Brief Thumbnail (1-4 sentences total)
Can include:
- Demographics
- Treatment history
- Diagnosis
- Reason for referral from clients and referrer’s point of view
If you are describing it below, you can skip it here

KC is a 37 year old Caucasian female with history of involuntary psychiatric hospitalization for suicidality who presents for treatment due to difficulty with affective instability resulting in self harm, suicidality, maladaptive physical aggression in relationships, and difficulty with employment, finances, and housing.
KC says she presents because she realizes that her current way of handling things is not working and is making things worse.

Client’s goal(s) (pp. 277) (what is the client’s passion, what does the client most want for the future):
- State in positive
- Ambitious relative to where client is at when they come to treatment
- Be sure goal is inspiring, something the client wants for itself not for greater/further/other reason (e.g., increase skills is not as good as to be more effective and get promoted at work)
- Goals are ideally described in a slogan or image to which that client has positive affective response when brought to mind

KC wants:
- The safety and stability of a steady income and housing. (safety and stability)
- Safety and stability in her relationships by being able to act on disappointment and anger in ways to solve the problem without damaging the relationship. (safety and stability)
- Complete her life passion of a chemistry thesis, which will prove to her that she is somebody. (self esteem and self validation)
Biosocial Theory (pp. 42-62; 256-7) – Give behavioral examples from client’s behavior and environment that illustrate these concepts and distinctions

<table>
<thead>
<tr>
<th>Biological Basis</th>
<th>Characteristics of Invalidating Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Vulnerability – sensitivity, reactivity, and slow return to baseline</td>
<td>Pervasive Invalidation of Private Experience</td>
</tr>
<tr>
<td><em>KC</em> tells me that when she gets emotionally aroused it tends to be pretty intense, particularly with anger, and she tends to ruminate and be “restless” and ineffective for extended periods of time. She describes emotional arousal as a daily experience to even small or common things. For example, being told no in a stern voice may really be hurtful and shaming, and she will ruminate on it for hours and be unproductive.</td>
<td>In her youth, <em>KC</em> was sexually abused, frequently told that she was stupid and worthless, and that she was not sick or in pain, and not taken to the doctor when she asked. Currently, she is sometimes ordered around by others, as if she has no will of her own.</td>
</tr>
<tr>
<td>Emotional Modulation – inability to control physiological responses, reorient attention, block mood-dependent behavior, experience emotions without escalating/blunting, and/or organize behavior in service of long-term goals</td>
<td>Ignoring or punishing normative pain behaviors and variable, intermittent reinforcement of escalated behavior</td>
</tr>
<tr>
<td><em>KC</em> was frustrated when traveling for an interview, which escalated to rage, and she impulsively destroyed cell phone, which caused her to miss the interview. She then became hopeless, and did not take reparative action with the potential school about missing the interview.</td>
<td>Growing up, <em>KC</em> was punished asking for help and asking to be taken to the doctor. Today, <em>KC</em> receives increased attention from significant others when doing self harm or acting physically aggressive, or when elevates her expression of distress (e.g. was so dysregulated at UWMC that security was called when there was difficulty picking up her prescription; she eventually got the prescription because of this behavior).</td>
</tr>
<tr>
<td>Oversimplification of Solving Problems or Achieving Goals</td>
<td>Currently, <em>KC</em> thinks that she should just be able to get and keep a job or stay in school, control her behavior, and finish her chemistry paper, not accounting for environmental or emotional difficulties, or thinking to ask or that she deserves any help. She tends to view anything short of perfect as due to a personal failure on her part, and feels shame.</td>
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</table>

Comment: Excellent – very behaviorally specific

Comment: Good example

(Developed by Kate Comtois, Ph.D., Harborview Mental Health Services DBT Program, University of Washington, Seattle, WA, USA)
Primary Targets: (Behavioral Chain Analysis (BCA) are not needed in this section, AND including any data from assessments really strengthens your case formulation)

I. Suicidal Behavior (pp.124-129)
   A. Suicide Crisis Behavior—(pp 125-126) behavior with imminent risk of death or sufficient risk that cannot reasonably be ignored

KC showed up an hour late to an appointment one day, and disclosed self harm behavior the day before, and went on talking about how she was hopeless and was not sure could go on. This was very alarming to me for ongoing suicidal risk, but she was able to rally in session and plan for safety.

