhanced rapport.

No studies specifically indicate that providing these DBT-informed skills will enhance the rapport between physician and patient. Although this has been seen in nurses using DBT skills, it has not been examined within the physician–patient dyad. To confirm this hypothesis, additional research would be needed that focuses directly on how DBT-informed skills impact physician–patient rapport.

The training was implemented by a licensed clinician with specific experience with emotionally dysregulated patients, which does not encompass the lens of a PCP. Given the facilitator and participants' different scopes of practice, this could also be seen as a barrier in terms of how this training pertains to participants' experiences. In order to address this issue, it would be important to utilize the aforementioned assessment of participants' interests; this would limit situations in which the facilitator is not meeting the needs of the participants in the training.

Overall, this training can be seen as a potential positive next step in addressing a huge problem within the mental health care system. It is a steppingstone—a temporary solution to the bigger issue of the extreme lack of mental health care facilities and

providers. This intervention is meant to provide some relief as we continue to evolve more permanent solutions to a need that continues to impact significant numbers of people daily

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APPENDIX A

TREATMENT MANUAL

DIALECTICAL BEHAVIOR THERAPY INFORMED SKILLS TRAINING

FACILITATED BY:

APRIL WOZENCROFT, LMFT

PROGRAM DESCRIPTION

The Anticipating Success within Mental Health Training (ASWMHT) provides a 2-day training that consumes two hours a day for a total of two days. This training provides emotion dysregulation techniques that can be done within 2-5 minutes of a patient and provider interaction. The skills promoted throughout this training will be Dialectical Behavioral Therapy informed, which is an evidence-based therapy that has been used in multiple health facilities and targets severe depression, anxiety, substance abuse, suicidal, homicidal, and self-mutilation behaviors.

PURPOSE

This training focuses on equipping doctors with the skills necessary to regulate the patients to a point that is necessary for assessments to be conducted. This program can provide a more efficient way of assisting the patient, lessen the vulnerability of misdiagnosing from erratic dysregulated behavior versus the true mental status of a patient, and elevate confidence levels for providers to perform the necessary service to the patient population. The idea is to provide a more immediate solution to the integration of behavioral health care and primary care. Considering the high demand for mental health facilities and providers this is a short-term approach to a problem that will require an expansion in facilities and providers. However, give that primary care physicians are the front-line providers currently for mental health patients, it is important to equip doctors with skills that are instrumental in working with mental health population who contend with emotion-dysregulation.

GOALS

For each participant in the training to feel confident and equipped n being able to facilitate practical implementable skills that will allow for an effective approach to service emotionally dysregulated mental health patients.

OBJECTIVES

Providing a two-day training lasting two hours each day is meant to facilitate focused training on adaptable skills for Physicians in divers work environments. The skills are influenced by Dialectical Behavior Therapy that targets emotion dysregulation the mental health population. The skills will be facilitated from a manual that will allow for Physicians to have access to after the training as a reference point throughout their career. The manual provided will include handouts that can be copied and utilized at the Physicians discretion.

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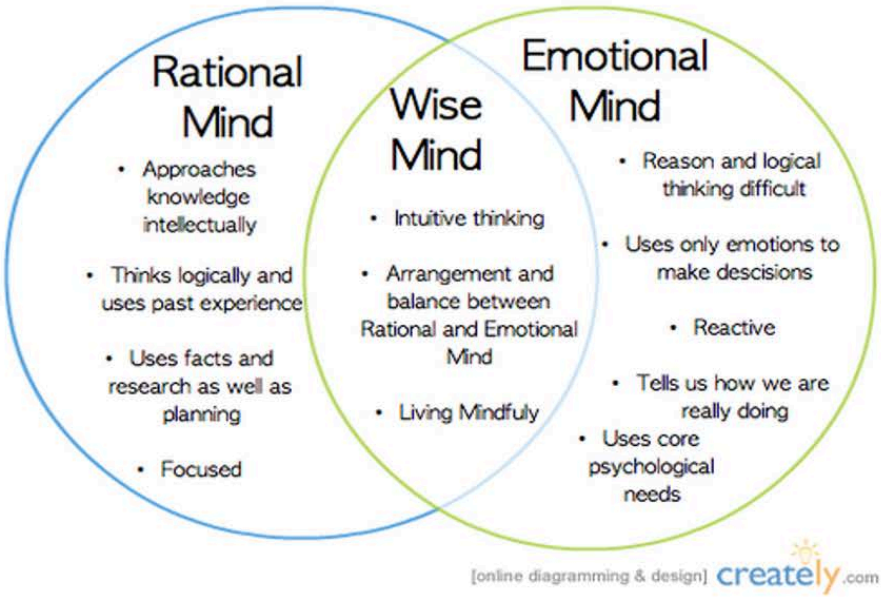
MINDFULNESS
States of Mind:

- Reasonable Mind
- Emotion Mind
- Wise Mind

Using the What Skills:
- Observe
- Describe
- Participate

Using the How Skills:
- Non-judgmentally
- One-mindfully:
  - Conscious Breathing
  - Doing One Thing at a Time
  - A Day of Mindfulness
- Effectively



DISTRESS TOLERANCE

Using Crisis Survival: Distraction with Wise Mind Accepts

- **A** Activities
- **C** Contributing
- **C** Comparisons
- **E** Emotions - use opposite
- **P** Pushing Away
- **T** Thoughts
- **S** Sensations

Using Self Soothe with five senses:

- Taste
- Smell
- See
- Hear
- Touch

Using Improve the moment:

- **I** Imagery
- **M** Meaning
- **P** Prayer
- **R** Relaxation
- **O** One thing at a time
- **V** Vacation
- **E** Encouragement

Using Pros and Cons

Guidelines for Accepting Reality

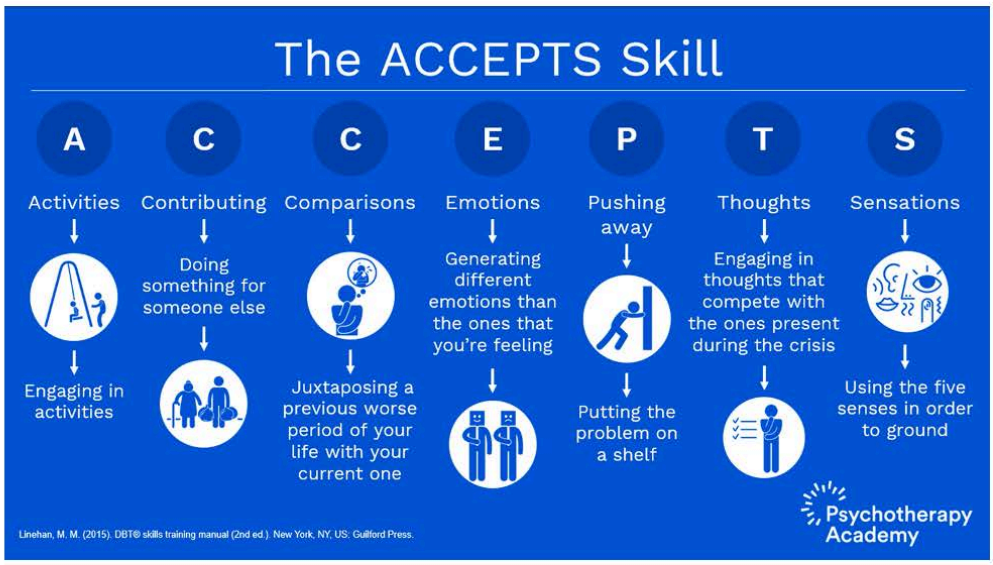
- Observing your Breath
- Half Smiling
- Awareness

Willingness

Turning your mind

Radical Acceptance

Alternate Rebellion



Improving the Moment

- IMPROVE:
  - Imagery: Imagine relaxing scenes, things going well, or other things that please you
  - Meaning: Find some purpose or meaning in what you are feeling
  - Prayer: Either pray to whomever you worship, or, if not religious, chant a personal mantra, LET GO
  - Relaxation: practice deep breathing, use self soothing
  - One thing in the moment: stay present
  - Vacation: take a brief break, allow yourself to be taken care of
  - Encouragement: cheerlead yourself

EMOTION REGULATION

Using Reduce Vulnerability: (Please)

- **P** & **L** Treat Physical Illness
- **E** eating
- **A** Altering Drugs (no drugs except those prescribed)
- **S** Sleep
- **E** Exercise

Identifying Emotions

Describing Emotions

Myths about Emotions

The Function of Emotions:

- Communicate & Influence
- Organize and Motivate

Self Validation

Adult Pleasant Activities

Using Build Mastery

Build Positive experiences

Be mindful of current emotion

Opposite to emotion action

Letting Go of Painful Emotions

Riding the wave of Emotions


Emotion Management
PLEASE MASTER
• Treat PhysicaL illness
• Balance Eating
• Avoid mood-Altering drugs
• Balance Sleep
• Get Exercise
• Build MASTERy – do simple activities that make you feel competent and in control


Opposite To Emotion (O2E)
EMOTION/ACTION
OPPOSITE ACTION
SADNESS
WATCH A FUNNY MOVIE,
FATIGUED/TIRED
LISTEN TO SOME FAST, LOUD MUSIC
ISOLATING
CALL A FRIEND,OR FAMILY MEMBER
FEAR
DO A LITTLE OF WHAT YOU FEAR
ANGER
NO LASHING OUT/MOVE AWAY FROM PERSON OR SITUATION
QUIT THERAPY
GO TO APPOINTMENTS

INTERPERSONAL EFFECTIVENESS

Interpersonal Effectiveness Overview

Using Objectiveness Effectiveness: (Dear Man)

- **D** Describe
- **E** Express
- **A** Assert
- **R** Reinforce
- **M** Mindful
- **A** Appear Confident
- **N** Negotiate

Using Relationship Effectiveness: (Give)

- **G** Gentle
- **I** Interested
- **V** Validate
- **E** Easy Manner

Self-respect effectiveness: (Fast)

- **F** Fair
- **A** Apologies (no Apologies)
- **S** Stick to value
- **T** Truthful

Myths about Interpersonal Effectiveness

Cheerleading Statements for Interpersonal Effectiveness

Options for Determining Intensity of the Situation

Situations for Interpersonal Effectiveness

Factors Reducing Interpersonal Effectiveness

DEAR MAN

for getting what you want

describe
the situation using facts

express
feelings and opinions

assert
by asking or saying no

reinforce
ahead of time by explaining consequences

mindful
keep your focus

appear confident
by voice tone and manner

negotiate
and be willing to give to get

GIVE

for keeping relationship

gentle
no attacks, threats, or judgements

interested
listen to the other person

validate
acknowledge person's feelings, wants difficulties, and opinions

easy manner
use humor, smile, ease

FAST

for keeping self-respect

fair
to self and others

aplogies
NONEof that

stick to values
don't sell out and be clear

truthful
don't lie, act helpless, or exaggerate

You can use your mobile device to help you with your DBT practice.

DBT Self-Help
Full practice app
IP, IPT, IPP, AD

DBT Diary
Diary card practice
IP, IPT, IPP

DBT Review
DBT skills list
IP, IPT, IPP

New! - DBT Self-Help is now available on Android!

ASK
Suicide prevention
IP, IPT, IPP, AD, BB

DBT Diary Card and Skills Coach
Diary card practice
This app hasn't been reviewed because I don't have the correct device, however you will find reviews for it on iTunes. **IP, IPP**

Device Key
IP = iPhone, **IPT** = iPod Touch, **IPP** = iPad, **AD** = Android, **BB** = Blackberry

WORK SHEETS FOR THE STREETS!!!!

