Chapter 23
Dialectical Behavior Therapy (DBT)-Informed Interventions for Psychosis

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Dialectical behavior therapy (DBT) is an evidence-based treatment for people struggling with severe emotion dysregulation. Developed initially to treat those diagnosed with borderline personality disorder who commonly experience psychotic symptoms, research over the years has demonstrated its efficacy for a wide range of issues including suicidal thoughts and suicide attempts, nonsuicidal self-injurious behaviors, problematic substance use, depression, bipolar disorder, posttraumatic stress disorder (PTSD), and eating disorders (Niemantsverdriet et al., 2017; Harley et al., 2008; Harned et al., 2014; Hill et al., 2011; Mehlum et al., 2016; van den Bosch et al., 2002; Van Dijk et al., 2013). These issues are commonly co-occurring among people diagnosed with psychotic spectrum disorders (PSD), and yet it is still uncommon for clinicians to offer DBT to these clients to cope with the emotion dysregulation they experience.

This gap between evidence and practice is only one symptom of a more general problem–the social and clinical stigmatization and neglect of people with PSD. People with psychosis face massive barriers to employment and housing, and experience disproportionately high rates of suicide, self-harm, substance use, trauma, institutionalization, and incarceration (Hor & Taylor, 2010; Schizophrenia Commission, 2012; Dallel et al., 2018; Güney et al., 2020). And until recently, the mental health field has mostly overlooked people with PSD. For example, the majority of psychotherapy research trials exclude people who experience psychosis. This is nonsensical because the same types of delusional beliefs occur in other diagnoses, but we do not exclude them from treatment so aggressively. Consider eating disorders, where people experience distorted beliefs about their bodies to the point that they are willing to risk significant health issues, or depression, where people experience distorted beliefs about their self-worth often to the point of wanting to harm themselves.

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The result is an overemphasis on medication as the primary treatment for psychosis even though psychotherapy is unequivocally effective for PSD. And although medications can be crucial for many people, they often come with harsh side effects that impact quality of life and physical health, and thus result in poor medication adherence that leads to further stigmatization of people with PSD.

For a long time, clinicians and researchers assumed people experiencing psychosis did not experience emotions in the same way as other people because they did not express them through their body language or affect (Kring & Moran, 2008). It is now widely known though that this is untrue, people with PSD commonly struggle with emotion dysregulation and negative or challenging emotions are consistently associated with an increase in paranoid thinking and a predictor of paranoid episodes for this population (Lawlor et al., 2020). The literature on emotion dysregulation in people with PSD is robust, including 25 current studies: 10 cross-sectional, 14 experimental, and 1 meta-analysis (Ludwig et al., 2019). This means that offering treatments such as DBT skills that interrupt and prevent dysregulation is an important component of treatment.

People with PSD often get caught in a vicious cycle where their strong emotions make it more likely their challenging psychotic experiences will worsen, and their psychosis tend to cause their emotions to escalate. For example, a client might share that he is feeling sad and irritated because he got into a fight with a friend. As a result of this increase in emotions, he then experiences more symptoms like hearing suspicious voices saying to him, "you can't trust anyone." In turn, the voices may now make him feel afraid in addition to his initial feelings of sadness and irritation. This cycle can continue, increasing his suspicious thoughts and fearful emotions and ends with him screaming and punching a wall. This is where DBT comes in as a treatment modality: It provides skills for the client to break the cycle of emotion dysregulation.

23.1 Goals of DBT

DBT is *not* a suicide prevention program, as is commonly assumed. It is not focused on keeping clients alive only to have a miserable life. Instead, application of DBT to people with PSD aims to help clients build a life that is worth staying alive for. Each client's life worth living looks unique because it is specifically embedded in their cultural viewpoints, personal goals, and value system. The job of providers is to help clients get there. This perspective of building a meaningful life is critical for people with PSD, who are often discouraged from pursuing their goals as the result of antiquated ideas about the likelihood of recovery for people with severe and persistent mental health issues.