   B. Suicide attempts and non-suicidal self-injury—(pp 126-7) include here behaviors with intent to cause injury to the body (not binging to lose weight or feel better) or sufficiently severe tissue damage or risk of tissue damage so that intent is less key because behavior itself is life threatening

   Behavioral Chain Analysis of Most Severe Suicide attempt (during first visit to IPU June 2014).
   - environment: unemployed, facing possible eviction due to noise complaints, poor relationship with landlord
   - prompt: received third and final noise complaint from her landlord, got into argument with landlord, felt that landlord was being dismissive just like her step father used to be
   - links: landlord yelling and invalidating her -> reminded her of her abusive and neglectful step father -> scared -> angry -> thought, "There is nothing I can do." -> "I am in this situation because I got sick." -> shame
   - maladaptive behavior: walking in traffic with intent to kill self, no actual collision
   - short term: coping, felt relief
   - long term: decreased self esteem and relationship problems

BCA of last self harm (9/13/14)
   - environment: unemployed, limited income, without phone and food at home
   - prompt: spent all of money at mall
   - links: judgment thought against self -> disappointed at self and mall -> anger at self and mall -> feeling of restlessness and tension and agitation -> access to means for self harm -> belief that self punishment is justified and good based on her behavior
   - maladaptive behavior: cut on self and burned self and banged head in front of significant others
   - short term: relief from anger, felt better
   - long term: decreased self esteem and relationship problems

C. Suicidal Ideation and Communications (p. 127)

BCA of most recent urge for self harm (10/15/14)
   - environment: was in place of previous self harm, alone, nothing to do
   - prompt: someone told her no in an invalidating way earlier that day
   - links: she feels shame and is inhibited -> she did not accomplish things that were important to her at the store -> judgment of self -> disappointment -> angry -> desire for self harm
   - adaptive behavior: used mindfulness and focused on music to let urge pass; felt better about herself

D. Suicide-related expectancies and beliefs (pp127-8)

   Has protective beliefs:
   1. Is afraid of having severe injury instead of relief with suicide.
   2. Is afraid of not ever finishing chemistry paper if she suicide, and never being a "worthwhile" person.

E. Suicide-related affect (p128)


II. Therapy Enhancing and Therapy-Interfering Behaviors (pp.129-137)

(Developed by Kate Comtois, Ph.D., Harborview Mental Health Services DBT Program, University of Washington, Seattle, WA, USA)
A. TIB of the client (e.g., non-attendance, non-compliant, non-collaborative, behaviors that burn out the therapist or reduce the therapist’s motivation to treat the client) — clearly review more subtle behaviors pp. 132-137 to include full universe of TIB—even things you may do if you were a therapy client yourself

Underlying therapy interfering themes:
- desire to please me, which can lead to apparent competence
- history of omitting information from providers e.g. in psychiatry emergency room

Therapy Interfering Behavior
- non-attentive - last no shows 9/21, 10/5; spaces out in session sometimes
- non-collaborative - occasional withdrawal/isolation with emotional discomfort
- non-compliant - diary card incomplete, does not follow up with me on homework completely
- interfere with other patients - none, though lack of organization in group and lack of attendance to group suboptimal
- burn out therapist/ pushing of limits: e.g. paging after hours, continuing to talk after - session time is up, bringing up topics after session is over
- does not have writing implement when calls
- frequent changes in phone number, phone out of money, destroys phone

