Principles Informing the Use of DBT Approaches in the ER

1) Productive interactions with emotionally sensitive or dysregulated people may require extra time and patience.
    a. Helpful reasons for spending extra time may include: taking time to listen actively and validate (reflect, summarise) exactly what you are hearing; offering skills coaching to someone who is dysregulated in the moment; brainstorming / problem-solving the issue(s) that led to the ER visit and are most relevant to that specific day; negotiating what to do next.
    b. Unhelpful reasons for spending extra time may include: focussing on distal life events; providing a strictly soothing or supportive response; sitting quietly while an angry patient vents or hurls abuse. Any of these are likely to reinforce the person for coming to the ER, and could lead to an increase in frequency of visits.
2) Patients need to learn new behaviours in all relevant contexts.
    a. Leaving the stressful environment when overwhelmed makes it impossible to learn how to cope in this environment.
    b. Hospitalisation is an avoidance behaviour.
    c. Avoidance behaviours (self-harm, substances, anger outbursts, requests for admission) are understandable but not helpful. Understandable because they solve the short-term problem of distress by providing an escape (relief). Unhelpful because they remove the possibility of tolerating the distress and actually solving the underlying problem of managing intense emotion.
    d. A useful outcome of your interaction with a patient in the ER could be to educate them about why avoidance behaviours are understandable but not helpful, to them, in meeting their own goals. (if they acknowledge that feeling less miserable in the long run is a goal)
3) Long-term problems (assertiveness, emotion regulation, relationships, substance abuse etc) require long-term solutions.
    a. We have no evidence that hospitalisation helps to reduce suicide risk in the long term. For some people it may reduce risk in the short term, but it may also increase it in the long term (by reinforcing avoidance).
    b. Refer patient back to outpatient therapist wherever possible. Help patient problem-solve how to cope with current distress, but redirect them to their therapist to work on everything else.
    c. Do not suggest the patient find a new therapist. Offer to assist them in being direct and clear (assertive) with current therapist. Eg, role play a difficult discussion. Explore factors (cognitive distortions?) that inhibit them from telling their therapist the important info they want to tell you.
    d. Do not decide that outpatient treatment is failing unless you have clear input from the primary outpatient therapist.
4) Power struggles disempower patients (and clinicians) and can increase dysregulation and therefore risk.
    a. Your best defense against a power struggle is prevention. Listen and validate; be clear and direct; be explicit about anything going on the

process (attend to affect changes etc); highlight the person's strengths and long-term goals/aspirations. If a power struggle develops, first calm yourself, then label it explicitly and work on stating what is valid from each person's perspective.

b. Reduce your own anxiety by recalling the following:
    i. Educating patients about the harm of admission (avoidance) may not convince them to choose discharge.
    ii. We cannot control the fact that patients/people are allowed to make choices that are not in their own best interests. We have to tolerate our own helplessness.
    iii. Sometimes you will admit a patient when you do not believe it is in the patient's best interests, because the only other option is an escalating power struggle you could lose. (eg by patient taking a severe OD outside on the sidewalk)

5) Clinicians must observe their own limits.
    a. Different clinicians have different levels of risk tolerance. Not everyone has to be the same.
    b. Not tolerating any risk is countertherapeutic for chronically suicidal patients.
    c. Read chart notes as carefully as you can, given time constraints – be more conservative with patients unknown to the hospital, or whose history shows high lethality attempts upon leaving the ER angry/rejected. Be less conservative if you have a documented history of threats that are not followed through on. Be more inclined to discharge despite the presence of risk, if patient has a documented history of getting worse in hospital (eg escalating self-harm behaviour, severe OD on the ward, etc). Be clear on exactly how the current presentation is the same or different from previous presentations and assess risk accordingly.
    d. At times it may be useful to tell the patient they are being admitted not because you think it will help them, but because you can't think of a way to document your conversation in a way that preserves your license.
    e. Patients can be pushed to accept discharge in the context of education, validation and earnest attempts at problem-solving. Sometimes we need to tolerate discharging an unhappy, dissatisfied or disapproving patient. It is possible to say "no" without engaging in a power struggle.

Based on:
Linehan, Marsha M. Cognitive Behavioral Treatment of Borderline Personality Disorder. New York: The Guildford Press, 1993.