The second goal of DBT is dialectical synthesis, meaning helping clients learn to think in a more balanced way rather than going to extremes and then acting on those beliefs. Put another way, finding what is left out in a client's thinking. This goal is

essential for people with PSD who deal with distorted and distressing thoughts that can cause increased anxiety.

In this chapter, I will explore how DBT skills and principles can be used to meet the needs of people experiencing PSD. Because research on DBT as a primary treatment for psychosis is still emerging, I will be discussing DBT-informed treatment rather than strict adherence to the full DBT model, which involves weekly individual therapy and skills class, a consultation team, and phone coaching. The main principles and skills of DBT were set out in Dr. Marsha Linehan's seminal DBT text from 1993, which stated: "In the research demonstrating the efficacy of DBT, patients were screened for active psychosis and organic mental disorders. For a non-research-oriented application of DBT, such screening would be needed only to the degree that significant cognitive impairments such as inability to attend to or grasp skill concepts would prevent patients from benefiting from the skills training" (p.440). DBT strategies reduce emotion dysregulation, including the behaviors clients perform in an attempt to cope with it, such as suicidal ideation, suicide attempts, drug use, and nonsuicidal self-injurious behaviors. The case example I will present utilizes primarily DBT skills and principles while occasionally weaving in other effective psychotherapies for PSD such as CBT for psychosis, prolonged exposure for PTSD, and exposure and response prevention for social anxiety.

23.2 Case Example

I will present "Laila" to demonstrate how I use DBT-informed treatment when working with someone with a PSD. Laila and I worked together for 11 months in an outpatient psychiatry department within a health maintenance organization in the United States. We met weekly for individual therapy, and she also attended my weekly DBT-informed skills group for people experiencing psychosis. In this group, she learned Dr. Linehan's foundational DBT skills class curriculum in a format where each skill and concept was broken down to be easier to grasp and more relevant to the experiences of people with PSD.

To make DBT more accessible to this population, clinicians must ensure that what is offered is concrete, simple, and free of psychological jargon. They also need to ensure the suggestions are accessible, meaning free and easy-to-use options because people with PSD are disproportionately on fixed incomes and likely to experience housing insecurity (Ayano et al., 2019). Lastly, a DBT-informed approach must integrate the reality of societal stigma faced by clients. An environment of stigma, discrimination, and often, violence, shapes their experience. Effective therapy must consider the factors that reinforce or punish certain behaviors clients perform.

For example, I often suggest to my clients that they communicate directly with their voices if distress tolerance options are not working for them. Because of the way others might judge them for doing so, however, we also must discuss the pros

and cons of speaking aloud to their voices because of the potential for negative consequences of appearing to talk to themselves.

23.2.1 Overview

Laila (she/her) is a 28-year-old, bisexual, African-American, cisgender woman. She lives in a multigenerational household with her grandparents, sister, and cousins in California. For the last several years, she has worked part-time as a library assistant at the local public library. She has a partner and their relationship is up and down. Outside of work, Laila spends her time taking dance classes and playing video games. While her mental health struggle is significant, she maintains a good sense of humor.

Laila experienced symptoms of anxiety and depression throughout her teenage years but never received any mental health treatment. After her first psychiatric hospitalization at age 20 when she was experiencing command hallucinations telling her to harm herself, distressing beliefs that someone had implanted a chip in her brain, and impairing suspicious thoughts, she was diagnosed with schizophrenia. While Laila reported no known family history of psychosis, she did note an aunt who had never sought treatment but was always considered "pretty crazy and erratic." Laila has since been hospitalized multiple times due to her psychotic symptoms and suicide attempts. She regularly self-harms by cutting herself and smokes marijuana when she is stressed. She was most recently diagnosed with PTSD from childhood sexual abuse and worsened by the trauma associated with events leading up to one of her hospitalizations.

