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Psychotherapy Academy

Introduction to Inter-Session Contact

Stephanie Vaughn, PsyD

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Individual therapists are required to be reasonably accessible between sessions in order to provide intersession contact in full comprehensive DBT. Intersession contact is one of the four components in the standard DBT protocol. Any contact therapists have with clients between therapy sessions is categorized as intersession contact. This includes email, text, phone calls and in-person exchanges. As the name implies, intersession contact is not a therapy session and should not be treated as such. DBT therapists will often use the term phone coaching to refer to both telephone calls and texts or simply coaching to comprise all methods of contact.

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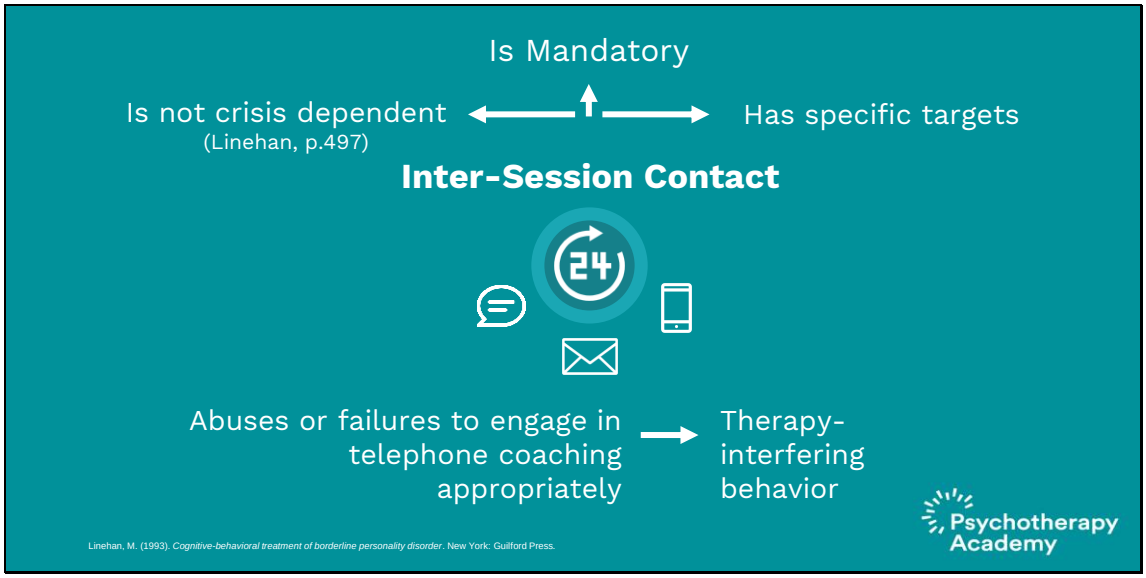

DBT is the only model of psychotherapy in which intersession contact is actually mandatory for treatment. This contact is not crisis dependent. In other words, the client is not required to need to contact the therapist in order to contact them. There are specific targets for telephone coaching that will be addressed in the next recording. Any abuses or failures to engage in telephone coaching appropriately are considered to be a therapy-interfering behavior.

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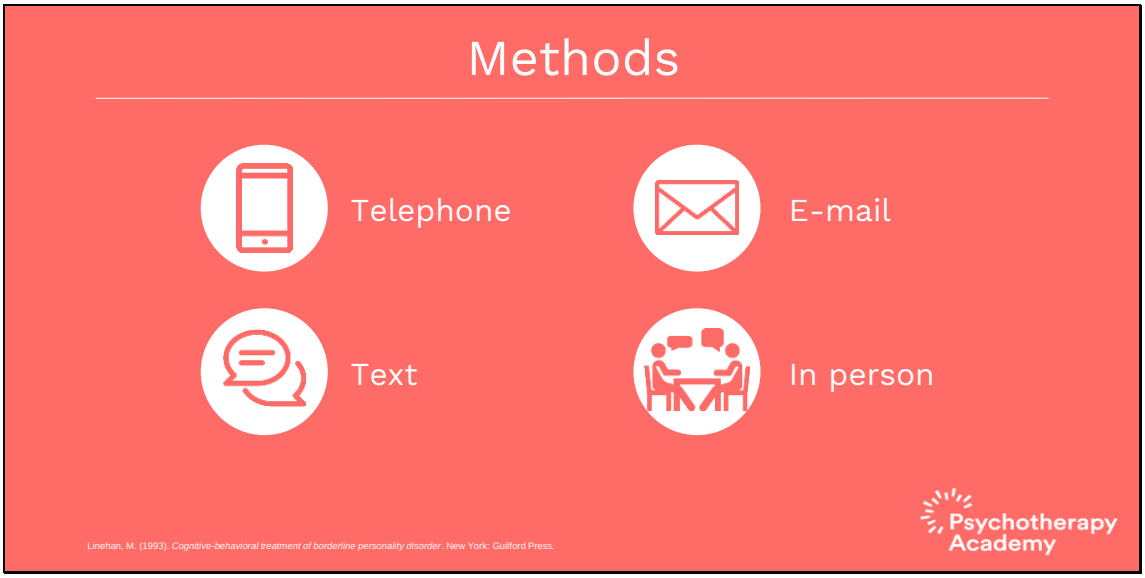

The methods for coaching include telephone, email, text and in-person and each of these is traditionally provided by the individual therapist.

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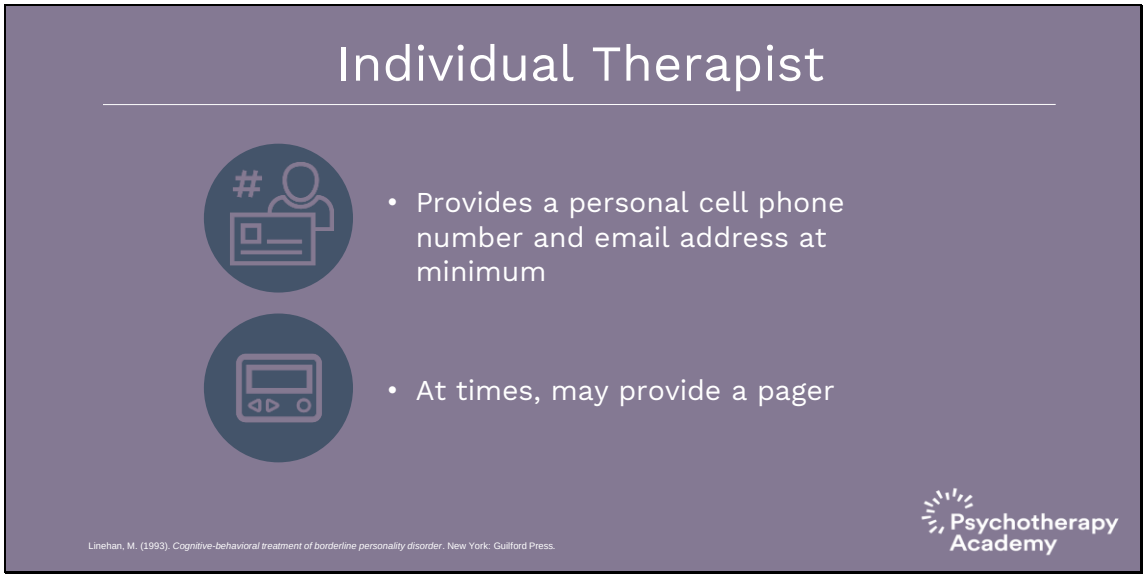

The individual therapist will provide a personal cell phone number and email address at minimum. At times, a therapist may provide a pager in order to allow a client to leave their telephone number and potentially the severity of their need so that the therapist may return their phone call.

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If a group leader talks to a patient between sessions whether that is in person or over the phone, most of the time, the function of the contact is going to be to keep the member in group or potentially to coach them on skills on a break within group. But the majority of the calls will be directed to the individual therapist. This is even during the course of group. If an individual group member's issue is such that it is not effective to address it one on one in group, the group leader may prompt them to call their individual therapist for coaching.

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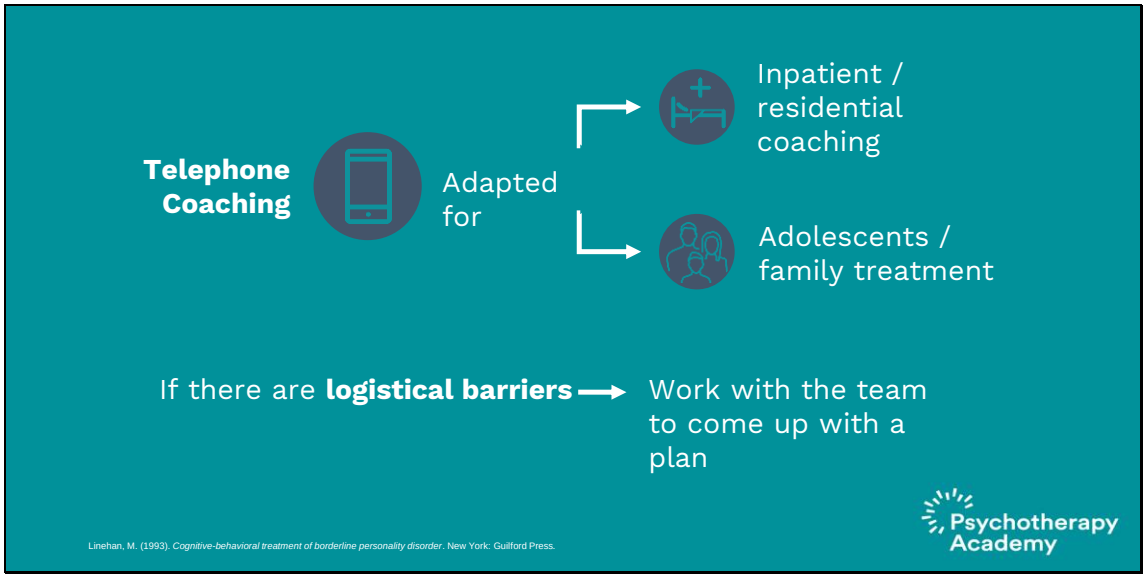

Telephone coaching may be adapted and would need to be adapted for individual or residential treatment or other places where having a phone and calling a therapist isn't feasible. It may also be adapted for adolescents and there are certain rules that do not apply in adolescent and family treatment. And in the case that there are logistical barriers for whatever reason, it's important to work with one's team in order to come up with a plan for addressing this vital component of the DBT to fidelity model.

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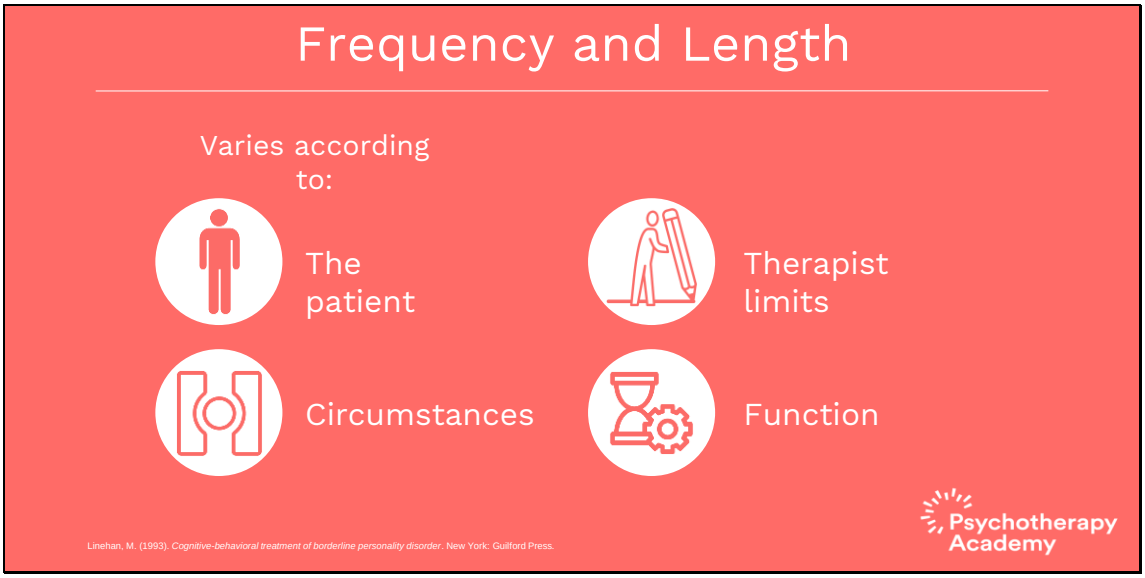

The frequency and length of intersession contact varies. It varies according to the patient, meaning their preferences and tendencies. Some will call more than others. In some, you will have difficulty getting them to call at all. It varies according to the therapist's limits. So some therapists are more willing than others to receive calls. Some are more willing to engage in texting. Some will or will not engage in email coaching. And the therapist's limits also vary from day to day and just from their general personality. This is addressed further in the section on Observing Limits.
Life circumstances will also determine the frequency and length of calls. This is life circumstances of the patients and the providers. So when a patient is in a higher state of need, most likely, they're going to be attempting to reach the therapist more frequently. This is not always the case but when you have a client who is consistently using telephone coaching as an adjunct, they are most likely going to increase their contact during stressful periods. The frequency and length also vary according to the function, meaning why is it that we're doing intersession contact to begin with? If the function is to increase the client's utilization of skills in their environment, then we may have more calls in the beginning of therapy when clients are just beginning to grasp the application of the skills versus later on down the line when they are better able to access, retrieve those skills from memory and have practiced them enough that they don't need the therapist's help in implementing them.