ADAPTED FROM *DBT SKILLS TRAINING HANDOUTS AND WORKSHEETS, SECOND EDITION*, BY MARSHA LINEHAN

DBT Skill: **The STOP Skill**

The STOP Skill is a great tool to use first in a crisis situation.

S – Stop! Don't react to whatever stimuli you may be facing. Stay in control of both your emotions and your physical body. Remain still.

T – Take a step back! Remove yourself from the situation. Take a quick break or a deep breath. Don't act impulsively based on your feelings.

O – Observe! Take a moment to notice your surroundings and environment—both inside and out. How do you feel? What are others doing or saying?

P – Proceed mindfully! Think about your goals in the situation and act with total awareness. What can you do to make the situation better, and what kind of action will make the situation worse?

Distress Tolerance Skill 1: TIPP

TEMPERATURE

Change your body temperature. Splash your face with cold water, hold an ice cube, let car AC blow on your face, take a cold shower

INTENSE EXERCISE

Do intense exercise to match your intense emotion. Sprint to the end of the street, do jumping jacks, push ups, intense dancing

PACED BREATHING

Try Box Breathing: Breathe in for 4 seconds, hold it for 4 seconds, breathe out 4, and hold 4. Start again, and continue until you feel more calm.

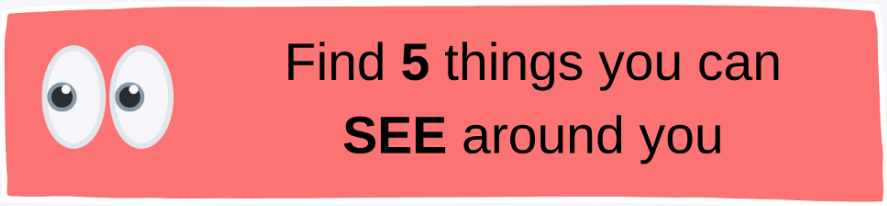
PAIRED MUSCLE RELAXATION

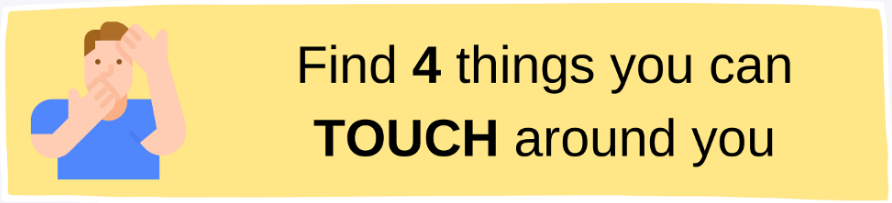
Focus on 1 muscle group at a time. Tighten your muscles as much as possible for 5 seconds. Then release & relax. Repeat with other muscle groups.

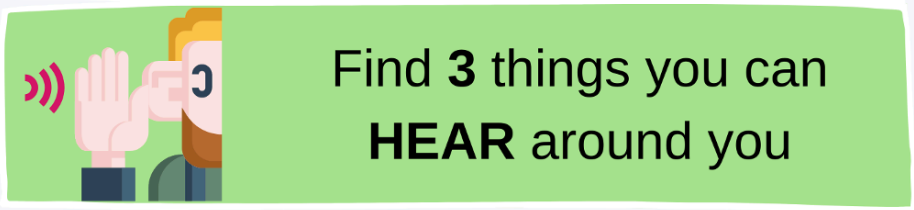
@the.love.therapist

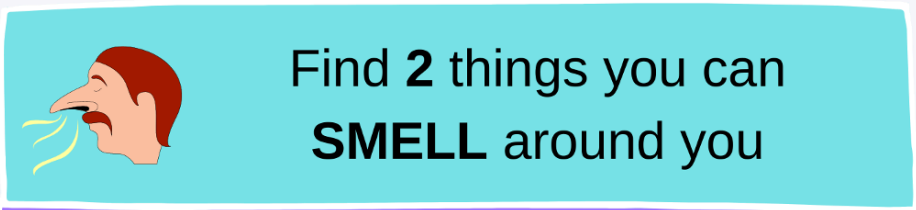
THE 5-4-3-2-1 GROUNDING TECHNIQUE

Feeling overwhelmed or pacing? This countdown method can help you calm your mind.