Laila often arrived at our appointments sharing situations that had occurred throughout the week. For example:

Laila reported that she recently became upset (emotionally dysregulated) at work after receiving critical feedback on her performance from her manager. On her way home from work, she heard voices (auditory hallucinations) saying critical things to her, such as "you're such an idiot, you don't deserve to live." In an effort to calm down, she smoked a joint. When Laila eventually arrived home, she experienced suspicious thoughts when her grandmother asked what was wrong and offered to help. Laila reported getting overwhelmed by these thoughts telling her not to trust her grandmother. She became upset and immediately self-harmed by cutting her leg in an effort to release the intense emotions she was feeling. She began to feel shame and isolated herself in her room for the next 36 hours, resulting in her missing work the next day.

Laila showed up to our session that day and had her head hung low, avoiding eye contact with me. She told me that she was worried she had made her situation at work worse by not showing up the next day. I started by validating Laila's honesty and noted that she seemed ashamed of her actions based on her body language. She agreed and said she regretted her decision and noted that "it all happened so fast." In DBT, we strive to balance two seemingly opposite but co-occurring needs:

acceptance and change. Before I could work on helping Laila change, I needed to start by using acceptance strategies, starting with validation.

23.2.2 Validation

I find it is easy to validate people's experience with psychosis. However, both mental health professionals and families often ask me how to validate because they are worried about reinforcing someone's distressing belief (what we formerly referred to as "delusions"). What I typically tell them is to start by validating their client's emotions, which acknowledges their struggle and ensures they feel heard. People with psychosis are often invalidated when they name their suspicious thoughts by others saying to them "that's not real" or "you're crazy." This completely disregards the fact that these experiences are very real to people with psychosis.

I encourage therapists and also loved ones to engage with people experiencing psychosis by validating their emotions first and foremost. For example, I said to Laila "of course you feel scared when you think your family is after you; I would feel that way too." And then ask curious, nonjudgmental questions like "what do the voices say?" and "what makes you worry?" Taking this approach does not mean you agree with their belief but instead you are trying to understand their experience and perspective.

In DBT, we talk about six levels of validation (Linehan, 1997). The first level is perhaps the most straightforward which involves simply being present and paying attention. In level one, you give that person your full attention and show you are listening. That means when I meet with Laila, I make eye contact and nod my head occasionally to show I am listening. Level two is reflecting back what you heard. When Laila explained what happened the day before, I could reflect back by saying, "you got overwhelmed after getting difficult feedback at work and things snowballed from there." The first two levels of validation are commonly used among mental health providers regardless of their therapeutic orientation.

Level three is to put yourself in your client's shoes and imagine the emotions and thoughts they might be experiencing. In this case, I would say to Laila, "I imagine that you were feeling scared when you started having those suspicious thoughts, is that right?" Make sure to include a similar question after to check for accuracy, and ensure you understand their experience.

Level four is to validate based on your client's history. Since I had been working with Laila for a few weeks at this point, I might say to her, "given your history of being discriminated against by your employers both for being Black and having a mental health issue, no wonder that meeting with your manager would make you feel overwhelmed." I was reminding her that her reaction makes sense in her individual historical and cultural context. In contrast, level five involves validating based exclusively on the current circumstances and sharing that the client's behavior makes sense given what happened. I said to Laila, "it makes sense that you'd feel upset after hearing critical voices."

Lastly, level six is radical genuineness which is an essential stylistic component of DBT. Radical genuineness involves communicating as you would with someone who is an equal rather than treating them as a patient. In Laila's case I told her, "I would want to escape too if I was hearing voices saying those cruel things to me that you heard!" Level six offers the strongest validation of the six levels, as the higher you move up the levels the more intensely validating the statement (Linehan, 1997). Keep in mind that all interventions we provide should be culturally responsive, so make sure to adjust your validating statements to reflect your and your client's cultural communication styles. In DBT, providers are taught to be their authentic selves and use irreverence or humor in our relationship with clients. In this case, I might both validate Laila and also joke that her day sounds like it was "very shitty."