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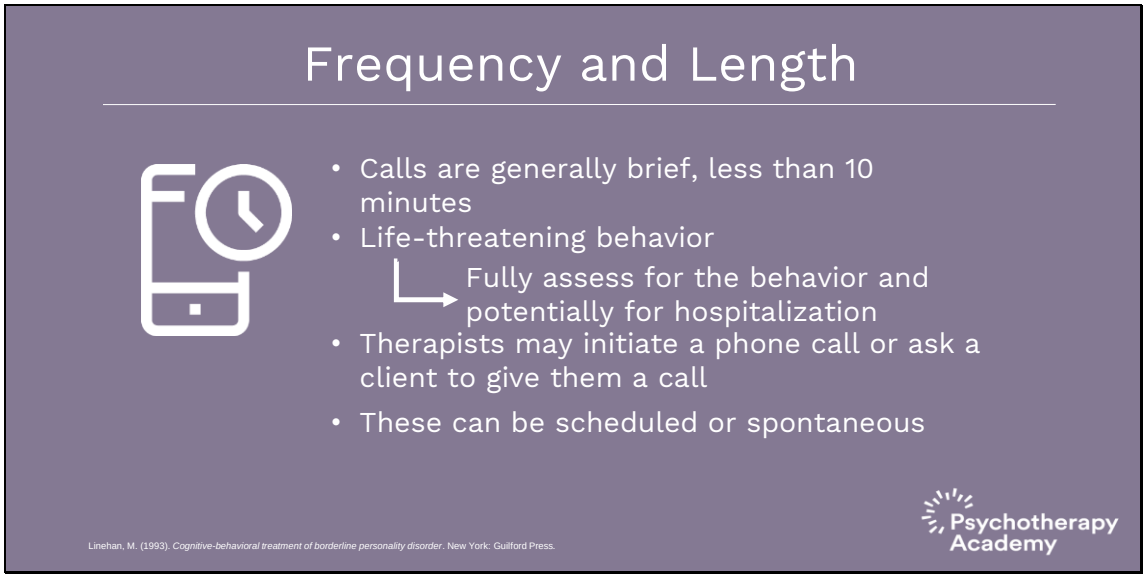

Generally, calls are brief. And calls lasting longer than 10 minutes are rare. It is possible for them to last up to 20 minutes or longer depending upon the nature of the call. For life-threatening behavior, hopefully, this is rare but there will be times when a therapist will need to fully assess a client for life-threatening behavior and potentially for hospitalization. Of course, this is the case with any model of psychotherapy and not specific to DBT. The calls can be scheduled or spontaneous. So there may be times when the therapist will initiate a phone call or perhaps may have asked a client to give them a call by the end of the day. Or in an example I had most recently, I asked a client to contact me and let me know that her diary card had been placed in the location that would be most helpful for her to remember to complete it. So she texted me a photo of that diary card. So these may be scheduled but also they may come out of the blue. They may be unexpected.

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Key points
Intersession contact includes any communication between therapists and patients other than that which occurs during designated therapy sessions
Intersession contact is not therapy
In DBT a patient does not have to be in crisis in order to contact the therapist

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Next Presentation:
Functions of
Telephone Coaching
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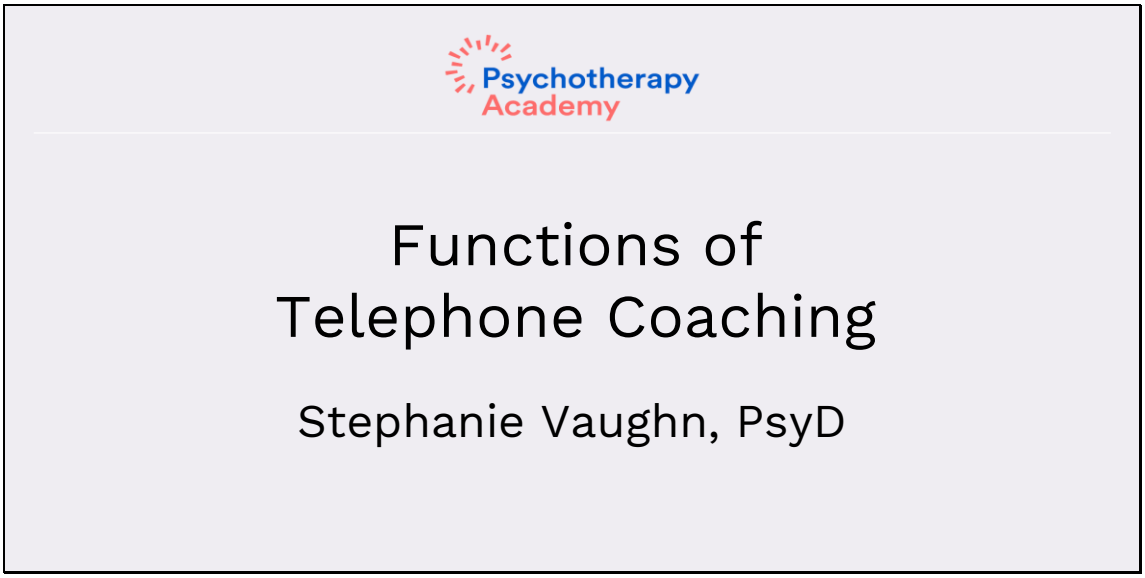
Slide 1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Functions of
Telephone Coaching
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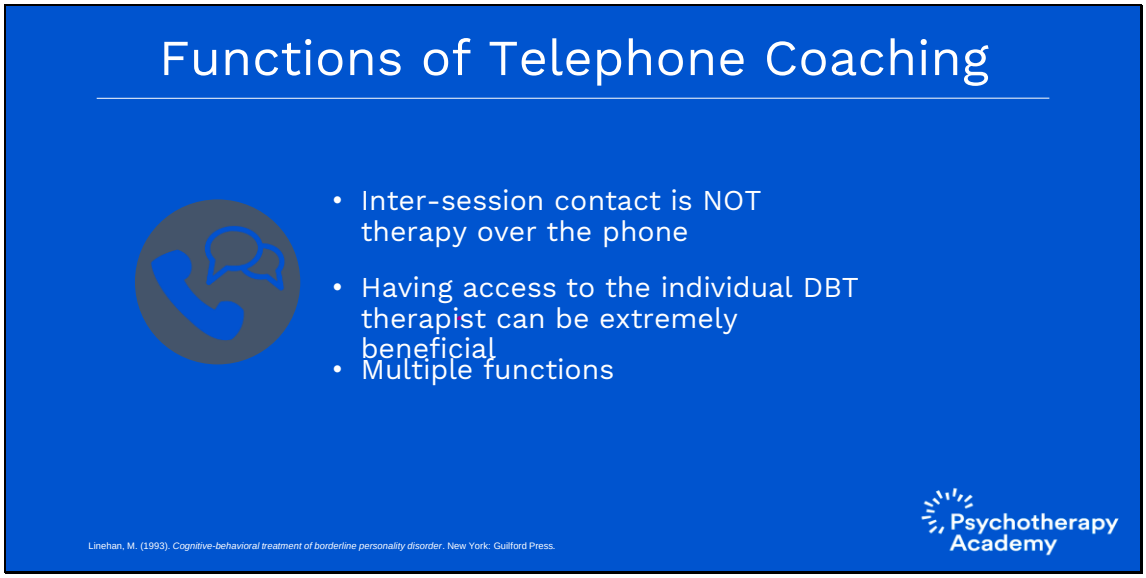
Slide 2



Intersession contact is not meant to be a substitute for therapy. It is not therapy over the phone. However, the patient having access to their individual DBT therapist between sessions can be extremely beneficial for a variety of reasons. There are multiple functions of intersession contact.

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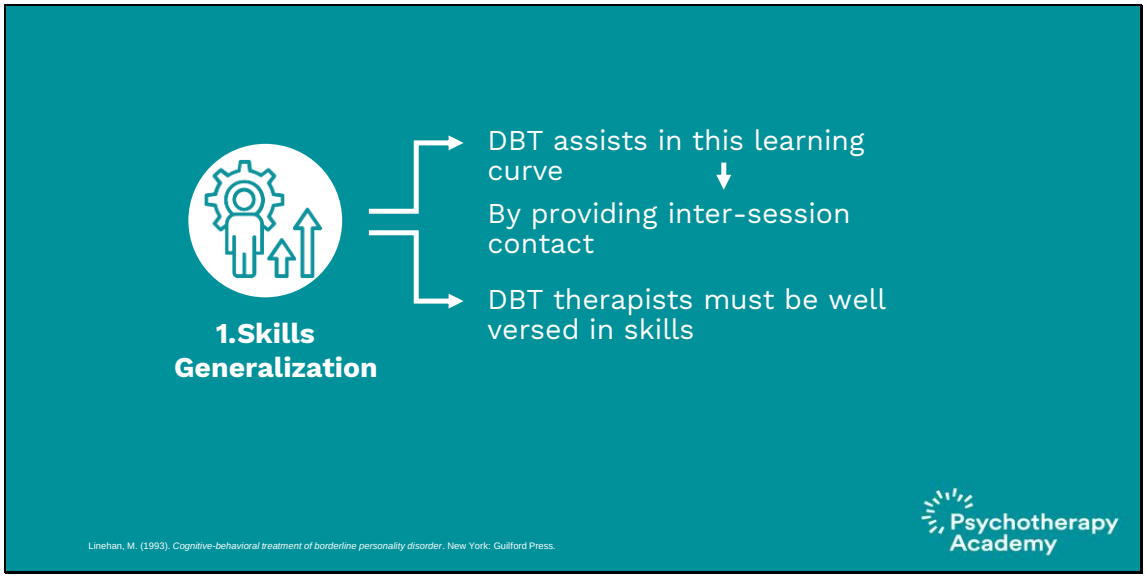

One of those is skills generalization. Although the patients are learning skills in group, learning something in a classroom and attaining the ability to apply it to the environment in the moment are two different things. So DBT assists in this learning curve by providing the opportunity for patients to contact their DBT therapists who hopefully are well versed in the DBT skills in order to ask them how they might apply the skills they're learning in group in the moment.

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So a DBT therapist is always going to be thinking about what skills the client could use that they're learning in group in that moment.
So although the situation may be a crisis in the moment and there's the tendency to want to assess and to do some therapy interventions, we always want to be thinking about how to apply skills like mindfulness, radical acceptance, interpersonal skills, communication. How might each of those or one of those apply to the client's crisis that they're calling you about?
So a question to ask would be: What skills could you use? So an individual therapist engaging in phone coaching could ask their patient over the phone, what skills could you use given what you've told me so far? We want to try to replace dysfunctional behavior that the client has engaged in time and time again with skills use instead. Rather than them going to their same old problem behavior like self-harm or an eating disorder behavior or getting into a conflict with someone, we can catch them before the dysfunctional behavior and try to apply skills.

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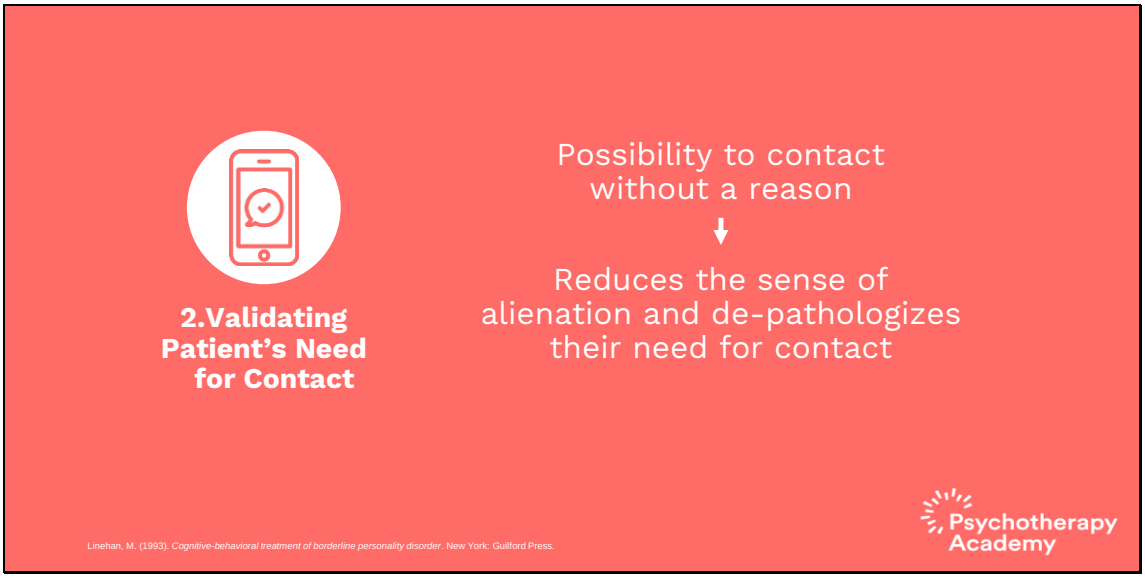

Another function of intersession contact would be validating the patient's need for additional contact. So the patient can contact their therapist without a reason. This doesn't mean that they're welcome to text 4or call at all hours of the day any time. What this does mean is that we don't want to have to set something up, a contingency up that they have to have a reason to call us.
For some patients, this would make it more likely that crisis would actually occur and that a problem would have to be created in order to have the need for the therapist contact to be reinforced. So I have some of my patients ask for validation actually when they call or text. So they ask for what it is that they need. Hopefully, this reduces the patient's sense of alienation and depathologizes their need for additional contact.

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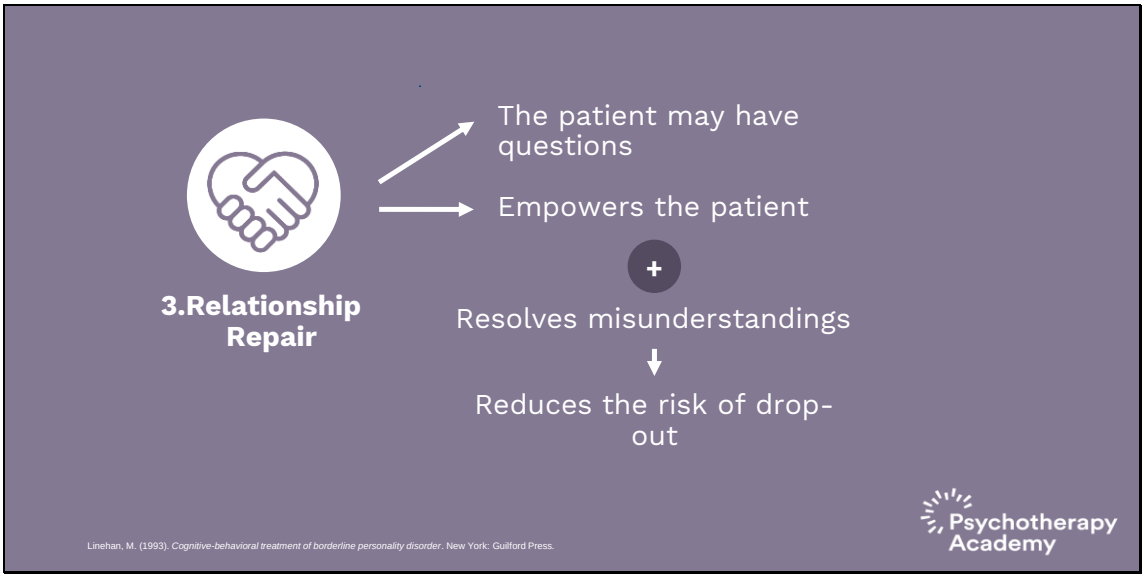

Relationship repair is another function of intersession contact. Patient may have questions about what transpired during the therapy session. They are often delayed processors. And a question that they may not have had while they were with you comes to the forefront of their mind several hours later or they're reflecting back on something that you said and really questioning whether they should continue in therapy.
While we don't want it to be a frequent occurrence in that they're seeking reassurance if that is a problem behavior in and of itself, from time to time, there have been situations that this empowers the patient and helps resolve misunderstandings that have happened in the therapy session overall reducing the risk for dropout.