B. TIB of the therapist(s) (e.g., lack of balance, disrespectful)(pp. 138-141) (including things listed on table 5.1 on p. 141)

- tend to favor acceptance and nurturing over emphasis on change, and reciprocal over irreverent communication
- delayed completing orientation to psychosocial model or elaborating goals of treatment in favor of being more nurturing in the moment
- not increasing commitment to homework prior to end of session or troubleshooting possible barriers to homework
- behind on diary card, catching up on reading, missed one supervision

C. Therapy enhancing behaviors of the client or therapist (i.e., behaviors demonstrating attendance, compliance, and collaboration for the client and balance in treatment and respect for the therapist)

- KC is able to directly acknowledge personal benefit from therapy, benefit of attending therapy sessions and group sessions.
- Therapist is able to show visible excitement and express directly his interest and fun in working with KC. Therapist reaches out to patient and ensures or arranges contact during week.

III. Quality of Life Interfering Behaviors (List all that are significantly affecting current quality of life. Order should reflect treating most disruptive first.) (including Table 5.2 on p.142)

Financial/Housing/Food/Transport - spent money at the mall; destroyed cell phone; runs out of money for food and transport
Relationship - physically breaks things in relationships when angry
Medical/Psychiatric - runs out of prescribed medication by not following up on refills appropriately; was not going to doctor for hormone replacement therapy, avoidance.
### Secondary Targets: List examples of secondary target behaviors or general patterns (pp. 66-92 and pp 162-164 on changing secondary targets)

<table>
<thead>
<tr>
<th>Emotion vulnerability</th>
<th>Self-invalidation</th>
<th>Inhibited grieving/experiencing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include both actual vulnerability to emotions as well as simultaneous awareness and experience of that vulnerability. On p 68 address 3rd and 4th characteristics of vulnerability as well as 1st and 2nd.</td>
<td>Include internalization of any characteristic of invalidating environment (i.e. oversimplifying ease of problem-solving, etc.)</td>
<td>Generally is grief but may involve other emotions; key is behaviors that indicate emotional avoidance or other inability to experience pain with acceptance</td>
</tr>
<tr>
<td>Has great reactivity to disappointment in others and especially herself, which results in anger and restlessness, which can turn into shame and urge to hurt or kill self. When stewing in restless and in anger/shame, KC has difficulty producing effective behavior, feels lack of control, and desperately wants to be back in control. For example, she spent money at the mall, was disappointed in the mall and herself, became very angry, which became shame, she felt hopeless and out of control and then she self harmed.</td>
<td>KC tends to deal with her feelings of disappointment and anger by invalidating others, but more often by invalidating herself. She sees the disappointment in her behavior as being related to some intrinsic flaw in herself, citing flawed intelligence, decision making, will power, values, and preferences. The result of this self invalidation is shame. She does not attribute disappointment to environmental factors or lack of skillfulness due to no fault of her own. She tends to look to others for cues on how to act or feel, and says she does not know when to trust her emotions. E.g. “I am so stupid. I should not have spend the money at the mall.”</td>