23.2.3 Behavioral Chain Analysis

After validating Laila's honesty with me, I helped her think through what she could do differently in the future to ensure a more effective outcome with fewer negative consequences. Every time Laila arrived at a session reporting she had engaged in self-harm, we would start our session with a behavioral chain analysis (Linehan, 2015). This tool helps clients understand the factors that led up to an ineffective behavior by examining the preceding emotions, thoughts, behaviors, and physical sensations, see Fig. 23.1 for illustration. The function of a behavioral chain analysis is to get a clearer picture of what exactly happened as well as the consequences of the problem behavior, and then to conduct a solutions analysis to brainstorm ways that your client can intervene more effectively in future situations (Linehan, 2015, p.143). This is not meant to shame your client for doing something ineffective, but instead to help them understand how to be more skillful and behave in a way that results in a more desirable outcome. Once we have a lay of the land, we could figure out where Laila can be more effective in the future.

I started by asking Laila to identify any vulnerability factors that would have increased her likelihood of experiencing emotion dysregulation that day. Vulnerability factors are the influences that make us more likely to feel emotionally overwhelmed. Examples include when you have not gotten enough sleep, are feeling hungry, have existing stressors, are using or withdrawing from drugs or alcohol, or being in physical pain. These elements decreased Laila's capacity to manage her emotions and also made it more likely her symptoms of psychosis would flare up.

Fig. 23.1 Behavioral chain analysis

Laila observed that she noticed increased anxiety the previous few days and that she accidentally missed her medication dose that morning.

Next, we went through the events of what happened, including identifying the thoughts, emotions, behaviors, and physical sensations she experienced along the way. We started from the prompting event, in this case receiving critical feedback from her manager, and identified each of the links in the chain that led up to her self-harming. This included identifying the thoughts she had that day (e.g., "I'm such an idiot") after the meeting with her manager that resulted in intense shame and sadness, the experience of hearing louder and more bothersome voices that distracted her at work, and the ineffective behaviors she performed in an attempt to cope such as smoking marijuana, which ultimately triggered her suspicious thoughts. We then examined how each of these links impacted each other.

Once we had a clear, detailed picture of what happened, Laila and I focused on solutions analysis. This involves reviewing the chain analysis to identify where Laila could be more skillful in the future to prevent her from getting to the point of self-harming and subsequently self-isolating and missing work.

Initially when Laila and I started meeting, she needed a lot of coaching to identify moments in which she could more skillfully intervene in the future. She found it difficult to identify when she needed to ask for support from others, and would get overwhelmed by emotions and unable to choose which skills to use when experiencing distressing voices. Over the course of 3 months, Laila developed a clearer awareness of the typical cycle she would experience where her stress would increase her emotions, her emotions would increase her symptoms, and so on. By month four, she was able to readily ask for help from her loved ones, use distress tolerance skills such as distraction or self-soothing, and practice emotion regulation skills.

Around this time, Laila learned how to do a behavioral chain analysis herself and would bring it into our sessions following instances of self-harm. The first time this happened, Laila walked into my office saying, "Don't even think about asking me for one of those stupid chains, I already did it!" which gave us both a good laugh and the opportunity for me to praise her skillful behavior, which served as positive reinforcement for Laila. Keep in mind that not all people are reinforced by praise so clinicians need to identify the most effective reinforcers for their individual clients. This can include creative options such as bringing in your client's favorite food to celebrate their victories or even spending the last 5 min of session discussing an unrelated topic of their choosing, such as a favorite television show or hobby.

For the solutions analysis, Laila and I identified the points in this sequence of events where she could have been more effective. I always started a solutions analysis by asking where Laila had already tried to be skillful to understand her attempts at a different outcome. In this case, she shared that she tried to calm down by smoking marijuana. What Laila could also point out though is that marijuana often made her feel more suspicious which typically activated her psychotic symptoms. The function of her behavior in that case was an attempt at self-soothing that unfortunately was not successful. Laila and I would then identify what else might be helpful instead.