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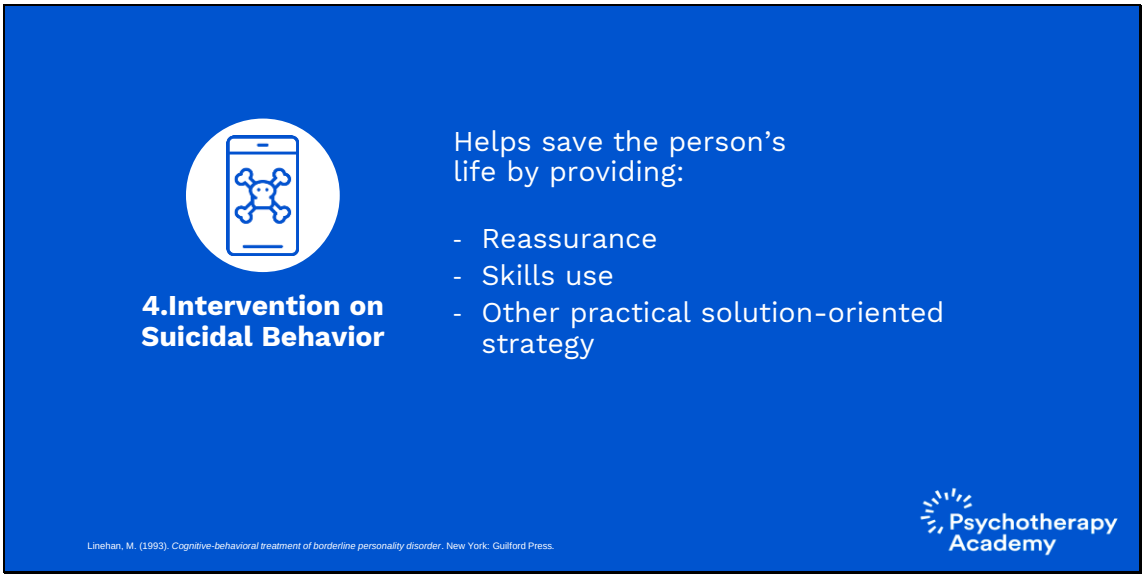

Another function of intersession contact is that the therapist may have the ability to intervene on suicidal behavior. Rather than expecting that the patient is going to go to the hospital or is going to call mobile crisis or is just going to figure it out, the therapist may actually be able to help save the person's life by talking to them over the phone and providing some reassurance, some skills use or some other practical solution oriented strategy.

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This potentially reduces the need for hospitalization and reduces the risk of completed suicidal behavior. So we also want to consider if we're intervening on suicidal behavior balancing, reducing the risk of suicide with minimizing reinforcement of suicidal behavior. And sometimes, that can be a very delicate balance.

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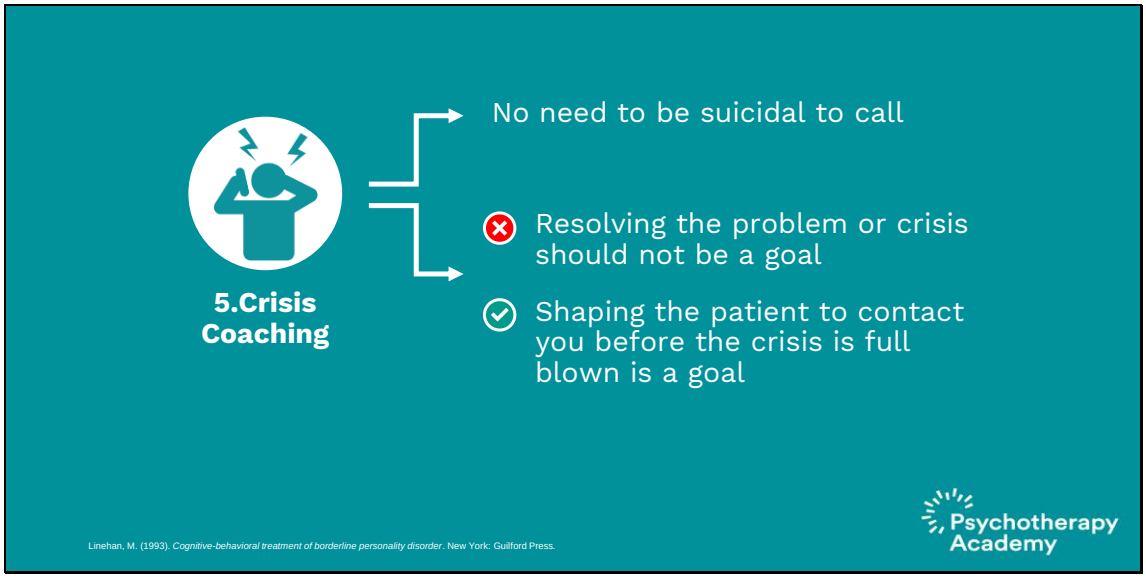

Another function of intersession contact that we've touched a little on is crisis coaching. So although a patient may not have life-threatening behavior, they may still feel that there's a crisis that they would like help with. But again, the patient does not have to be suicidal in order to call the therapist. When speaking to a patient who is in crisis, we want to make sure that we don't insist that the problem or crisis be resolved. I have said to patients on a number of occasions "this problem that you have is an ongoing issue and it is unlikely that you and I are going to get it solved tonight over the phone or it's unlikely that in the 10 minutes we're chatting over the phone we're going to get this fixed. Would you agree?" And I have actually never had a patient say "no, we're going to get this fixed" because many times we're talking about things like a relationship with a mother or a spouse or a child or a neighbor or an employer. And so those are ongoing pervasive problems that are not going to be solved in a brief phone call. So we want to resist the urge to have the crisis resolved entirely.

Shaping the patient to contact you before the crisis is full blown is really a goal. It's very difficult to intervene on a crisis whenever it is absolutely full blown. We want to try to get them to call far earlier. Sometimes, patient crisis will have been ongoing for a couple of days before they'll call. And if the crisis is full blown and they are in an emotionally distressed state, they may be sobbing. You may have difficulty understanding what they're saying. There's very little that can be accomplished over the phone at that time. So if we can get them to call earlier, it's a whole lot easier to melt a snowball, so to speak, that's just been packed by hand as opposed to melting an entire snowman. And when patients have allowed a crisis to continue mounting and packing on more and more emotions and more and more problems, it's like trying to melt a huge glacier. And that could be too overwhelming for both the therapist and the patient to approach.

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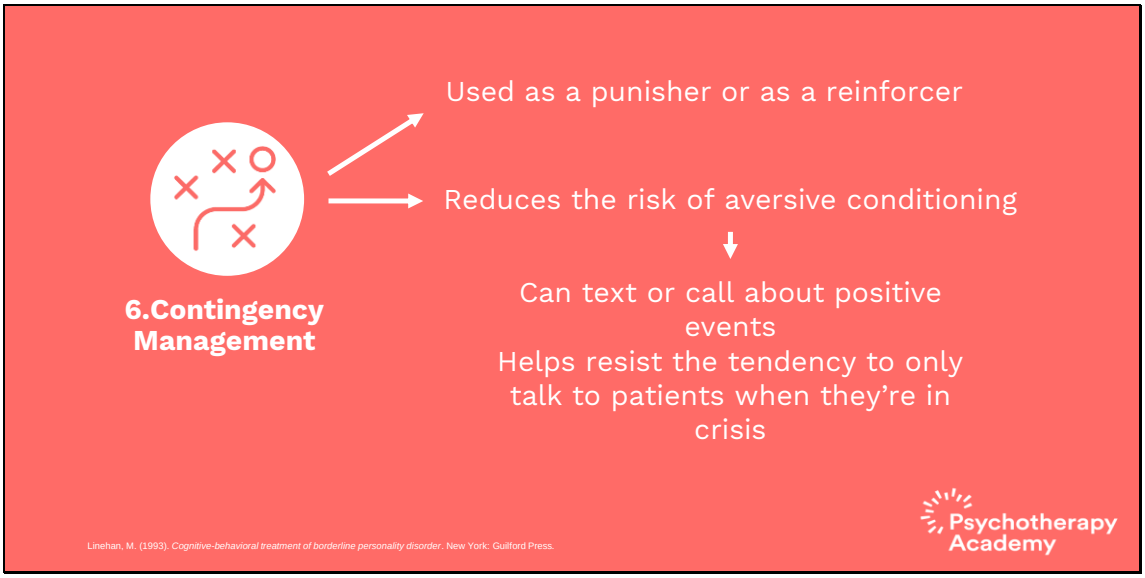

Finally, another function of intersession contact is we can use it for contingency management purposes. In other words, we can use it as a punisher, as a reinforcer. We can use the interactions on the phone as reinforcers, punishers in order to bring about a goal. So I have definitely changed up the contingencies with a patient before whom I've had multiple aversive interactions with. And this is in order to help strengthen the relationship and to help reinforce more, I guess positive is the word not in the behavioral sense but more behaviors that are conducive to a positive relationship with the therapist. Rather than only calling when in crisis or when they need help or when something negative is occurring, I have asked for a ratio of more positives to negatives. And so then the patient can contact me and let me know a way that they've used skills effectively or something that's gone right during the day or a positive thought that's crossed their mind.

In this way, I am resisting the tendency to only talk to patients whenever they're in crisis. Second, I'm minimizing the likelihood that I'm going to accidently be conditioned to see this patient's phone number come up on my phone and have an immediate aversive response because I've had so many unfortunate or aversive interactions with them. So I don't want the conditioning to be such that I'm dreading their phone call and this is one way to minimize the likelihood that that's going to happen. So the patient can call or text or email about positive events. So we can talk more about other ways to manage problematic phone and text in our section on Setting Limits and Intersession Contact.

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Key points
The DBT therapist provides intersession contact for a variety of reasons including helping the patient apply the skills in the moment they are in, to intervene in a crisis or when the patient is at risk, for contingency management purposes or to strengthen the relationship with the therapist.
A main goal of intersession contact is to shape the patient to contact the therapist before a crisis is full blown

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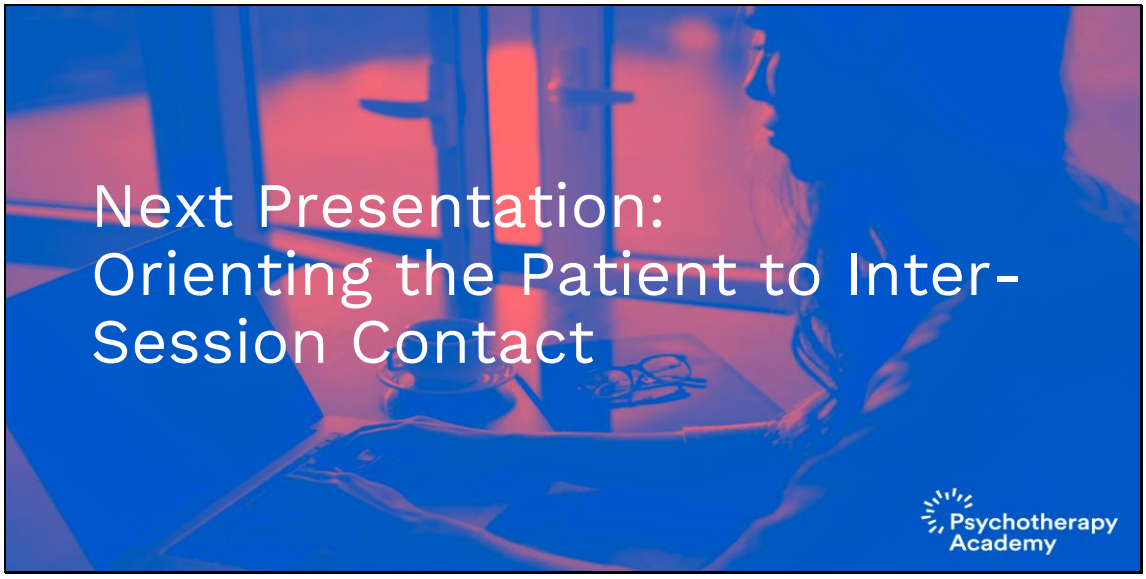

Next Presentation:
Orienting the Patient to Inter-Session Contact
Psychotherapy Academy

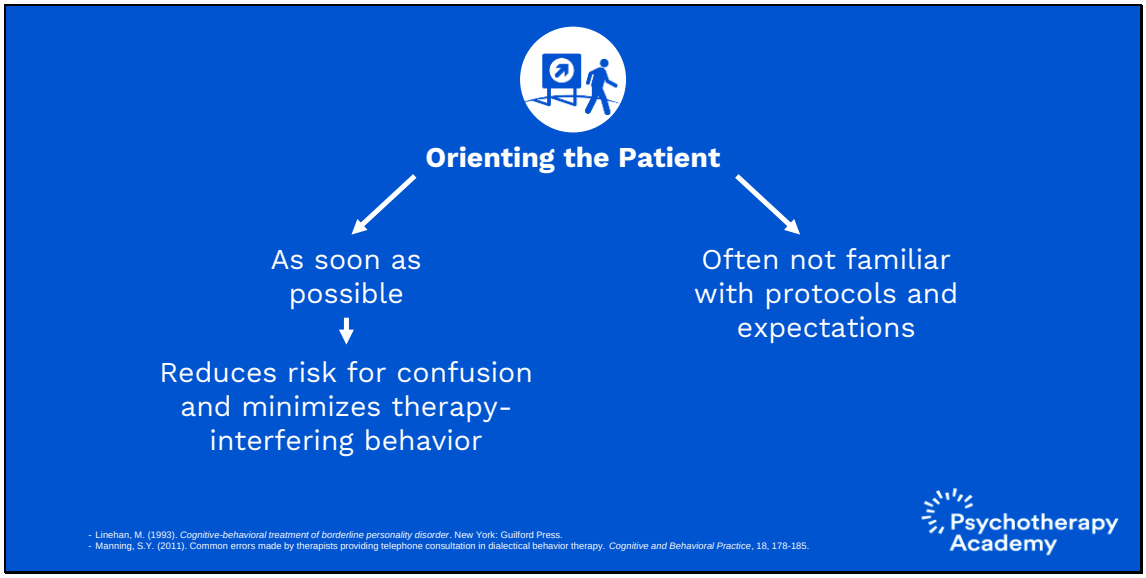
Slide 1

Psychotherapy Academy

Orienting the Patient to Inter-Session Contact

Stephanie Vaughn, PsyD

Slide 2



Orienting the patient to intersession contact. As DBT is the only psychotherapy model which formally incorporates the use of intersession contact, patients are often not familiar with the corresponding protocols and expectations. They've not had access to be able to call their therapist before and especially not when they were not in a crisis. So it is important to orient the patient to the use of intersession contact as soon as possible in order to reduce the risk for confusion and to minimize therapy-interfering behavior. Failure to orient a client properly is a common error even for seasoned DBT therapists.