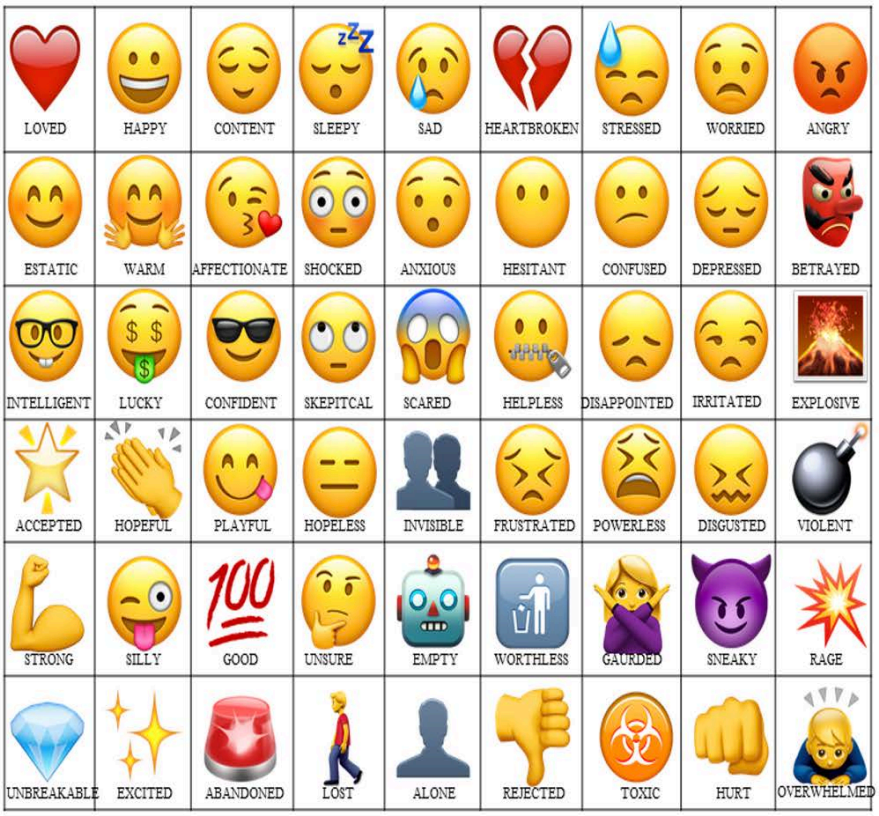


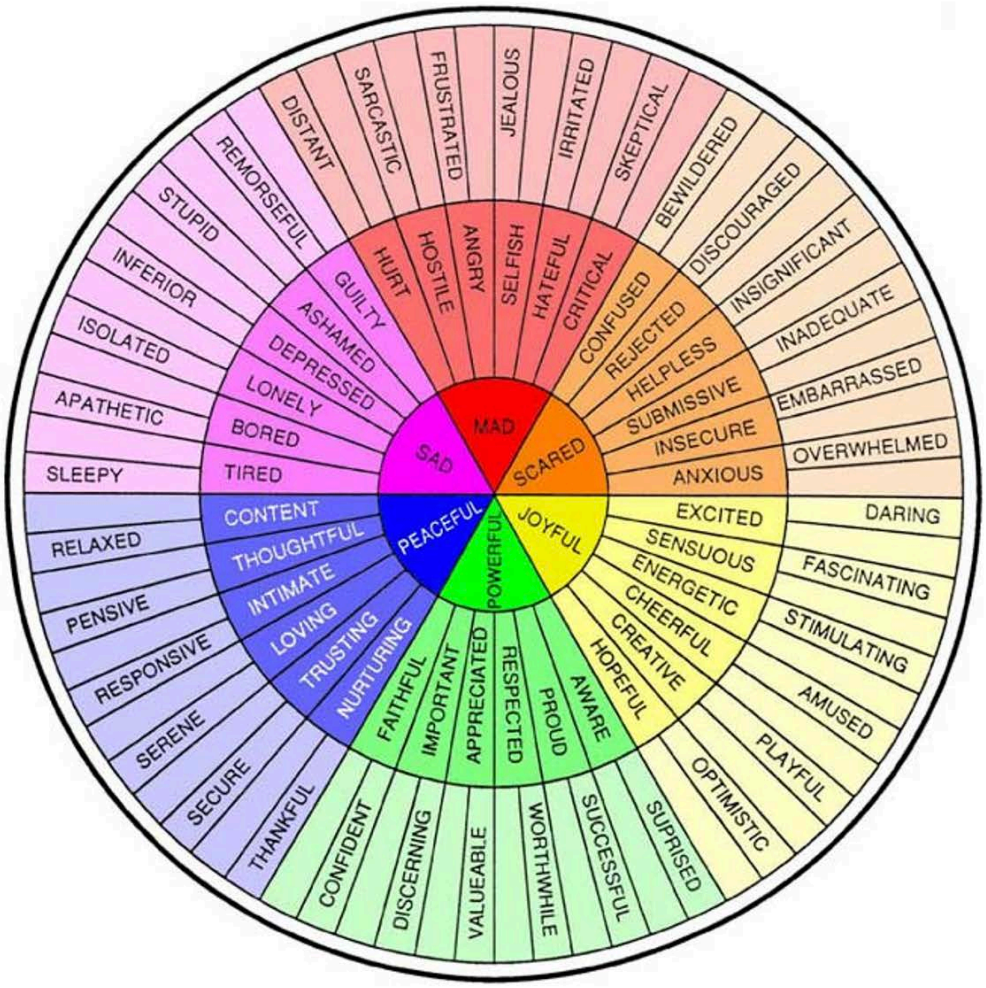


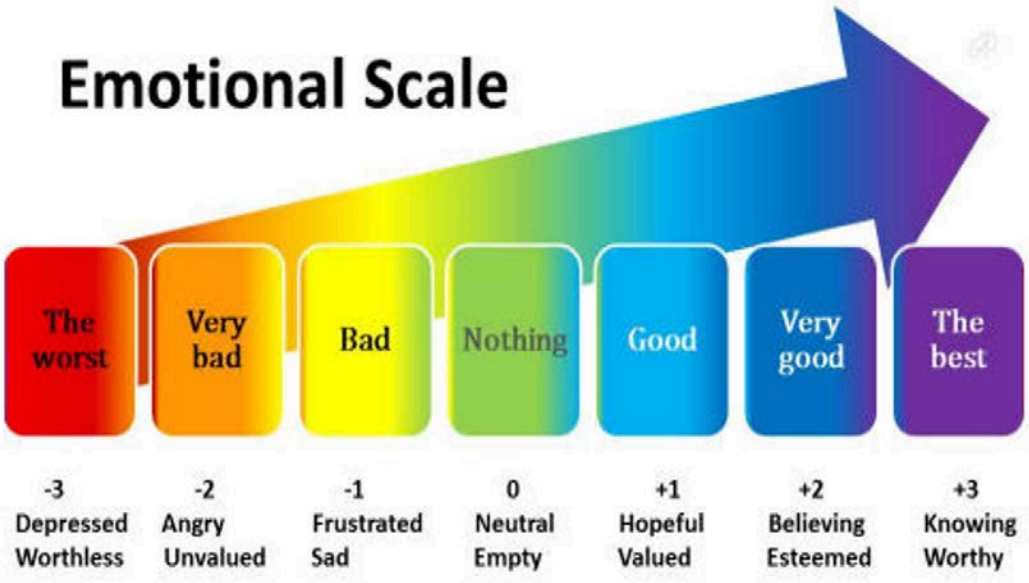


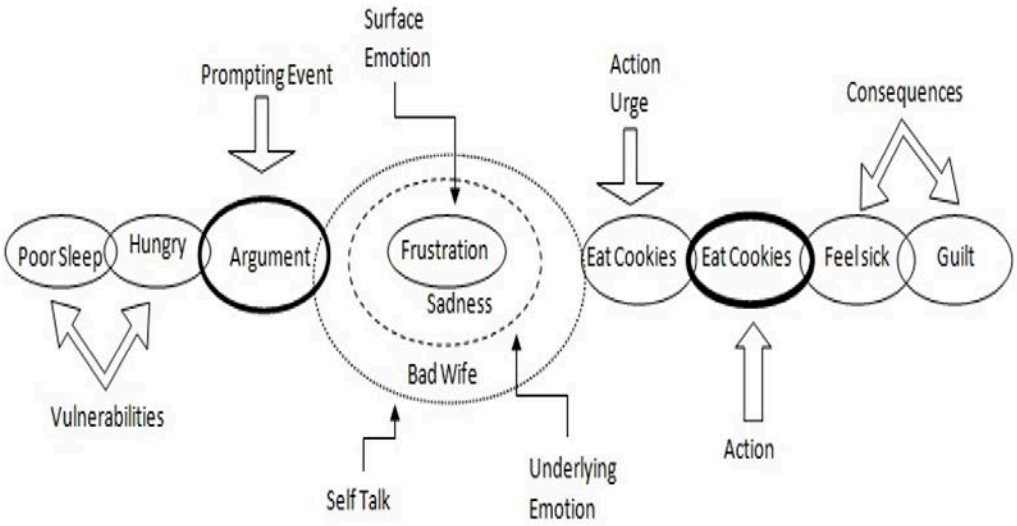


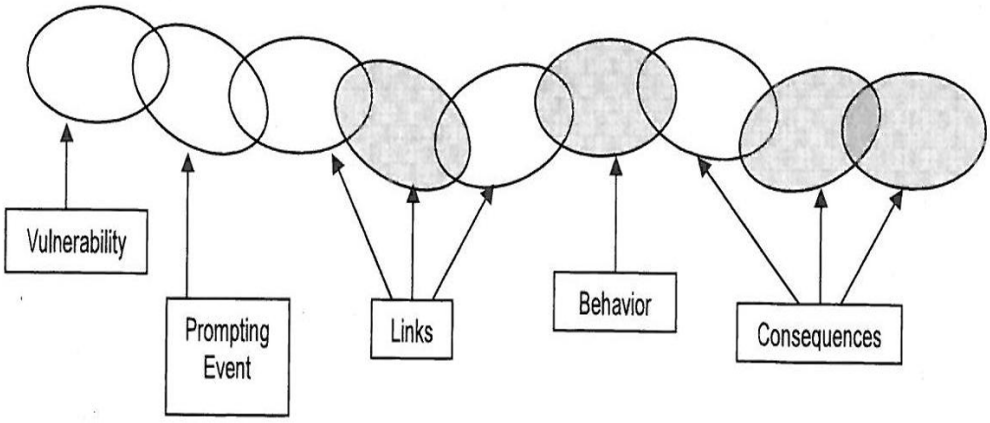
How do you feel today?




MAD
SCARED
JOYFUL
POWERFUL
PEACEFUL
SAD
ANGRY
HOSTILE
HURT
SELFISH
HATEFUL
CRITICAL
FRUSTRATED
SARCASTIC
DISTANT
JEALOUS
IRRITATED
SKEPTICAL
REMORSEFUL
STUPID
INFERIOR
ISOLATED
APATHETIC
SLEEPY
GUILTY
ASHAMED
DEPRESSED
LONELY
BORED
TIRED
CONFUSED
REJECTED
HELPLESS
SUBMISSIVE
INSECURE
ANXIOUS
BEWILDERED
DISCOURAGED
INSIGNIFICANT
INADEQUATE
EMBARRASSED
OVERWHELMED
EXCITED
SENSUOUS
ENERGETIC
CHEERFUL
CREATIVE
HOPEFUL
AWARE
PROUD
RESPECTED
APPRECIATED
IMPORTANT
FAITHFUL
NURTURING
TRUSTING
LOVING
INTIMATE
THOUGHTFUL
CONTENT
RELAXED
PENSIVE
RESPONSIVE
SERENE
SECURE
THANKFUL
CONFIDENT
DISCERNING
VALUEABLE
WORTHWHILE
SUCCESSFUL
SUPRISED
OPTIMISTIC
PLAYFUL
AMUSED
STIMULATING
FASCINATING
DARING


Emotional Scale
The worst
Very bad
Bad
Nothing
Good
Very good
The best
-3 Depressed Worthless
-2 Angry Unvalued
-1 Frustrated Sad
0 Neutral Empty
+1 Hopeful Valued
+2 Believing Esteemed
+3 Knowing Worthy


Surface
Emotion
Prompting Event
Action
Urge
Consequences
Poor Sleep
Hungry
Argument
Frustration
Sadness
Eat Cookies
Eat Cookies
Feel sick
Guilt
Bad Wife
Vulnerabilities
Action
Self Talk
Underlying
Emotion


Vulnerability
Prompting Event
Links
Behavior
Consequences

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cCegQIABAA&oq=distress+tolerance+skill+tipp&gs_lcp=CgNpbWcQAzoHCCMQ6gIQJzoECCMQJzoCCAA6BQgAELEDOggIABCxAxCDAToECAAQQzoECAAQHjoGCAAQCBAeOgYIABAKEBhQq-kBWJKrAmDUuQJoAnAAeACAAWiIAZUSkgEEMjkuMZgBAKABAaoBC2d3cy13aXotaW1nsAEKwAEB&sclient=img&ei=7_SZYNOEItOm-gSlsZ3IBw&bih=909&biw=1745&safe=active&ssui=on#imgrc=FU1_7rhBDgXd5M

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DEAR MAN

The acronym **DEAR MAN** outlines a strategy for communicating effectively. This strategy will help you express your wants and needs in a way that is respectful to yourself and others. Using DEAR MAN will increase the likelihood of positive outcomes from your interactions.

Describe

Clearly and concisely describe the *facts* of the situation, without any judgment. *"You have asked me to work late 3 days this week."*

Express

Use "I" statements to express your emotions.
"I feel overwhelmed by the extra work I've been given."

Assert

Clearly state what you want or need. Be specific when giving instructions or making requests. *"I need to resume my regular 40-hour work week."*

Reinforce

Reward the other person if they respond well to you.
Smiling, saying "thank you", and other kind gestures work well as reinforcement.

Mindfulness

Being mindful of your goal means not getting sidetracked or distracted by other issues. *"I would like to resolve the overtime issue before talking about the upcoming project."*

Appear confident

Use body language to show confidence, even if you don't feel it.

Stand up straight, make appropriate eye contact, speak clearly, and avoid fidgeting.

Negotiate

Know the limits of what you are willing to accept but be willing to compromise within them.

"I'll finish the extra work this week, but I won't be able to manage the same amount of work next week."

DEAR MAN

Instructions: Choose a specific interpersonal challenge you are dealing with, or that you have dealt with in the past.

Answer the prompt for each step to create a plan for communicating about the issue.

Describe: What are the *facts* of the situation? Do not include opinions or interpretations.

Express: Write an "I" statement to express your feelings: "I feel _____ when _____."

Assert: How will you tell someone what you need? Respond with the specific language you will use.

Reinforce: How will you reward the other person for responding well to you?

Mindfulness: What is the goal of your interaction? What other topics might distract from the goal?

Appear confident: Describe the posture, eye contact, and tone of voice you will use.

Negotiate: What are the limits of what you are willing to accept?

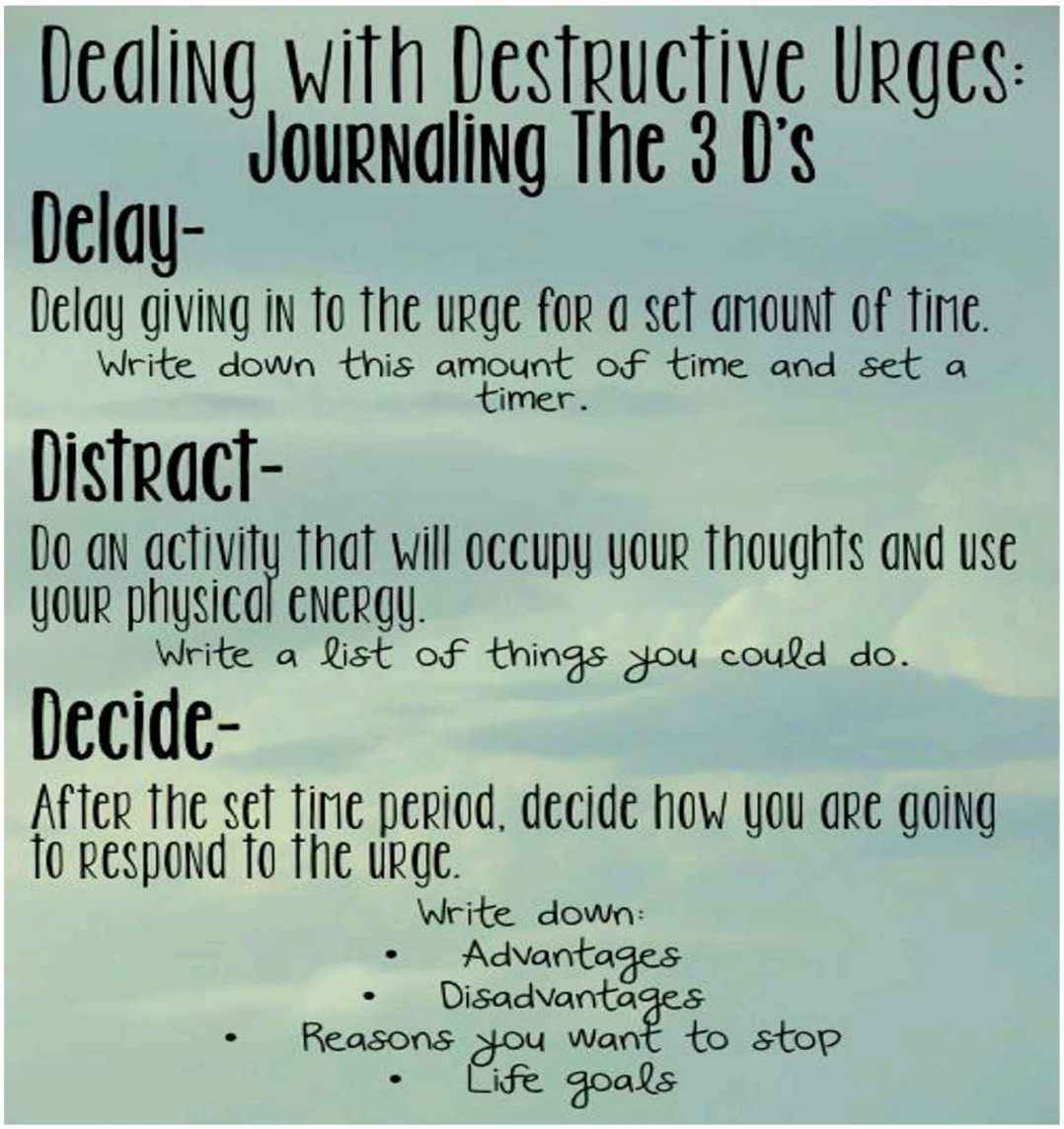
TIP

Tip the temperature of your face with cold water. Holding your breath put your face in a bowl of cold water or hold a cold pack of cold water over your eyes and cheeks. Hold for 30 seconds.