Because Laila was having a strong emotional reaction to the feedback from her manager, we started with what she might have been able to do after the meeting to manage her increasing emotions of shame and sadness. Laila noted that starting with distress tolerance might have been helpful since she was in *emotion mind*, meaning her thoughts were driven entirely by her emotions over facts or reason. This state of mind is in contrast to *reasonable mind*, where thinking is exclusively focused on facts and reason and emotion is ignored. DBT aims to help clients find balance in their thinking by finding *wise mind*, where both emotion and reason are valued (Linehan, 2015).

In Laila's case, she identified wanting to use temperature change and progressive muscle relaxation (PMR) immediately after the meeting to try to calm herself down. Temperature change involves simulating the mammalian dive reflex, where your heart rate slows down when your face is immersed in cold water (Linehan, 2015). We discussed ways to make this skill accessible while at work by keeping an ice pack in the freezer that she could readily put on her face while bending over and holding her breath for a brief period. PMR is the practice of tensing one muscle group at a time followed by a release of that tension in an effort to relax your body. Laila indicated that she could do this while in her office at work while listening to a PMR recording from YouTube on her phone.

When Laila recognized that smoking marijuana was not a successful self-soothing method after she began hearing distressing voices, we explored other strategies she could try instead such as urge surfing, distracting herself with videos on her phone, and putting in earplugs. Laila also wanted to be more skillful when her mom offered her help, so we looked at interpersonal effectiveness strategies that could be helpful such as about how to make a skillful request for help or to be left alone temporarily. In an effort to avoid self-harm when she was feeling overwhelmed, I encouraged Laila to make a pros and cons list of whether it would be effective in the long term to engage in this behavior. A solutions analysis allowed Laila to reflect on a difficult situation with a new perspective and identify how she could be more skillful in future situations (see Fig. 23.2).

Each week, Laila was learning new tools in the group session that she could use to navigate her overwhelming emotions. These skills were based on the four modules of DBT: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

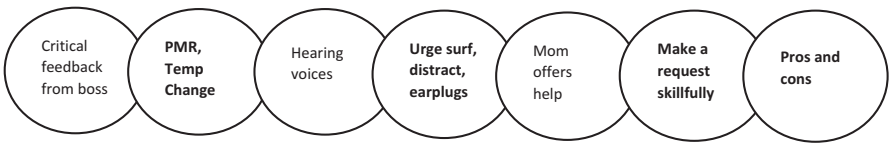

Fig. 23.2 Solutions analysis

23.2.4 Mindfulness

Mindfulness is a foundational approach in DBT. Mindfulness is at the core of all other skills and interventions because we first need to be aware of what is going on for ourselves internally as well as in our external surroundings in order to consider how to handle a situation. For example, Laila first needed to notice she was feeling anger at an 8 (out of 10) level so that she could decide she needed to use skills to deescalate her emotions.

Mindfulness is about taking an in-the-moment, nonjudgmental approach to the world where you are focused on just one thing at a time. Mindfulness is one of the first skills I taught to Laila. Research demonstrates that mindfulness can help people with PSD reduce their depressive symptoms, manage the distress that results from their symptoms by using an acceptance-based approach, and improve negative symptoms (Aust & Bradshaw, 2017; Jansen et al., 2020). General rules for practicing mindfulness with people with psychosis are choosing a shorter duration, providing more verbal guidance than silent time, and including specific mention of psychotic symptoms in a way that is normalizing during the guidance (Chadwick, 2014).

When I worked with Laila I started with mindfulness activities that were approximately 1–2 min in total, based on what she could tolerate that day based on her symptoms. During the mindfulness practice, I would help her focus on her breath, pausing only briefly before providing more guidance to keep her focused. I would mention things like, "If you notice yourself being distracted by distressing thoughts or voices, try to gently bring your attention back to your breath." On days when Laila had trouble focusing inwardly because of overwhelming voices or intrusive thoughts, I would ask her to observe and describe items in her external environment instead. Laila would practice these kinds of mindfulness activities for homework each week to build a regular mindfulness practice.