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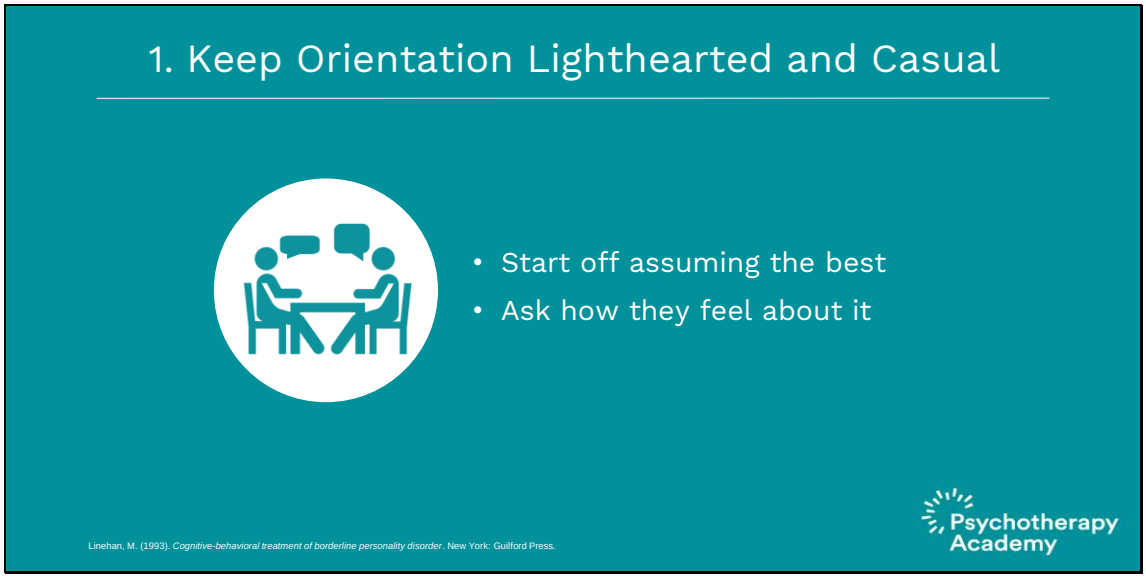

There are a few guidelines for orienting and introducing the patient to intersession contact. You want to first and foremost keep orientation lighthearted and casual. We don't want it coming across as though the patient is automatically going to abuse intersession contact, that they're going to be calling you in the middle of the night and waking you up and overcalling you and being demanding and so forth. We want to start off assuming the best as much as possible. And so our attitude is less legalistic and more conversational.

I like to ask clients how they feel about the fact that intersession contact or calling me or texting me, contact between session is not only permitted but it's encouraged. And oftentimes, the patients will express feeling cautious and that can obviously lead to a very fruitful discussion about what their concerns and fears are. Some express feeling relieved and the exploration of that can be very helpful.

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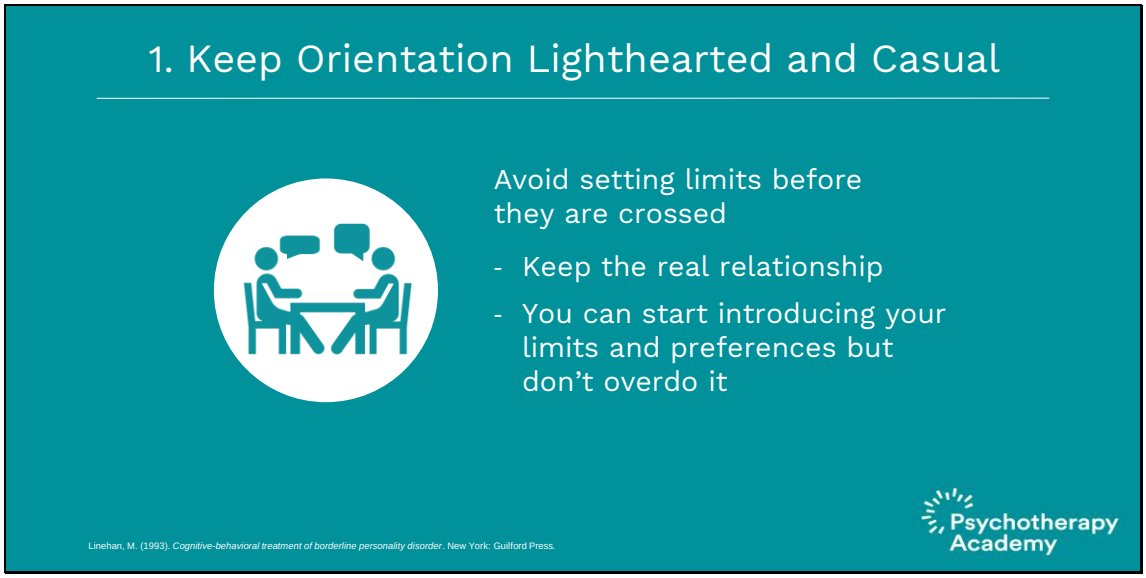

But we want to try to avoid as much as possible setting limits before they're crossed. And you want to think about when you give your phone number or your email address to a colleague or to someone new that you met you don't really lay out exactly the parameters of what you expect from them in terms of contact. You don't give them a list of bullet pointed rules.
Now, this is obviously not a collegial relationship and it's not a friendship and it's not the same thing as those but we definitely want to keep the real relationship. We're going to take that into consideration when we're introducing the parameters of intersession contact. You can start introducing your limits and preferences but don't overdo it. We don't want it to seem too stilted and scare the patient away from using it at all.

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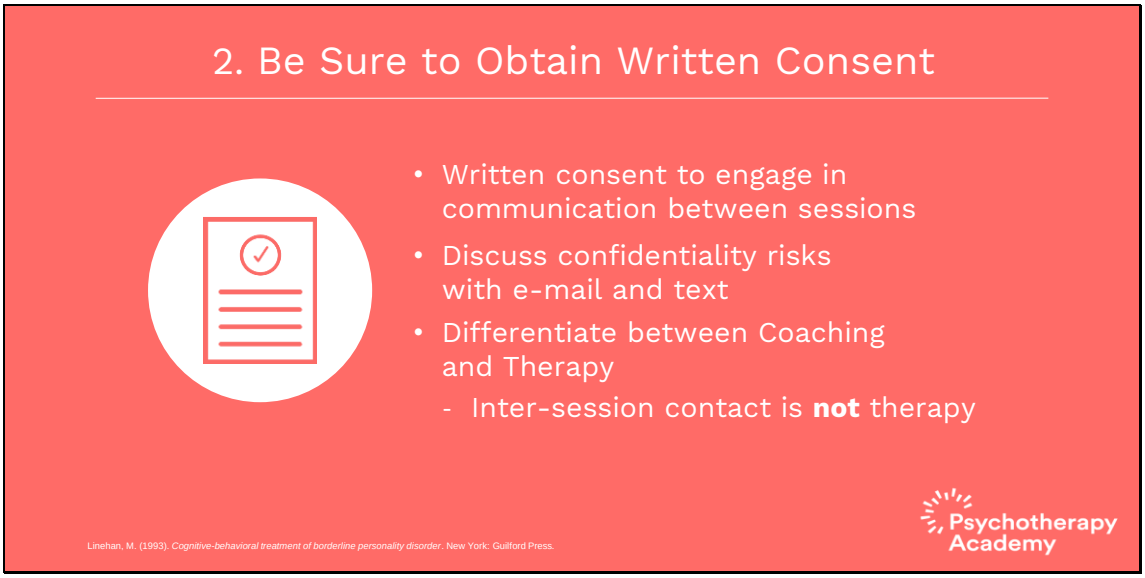

Be sure that you obtain written consent to engage in any intersession contact. That means you want to have signed consent for email, phone, text, any way that you're going to communicate with the patient in between sessions. Of course, you want to make sure that you let them know any limits to confidentiality. And at our practice, we just let patients know that if you are communicating via email, you really are giving up your right to confidentiality because we can't guarantee the security of even the email service providers and all of the regulations that we can purchase. We personally cannot guarantee that they are going to 100% of the time do their job.
And with text, of course, you want to think about the fact that although you can see who has access to your phone and that you may have all kinds of restrictions and passcodes and what not on them, you cannot guarantee that the other end of the line has those kinds of restrictions. And so when you send a text over, you want to be aware that it is possible that other people in the person's life have access to see that if it's sitting right beside them or they may have access to get in to their phone. And so I highly discourage the use of text for any seriously confidential information or any information that is discussing another person. For example, if we're just talking about scheduling or if I'm just recommending a particular skill, I feel like there's no problem with that. But there are risks to text and email communication in the same way.
So we want to have that written consent to engage in all forms of communication between session and we want to have some understanding, for the patient to have some understanding and consent about the difference between coaching versus therapy. So the intersession contact is not therapy. I know that we've said this before but it's important to continually emphasize. Coaching is more about in the moment. It's short term. It's solution focused. It also can be based on radical acceptance of the moment and getting through until the next therapy session and that's a lot of, you know, what we may discuss is okay, well, what can we do to get you to the next therapy session alive? So we're not engaging in therapy over the phone, catching up with what's happened. Say that a patient has missed a therapy session and that they call and say, oh, I'm so sorry and I want to catch you up on what's going on. I need to fill you in. That's not a productive use of intersession contact and may decrease the likelihood that the patient actually even presents for the therapy session. So we want to be sure to differentiate between those two.

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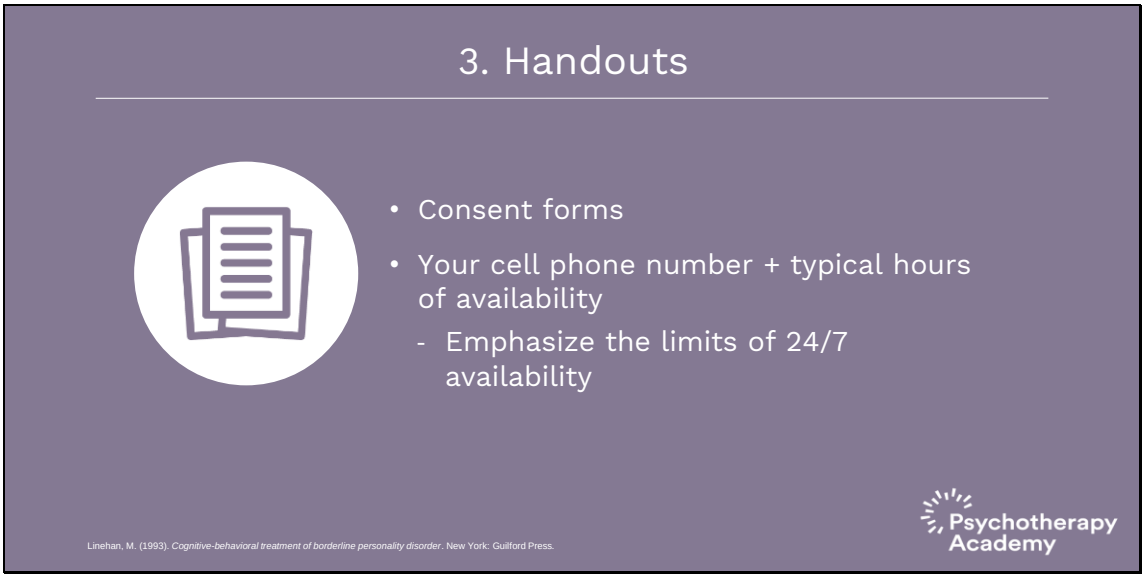

You'll have handouts that you will give based on what types of intersession contact you engage in. You will have your consent forms of course. You'll hand out your cell phone number and you may include your typical hours of availability. Again, we're balancing between setting limits before they're crossed and providing what is a reasonable schedule for the patient to follow. So you want to consider 24-hour contact. Now, 24-hour contact is different than 24-hour availability. So no one of course can be available 24 hours a day. No human being and I'm not sure even any computer could be available 24 hours a day because things happen. So although we may talk about 24/7 contact, we want to make sure to emphasize the limits of 24/7 availability.