Engage in intense exercise to calm your body when it is revved up by emotion. Walk fast, lift weights, dance, etc to expend your body's energy if only for a short while

Pace your breathing by slowing it down. Breathe deeply into your belly. Slow your pace of inhaling and exhaling way down . Breathe in for 5 seconds and out for 7 seconds.

While breathing in your belly deeply tense your body muscles. Notice the tension in your body. While breathing out, say the work 'RELAX' in your mind. Let go of the tension. Notice the difference in your body.


Dealing with Destructive Urges:
Journaling The 3 D's
Delay-
Delay giving in to the urge for a set amount of time.
Write down this amount of time and set a timer.
Distract-
Do an activity that will occupy your thoughts and use your physical energy.
Write a list of things you could do.
Decide-
After the set time period, decide how you are going to respond to the urge.
Write down:
• Advantages
• Disadvantages
• Reasons you want to stop
• Life goals

APPENDIX B

EVALUATION MEASURES

Adapted General Self-Efficacy Scale

1. I have effective skills to manage mental health patients who struggle with emotion regulation.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

2. I can implement effective skills that will enable me to treat emotionally dysregulated patients within the allotted time I have to see patients where I work.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

3. I can identify skills that I can think of utilizing with an emotionally escalated patient who suffers from mental health illness on my own.

- Strongly agree

- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

4. I can identify and implement skills effectively with an emotionally escalated patient who suffers from mental health illness on my own.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

5. I can identify specific training that I have attended that has helped me with skills to help manage effectively emotionally dysregulated patients who struggle with mental health.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

6. I think that having training to help manage emotionally dysregulated mental health patients would be beneficial to me where I work.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

7. Acquiring emotion regulation skills for mental health patients will help me in my assessment process.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

8. I feel that learning skills for emotionally dysregulated patients will help with other patients who do not suffer from mental health illness.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree

- Decline to answer

9. I feel that I do not need any additional training to manage mental health patients who present as emotionally dysregulated.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

10. I feel that having skills that manage emotional dysregulation with mental health patients would be an effective way to assist with time management for patient visits.

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
- Decline to answer

Adapted Self-Perception Profile for Adults

1. As a physician I feel that I am adequately trained to manage emotionally dysregulated patients who suffer from mental health illness.

- Extremely adequate
- Somewhat adequate

- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

2. As a physician I feel confident that I am able to perform my assessment effectively in the allotted time where I work for emotionally dysregulated patients who suffer from mental health illness.

- Extremely adequate
- Somewhat adequate
- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

3. As a physician I think that having training on skills to manage emotional dysregulation in mental health patients will help with my assessment process within my work environment.

- Extremely adequate
- Somewhat adequate
- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

4. As a physician I feel confident that I know of effective skills that will de-escalate emotionally dysregulated patients who suffer from mental health illness in order for me to assess patients accurately in my work environment.

- Extremely adequate

- Somewhat adequate
- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

5. As a physician I feel confident that I know of effective skills and can implement these skills that will de-escalate emotionally dysregulated patients who suffer from mental health illness in order for me to assess patients accurately in my work environment.

- Extremely adequate
- Somewhat adequate
- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

6. As a physician I am confident that I have I have access to training to assist in skill building for effective skills to use for the purposes of de-escalating emotionally dysregulated mental health patients.

- Extremely adequate
- Somewhat adequate
- Neither adequate nor inadequate
- Somewhat inadequate
- Extremely inadequate

APPENDIX C

TELEPHONE SCRIPT TO RETRIEVE TRAINING ASSESSMENTS 1 MONTH POSTTRAINING

[As part of the contact from the Loma Linda University (LLU) research team for the ASWMHT program study, after obtaining a roster with the names, phone numbers, and corresponding emails of the individuals participating in the study, the research team will be responsible for calling all the participants in order to ensure that all the 1-month postassessments from the study are received and completed through email. Below is a sample script for the initial telephone call:]

Hello. My name is April Wozencroft and I am part of a research team calling you from Loma Linda University (LLU) to follow up with you on the completion of the 1-month postassessment from the Anticipating Success Within Mental Health Training Program. If you are able to complete your 1-month postassessment that was sent through your email address provided through the training it would be greatly appreciated. This will be of great benefit in assisting with improving the skill level for providers in managing emotionally dysregulated mental health patients.

Would you be able to submit your 1-month postassessment through email by the end of week? The assessment automatically will be stored through Survey Monkey for my retrieval and review.

(pause) (wait for answer)

Thank you.

APPENDIX D

PROGRAM AGENDA

2- Day Informed Dialectical Behavior Therapy Skills Training

1. *Announcements to ensure that all participants have completed informed consents prior to attending training session.*

2. *Defining emotional dysregulation and how this manifests in patients and the percentage of patients that will be seen by primary care physicians*

3. *DBT is a skill-based therapy that assists with managing intense emotions that vacillate from mild acuity to severe acuity with the inclusion of suicidal patients.*

Definitions to Keep in Mind throughout Training

Emotional dysregulation defined: *"any excessive or otherwise poorly managed mechanism or response." An example of this could be emotional dysregulation as "an extreme or inappropriate emotional response to a situation (e.g., temper outbursts, deliberate self-harm); it may be associated with [mental health related disorders that include] bipolar disorders, borderline personality disorder, autism spectrum disorder, psychological trauma, or brain injury" (American Psychological Association, n.d.).*

Effectiveness *is the ability of an intervention to have a meaningful effect on patients in normal clinical conditions (Burches & Burches, 2020).*

12:00pm to 1:00pm

Introduction of Instructor and Participants of the Training

- *This discussion identifies specific interests of participants regarding what they would like to gain from the training.*
- *Introduction of trainer and experience*
- *Discuss objectives and goals of training*

Introduction to dialectical behavior therapy and why the skills that will be taught have been influenced by this form of therapy. Identifying the four modules that will be addressed through the different skills that will be taught in training

Mindfulness – Introduction of What It Is

- *Experiential activity of mindfulness that the class will engage in*
- *Identify skills that create awareness*

Break 1:00pm to 1:10pm

1:10pm to 2:00pm

Introduction to Distress Tolerance

- *Identify what distress tolerance is*
- *Identify the skills that can be used targeting distress tolerance*
- *How to use distress tolerance skills*

Provide examples from challenging cases from previous experiences
Conducting role playing to demonstrate how this can be used in practical ways

Introduction to Emotion Regulation

- *Defining emotion regulation*

Feedback Session

- *Provide feedback session at the end of group to address questions that may have gone unanswered during group for the last 10 minutes*

DAY TWO

12:00pm to 1:00pm

Introduction with Opening Questions from Participants

- *Brief overview of the concepts of mindfulness and distress tolerance*

Emotion Regulation Skills Review

- *When to apply these skills*
- *How to utilize these skills in patient care in ways that are practical and implementable*
- *Role play to help demonstrate how the skill can be implemented*

Differentiating between distress tolerance circumstances versus emotion regulation circumstances

Introduction to interpersonal effectiveness and what the focus points of these skills provide

Break 1:00pm to 1:10pm

1:10pm to 2:00pm

Identify the Skills from Interpersonal Effectiveness

- *When to apply these skills*

- *How to utilize these skills in patient care in ways that are practical and implementable*
- *Role play to help demonstrate how the skill can be implemented*

Feedback Session

- *Identifying specific common scenarios where the use of these skills would be most beneficial*
- *Identify important resources to have for patient care*
- *Announcements of responding to the surveys that will be used*
- *Provide feedback at the end of group to address questions that may have gone unanswered during group for the last 10 minutes*

APPENDIX E

DECISION LEARNING TOOL

Mild Acuity Cases

DECISION LEARNING TOOL

SCENARIO

Paul is a 52-year-old self-employed builder who has diabetes. He presents to his PCP (primary care physician) complaining that he has been feeling increasingly tired for the last 4 months. His sleep is poor, and he says he can't be bothered to shave in the morning. He says that the practice nurse was unhappy with his diabetic control and his wife has now insisted that he see a doctor.

DECISION

Treat the patient for his issues with diabetes and possible symptoms of depression, with the recommendation to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for his issues with diabetes and possible symptoms of depression, with the recommendation to be seen by a mental health provider. Utilize interpersonal effectiveness skills to handle possible resistance to recommendations due to the visit being influenced by his wife.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

OUTCOME

The patient receives immediate care from PCP. In addition, using skills to discuss recommendations can validate the patient's hesitance in coming to the visit and build rapport to further help with treatment and compliance with after-visit care.

Rationale: This type of patient does not present with any emotional dysregulation symptoms and is overall compliant with the provider. However, in mild acuity cases such as this one, having skills that help with effective communication can enhance the possibility of compliance and rapport building.

DECISION LEARNING TOOL

SCENARIO

Dan is a 32-year-old man presenting with shoulder pain. He has not been seen since the surgery for a couple of years and in passing mentions poor sleep, annoyance about his benefits, and dissatisfaction with his accommodation. It quickly becomes clear that the main problem affecting Dan is mental-health related and that his shoulder pain is related to a minor injury he sustained 2 or 3 weeks ago that is already resolving itself. A brief history shows that he has symptoms that fulfill the criteria for both anxiety disorder and depression. When asked how he had been in previous months, he seems a little uncertain how to answer, and then he admits that he has been in prison. On further questioning, Dan informs you that he was convicted of assault with ABH (actual bodily harm) and resisting arrest.

DECISION

Treat the patient for physical symptoms and presenting symptoms of anxiety and depression. Provide the patient with the recommendation to follow up with a mental health provider for continued care for anxiety and depressive symptoms until patient is able to meet with his mental health treatment provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for physical symptoms and presenting symptoms of anxiety and depression. Provide the patient with the recommendation to follow up with a mental health provider for continued care for anxiety and depressive symptoms. Utilize skills for emotion regulation and mindfulness to address the irritability in the patient during the visit.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

OUTCOME

The patient receives immediate care from PCP. In addition, using skills to address the irritability in the patient can possibly provide a more validating experience that enhances rapport and increases the chance of treatment compliance.

Rationale: This type of patient seems to be experiencing some low levels of emotional dysregulation with an annoyed temperament. Using skills that help the patient feel heard in addition to skills that help refocus the patient in the moment will lessen the patient's feelings of annoyance. This can be beneficial in that the patient may become more receptive to adhering to the primary care physician's recommendations in addition to feeling less irritable during the visit. Lessening intense emotions within a visit can also potentially provide an opportunity to have a more cooperative patient that is willing to share more about their symptoms.

DECISION LEARNING TOOL

SCENARIO

Violet is 84 years old. She has been in a residential home for 4 months following time in hospital with a fractured femur after a fall. She is a widow, and her only visitor has been her younger brother, who suffered a stroke 6 weeks ago and has not been able to visit her since. Violet has become increasingly quiet and withdrawn. The care staff report that she is not eating and is staying in her room much of the time. The PCP is asked to visit Violet because her weight has dropped by 4 pounds in 1 month.