<td>KC has an extreme difficulty dealing with sadness related to disappointment and loss. With painful sadness, she has a tendency to isolate her affect, space out, become robotic, disassociate. Most often, she does not experience sadness, rather she experiences anger, and then shame. When she does experience sadness, it is very intense, and so intense that it does not seem integrated into the context of her other life. For example, the tears are all the way on and she is extremely sad, or they are all the way off, and she is not even aware of sadness or the thing she is sad about.</td>
</tr>
<tr>
<td>Active-passivity—expressing distress in a way that functions to get others to change or solve problems (without actively solving them oneself); can be experienced by therapist as rigid attachment to hopelessness or passive strategies which can dysregulate the therapist. When KC is feeling miserable, she sometimes becomes demoralized, not believing that she can improve her situation. During these times she is confused about why she is feeling so bad, and does not know how to feel better. She also feels cowardly, and cannot recall times when she acted courageous and improved her situation. During these times of demoralization and hopelessness, she makes statements in front of people that she cannot go on as she is. This sometimes results in a response from people to soothe her. When she does this in session, I find it distressing, irritating, and draining. E.g. “I don’t know (sigh). I don’t know.”</td>
<td>Apparent competence – behaviors that function to get others to think the person has competence that he/she doesn’t have or hasn’t generalized to all relevant contexts. KC will often say that she understands something or agrees. However, when she is prompted explain what was just explained, she does not understand. This behavior sometimes seems automatic, and at other times seems volitional. I suspect she thinks it is necessary to appear competent to keep the environment running smoothly. She often does not say when she is feeling scared or overwhelmed, and very rarely offers up feelings of confusion. She often appears moderate to high functioning in session when in my presence, and then talks about greater difficulty in functioning in between sessions. E.g. “Page me if you have a question.” KC “OK.” “What is my pager?” KC: “I don’t know.”</td>
<td>- tends to cause more of problem with work and chemistry paper, then self harm. Unclear in relationships, but likely plays role</td>
</tr>
<tr>
<td>Crisis-generating behavior—can include maintaining existing crisis as well as generating new crises</td>
<td>Apparent competence – behaviors that function to get others to think the person has competence that he/she doesn’t have or hasn’t generalized to all relevant contexts. KC will often say that she understands something or agrees. However, when she is prompted explain what was just explained, she does not understand. This behavior sometimes seems automatic, and at other times seems volitional. I suspect she thinks it is necessary to appear competent to keep the environment running smoothly. She often does not say when she is feeling scared or overwhelmed, and very rarely offers up feelings of confusion. She often appears moderate to high functioning in session when in my presence, and then talks about greater difficulty in functioning in between sessions. E.g. “Page me if you have a question.” KC “OK.” “What is my pager?” KC: “I don’t know.”</td>
<td>- plays more of role in self harm and relationship problems, than work or chemistry paper</td>
</tr>
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(Developed by Kate Comtois, Ph.D., Harborview Mental Health Services DBT Program, University of Washington, Seattle, WA, USA)
Relevant Dialectical Tensions in Client’s Life or in Therapy (pp. 28-35, 120-124, 199-205)