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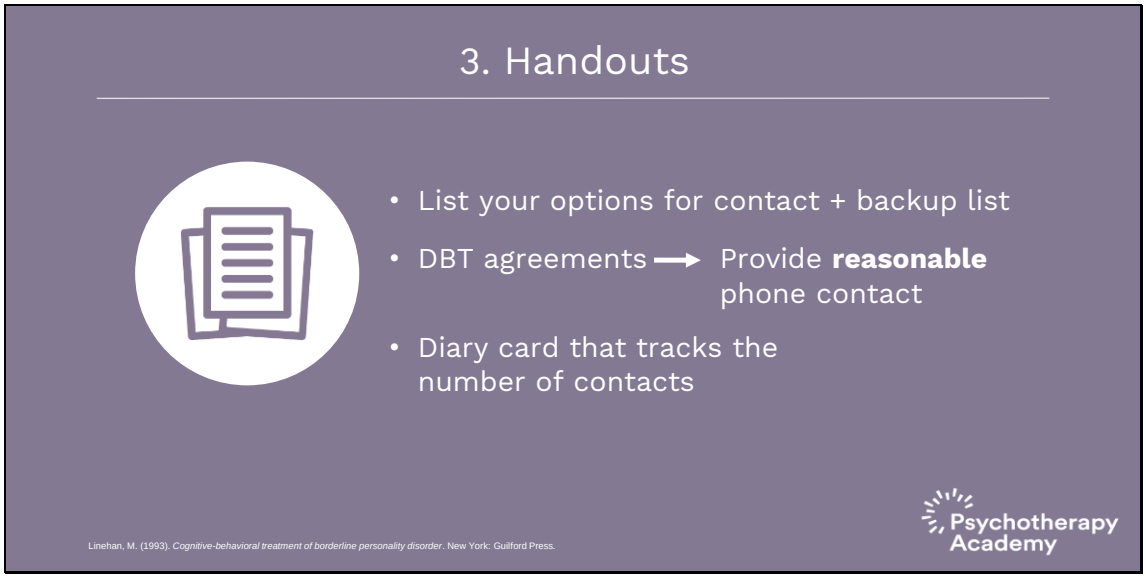

You want to list your options for contact but you also want to have a backup list. And your backup list may be if you're unable to reach me in this amount of time, then please contact my colleague and provide that number or if you are in crisis and can't keep yourself safe, please call 911 or present to your nearest emergency room or call mobile crisis. So you want to have a backup resource that the patient can go to in case that they cannot reach you for whatever reason. And with that, you also hand out and discuss the DBT agreements. So one of the therapist agreements is to provide reasonable phone contact. It's not to be immediately available 24/7. It is to provide reasonable phone contact.
At some point, you will hand out a diary card. There is a section on a Standard Diary Card that tracks the number of contacts that a patient has made with their therapist between sessions. And if you were working on either increasing or decreasing or improving the quality of intersession contact, it's going to be important to touch base on that particular variable during each session.

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Finally, one of the most helpful ways of orienting a patient I think to intersession contact is to actually practice a call or a text in session. And so it can be fun and lighthearted but I will usually role play a call with a patient in session even if it's the very first time that we've met and I'll give them examples of why somebody might call and then we just role play back forth. It's a little bit of exposure helping them to get past that initial anxiety of contacting you. In my opinion, because the role play is causal and I never choose a crisis situation to role play, the patient then gets the idea that they don't have to be in crisis. They don't have to justify their reason for getting in touch with you.

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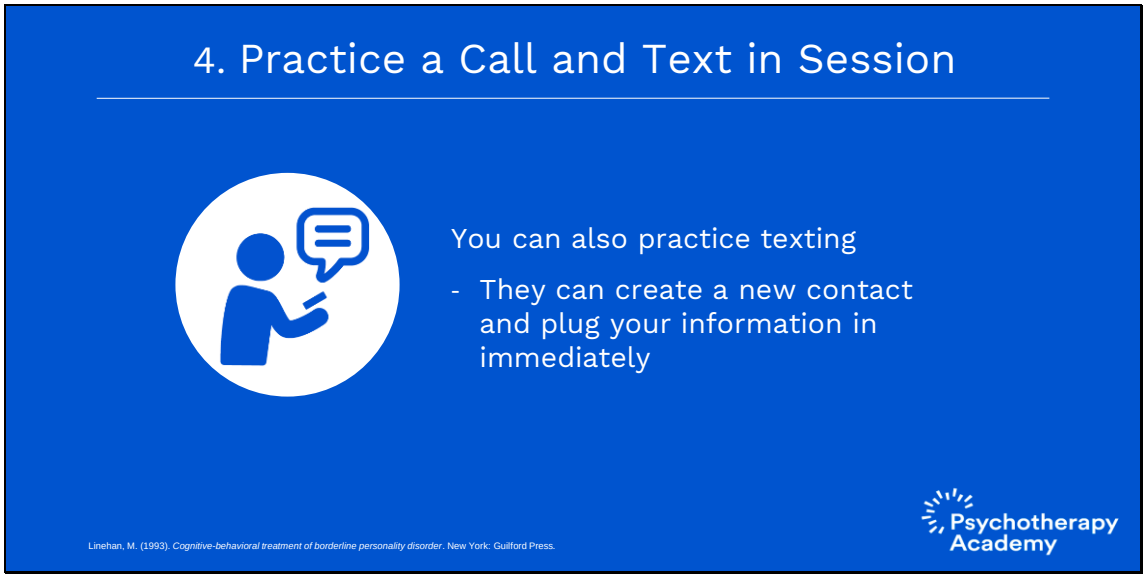

You can also practice a text in session. And rather than writing something down on a piece of paper that they're going to have to plug your number in later, it gives them an immediate entry into their phone. They can create a new contact and plug your information in immediately. And you have their information, they have yours. And more often than not, a client will first text you before they will call you in this day and age. So you will have that immediately available to you.

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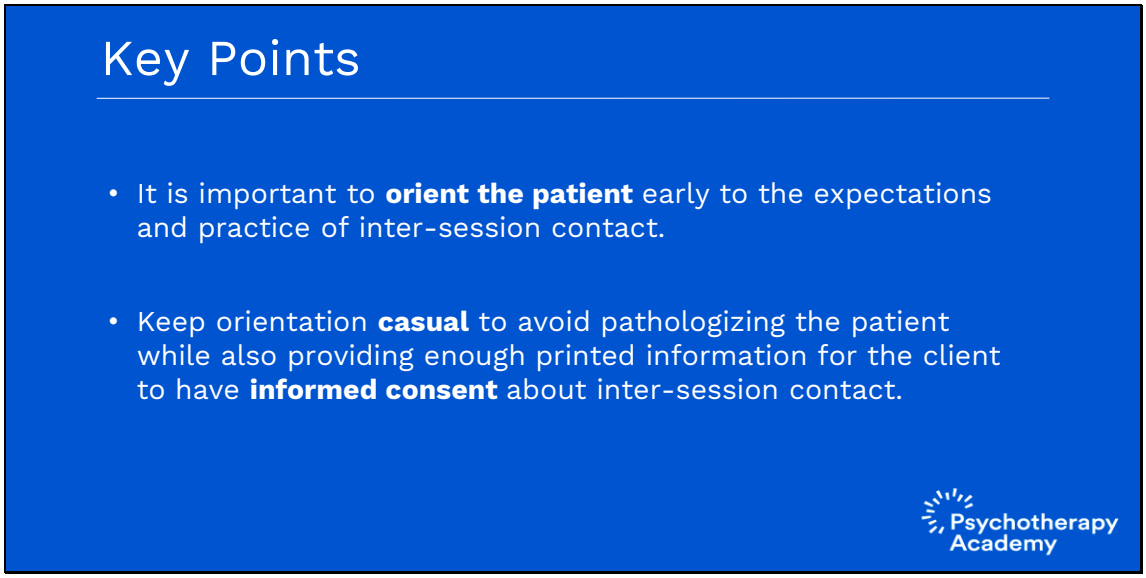

Key points
It is important to orient the patient early to the expectations and practice of intersession contact.
Keep orientation casual to avoid pathologizing the patient while also providing enough printed information for the client to have informed consent about intersession contact.

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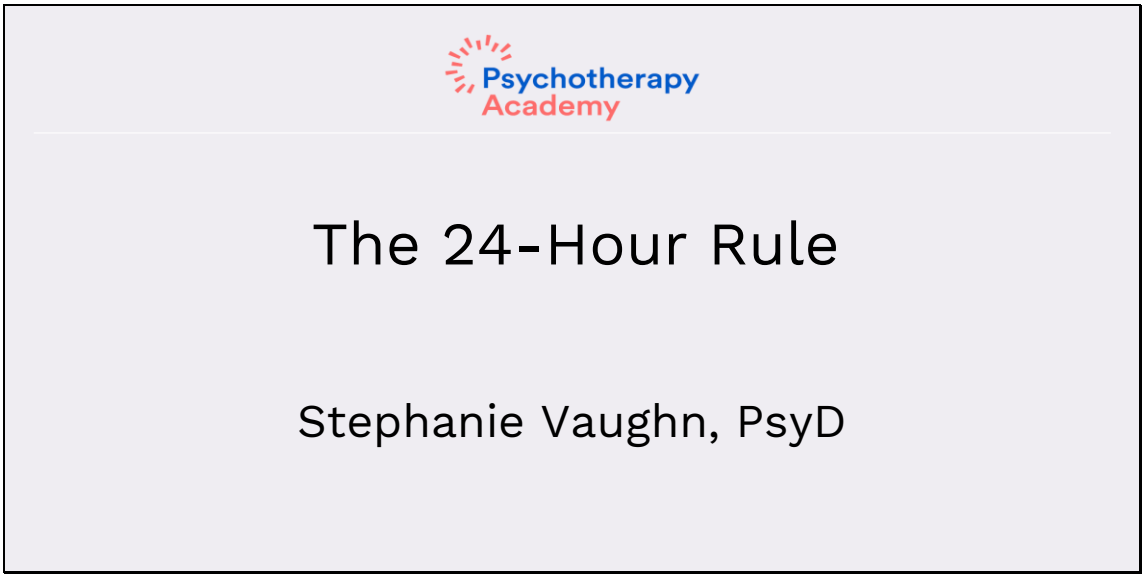
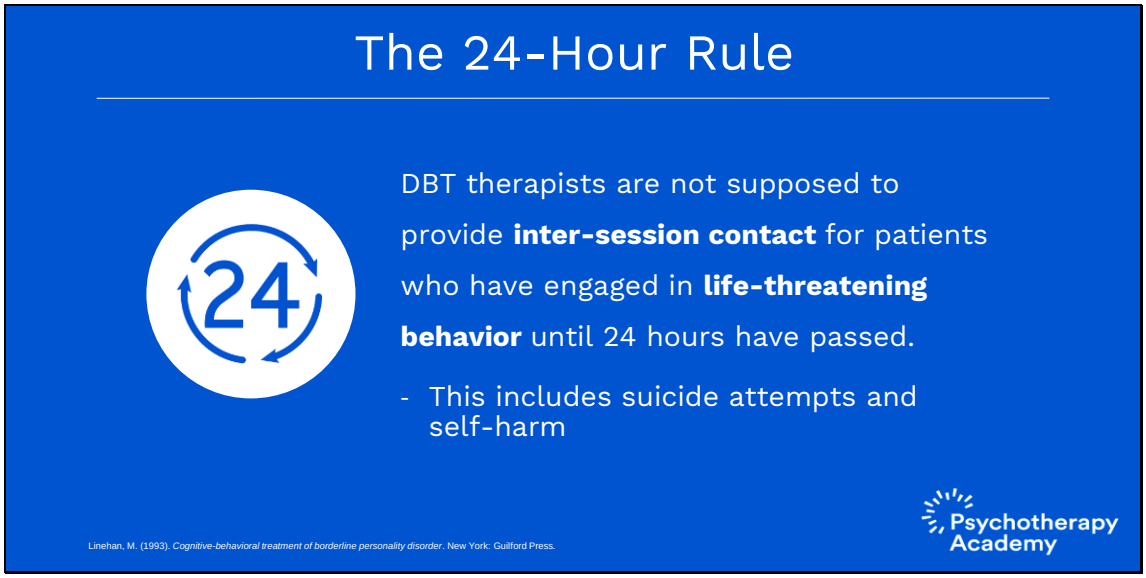
Slide 1



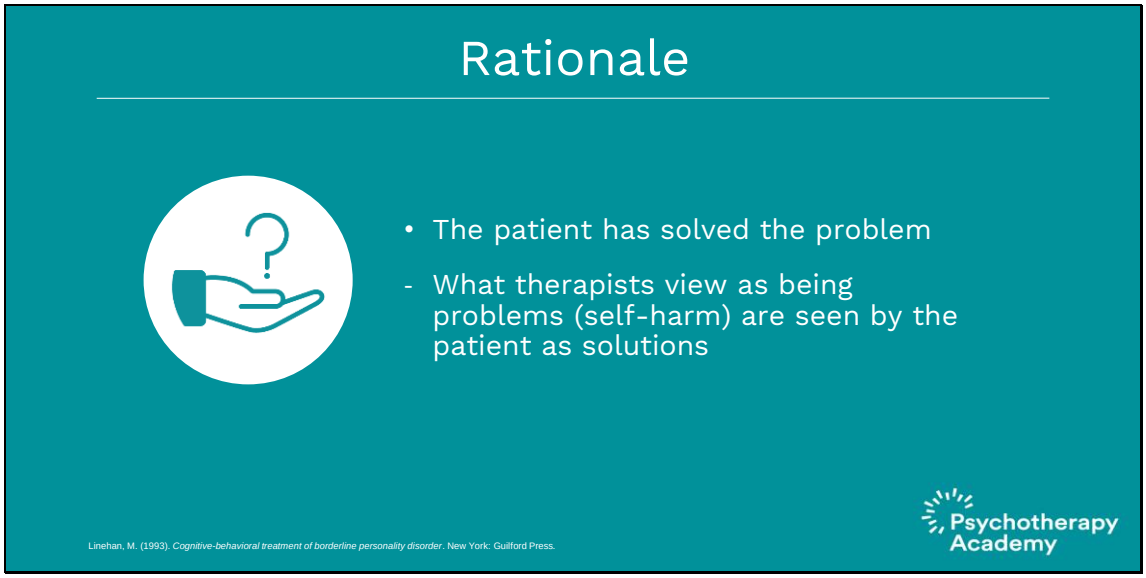
The 24-hour rule.