DECISION

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider. Using emotion regulation skills may be helpful in increasing this patient's engagement to gather additional information and in building rapport for treatment compliance until patient is able to meet with her mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using emotion regulation skills to assist with increased engagement with the patient can increase rapport between the PCP and the patient and increase the chance of treatment compliance.

Rationale: This type of patient may present as very withdrawn, which may make it very difficult to assess the patient and make accurate recommendations. Using emotion regulation skills can help elevate the patient's mood on the spot, which may increase the opportunity to gain better insight on how best to treat the patient until the patient can be seen by a mental health provider.

DECISION LEARNING TOOL

SCENARIO

A patient comes in feeling depressive symptoms including lethargy, poor concentration, anhedonia, and a loss of interest in things they used to enjoy, with no risk factors of suicidal behaviors or risk of harming others. This patient has no history of suicidal behaviors/suicide attempts or self-harm behaviors.

DECISION

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression. The use of interpersonal effectiveness skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her/his mental health treatment provider.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as very withdrawn. Although this patient does present with symptoms that directly correspond with depression and does not present with any resistance or opposition, it can still be beneficial to utilize interpersonal effectiveness skills that help provide a validating environment and that facilitate effective communication.

DECISION LEARNING TOOL

SCENARIO

A patient arrives complaining about feeling continuously anxious and ruminating on worry and fear to the point that it is disrupting sleep. Patient has no risk factors of suicidal behaviors or risk of harming others. This patient has no history of suicide attempts or self-harm behaviors.

DECISION

Treat the patient for what seem to be symptoms of anxiety, with a follow-up recommendation for the patient to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of anxiety, with a follow-up recommendation for the patient to be seen by a mental health provider. Utilization of distress tolerance skills in this interaction may be beneficial in approaching the possible irritability this client may be experiencing due to rumination and poor sleep. The use of distress tolerance skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her/his mental health treatment provider.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

OUTCOME

The patient receives immediate care from PCP. In addition, using the distress tolerance skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present with irritability since the patient expresses feeling constant worry and has not slept well because of this. Utilizing skills that assist with presenting distress can help the patient be more engaged in the visit and may lessen the intensity of the patient's distress. This approach can promote enhanced rapport and increase the chance of treatment compliance following this visit.

DECISION LEARNING TOOL

SCENARIO

Shubha can speak limited English. She is unhappy about the appointment with the PCP, as she feels this will bring shame to the family. She sees you—a White male PCP—with her husband, who acts as an interpreter. Her husband says that Shubha seems unhappy and does not want to do anything. She is reluctant to get out of bed or to look after the baby, and she complains of pain in her stomach constantly. He discloses that his mother thinks she is lazy because she is unwilling to do household chores.

DECISION

Treat the patient for what seem to be symptoms of postpartum depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

DECISION TO USE DBT-INFORMED SKILLS

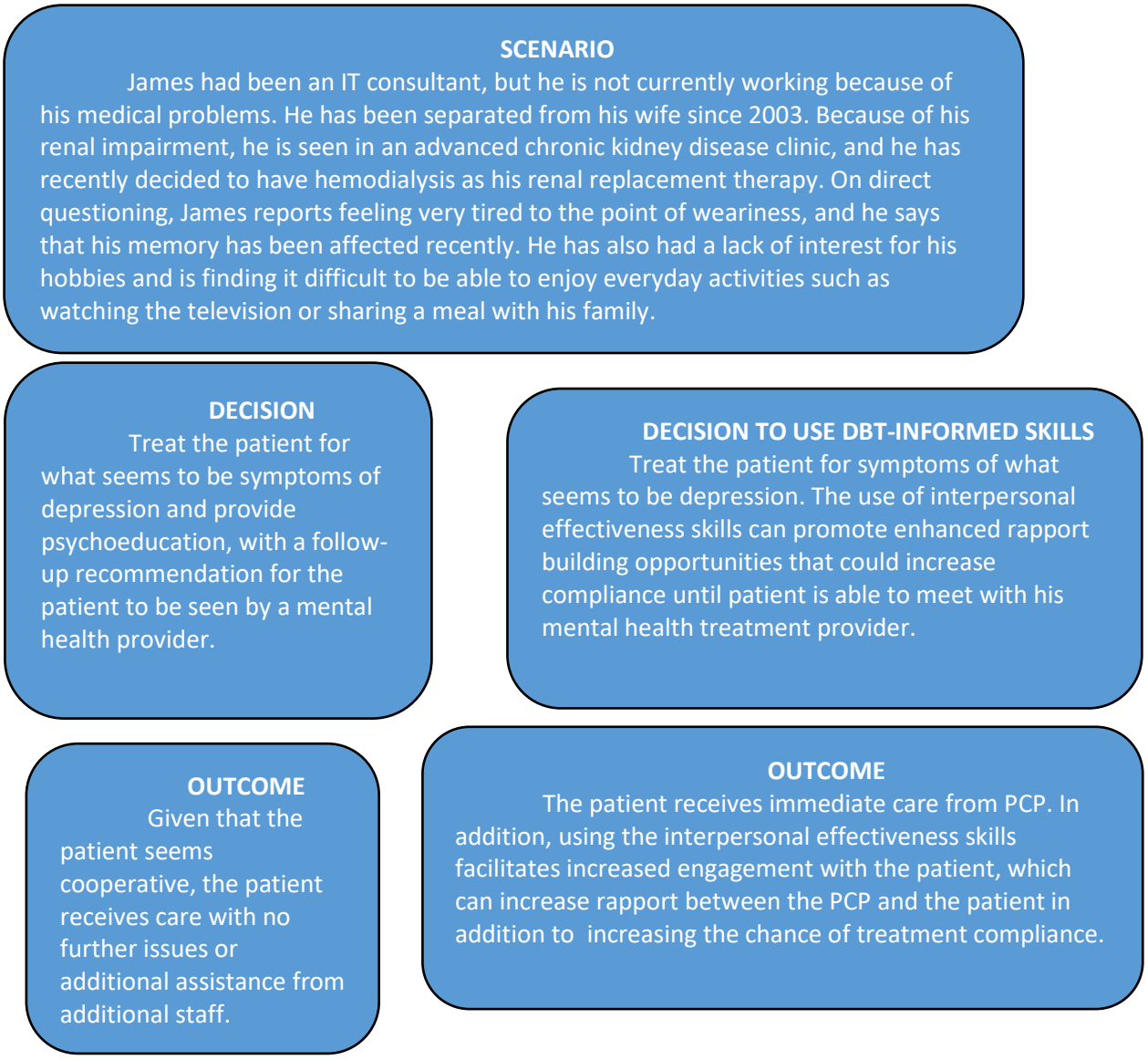
Treat the patient for what seem to be symptoms of postpartum depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider. The use of interpersonal effectiveness skills and distress tolerance skills may help the patient manage her distress in coming to the appointment, and these skills may also encourage more engagement and understanding from the patient and family. The use of these skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as resistant since the patient sees this appointment as shameful. This can directly impact the level of adherence and engagement from the patient during this visit. Skills that can assist with the patient's distress can promote enhanced rapport and increase the chance of treatment compliance following this visit.

DECISION LEARNING TOOL



Rationale: This type of patient may present as withdrawn, which could impact his engagement with the PCP. Using interpersonal effectiveness skills could improve the chance of getting additional information that may be helpful in the assessment and may promote enhanced rapport, which could potentially increase the chance of treatment compliance following this visit.

DECISION LEARNING TOOL

SCENARIO

Fred, aged 45, is a locksmith. He has long-standing and persistent worries that he has not done his job properly and that someone might get burgled as a result. He worries that he might have given customers the wrong change whenever they have paid him in cash. Fred informs you that he worries about many things in his life, and his most common thought is "What if?" He often imagines the worst happening and states that when he worries, he often feels sick, has headaches, feels butterflies in his stomach, and is aware of his heart pounding. Fred often gets hot and sweaty and says his anxiety makes it difficult to concentrate and do his job or play with his children. He is very distressed by his constant worrying and feelings of anxiety, and he regards this as a sign of weakness. At the beginning of the consultation with his PCP, Fred states he is attending because of problems with sleeping. But after questioning about how things have been for him recently, Fred discloses to his PCP that he is feeling under considerable stress.

DECISION

Treat the patient for what seem to be symptoms of anxiety and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems cooperative, the patient receives care with no further issues or additional assistance from additional staff.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of anxiety and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider. The use of distress tolerance skills to assist with the patient's level of intense worry may promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with his mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using the distress tolerance skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient presents with intense anxiety with physical symptomatology such as headaches and heart-pounding sensations, which may cause distress for the patient during the visit. Utilizing distress tolerance skills may not only be helpful in lessening the patient's discomfort during the visit but may also help the patient feel more comfortable with the PCP, enhancing rapport building and potentially increasing the chance of treatment compliance following this visit.

Moderate to Severe Cases

DECISION LEARNING TOOL

SCENARIO

Paul is a 52-year-old self-employed builder who has diabetes. He presents to his PCP complaining that he has been feeling increasingly tired for the last 4 months. His sleep is poor, and he says he can't be bothered to shave in the morning. He says that the practice nurse was unhappy with his diabetic control, and his wife has now insisted that he see a doctor. Paul's tone is heightened, and he does not allow you to talk at all because he is so agitated with having to see you in the first place.

DECISION

Treat the patient for his issues with diabetes and possible symptoms of depression, with the recommendation to be seen by a mental health provider.

OUTCOME

Given that the patient seems uncooperative, the PCP may need to inform the patient that the PCP can allow the patient to take a moment, and the PCP can come back in a few minutes to discuss treatment when the patient is in a calmer state. The PCP may also enlist additional staff to help the patient calm down so that PCP can assess the patient. In both instances, this requires additional time and possibly additional staff to treat this patient.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for his issues with diabetes and possible symptoms of depression, with the recommendation to be seen by a mental health provider. Utilize interpersonal effectiveness skills to assist with possible resistance to recommendations due to the visit being influenced by his wife. The use of distress tolerance skills can address Paul's agitation, which can lessen the intensity of his emotions and potentially allow for Paul to be more cooperative during the visit.

OUTCOME

The patient receives immediate care from PCP. In addition, using skills to discuss recommendations can validate the patient's hesitance in coming to the visit and build rapport to further help with treatment and compliance with after-visit care.

Rationale: This patient presents with symptomatology of being emotionally dysregulated through agitation during the visit, which may impact the patient-to-PCP interaction. Utilizing distress tolerance skills in addition to interpersonal effectiveness skills can provide an opportunity for the PCP to assess the patient more efficiently without the need to step out of the room for the patient to calm down or for additional staff to get involved. The provider's ability to assist the patient through his emotional dysregulation during the visit may enhance the likelihood of rapport building and treatment compliance following the visit.

DECISION LEARNING TOOL

SCENARIO

Dan is a 32-year-old man presenting with shoulder pain. He has not been seen in the surgery for a couple of years and in passing mentions poor sleep, annoyance about his benefits, and dissatisfaction with his accommodation. It quickly becomes clear that the main problem affecting Dan is mental-health related and that his shoulder pain is related to a minor injury he sustained 2 or 3 weeks ago that is already resolving itself. A brief history shows that he has symptoms which fulfill the criteria for both anxiety disorder and depression. When asked how he had been in previous months, he seems a little uncertain how to answer, and then he admits that he has been in prison. On further questioning, Dan informs you that he was convicted of assault with ABH (actual bodily harm) and resisting arrest. Dan's irritability increases, and he escalates by raising his voice about how no one wants to help him and seeing a doctor is useless.