In addition to specific mindfulness activities, I taught Laila about the principles of mindfulness that can be brought into any activity she is engaged in, such as brushing her teeth, walking the dog, or riding the bus. DBT explains mindfulness principles as the *What* and *How* skills of mindfulness, referring to the skills of what you are doing when you practice mindfulness and how you are doing it. The What skills include observing your experience using all five senses, describing what you notice with words, and participating by throwing yourself fully into whatever you are doing. The How skills include taking a nonjudgmental stance, doing one thing at a time, and focusing on what is effective (Linehan, 2015). I would regularly encourage Laila to practice the principles of mindfulness to notice what was coming up for her when she felt emotionally overwhelmed. By the end of our time together, Laila developed a regular daily mindfulness practice of 5–10 min of guided meditation.

23.2.5 Distress Tolerance

Along with mindfulness, distress tolerance skills were among the first tools I offered to Laila at the start of treatment. Distress tolerance skills manage crises and ultimately help us get through a difficult situation without doing something to make it worse. Examples include distraction, self-soothing with your five senses, changing your physical state, doing a pros and cons list, and urge surfing. As with any skill offered to people experiencing psychosis, distress tolerance skills need to be concrete and accessible. Because of limitations on her income due to working part-time, I ensured that any options I offered Laila were cheap or free, such as going for a walk in the park, talking with a friend on the phone, drinking tea, or using temperature change.

After Laila was able to successfully utilize mindfulness to notice when her emotions felt overwhelming or her urges to engage in problem behaviors were high, I taught her to employ distress tolerance skills to get through those moments of heightened emotion without engaging in self-harm or marijuana use. I started by helping Laila identify what kind of distress tolerance skills she was already practicing as I find most of the clients I work with already engaged in some form of skillful distraction or self-soothing without necessarily calling it that. We found she would sometimes distract herself with a game on her phone or self-soothe by eating her favorite foods when she felt stressed, but she was not yet using these skills with much regularity or awareness. The key to our work was then to help Laila intentionally use these skills in moments of strong emotion as well as to offer her more options so she had many tools in her toolbox.

For instance, when Laila felt the urge to smoke marijuana to deal with intrusive thoughts, I helped her think through what skills she could practice and problem solve around barriers that would get in the way to using them. Laila was a particularly big fan of skills to change her physical state such as temperature change, exercise, and PMR as she felt they worked quickly. Once she noticed the urge to use marijuana went down, she could then deal with the prompting issue–intrusive thoughts–and identify strategies to manage them.

Distress tolerance skills are acceptance-based, meaning they are meant to be used to get through the moment without acting on urges but do not change the current problem (Linehan, 2015). This means that once a client has utilized distress tolerance skills to get back to a place where they can think more clearly, they may need to use other skills from the other modules of DBT to deal with the original problem. In Laila's example, once her emotions felt more in control, she needed to strategize around ways to reduce the intensity of her intrusive thoughts. With coaching, she was able to utilize mindfulness to simply notice her thoughts rather than engaging with them. In addition, she noticed a pattern where her intrusive thoughts tended to be worse when she had not slept well, so she then worked on emotion regulation strategies related to reducing this emotional vulnerability and improving her sleep.

23.2.6 Emotion Regulation

Emotion regulation is another core module of DBT. People who struggle with emotion dysregulation tend to experience their feelings as overwhelming or even explosive. As a result, they may go to great lengths to avoid feeling them. Laila was no exception. She would come into sessions in the beginning of treatment recounting how she would feel completely flooded with anger and shame when her partner said something invalidating to her. She would work hard to suppress her emotions, but without having effective skills to manage them, she would turn to self-harm to release her pain. Emotion regulation strategies work to change existing emotions, reduce the frequency of challenging emotions, and increase pleasurable emotions.