Slide 2



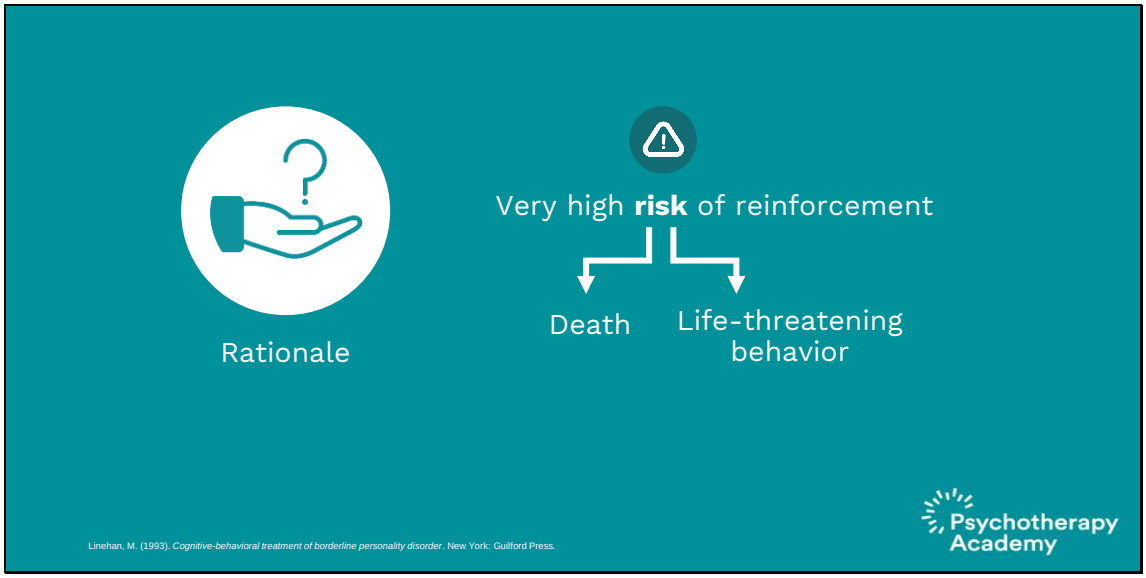
It may come as a surprise that DBT therapists are actually not supposed to provide intersession contact for patients after they have engaged in life-threatening behavior. Therapists are not allowed in DBT to speak with patients or to have contact with them other than regularly scheduled therapy sessions until a full 24 hours have passed since the patient's last life-threatening behavior. That includes suicide attempts and self-harm. This practice is referred to in DBT as the 24-hour rule.

Slide 3



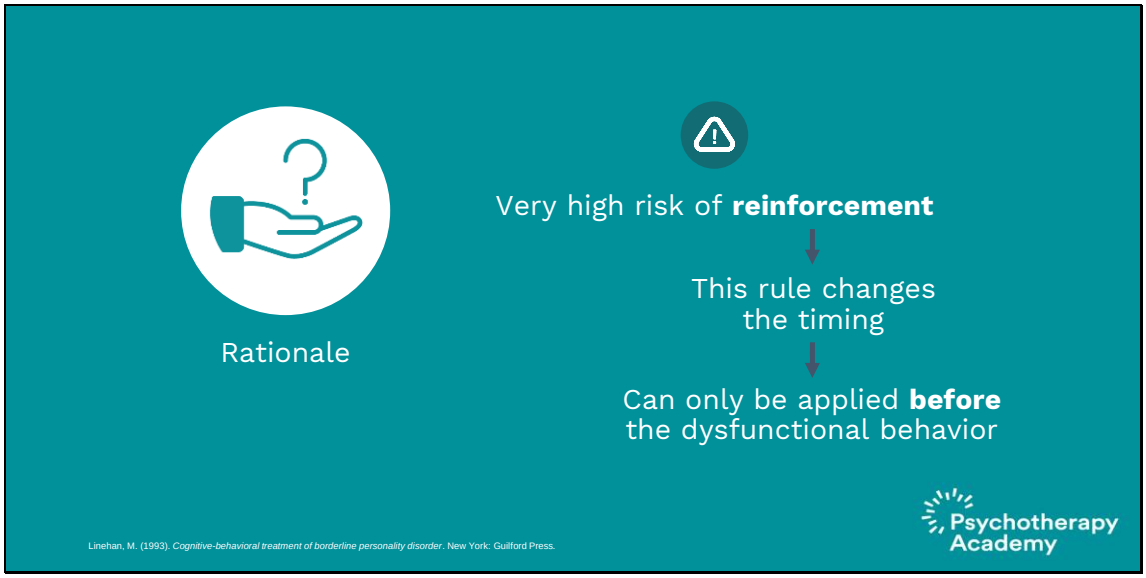
The rationale for the 24-hour rule goes like this. The patient has solved the problem. In DBT, what therapists view as being problems such as self-harm are seen by the patient as solutions. I cut myself and I feel better. DBT provides a set of alternative solutions known as skills that are meant to substitute or to replace the problematic and dysfunctional behaviors that the patient was engaging in previously. So one of the reasons why we do not provide telephone coaching which is a skills-based intervention, why we do not provide telephone coaching after a life-threatening behavior such as self-harm or a suicide attempt is because the patient has solved the problem.

Slide 4



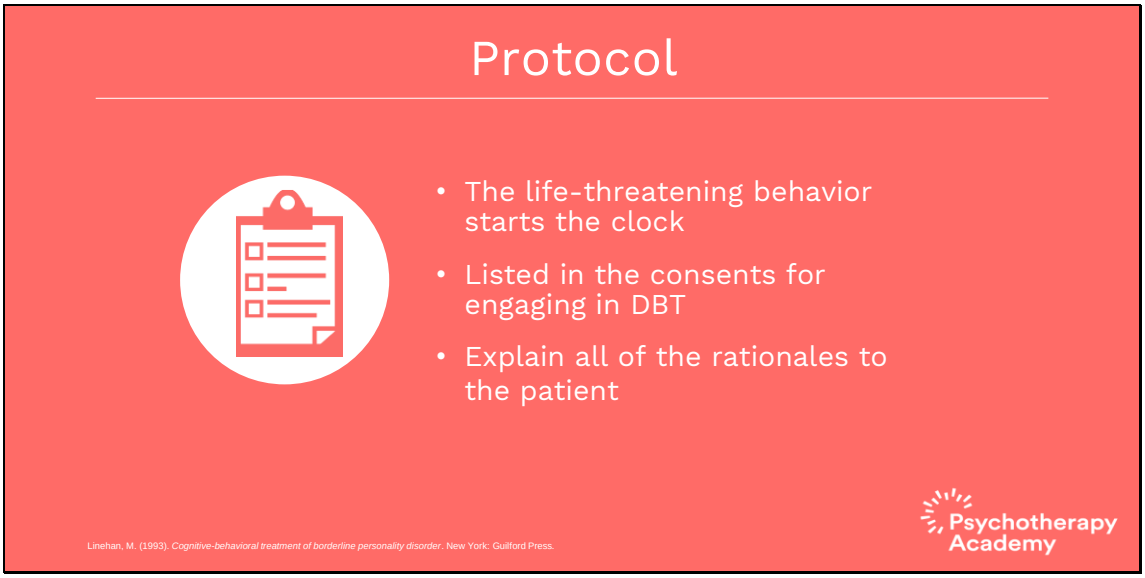
This is not the only rationale.
The other reason is because the risk of reinforcement of a life-threatening behavior is so high if a therapist engages in telephone coaching or reassurance or soothing with a patient immediately following a life-threatening behavior. So although the patient may feel better in the short term, in the long term, there can be a much greater risk of death or continued life-threatening behavior if the therapist does not abide by the 24-hour rule.

Slide 5



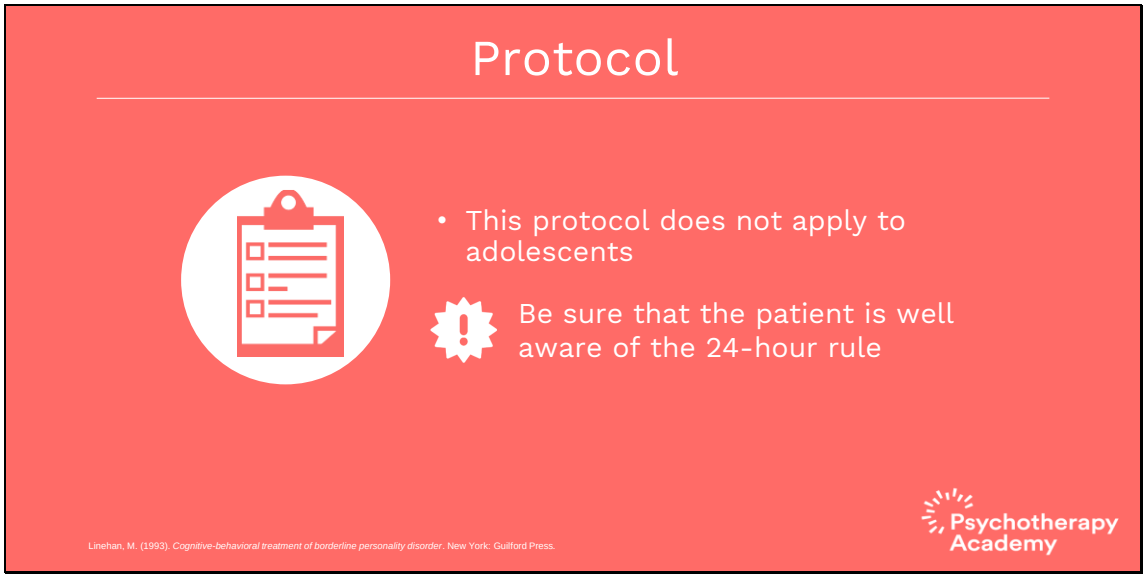
This changes the timing of the reinforcer. Of course, this presumes that the therapist themselves are a reinforcer. And in the case that calls from the therapist are not reinforcing, it is possible to modify this rule. But it changes the timing of the reinforcer such that the reinforcer which is contact with the therapist can only be applied before the dysfunctional behavior. Again, we are trying to get the patient to call earlier in a crisis rather than when the crisis is full blown or after they have implemented their own dysfunctional solutions to the problem.

Slide 6



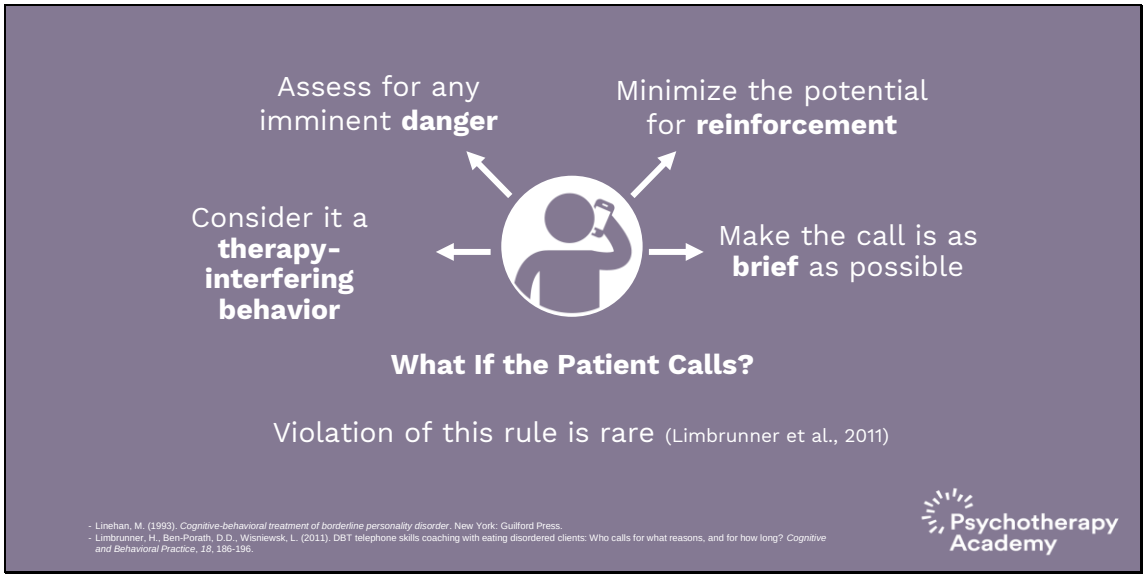
So the protocol is if a patient self-harms or overdoses, for example, that starts the 24-hour clock. Of course, a patient is oriented to the 24-hour rule in the beginning of therapy and this would be listed on your consents for engaging in DBT. We also explain all of the rationales to the patient from the very beginning. And in my experience, the patients really get this. They understand the idea that there's very little that you can say after someone has cut themselves other than, you know, I'm so sorry that you did this and I hate that that happened and we'll get it next time. There's very little benefit that can come from talking with the therapist other than the relief of any shame or guilt that might come as a result. And that shame and guilt can really be at times the only thing that motivates a client to change. So we definitely don't want to take that away from them. And during the orientation for DBT, I have very frequently seen patients resonate with this idea and just totally get it.

Slide 7



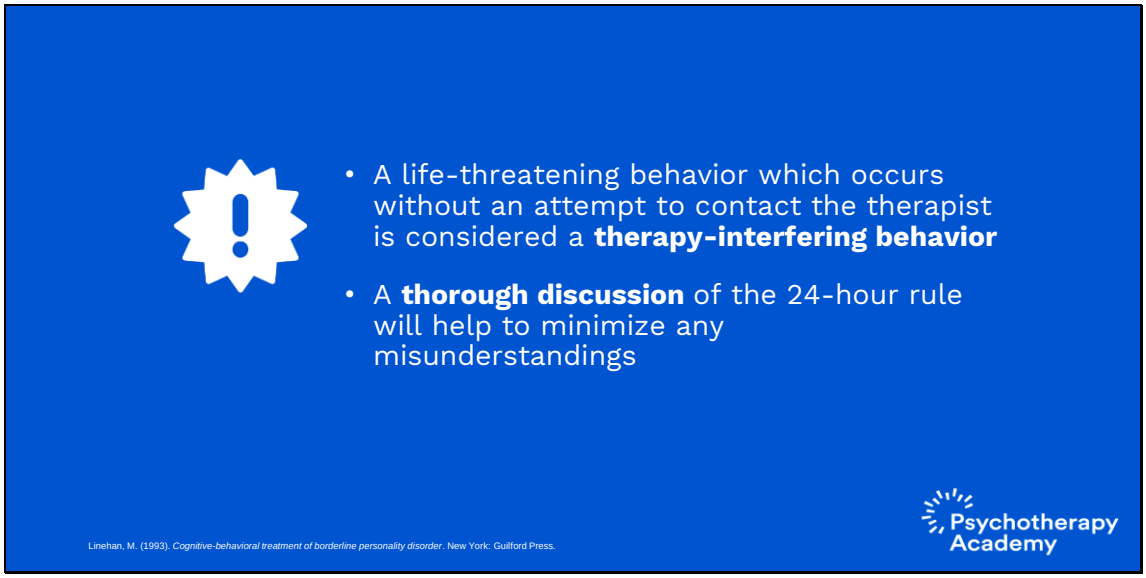
So this protocol of no contact does not apply to adolescent DBT and we'll talk more about doing DBT with adolescents in another discussion. Although we don't abide by the 24-hour rule with adolescents, we still want to keep the idea in mind that contact with the therapist immediately after a life-threatening behavior can be highly reinforcing and can accidentally increase the likelihood that the very behavior you're trying to eliminate is actually increased. So orient, be sure that your patient is well aware of the 24-hour rule.