KC has been raised to conform to the invalidating environment. She has been pretty successful, so as a result, she has internalized many of the invalidating characteristics. As a result she tends to favor environmental compatible behavior, over her intrinsically biologic behavior.

(Biologic vs Sociologic/Environment)

Emotional Vulnerability << Self Invalidation
Active Passivity << Apparent Competence
Unrelenting Crisis << Inhibited Grieving

In general, KC’s main dialectic right now seems to be: Caring/hoping vs Not caring/hopelessness, which directly informs trying vs not-trying to improve her life. For example, at the start of therapy, KC had more of a tendency to feel hopeless and invalidate her own cares and her own prospect of happiness. This would translate into her not even trying to improve her situation. There were several times where she would easily becomes discouraged and hopeless and quit trying with the slightest disappointment or hint of challenge.

Wanting to change vs not wanting to change: Pt becomes discouraged and hopeless with the hint of a challenge yet is enrolled in therapy to change her life.

Strengths and Weaknesses: Based on chain analyses, your observations, or history, note critical weak links which lead to target behaviors and types of skills (pp. 143-154) client is already doing effectively. Consider: urges, physical sensations, emotions, cognitions, and actions as well as events in the client’s environment.

Self Harm/Suicide:

\[
\text{crisis generating behavior} \leftrightarrow \text{active passivity, OR invalidating environment} \rightarrow \text{disappointment [emotional vulnerability, limited emotional regulation and distress tolerance]} \rightarrow \text{[inhibited grieving, skips over sadness]} \rightarrow \text{intense and increasing anger [emotional vulnerability, limited emotional regulation and distress tolerance]} \rightarrow \text{restlessness/coiled spring [emotional vulnerability, limited emotional regulation and distress tolerance]} \rightarrow \text{[self invalidation, turns anger inwards]} \rightarrow \text{shame/self hate [emotional vulnerability, limited emotional regulation or distress tolerance]} \rightarrow \text{self harm/suicide [emotion mind, lack of mindfulness of longer term consequences]}
\]

[note - for path out this need problem solving or radical acceptance + tolerance along the way, she is actually getting skillful at the latter presently]

<table>
<thead>
<tr>
<th>Critical weak links</th>
<th>Strong skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness (seem like a longer term goal)</td>
<td>Has clear cut and ambitious goals.</td>
</tr>
<tr>
<td>• amplified amount due to judgmentalness</td>
<td>Intelligent with adept &quot;rational&quot; mind.</td>
</tr>
<tr>
<td>• greatly decreased mindfulness/awareness (urge to cry and sob, sensations related to that)</td>
<td>Able to acknowledge her own progress.</td>
</tr>
<tr>
<td>• very minimal ability to regulate or accept/tolerate</td>
<td>Increasingly skillful with:</td>
</tr>
<tr>
<td>Anger (a near term goal, improving)</td>
<td>• Non-judgmental</td>
</tr>
<tr>
<td>• amplified due to judgmentalness</td>
<td>• Emotion regulation &quot;check the facts&quot;</td>
</tr>
<tr>
<td>• decreased ability to regulate or accept anger (feelings of restlessness, clenched fists and tight chest)</td>
<td>• Distress tolerance &quot;TIPP&quot;</td>
</tr>
<tr>
<td>• (Note, she is improving here, and this is no longer critically weak).</td>
<td></td>
</tr>
</tbody>
</table>

Self Invalidation, often disappointment, sadness, and anger, which turns to shame and feeling/idea that she deserves to be hurt or killed. (This is probably the most critical link which bridges affect to action of self harm or suicide).

Shame (a near term goal, improving, but more slow than anger)
• Amplified due to judgmentalness
• Decreased ability to regulate or accept (sensation

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(Developed by Kate Comtois, Ph.D., Harborview Mental Health Services DBT Program, University of Washington, Seattle, WA, USA)
of self loathing and urge to harm self)
• (Note, exposure here is difficult because it can quickly slip to self harm).

Currently constant crisis generating behavior and lack of distress tolerance and emotional regulation are precluding problem solving. Unclear how strong problem solving is currently.

As relating to interfering with goals: Getting and maintaining work.
• Crisis generating behavior and apparent competence interfere
• Interpersonal and problem solving effectiveness limited by anxiety
• Interpersonal priorities skewed to objective and relationship over self esteem
• Mindfulness and attention disrupted due to anxiety and distress

Relationship (similar to self harm, but ends in physical aggression to objects)
• Disappointment -> Judgmentalness amplifies -> sadness skipped -> anger -> destructive (lack of emotional regulation and problem solving)
• Tends to sacrificed objective and self respect in favor of continuing the relationship

Chemistry Paper
• Crisis generating behavior disrupts chance to work.
• Emotional regulation not adequate to permit rational mind enough time to function (needs PLEASE MASTER)
• Oversimplification/Aparent Competence - tends to think she should be able to do it easily, on her own

Crisis generating behavior (lack of emotional regulation and problem solving), creates constant nidus for problems with all goals: self harm, work, relationship, and chemistry paper.