Early in treatment, I introduced emotion regulation strategies that focus on reducing the number of challenging emotions Laila experienced, such as sadness, anger, shame, guilt, envy, or jealousy, and increasing the pleasurable ones, such as happiness, joy, or excitement. Laila and I began by discussing strategies to reduce emotional vulnerabilities such as taking care of her health, developing healthy sleep habits, eating regular meals, and taking her medication as prescribed. In particular, we looked at DBT strategies related to reducing rumination, which was one factor that made it difficult for her to sleep at night. We also problem solved ways to increase her likelihood of taking her medication regularly, such as getting a pill organizer and setting a daily alarm. Laila also noticed that she tended to have more severe psychotic symptoms just before she menstruated, so we identified ways she could manage these. Interventions included scheduling more relaxation during this time, being compassionate and nonjudgmental toward herself, and an evaluation by her gynecologist, who recommended Laila start an oral contraceptive to help with mood fluctuation.

Through evaluation of her daily activities, I learned that Laila was not engaging in almost any pleasurable activities or hobbies. We explored interests that she was willing to engage in that might increase her enjoyable emotions such as dancing to music, spending time with friends, and eating food she loves. Because she often did not notice whether an activity brought her pleasure, I instructed her to do a mood rating before, during, and after each activity so she could assess whether it was in fact helpful. For people with PSD, feeling motivated to engage in activities can be a challenge, so this rating gave her data she could remind herself of in the future. The function behind increasing pleasurable emotions was twofold: One was to tip the scale so Laila experienced more pleasurable emotions than challenging ones; the second was to help her build a life worth living that was intentionally filled with experiences she chooses and enjoys.

Laila and I examined her values to explore what her life worth living looked like. Laila identified her core values as community, integrity, self-determination, creativity, humor, and love. From here, I helped her determine how to use these values to guide her behavior and bigger goals, because when she did so, it increased her pleasurable emotions as well as her sense of self-respect. Laila was particularly excited

to set goals of living outside her family's home, getting a dog, improving her relationship with her partner, and going back to school.

Laila regularly experienced suspicious thoughts (e.g., "the government is controlling my thoughts") that would distract her from her activities and increase her emotion dysregulation. When these thoughts arose, I taught her to use the strategy of checking the facts to determine whether her emotions and thoughts made sense based on the current situation. When she noticed her emotions did not fit the facts of the situation because they were unjustified, she would engage in opposite action, meaning doing the opposite of whatever her emotion was telling her to do. In the case of unjustified fear or "paranoia," Laila would approach the situation in spite of her urge to avoid or run away from it.

For people who experience psychosis, checking the facts can be more challenging because they have difficulty differentiating their individual psychotic experiences from others' shared reality. When this came up for Laila, I encouraged her to adopt the perspectives of the people she trusts by asking them to weigh in on the situation. Thus, Laila would ask her grandmother and partner for their interpretation of the situation and then use this information to decide how to proceed.

23.2.7 Interpersonal Effectiveness

Interpersonal effectiveness, the fourth and final module in DBT, is focused on learning to be a more effective communicator who can ask for what they want, say "no," and make and maintain relationships.

Having loved ones and a strong social support network is an essential part of many people's life worth living, yet not everyone knows how to build and maintain relationships. Many people with PSD experienced their first psychotic episode during their teens and twenties, a developmentally critical time for refining relationship skills. As a result of the demand to focus their time and energy on their mental health, many people experiencing psychosis do not develop those crucial communication and relationship skills. People experiencing psychosis may also face a number of specific barriers to being effective communicators such as co-occurring social anxiety disorder (SAD), PTSD, negative symptoms, and suspicious thoughts. It is essential to screen for these issues and then adapt the intervention strategies to incorporate these specific issues.