DECISION

Treat the patient for physical symptoms and presenting symptoms of anxiety and depression. Provide the patient with the recommendation to follow up with a mental health treatment provider for continued care for anxiety and depressive symptoms.

OUTCOME

Given that the patient seems agitated and demonstrates some symptomatology of emotion dysregulation, the PCP may need to take additional time with the patient until he is able to calm down and/or involve additional staff to assist with managing the patient's irritability until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for physical symptoms and presenting symptoms of anxiety and depression. Provide the patient with the recommendation to follow up with a mental health provider for continued care for anxiety and depressive symptoms. Utilize skills for emotion regulation and mindfulness to address the irritability in the patient during the visit.

OUTCOME

The patient receives immediate care from PCP. In addition, using skills to address the irritability in the patient can possibly provide a more validating experience that enhances rapport and increases the chance of treatment compliance. The use of skills to manage the emotional dysregulation the patient is experiencing may lessen the likelihood of the patient's assessment being inaccurate.

Rationale: This type of patient seems to be experiencing some low levels of emotional dysregulation with an annoyed temperament. Using skills that help the patient feel heard in addition to skills that help refocus the patient in the moment will lessen the patient's feelings of annoyance. This can be beneficial in that the patient may become more receptive to adhering to the primary care physician's recommendations in addition to feeling less irritable during the visit. Lessening intense emotions within a visit may also provide an opportunity to have a more cooperative patient that is willing to share more about their symptoms.

DECISION LEARNING TOOL

SCENARIO

Violet is 84 years old. She has been in a residential home for 4 months following time in hospital with a fractured femur after a fall. She is a widow, and her only visitor has been her younger brother, who suffered a stroke 6 weeks ago and has not been able to visit her since. Violet has become increasingly quiet and withdrawn. The care staff report that she is not eating and is staying in her room much of the time. The PCP is asked to visit Violet because her weight has dropped by 4 pounds in 1 month. Violet starts crying profusely in the office visit about how lonely she is.

DECISION

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems withdrawn and demonstrates some symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until she is able to calm down and/or involve additional staff to assist with managing the patient's crying outburst until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider. Using emotion regulation and mindfulness skills may be helpful in increasing this patient's engagement to gather additional information and in building rapport for treatment compliance until patient is able to meet with her mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using emotion regulation and mindfulness skills to assist with increased engagement with the patient can increase rapport between the PCP and the patient and increase the chance of treatment compliance. This can also potentially increase accuracy of the assessment and diagnosis.

Rationale: This type of patient may present as very withdrawn, which may make it very difficult to assess the patient and make accurate recommendations. Using emotion regulation skills and mindfulness skills can help elevate the patient's mood on the spot and help the patient become more present for the visit, which may increase the opportunity to gain better insight on how best to treat the patient until the patient can be seen by a mental health provider.

DECISION LEARNING TOOL

SCENARIO

A patient comes in feeling depressive symptoms including lethargy, poor concentration, anhedonia, and a loss of interest in things they used to enjoy, with no risk factors of suicidal behaviors or risk of harming others. This patient has no history of suicidal behaviors/suicide attempts or self-harm behaviors. This patient appears agitated in their presentation and proceeds to yell at you for having him/her wait long to see you. Every time you try to say something, the patient continues to escalate with his/her tone of voice.

DECISION

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider for continued care for depression.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression. The use of interpersonal effectiveness skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her/his mental health treatment provider.

OUTCOME

Given that the patient seems agitated and uncooperative and is demonstrating symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until the patient is able to calm down and/or involve additional staff to assist with managing the patient's irritability and verbal aggression until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as very agitated and verbally aggressive. The use of distress tolerance skills and interpersonal effectiveness skills can help the PCP guide the patient to lessen the intensity of their agitation, which will allow the PCP to assess the patient in a more effective way. Utilizing these skills may increase the opportunity to gain better insight on how best to treat the patient until the patient can be seen by a mental health provider.

DECISION LEARNING TOOL

SCENARIO

A patient arrives complaining about feeling continuously anxious and ruminating on worry and fear to the point that it is disrupting sleep. Patient has no risk factors of suicidal behaviors or risk of harming others. This patient has no history of suicide attempts, self-harm behaviors, or drug or alcohol abuse. The patient starts pacing in the room and says that he/she is having a hard time with the constant worry. Patient ruminates on how things will never change.

DECISION

Treat the patient for what seem to be symptoms of anxiety, with a follow-up recommendation for the patient to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of anxiety, with a follow-up recommendation for the patient to be seen by a mental health provider. Utilization of distress tolerance skills in this interaction may be beneficial in approaching the possible irritability this client may be experiencing due to rumination and poor sleep. The use of distress tolerance skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her/his mental health treatment provider.

OUTCOME

Given that the patient seems emotionally dysregulated and unable to focus, the PCP may need to take additional time to help the patient focus enough to provide an assessment. This may require the help of additional staff in the event that the patient cannot provide information to the PCP in the moment. The patient will receive care once the patient is in a calmer state.

OUTCOME

The patient receives immediate care from PCP. In addition, using the distress tolerance skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present with emotional dysregulation evidenced by rumination and pacing. The patient expresses feeling constant worry and has not slept well because of this. Utilizing skills that assist with presenting distress can help the patient be more engaged in the visit and may lessen the intensity of the patient's distress. This approach can promote enhanced rapport and increase the chance of treatment compliance following this visit.

DECISION LEARNING TOOL

SCENARIO

Shubha can speak limited English. She is unhappy about the appointment with the PCP, as she feels this will bring shame to the family. She sees you—a White male PCP—with her husband, who acts as an interpreter. Her husband says that Shubha seems unhappy and does not want to do anything. She is reluctant to get out of bed or to look after the baby, and she complains of pain in her stomach constantly. He discloses that his mother thinks she is lazy because she is unwilling to do household chores. During the visit, Shubha begins crying and says that you (PCP) don't understand anything. She states, "Nothing will change, and I don't know why I am here."

DECISION

Treat the patient for what seems to be symptoms of postpartum depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems agitated and demonstrates some symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until she is able to calm down and/or involve additional staff to assist with managing the patient's irritability until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of postpartum depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider. The use of interpersonal effectiveness skills and distress tolerance skills may help the patient manage her distress in coming to the appointment, and these skills may also encourage more engagement and understanding from the patient and family. The use of these skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness and emotion regulation skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as resistant since the patient sees this appointment as shameful. This can directly impact the level of adherence and engagement from the patient during this visit. Utilizing interpersonal effectiveness and emotion regulation skills that can assist with the patient's distress can promote enhanced rapport and increase the chance of treatment compliance following this visit.

DECISION LEARNING TOOL

SCENARIO

James had been an IT consultant, but he is not currently working because of his medical problems. He has been separated from his wife since 2003. Because of his renal impairment, he is seen in an advanced chronic kidney disease clinic, and he has recently decided to have hemodialysis as his renal replacement therapy. On direct questioning, James reports feeling very tired to the point of weariness, and he says that his memory has been affected recently. He has also had a lack of interest for his hobbies and is finding it difficult to be able to enjoy everyday activities such as watching the television or sharing a meal with his family. When you try to discuss the treatment plan, James immediately interrupts you and says, "See, you are just like everyone else. You don't listen to me at all, and I am tired of this."

DECISION

Treat the patient for what seems to be symptoms of depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression. The use of interpersonal effectiveness skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with his mental health treatment provider.

OUTCOME

Given that the patient seems emotionally dysregulated and unable to focus, the PCP may need to take additional time with the patient to help him focus enough to provide an assessment. This may require the help of additional staff in the event that the patient cannot provide information to the PCP in the moment. The patient will receive care once he is in a calmer state.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness and distress tolerance skills lessens the patient's emotional dysregulation, which facilitates more effective engagement with the patient. This can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as highly aggravated, which could impact the engagement with the PCP. Using interpersonal effectiveness and distress tolerance skills could improve the chance of getting additional information that may be helpful in the assessment and may promote enhanced rapport, which could potentially increase the chance of treatment compliance following this visit.

DECISION LEARNING TOOL

SCENARIO

Fred, aged 45, is a locksmith. He has long-standing and persistent worries that he has not done his job properly and that someone might get burglarized as a result. He worries that he might have given customers the wrong change whenever they have paid him in cash. Fred informs you that he worries about many things in his life, and his most common thought is "What if?" He often imagines the worst happening and states that when he worries, he often feels sick, has headaches, feels butterflies in his stomach, and is aware of his heart pounding. Fred often gets hot and sweaty and says his anxiety makes it difficult to concentrate and do his job or play with his children. He is very distressed by his constant worrying and feelings of anxiety, and he regards this as a sign of weakness. At the beginning of the consultation with his PCP, Fred states he is attending because of problems with sleeping. But after questioning about how things have been for him recently, Fred discloses to his PCP that he is feeling under considerable stress. When you attempt to discuss the treatment plan, the patient immediately begins having a crying spell and says to you, "I don't think you can help me at all. This is the third time I have been to a doctor, and no one seems to help me or understand what I need at all."

DECISION

Treat the patient for what seem to be symptoms of anxiety and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems highly agitated and demonstrates symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until he is able to calm down and/or involve additional staff to assist with managing the patient's crying outburst until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of anxiety and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider. The use of distress tolerance skills to assist with the patient's level of intense worry may promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with his mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using the distress tolerance skills to lessen the intensity of the patient's emotions facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient presents with intense anxiety with physical symptomatology such as headaches and heart-pounding sensations, which may cause distress for the patient during the visit. Utilizing distress tolerance skills may not only be helpful in lessening the patient's discomfort during the visit but may also help the patient feel more comfortable with the PCP, enhancing rapport building and potentially increasing the chance of treatment compliance following this visit.

Acute Cases

DECISION LEARNING TOOL

SCENARIO

Paul is a 52-year-old self-employed builder who has diabetes. He presents to his PCP complaining that he has been feeling increasingly tired for the last 4 months. His sleep is poor, and he says he can't be bothered to shave in the morning. He says that the practice nurse was unhappy with his diabetic control, and his wife has now insisted that he see a doctor. When you walk in, you can see that the patient presents as agitated and does not respond to your greeting. When you attempt to share the treatment plan, Paul immediately interjects and says, "I am not doing any of that." The patient proceeds to state how you don't know how to do your job and that being here is a waste of his time.

DECISION

Treat the patient for his issues with diabetes and possible symptoms of depression, with the recommendation to be seen by a mental health provider.

OUTCOME

Given that the patient seems uncooperative, the PCP may need to inform the patient that the PCP can allow the patient to take a moment, and the PCP can come back in a few minutes to discuss treatment when the patient is in a calmer state. The PCP may also enlist additional staff to help the patient calm down so that PCP can assess the patient. In both instances, this requires additional time and possibly additional staff to treat this patient.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for his issues with diabetes and possible symptoms of depression, with the recommendation to be seen by a mental health provider. Utilize interpersonal effectiveness skills to assist with possible resistance to recommendations due to the visit being influenced by his wife. The use of distress tolerance skills can address Paul's agitation, which can lessen the intensity of his emotions and potentially allow Paul to be more cooperative during the visit.

OUTCOME

The patient receives immediate care from PCP. In addition, using skills to discuss recommendations can validate the patient's hesitance in coming to the visit and build rapport to further help with treatment and compliance with after-visit care.