Slide 8



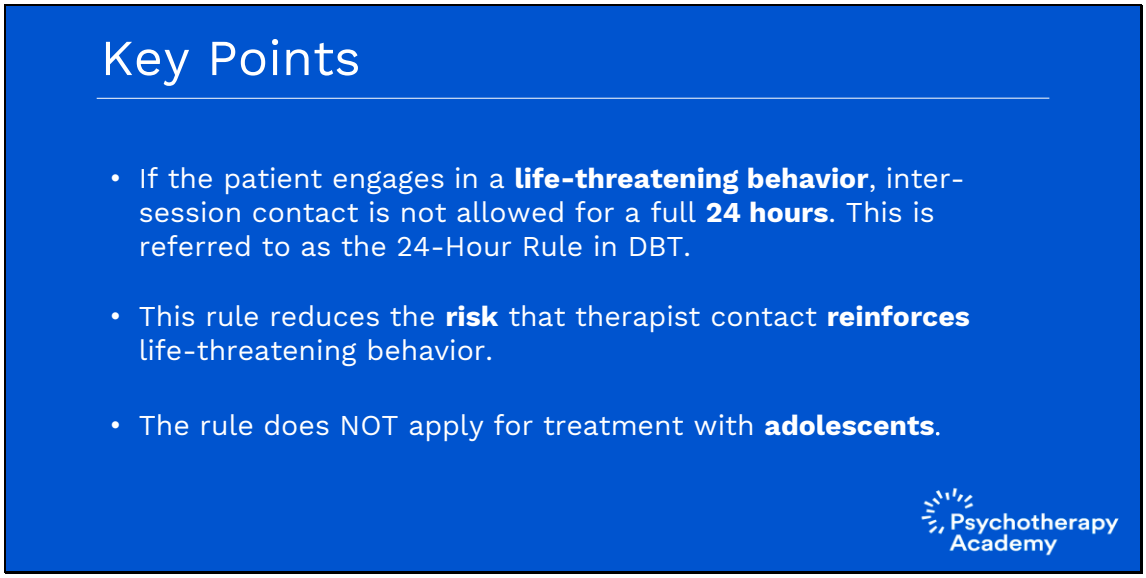
And violation of this rule is actually rare. If the patient does call, you want to make sure that you consider it a therapy-interfering behavior. If they do call, the whole idea is to make sure that the call is as brief as possible, of course that you assess for any imminent danger and you minimize the potential for reinforcement. We'll go into more detail on this also in the Therapy-Interfering Behavior Module.

Slide 9



Self-harm or any other life-threatening behavior which occurs without an attempt to contact the therapist is considered a therapy-interfering behavior. So if you get a diary card that shows that a patient self-harmed and you did not get a phone call or any attempt from them to contact you, then you're going to make sure to assess that on both a life-threatening behavior and a therapy-interfering behavior, from that perspective.
So a thorough discussion of the 24-hour rule will help to minimize any misunderstanding the patient may have in what constitutes the need for a phone call in DBT. Although the 24-hour rule can be extremely difficult to abide by, it is essential and one of the classic DBT rules so to speak which may only be modified with consistent data to suggest that talking to the patient after a life-threatening behavior is not reinforcing.

Slide 10



Key points
If the patient engages in a life-threatening behavior, intersession contact is not allowed for a full 24 hours. This is referred to as the 24-hour rule in DBT.
The 24-hour rule reduces the risk that therapist contact reinforces life-threatening behavior.
The 24-hour rule does not apply for treatment with adolescents.

Slide 11


Next Presentation:
Observing Limits &
Inter-Session Contact
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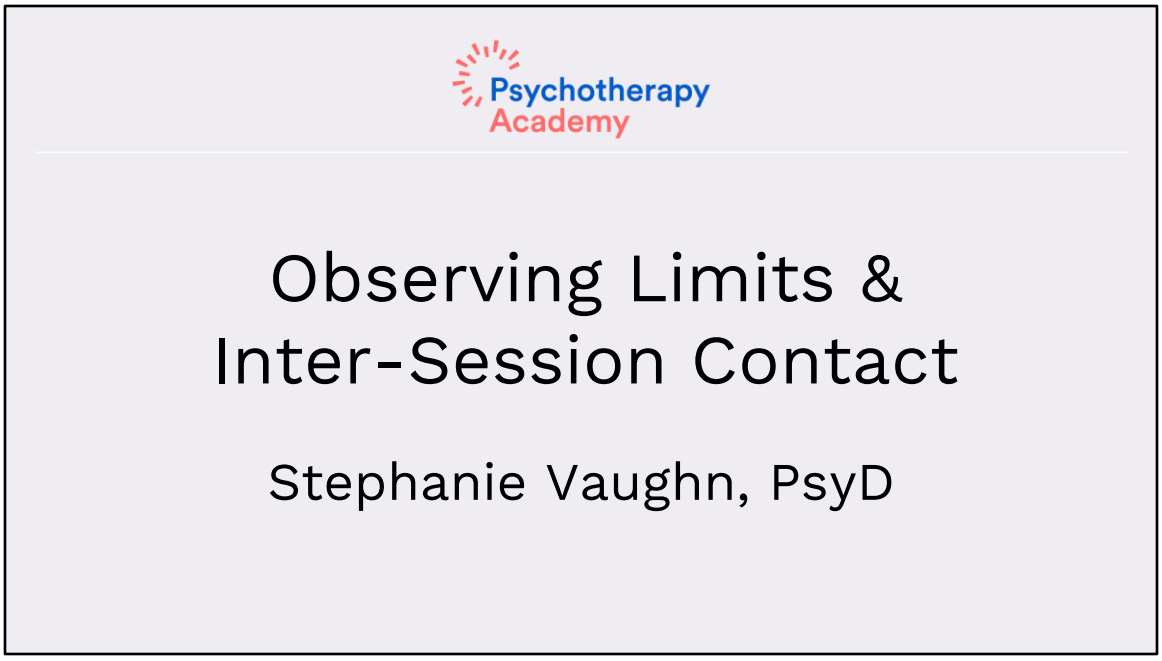

Observing limits in intersession contact.

Observing Limits & Inter-Session Contact

Providing their cell phone number may prevent therapists from offering DBT

There is evidence supporting its utility

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

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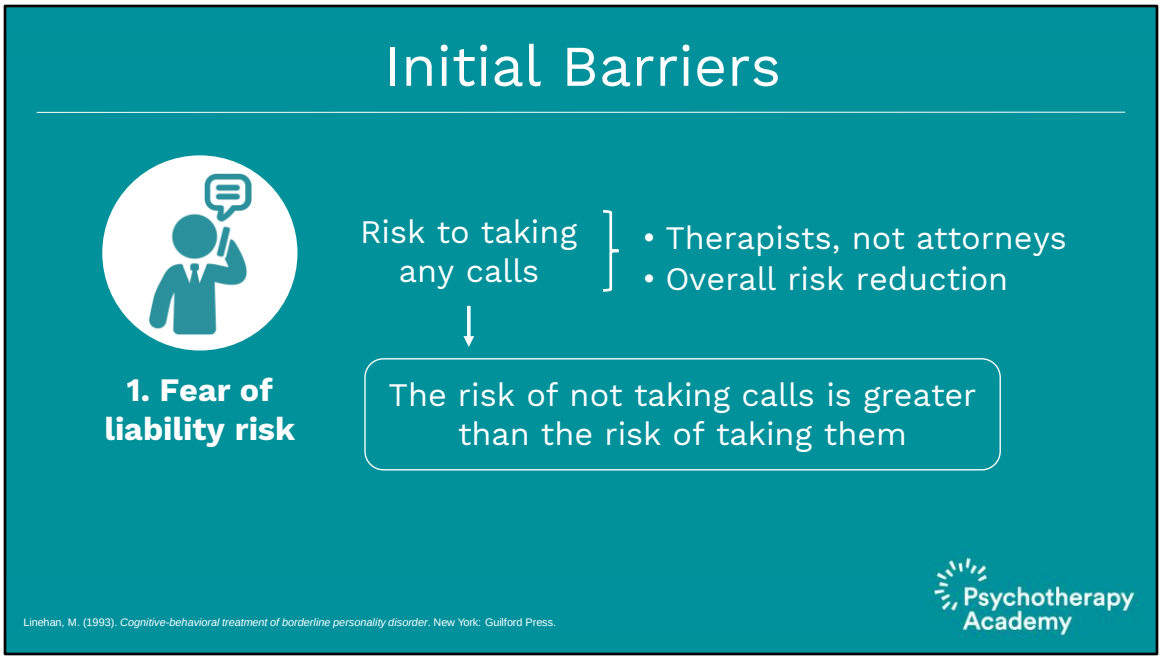
For therapists new to DBT, the concept of providing patients with their personal cell phone numbers and emails may be enough to prevent them from offering DBT at all. This is a shame considering all the evidence supporting DBT's utility for a variety of populations.

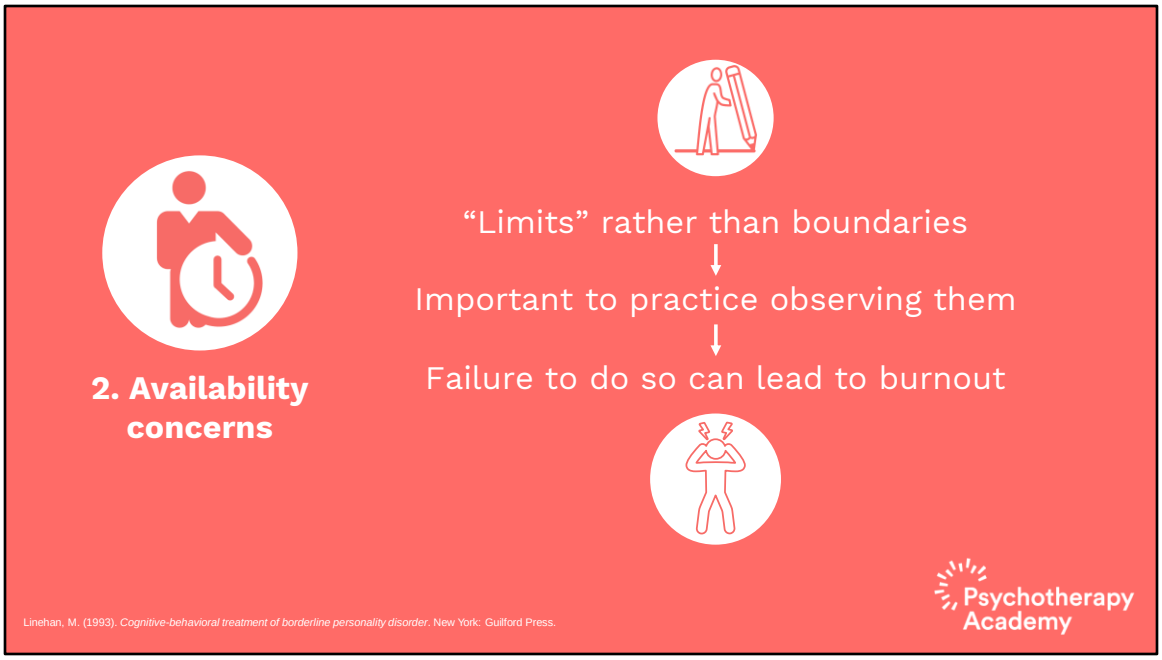


There are a few therapist beliefs I've encountered which get in the way of offering intersession contact. One of those is a fear of liability risk. The thing that I usually ask therapists is whether they take any calls now. And most of the time, they say that yes, they do. So of course, there is a risk to taking any calls. So I want to validate that that's the case. But I also want to emphasize the fact that most of the time therapists are not attorneys. And so for us to speak about things like liability I think is a bit of a stretch. I encourage therapists to consult attorneys for specific questions about telephone coaching but as a rule, DBT requires telephone coaching actually to minimize the risk to the patient. The way that we look at intersession contact is that we're helping reduce the overall risk to the suicidal patient and that the risk of not taking calls is greater than the risk of taking calls.

Some therapists fear that they will miss a call and in missing a call, they're going to increase their liability risk. You will definitely miss calls and you are missing calls now if you are not taking calls. Nowhere does DBT insist that immediate responsive is required. In fact, it is argued by some that immediate responsiveness, consistent immediate responsiveness, always, all the time kind of thing could be detrimental. So it's actually not required to be immediately responsive.