At least 14.9% of people with schizophrenia, for example, meet criteria for SAD, and some research suggests that people with co-occurring schizophrenia and SAD have more lifetime suicide attempts (and specifically more lethal attempts), increased substance use problems, and overall lower quality of life (Achim et al., 2011; Pallanti et al., 2004). Laila met criteria for SAD, so we utilized exposure principles to address this problem by utilizing an exposure hierarchy of feared tasks she could engage in to create new learning that challenged her worries about social engagement.

Additionally, Laila and I role-played different scenarios in our sessions where she utilized DBT's interpersonal effectiveness scripts such as asking for what you want and saying no using DEARMAN, keeping the relationship with GIVE, and maintaining your self-respect utilizing FAST to practice what she might say to others (Linehan, 2015). We also practiced skills specific to making friends and ending unhealthy relationships. After spending time adapting these skills to her cultural communication style, I gave Laila homework assignments to practice these skills throughout the week. Initially, she used her therapy support group as a place to practice these communication skills, and then eventually integrated them into the rest of her life. By the end of our time together, Laila developed a regular routine of identifying when she needed help and then asking for it from her trusted loved ones. She also began building and maintaining friendships after a long period of social isolation.

In addition to SAD, PTSD is common among people with PSD given the number of traumatic experiences people with PSD typically experience such as childhood abuse, homelessness, hospitalization, and incarceration. A recent systematic review of 38 studies found a range of prevalence of co-occurring PTSD of 0–55%, with 30 studies finding a prevalence of 10% or greater (Dallel et al., 2018). Laila met criteria for PTSD, including having regular nightmares, flashbacks, and beliefs about the world being unsafe as well as engaging in avoidance behavior. After life-threatening behaviors are eliminated in stage 1 of DBT treatment, stage 2 involves treating PTSD for clients who meet criteria utilizing DBT-Prolonged Exposure (DBT-PE) therapy. After Laila's psychosis was brought to a more manageable place with the help of DBT-informed treatment, psychotropic medication, and family education and support, she was able to engage in a full course of DBT-PE to treat her PTSD.

23.2.8 Outcomes

After 11 months in treatment, Laila could more effectively manage her emotions as represented by her Difficulties in Emotion Regulation Scale (DERS) score moving from a 108 to a 45. She had avoided engaging in any life-threatening behaviors such as self-harm or suicide attempts in 8 months, and readily used distress tolerance and emotion regulation skills when feeling emotionally overwhelmed. She also implemented a daily mindfulness practice that she had maintained for the last 5 months of our time together. Her work in DBT-PE brought her initial Posttraumatic Stress Disorder Checklist (PCL-5) score down from a 64 to a 28, indicating she no longer met criteria for PTSD.

Laila described her time in DBT-informed treatment as a period of both great difficulty and great success, as she was pushed to work hard, be consistent with her self-care, and be less judgmental toward herself and her symptoms. Laila continued to experience psychotic symptoms throughout our treatment together but she described them as more manageable than before as a result of psychotherapy and medication management. For example, Laila reported being able to hear voices but not having them run her life anymore as a result of her ability to now communicate

with them directly and compassionately. She also noted taking a more acceptance-based approach to her symptoms overall so that she could experience distressing or suspicious thoughts without such a strong level of agitation and fear in response to them. She also increased her adherence to her medication by coming to a place of radical acceptance on the role of medication and by creating a more balanced life in which she sought to minimize stress and increase self-care. Laila even made a video for her future self describing why staying on her medications, getting adequate sleep, and taking care of herself were critical to her stability in case she doubted it in the future.

23.3 Conclusion

Emotion dysregulation is a common experience among people with psychotic spectrum disorders. Without proper attention, dysregulation can exacerbate psychotic symptoms and make pursuing a life worth living even more difficult. Dialectical behavior therapy–informed treatment offers the opportunity for people with PSD to become more mindful as they simultaneously work on improving interpersonal relationships, tolerating distress, and regulating intense emotions. Laila's case demonstrates how DBT skills and principles can be used to meet the needs of people experiencing psychosis.

Disclaimer Clinical cases presented in this chapter do not include real names or personal information of real persons.

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