Rationale: This patient presents with symptomatology of being emotionally dysregulated through agitation during the visit, which may impact the patient-to-PCP interaction. Utilizing distress tolerance skills in addition to interpersonal effectiveness skills can provide an opportunity for the PCP to assess the patient more efficiently without the need to step out of the room for the patient to calm down or for additional staff to get involved. The provider's ability to assist the patient through his emotional dysregulation during the visit may enhance the likelihood of rapport building and treatment compliance following the visit. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

Dan is a 32-year-old man presenting with shoulder pain. He has not been seen in the surgery for a couple of years and in passing mentions poor sleep, annoyance about his benefits, and dissatisfaction with his accommodation. It quickly becomes clear that the main problem affecting Dan is mental-health related and that his shoulder pain is related to a minor injury he sustained 2 or 3 weeks ago that is already resolving itself. A brief history shows that he has symptoms which fulfill the criteria for both anxiety disorder and depression. Dan appears very agitated. When you provide a recommendation for his treatment, his response is that he has already tried that and it does not work. Dan begins to raise his voice at you and accuses you of just trying to pass him on to other providers. He expresses his dismay with doctors and how they don't really care. Dan says, "I don't think you really want to help me at all."

DECISION

Treat the patient for physical symptoms and presenting symptoms of anxiety and depression. Provide the patient with the recommendation to follow up with a mental health provider for continued care for anxiety and depressive symptoms until patient is able to meet with his mental health treatment provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for physical symptoms and presenting symptoms of anxiety and depression. Provide the patient with the recommendation to follow up with a mental health provider for continued care for anxiety and depressive symptoms. Utilize skills for emotion regulation and mindfulness to address the irritability in the patient during the visit.

OUTCOME

Given that the patient seems agitated and uncooperative and demonstrates symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until he is able to calm down and/or involve additional staff to assist with managing the patient's irritability until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

OUTCOME

The patient receives immediate care from PCP. In addition, using the skills to address the irritability in the patient can possibly provide a more validating experience that enhances rapport and increases the chance of treatment compliance. The use of skills to manage the emotional dysregulation the patient is experiencing may lessen the likelihood of the patient's assessment being inaccurate.

Rationale: This type of patient seems to be experiencing some high levels of emotional dysregulation with an annoyed temperament and verbal aggression. Using interpersonal effectiveness skills and distress tolerance skills to help the patient feel heard and to help refocus the patient in the moment will lessen the patient's feelings of annoyance. This can be beneficial in that the patient may become more receptive to adhering to the primary care physician's recommendations in addition to feeling less irritable during the visit. Lessening intense emotions within a visit may also provide an opportunity to have a more cooperative patient that is willing to share more about their symptoms. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

Violet is 84 years old. She has been in a residential home for 4 months following time in hospital with a fractured femur after a fall. She is a widow, and her only visitor has been her younger brother, who suffered a stroke 6 weeks ago and has not been able to visit her since. Violet has become increasingly quiet and withdrawn. The care staff report that she is not eating and is staying in her room much of the time. The PCP is asked to visit Violet because her weight has dropped by 4 pounds in 1 month. During the visit, Violet begins crying about how sad and lonely she is and then gets increasingly agitated. Violet accuses you of not understanding her and says that there is nothing wrong with her. She states, "I just want to be left alone."

DECISION

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems highly agitated and demonstrates symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until she is able to calm down and/or involve additional staff to assist with managing the patient's crying outburst until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider. Using emotion regulation and mindfulness skills may be helpful in increasing this patient's engagement to gather additional information and in building rapport for treatment compliance until patient is able to meet with her mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using emotion regulation and distress tolerance skills to assist with increased engagement with the patient can increase rapport between the PCP and the patient and increase the chance of treatment compliance. This can also potentially increase accuracy of the assessment and diagnosis.

Rationale: This type of patient may present as very withdrawn, which may make it very difficult to assess the patient and make accurate recommendations. Using emotion regulation skills and distress tolerance skills can help elevate the patient's mood on the spot and help the patient become more present for the visit, which may increase the opportunity to gain better insight on how best to treat the patient until the patient can be seen by a mental health provider. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

A patient comes in feeling depressive symptoms including lethargy, poor concentration, anhedonia, and a loss of interest in things they used to enjoy, with no risk factors of suicidal behaviors or risk of harming others. This patient has no history of suicidal behaviors/suicide attempts or self-harm behaviors. You recognized this patient to be highly agitated because the patient has been waiting for this appointment for a very long time. The patient states that it feels like no one cares and that it is just ridiculous how much time he/she had to wait just to be seen.

DECISION

Treat the patient for symptoms of what seems to be depression, with a follow-up recommendation for the patient to be seen by a mental health provider for continued care for depression.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression. The use of interpersonal effectiveness skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her/his mental health treatment provider.

OUTCOME

Given that the patient seems agitated and uncooperative and is demonstrating symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until the patient is able to calm down and/or involve additional staff to assist with managing the patient's irritability and verbal aggression until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as very agitated and verbally aggressive. The use of distress tolerance skills and interpersonal effectiveness skills help the PCP guide the patient to lessen the intensity of their agitation, which will allow the PCP to assess the patient in a more effective way. Utilizing these skills may increase the opportunity to gain better insight on how best to treat the patient until the patient can be seen by a mental health provider. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

A patient arrives complaining about feeling continuously anxious and ruminating on worry and fear to the point that it is disrupting sleep. Patient has no risk factors of suicidal behaviors or risk of harming others. This patient has no history of suicide attempts or self-harm behaviors. The patient starts escalating by stating that she/he feels like things are going wrong all the time. The patient continues to perseverate over the idea that he/she will be fired without any evidence of this being true. You try to discuss the treatment plan, but the patient continues to interject by saying, "What am I going to do if I get fired from my job?"

DECISION

Treat the patient for what seem to be symptoms of anxiety, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems emotionally dysregulated and unable to focus, the PCP may need to take additional time to help the patient focus enough to provide an assessment. This may require the help of additional staff in the event that the patient cannot provide information to the PCP in the moment. The patient will receive care once the patient is in a calmer state.

DECISION TO USE DBT-**INFORMED** SKILLS

Treat the patient for what seem to be symptoms of anxiety, with a follow-up recommendation for the patient to be seen by a mental health provider. Utilization of distress tolerance skills in this interaction may be beneficial in approaching the possible irritability this client may be experiencing due to rumination and poor sleep. The use of distress tolerance skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her/his mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using the distress tolerance skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present with emotional dysregulation evidenced by rumination and pacing. The patient expresses feeling constant worry and has not slept well because of this. Utilizing skills that assist with presenting distress can help the patient be more engaged in the visit and may lessen the intensity of the patient's distress. This approach can promote enhanced rapport and increase the chance of treatment compliance following this visit. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

Shubha can speak limited English. She is unhappy about the appointment with the PCP, as she feels this will bring shame to the family. She sees you—a White male PCP—with her husband, who acts as an interpreter. Her husband says that Shubha seems unhappy and does not want to do anything. She is reluctant to get out of bed or to look after the baby, and she complains of pain in her stomach constantly. He discloses that his mother thinks she is lazy because she is unwilling to do household chores. Shubha begins crying and refuses to answer any questions during the visit.

DECISION

Treat the patient for what seem to be symptoms of postpartum depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

OUTCOME

Given that the patient seems agitated and demonstrates some symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until she is able to calm down and/or involve additional staff to assist with managing the patients irritability until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of postpartum depression and psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider. The use of interpersonal effectiveness skills and distress tolerance skills may help the patient manage her distress in coming to the appointment, and these skills may also encourage more engagement and understanding from the patient and family. The use of these skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with her mental health treatment provider.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness and emotion regulation skills facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as resistant since patient sees this appointment as shameful. This can directly impact the level of adherence and engagement from the patient during this visit. Utilizing interpersonal effectiveness and emotion regulation skills that can assist with the patient's distress can promote enhanced rapport and increase the chance of treatment compliance following this visit. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

James had been an IT consultant, but he is not currently working because of his medical problems. He has been separated from his wife since 2003. Because of his renal impairment, he is seen in an advanced chronic kidney disease clinic, and he has recently decided to have hemodialysis as his renal replacement therapy. On direct questioning, James reports feeling very tired to the point of weariness, and he says that his memory has been affected recently. He has also had a lack of interest for his hobbies and is finding it difficult to be able to enjoy everyday activities such as watching the television or sharing a meal with his family. As you begin sharing the treatment plan, you notice that James appears agitated. He interjects immediately by saying, "These are things my wife used to tell me to do, and I feel like you are against me." James continues to accuse you of being on his wife's side of things and says that he doesn't see the point in listening to you at all. James begins to say "I am sick of this" in a loud tone.

DECISION

Treat the patient for what seem to be symptoms of depression and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for symptoms of what seems to be depression. The use of interpersonal effectiveness skills can promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with his mental health treatment provider.

OUTCOME

Given that the patient seems emotionally dysregulated and unable to focus, the PCP may need to take additional time with the patient to help him focus enough to provide an assessment. This may require the help of additional staff in the event that the patient cannot provide information to the PCP in the moment. The patient will receive care with once he is in a calmer state.

OUTCOME

The patient receives immediate care from PCP. In addition, using the interpersonal effectiveness and distress tolerance skills lessens the patient's emotional dysregulation, which facilitates more effective engagement with the patient. This can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient may present as highly aggravated, which could impact the engagement with the PCP. Using interpersonal effectiveness and distress tolerance skills could improve the chance of getting additional information that may be helpful in the assessment and may promote enhanced rapport, which could potentially increase the chance of treatment compliance following this visit. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

DECISION LEARNING TOOL

SCENARIO

Fred, aged 45, is a locksmith. He has long-standing and persistent worries that he has not done his job properly and that someone might get burgled as a result. He worries that he might have given customers the wrong change whenever they have paid him in cash. Fred informs you that he worries about many things in his life, and his most common thought is "What if?" He often imagines the worst happening and states that when he worries, he often feels sick, has headaches, feels butterflies in his stomach, and is aware of his heart pounding. Fred often gets hot and sweaty and says his anxiety makes it difficult to concentrate and do his job or play with his children. He is very distressed by his constant worrying and feelings of anxiety, and he regards this as a sign of weakness. At the beginning of the consultation with his PCP, Fred states he is attending because of problems with sleeping. But after questioning about how things have been for him recently, Fred discloses to his PCP that he is feeling under considerable stress. As you begin to share the treatment plan, Fred states that this is yet another thing to stress out about. Fred states, "You are just trying to create even more stress, and how the hell am I supposed to get better with all these extra things that you are giving me to do? I am just sick of this." Fred is raising his voice.

DECISION

Treat the patient for what seem to be symptoms of anxiety and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider.

DECISION TO USE DBT-INFORMED SKILLS

Treat the patient for what seem to be symptoms of anxiety and provide psychoeducation, with a follow-up recommendation for the patient to be seen by a mental health provider. The use of distress tolerance skills to assist with the patient's level of intense worry may promote enhanced rapport building opportunities that could increase compliance until patient is able to meet with his mental health treatment provider.

OUTCOME

Given that the patient seems highly agitated and demonstrates symptomatology of emotional dysregulation, the PCP may need to take additional time with the patient until he is able to calm down and/or involve additional staff to assist with managing the patient's crying outburst until the PCP is able to assess the patient. The patient receives care with possible delays, and additional staff may be required to treat this patient due to the patient's emotional dysregulation.

OUTCOME

The patient receives immediate care from PCP. In addition, using the distress tolerance skills to lessen the patient's emotional dysregulation facilitates increased engagement with the patient, which can increase rapport between the PCP and the patient in addition to increasing the chance of treatment compliance.