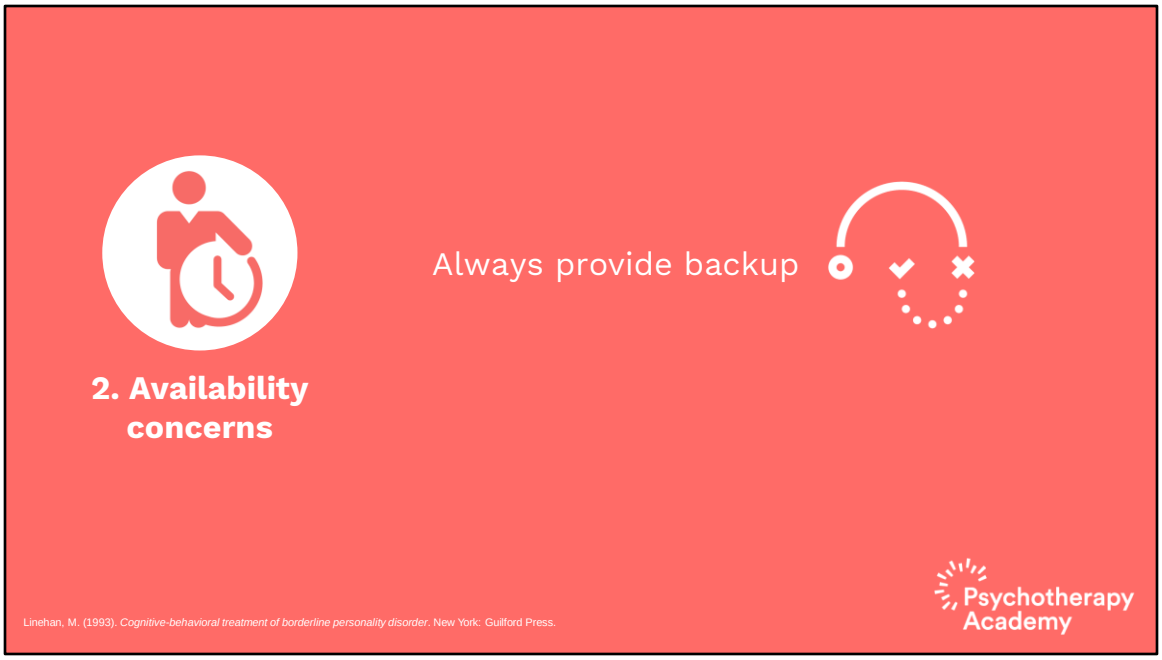
In thinking about the fear of liability risk, I also will challenge therapists with Kohlberg's stages of moral reasoning and how we want to make sure that our motives in doing things are not necessarily simply to avoid punishment and to gain reward. Most of us got into the profession because we have a desire to help people and we feel an obligation to help people. And this is yet another way that we can help people and is vitally necessary for treating people who are at high risk for life-threatening behaviors. So we need to encourage people to go back to the reasons why they're doing what they're doing and that we all have to be able to sleep with ourselves at night. And I can sleep more easily knowing that I've done the best that I can, that I'm providing the best care that I can and the full comprehensive package rather than simply trying to avoid punishment or risk.

Another belief that gets in the way that I've touched a bit on is this availability concern. So some therapists will say that they have a new baby or they're afraid when they get ill or they go on vacation or they're traveling and this 24-hour availability isn't something that they feel like they can provide. It's important to recognize that just because patients have the potential for accessing their therapists 24/7 doesn't mean that they actually will access their therapists 24/7. So the possibility and the reality may not coincide.

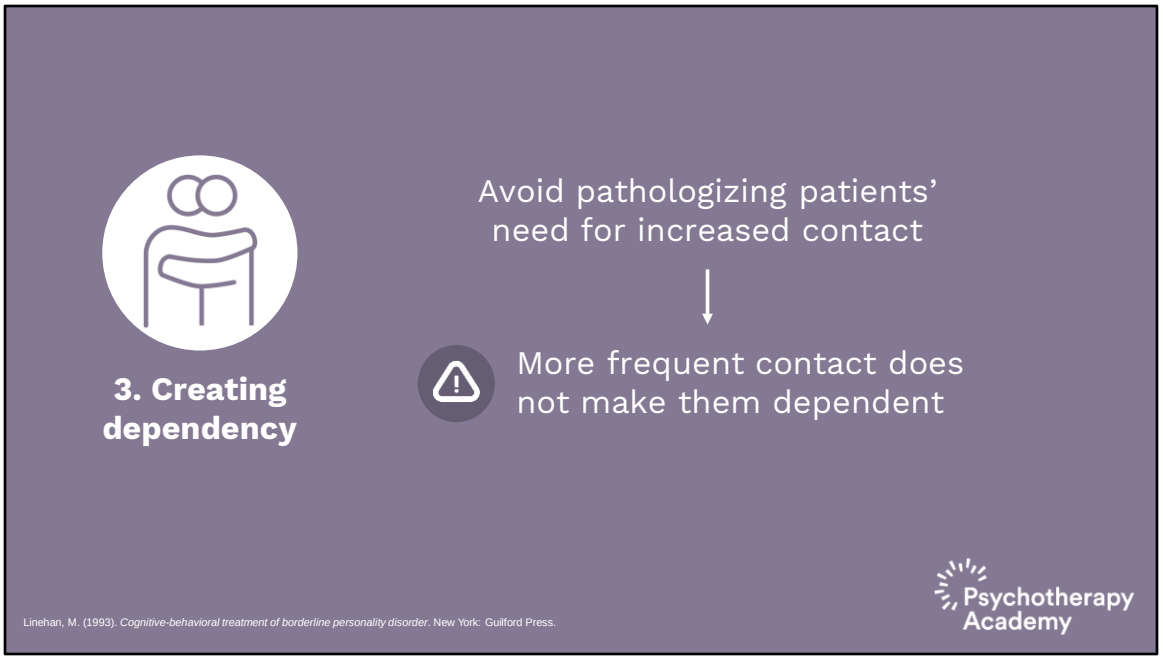


In DBT, the word limits is used rather than boundaries. This can be what some therapists refer to as a boundaries discussion but in DBT, the word is limits. It's important that therapists practice observing their limits when it comes to intersession contact. Observing limits means observing limits as an individual. When you're on vacation, you may want to take phone calls or you may not. Depending on the severity of your illness, you may feel less inclined to take intersession contact. DBT takes this into account. Failure to observe one's limits as a therapist can lead to burnout. We have more discussion on how a therapist can observe limits in the Therapy-Interfering Behaviors Module.

That being said, it is helpful to discuss your expected limitations with the patient early.
So I travel for business purposes more frequently than other therapists in my practice. So I usually discuss this with my new intakes immediately thereby giving them informed consent and opening up their options for securing treatment with another provider if they felt that they needed more availability, more contact.
For our therapists who are either expecting a baby or have a new baby, we have also let patients know and they have let their patients know upfront that they're going to be less willing both emotionally, physically and logistically to be able to provide phone coaching. So that patient has the option of either securing treatment with someone else or arranging some sort of backup which is something that we highly encourage.



You can have a backup system so that each one of your DBT providers rotates and some take calls one week and others take calls another week. You can have a designated backup person. You could make your backup the 911 service or mobile crisis service. Optimally, the backup that you provide will be trained in DBT. But in the case that none of those options are available, it is important that you provide your patients with options for backup in crisis. If you think about it, this is more than they would've had if you didn't provide contact at all. So I don't believe that providing more opportunity takes anything away from the patient.



Another belief that can be a barrier is the therapist's fears of creating dependency in the patient. They're afraid that they're going to make the patient somehow dependent upon their advice or reassurance from them. What we don't want to do is pathologize the patient's need for increased contact. And the differences between therapists in the limits that they observe can be great. Some therapists will take calls late into the evening. Some put a hold on coaching calls after 8 PM, for example. Some therapists are early birds and others are night owls. So we don't want to pathologize the patient's need for increased contact in thinking that more frequent contact makes them dependent.

3. Creating dependency

Keep the contingency management principles in mind

- Don’t be overly warm
- Keep track

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

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At the same time, we want to keep in mind that it is possible that patient may utilize phone coaching at the expense of using skills on their own or to reduce anxiety rather than using exposure protocols to do so or other skills-based measures. So we want to keep the contingency management principles in mind. When providing phone contact, we don’t want to be overly warm. We don’t want to linger on the call. We don’t want to make calls too reinforcing if there is behavior going on on the other end that we don’t want to see more of.
We want to keep track of the frequency and duration of the calls and keep track of whether it’s increasing, decreasing, staying the same.

3. Creating dependency

Are you observing your own limits?

Address any problems early

- Be frank and open
- Use DBT skills
- Take a holiday from telephone coaching

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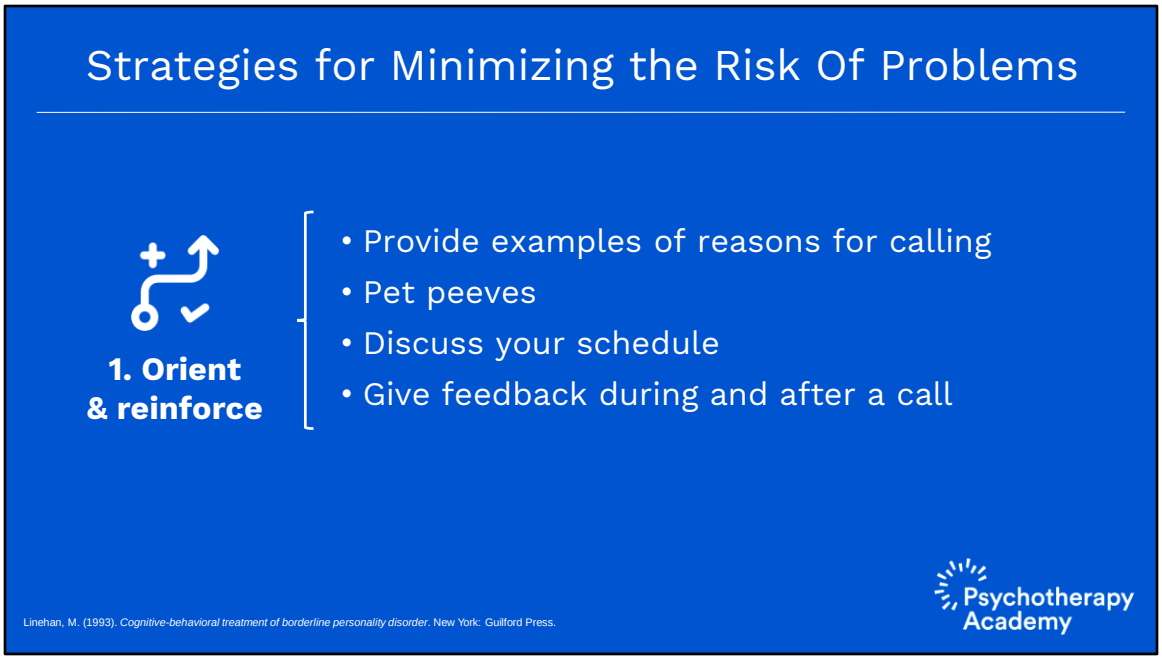
And the therapist needs to consider whether or not they're observing their limits. Sometimes, therapists will blame the patient and say that the patient is becoming dependent when in fact it's actually the therapist who is not observing their own limits.

They're not discussing this with the patient and they're not being frank and open. In my experience, it's important to as early as possible be genuine and disclose when your limits have been crossed or when you're feeling like you're taking more calls than you are comfortable with doing. And the earlier you address it, the less awkward it's going to be. You want to use those same DBT skills that you're teaching your patients. You want to dive right in. You want to use DEAR MAN. You want to reinforce. You want to validate. But you do not want to pathologize the patient.

When all else fails, you can take a holiday from telephone coaching and either give another one of your colleagues the opportunity to provide phone coaching, get a backup or just take a holiday all together for a finite period of time.



To minimize the risk of problems, we go back to that orienting and reinforcement in the beginning of treatment where you can provide examples of reasons for calling. I like to share my pet peeves when it comes to phone coaching and I'll illustrate examples with a role play with the patients. I let them know, for example, that I'm not a fan of what I refer to as the FYI text in which someone will, and this goes for anybody, a patient or a friend, family member, when someone will send me a text about a problem, doesn't ask me a question, doesn't elicit my thoughts about it and just sort of drops something in my lap that I'm not sure how to respond to. So sharing your pet peeves, giving a general idea about your schedule and giving feedback both during and after a call can really help head off the risk of problems.
Discussing those calls in session and how you feel like that they went, giving praise where you felt like that patient used skills and effectively utilized telephone coaching can help keep things moving and prevent problems.

Strategies for Minimizing the Risk Of Problems

2. Encourage them to use skills prior to calling

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You can also encourage patients to use their skills prior to calling. And it has been suggested from some providers to ask patients to use X number of skills before they'll make a call. And in my experience if that's required, if you ask patients to use skills before calling, you're actually increasing the likelihood that those skills wouldn't work, meaning that if the function of the intersession contact is to get in touch with one particular therapist, then they're going to need to create a situation that will make that happen.

Strategies for Minimizing the Risk Of Problems

3. Keep contingency management in mind

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So be sure that you're not setting yourself up for problems with your contingency management. Make sure the patient does not have to do X, Y and Z in order to get in touch with you.

When a Patient Crosses a Limit

- Manage it as a therapy-interfering behavior
  - Behavioral chain analysis + solution analysis
  - Continuous discussion
- Don't assume
- Take a holiday from phone coaching

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If there is a limit that's crossed and say that the patient violates 24-hour rule, violates one of your discussed limits and/or you're just burnt out, you're going to want to manage it as you would any therapy-interfering behavior. You'll want to do a behavioral chain analysis, come up with a solution analysis. You'll want to have continued discussion. This can be one of the most awkward and uncomfortable parts of doing DBT but this really is where excellent therapeutic progress can be made when we're able to have open and transparent discussions with patients about our limits and their use of intersession contact. Don't assume. It's very important that you not assume that a patient is familiar with your limits, knows when your limit is being crossed and otherwise knows better. Be sure that you are being clear in what bothers you and when your limits are crossed. And finally, worst case scenario, a holiday from phone coaching, a defined period of time away from phone coaching could be the answer when all else fails.

Key Points

- It is essential to provide inter-session contact for patients at **risk** for **life-threatening behavior**.
- Inter-session contact is less likely to be an intrusion when they:
  1. Observe their **limits**
  2. Engage in frequent **discussions** with the patient
  3. Conduct a thorough **orientation**
- Problems with inter-session contact are considered **therapy-interfering behaviors** and should be addressed as such.

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Key points
From a DBT perspective, it is essential to provide intersession contact for patients at risk for life-threatening behavior.
Intersession contact is less likely to be an intrusion for the therapist when they observe their limits, engage in frequent discussions about their experience with the patient during intersession contact and conduct a thorough orientation.
Problems with intersession contact are considered therapy-interfering behavior and should be addressed as such.