Task Analysis: Essentially, create a to-do list for yourself. Consider: areas for further assessment, which primary targets to address and how, DBT skills to increase, avoidance vs. exposure behaviors, cognitive modification areas, reinforcing contingencies, behaviors to extinguish or suppress, validation needed, dialectical syntheses to find, psychology of normal behavior, and your own personal experience in handling the problems your client has. Consider your own therapy interfering behaviors and skills deficits to target as well – both in and out of the session.
Self Harm/Suicide:
- Self Validation "I'm worthless"
  - Build in explicit times where she gives herself credit, self congratulates
  - Start with monitoring. Have her monitor self invalidating thoughts first. Then when those start to decrease, make list at end of day where she lists everything positive that she did, and overtly gives herself credit and self congratulates herself while reading this list (observe, describe, participate, one mindfully, FAST)
  - When doing Checking the Facts, emphasize how he emotions ARE valid. Have her do check the facts exercises not to reduce distress, but to show her just how valid her feelings are (check the facts, observe, describe, participate, one mindfully, FAST)
  - Use Accumulate the Positives (emotional regulation), and to mindfully think of how she is deserving to feel good in the moment (observe, describe, participate, one mindfully, FAST)
- Problem Solving (shift from distress tolerance and emotion regulation without problem solving to problem solving)
  - Develop more focus on how she can influence her environment to solve the problem, rather than having to deal with invalidating or unlikely environment. Solutions will depend on problem precipitating self harm urges.
  - Practice PLEASE and Build Mastery as self caring and preventive skills

Therapy Interfering
- Start to be proactive about getting ahead of crisis behavior which interferes with attendance.
- Avoid re-enforcing lack of attendance (avoid therapy phone sessions, decrease warmth on phone during calls addressing missing)
- Water over rock.

Building a Life Worth Living/Quality of Life:
- Need to start actively formulating and working on developing life worth living, to more firmly shift stance from not caring/hopeless/not trying to caring/hopeful/trying
  - Will need to develop Goals and break down into Tasks; expect this to be ongoing process
  - Find her #1 most motivating goal, do analysis, generate SMART goal and tasks.
  - Look at historical attempt to understand patterns of skills deficits, and determine what needs to be bolstered.
- Need to squelch crisis generating behavior, and get proactive and constructive vs reactive and in crisis
  - Will start to focus on goals and daily activities more
  - Start to develop targets where she can work on small goals through week linked to big goals

Key Dialectics:
Caring/hopeful/trying vs not caring/hopeless/not trying
Synthesis: I feel hopeless right now, and there can still be hope.
How:
- Identify reason for demoralization (confusion, powerlessness, isolation, meaninglessness, resentment, cowardice, despair); validate, and show how she has overcome these things in the past.
- Emphasize after she does rally and get hope, how before she felt hopeless, but now she feels hopeful, and so you can feel like there is not hope, but hope is still there, it just needs to be found.

I am perfect vs I am worthless
Synthesis: The imperfect is worthwhile.
How:
- See self validation ideas above.
- Emphasize how when she or others fall short, she and others are still worthwhile.

Therapist TIB
- Reading
- Start to slowly increase expectation for change

Consultation Questions:
Please check my assessment and help point out holes, or where I need more assessment with KC. Therapy interfering behavior (missing sessions, incomplete).
What issues, behaviors, dilemmas do you need help with? Therapy interfering behavior (missing sessions, incomplete). KC did now show up to group last week. She continues to vacillate between being and hopeful active participant, and in constant crisis an being “dragged” though therapy with less proactive participation and problem solving. Help me understand this and help KC produce less therapy interfering behavior!

Adam Carmel 11/13/15 9:05 PM

Comment: Reading this last sentence made me think of the tension between apparent competence (demonstrating context-dependent hopefulness) and active passivity (being dragged through therapy with less problem solving). Perhaps there will an opportunity at some point in tx to discuss these secondary targets and how this might come up in other relationships in her life outside of tx. Given the fears associated with disappointing others and goals to increase interpersonal “safety and stability”, being able to activate more problem solving during times when she is in emotion mind would be an important goal as I’m guessing many of relationships can have this similar level of imbalance – perhaps self-disclosing your reactions to her missing sessions and not completing assignments, combined with a lot of validation is a way to start working on these relevant secondary targets.