Rationale: This type of patient presents with intense anxiety with physical symptomatology such as headaches and heart-pounding sensations, which may cause distress for the patient during the visit. Utilizing distress tolerance skills may not only be helpful in lessening the patient's discomfort during the visit but may also help the patient feel more comfortable with the PCP, enhancing rapport building and potentially increasing the chance of treatment compliance following this visit. With this level of emotional dysregulation, using the skills can lessen the likelihood of misdiagnosis from inaccurate assessments.

Acute Higher Level of Care

DECISION LEARNING TOOL

SCENARIO

A 35-year-old woman who self-referred for therapy reports during her fourth session that she has been suicidal over the past several days. The trigger for her ideation is reported to be her relationship with her boss. After talking to her by phone nightly for several weeks, her boss now refuses her calls and is cold and remote at work. The client feels hurt, angry, and rejected and has threatened to kill herself. She has a plan to drive her car off a bridge that she passes on her way home from work. She also reports ongoing anger at her mother, who will not allow her to smoke or entertain men at their home. In the session, the woman appears somewhat confused and repeats elements of her story. When asked, she admits to having had several glasses of wine today.

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of her mental health needs. This may include additional staff to assist with coordination of care for the patient.

OUTCOME

The patient is transported to a higher level of care facility.

DECISION TO USE DBT-INFORMED SKILLS

Arrange for the patient to be transported to a higher level of care due to the acuity of her mental health needs. This may include additional staff to assist with coordination of care for the patient. Using distress tolerance skills and mindfulness skills to help the patient remain as grounded as possible in the moment will lessen her risk of eloping, escalating emotionally, or resisting a higher level of care. (Usually when a patient needs to be transported to a higher level of care, there is a time lapse that can make the patient at risk of resistance and eloping.)

OUTCOME

The patient is transported to a higher level of care facility.

Rationale: This type of patient requires a higher level of treatment. Therefore, skills such as distress tolerance and mindfulness skills are meant to better equip the PCP to manage the patient's emotional state, with the goal of decreasing the risk of escalating emotional dysregulation and/or elopement. The skills are meant to help contain the patient until the patient can be handed off to staff who will transport the patient to a higher level of care.

DECISION LEARNING TOOL

SCENARIO

The client, a 19-year-old female of Native American descent, was assessed in the ED following treatment to close two deep lacerations on both forearms. The cuts required 28 stitches to close but did not involve tendon damage. The woman's blood alcohol level is normal, and she denies any drug use. When asked, she refers to her suicide attempt as "a mistake and a stupid stunt" and denies further suicidal intent or any past history of attempts. "It was a stupid thing to do. He's not worth it," she states, referring to her boyfriend and the fight that precipitated the suicide attempt. She relates that the attempt was impulsive and happened after her boyfriend stormed out of their apartment during a fight. After cutting herself, she immediately called her friend, who rushed her to the hospital. She denies any mood or vegetative signs of depression as well as any history of depression. "I did it to hurt him, that's all."

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of her mental health needs. This may include additional staff to assist with coordination of care for the patient.

OUTCOME

The patient is transported to a higher level of care facility.

DECISION TO USE DBT-INFORMED SKILLS

Arrange for the patient to be transported to a higher level of care due to the acuity of her mental health needs. This may include additional staff to assist with coordination of care for the patient. Using distress tolerance skills and mindfulness skills to help the patient remain as grounded as possible in the moment will lessen her risk of eloping, escalating emotionally, or resisting a higher level of care. (Usually when a patient needs to be transported to a higher level of care, there is a time lapse that can make the patient at risk of resistance and eloping.)

OUTCOME

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Rationale: This type of patient requires a higher level of treatment. Therefore, skills such as distress tolerance and mindfulness skills are meant to better equip the PCP to manage the patient's emotional state, with the goal of decreasing the risk of escalating emotional dysregulation and/or elopement. The skills are meant to help contain the patient until the patient can be handed off to staff who will transport the patient to a higher level of care.

DECISION LEARNING TOOL

SCENARIO

The client is a 22-year-old White male who self-referred to the intake office today. He reports that he bought a gun 2 months ago with the plan to end his life, and he has the gun in his car. Police are called and find the gun as stated, but no bullets. The man reports having made suicide plans with specific timetables to end his life several times over the past 8 weeks, but he held back at the last minute. He says, "I cannot live any more with the pain of my wife leaving" (3 years previous). He describes his distress having increased over the past week, though the client can give no specific reasons for this. The client reports an extensive history of substance dependence, including alcohol, pot, and prescription medication, that led to his divorce, but he states that he has been clean and sober for 14 months with the help of a detox and ongoing attendance in AA/NA.

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient.

OUTCOME

The patient is transported to a higher level of care facility.

DECISION TO USE DBT-INFORMED SKILLS

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient. Using distress tolerance skills and mindfulness skills to help the patient remain as grounded as possible in the moment will lessen his risk of eloping, escalating emotionally, or resisting a higher level of care. (Usually when a patient needs to be transported to a higher level of care, there is a time lapse that can make the patient at risk of resistance and eloping.)

OUTCOME

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Rationale: This type of patient requires a higher level of treatment. Therefore, skills such as distress tolerance and mindfulness skills are meant to better equip the PCP to manage the patient's emotional state, with the goal of decreasing the risk of escalating emotional dysregulation and/or elopement. The skills are meant to help contain the patient until the patient can be handed off to staff who will transport the patient to a higher level of care.

DECISION LEARNING TOOL

SCENARIO

The client was seen initially in the school social worker's office following an explosive loss of temper in the halls at school that involved threats of violence and death threats to the people around him. The school resource officer was able to de-escalate the situation only after threatening to pepper spray the youth. Witnesses report that the precipitant was the client's being confronted by several rowdy members of a sports team who were teasing him about his style of dress. He is an 18-year-old junior of somewhat slight build who favors dark, baggy clothing and wears his hair long and loose. He calms somewhat in the social work office, but he continues to pace, muttering under his breath half-heard threats about the boys involved. The client is normally quiet and somewhat withdrawn from social circles. He has come to the attention of staff in recent weeks due to the violent themes of death incorporated into his writing and art projects. When the SRO searched him after the incident, he was found to be carrying a large sheath knife that he angrily stated was for his own protection. He said, "If you take that, you might as well kill me, because I'm dead meat without it; they'll kill me for sure now." When asked to explain himself, the boy refused to talk further. He also refused to answer questions about any suicidal or violent ideation. His parents report that he has been increasingly withdrawn over recent weeks and has isolated himself in his room on the computer. They indicated that he barely talks to them, is often heard up and pacing late into the night, and seems to be talking to himself at these times.

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient.

DECISION TO USE DBT-INFORMED SKILLS

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OUTCOME

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Rationale: This type of patient requires a higher level of treatment. Therefore, skills such as distress tolerance and mindfulness skills are meant to better equip the PCP to manage the patient's emotional state, with the goal of decreasing the risk of escalating emotional dysregulation and/or elopement. The skills are meant to help contain the patient until the patient can be handed off to staff who will transport the patient to a higher level of care.

DECISION LEARNING TOOL

SCENARIO

Cindy is a 27-year-old woman brought in by her husband and her mother. She is 7 weeks postpartum with her second child. Her first child is almost 3. Cindy's family is concerned because she has made statements that her life is at its end and that she should never have brought children into this world. She has been sleeping little, even for a breastfeeding mother of a colic-prone infant. Her husband has found her several times late at night standing over the crib and weeping. She appears to be in a stable marriage with a decent level of income. Her support from extended family and friends is strong. Her mother is currently staying with the couple to help out. When interviewed, Cindy is anxious and weepy with restless hands and feet. She states that she doesn't feel she can do anything right, can't focus for more than a minute, and is constantly worried about the safety and health of Molly, her infant. She denies any history of mental illness though does indicate that she saw a counselor for a while in high school "because I was always worried." She reports no use of alcohol since discovering she was pregnant and no history of abuse. When asked about suicidal thoughts, she paused, denied any ideation and then stated, "You know, my kids would be better off if I was dead." She denies any history of attempts.

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of her mental health needs. This may include additional staff to assist with coordination of care for the patient.

OUTCOME

The patient is transported to a higher level of care facility.

DECISION TO USE DBT-INFORMED SKILLS

Arrange for the patient to be transported to a higher level of care due to the acuity of her mental health needs. This may include additional staff to assist with coordination of care for the patient. Using distress tolerance skills and mindfulness skills to help the patient remain as grounded as possible in the moment will lessen her risk of eloping, escalating emotionally, or resisting a higher level of care. (Usually when a patient needs to be transported to a higher level of care, there is a time lapse that can make the patient at risk of resistance and eloping.)

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DECISION LEARNING TOOL

SCENARIO

Joshua is a 22-year-old male, a recent graduate from a much-respected college, and an active member of several campus initiatives. His sister and father brought him in after they found him with a large quantity of medication. He has confided to his sister that he does not want to see his 23rd birthday. Josh has been withdrawing from family and friends and showing increasing signs of a black mood. Most people know him as a vibrant man, committed sustainable community builder, and the head of a campus group that started and developed an organic garden that now provides the bulk of the vegetables for the campus. To his sister and a couple of closest friends, he gives glimpses of another side, someone who never feels he can do enough, is hopeless about the state of the world, and feels burdened by life. He has been treated for depression in the past, as have several other immediate family members. His artwork and his writing reflect a brooding and dark mood and a preoccupation with death. He struggles with taking antidepressant medication and has sought for some time to manage his illness with exercise, diet, and herbal supplements. He avoids drugs and uses very little alcohol, by all reports. Today he is hostile and uncooperative and states that he has no "intention of dying today."

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient.

OUTCOME

The patient is transported to a higher level of care facility.

DECISION TO USE DBT-INFORMED SKILLS

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient. Using distress tolerance skills and mindfulness skills to help the patient remain as grounded as possible in the moment will lessen his risk of eloping, escalating emotionally, or resisting a higher level of care. (Usually when a patient needs to be transported to a higher level of care, there is a time lapse that can make the patient at risk of resistance and eloping.)

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DECISION LEARNING TOOL

SCENARIO

A 45-year-old corporate lawyer presents for treatment of problem drinking. He tried alcohol for the first time at age 17, drank occasionally through college, and began drinking heavily in law school. He reports having at least 6 beers daily and drinks up to 14 drinks in a day. He often wakes up with hangovers and arrives late at work. He states, "I have this intense urge to drink and keep thinking about alcohol all the time." He misses family events, has stopped playing tennis, and spends time at a local bar. His wife has threatened to move out with their children. He has been trying to cut down on his own but has not been able to do so. He denies any prior psychiatric diagnosis. He scored a 24 on the Alcohol Use Disorder Identification Test. He is eager to get help and has some insight into his problem with alcohol. He is interested in a treatment program.

DECISION

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient.

OUTCOME

The patient is transported to a higher level of care facility.

DECISION TO USE DBT-INFORMED SKILLS

Arrange for the patient to be transported to a higher level of care due to the acuity of his mental health needs. This may include additional staff to assist with coordination of care for the patient. Using distress tolerance skills and mindfulness skills to help the patient remain as grounded as possible in the moment will lessen his risk of eloping, escalating emotionally, or resisting a higher level of care. (Usually when a patient needs to be transported to a higher level of care, there is a time lapse that can make the patient at risk of resistance and eloping.)

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The patient is transported to a higher level of care facility.

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APPENDIX F

DECISION TREE