Prioritizing Suicidal Behaviors in the Treatment of Eating Disorders: Evidence-based Approaches for Assessing, Targeting and Consulting

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Discussant: Leslie Karwoski Anderson, PhD

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Intro to Suicidality in EDs

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EDs and suicidal ideation

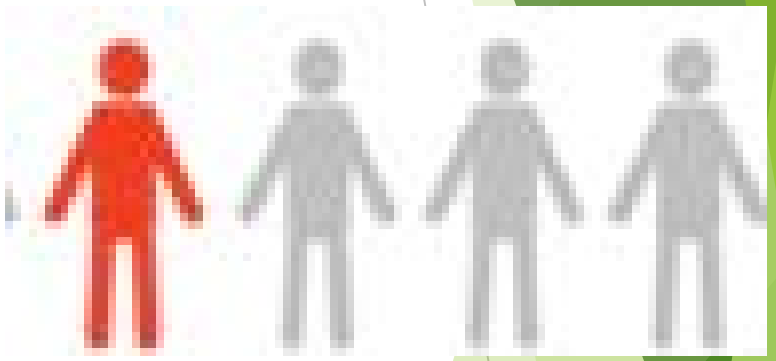
- AN:
  - 24-43% *current* (Milos et al., 2004)
  - 20-34% lifetime (Favaro & Santonastaso, 1997)
- BN
  - 15-23% *current* (Milos et al., 2004)
  - 26-38% lifetime (Favaro & Santonastaso, 1997)
  - OR [4.60-8.15] (Forrest, Zuromski, Dodd, & Smith, 2016)
- BED:
  - 27.5% *current* (Carano et al., 2012)
  - 21% (Favaro & Santonastaso, 1997)

EDs and self-injury (NSSI)

- AN-R
  - 26.1-34.3% (Claes, Vandereycken, & Vertommen, 2001, 2003)
- AN-BP
  - 27.8-51.8% (Claes, et al., 2001, 2003)
- BN:
  - 43.6-55.2% (Claes, et al., 2001, 2003)
- BED:
  - 8% (Favaro & Santonastaso, 1997)

EDs and suicide attempts

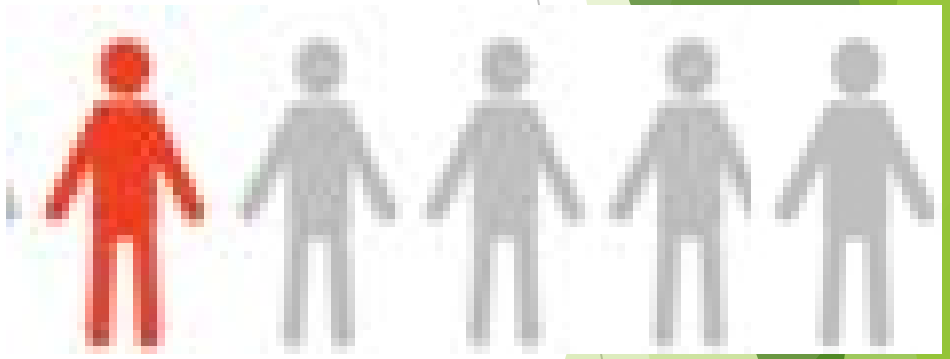
- AN
  - 3-20% (Franko & Keel, 2006)
  - 11-35% (Milos et al., 2004)
- BN:
  - 25-35% (Franko & Keel, 2006)
  - 14-30% (Milos et al., 2004)
  - OR = 8.57 (Forrest et al., 2016)
- BED:
  - 12.5% (Carano et al., 2012)
  - OR [4.64-4.96] (Forrest et al., 2016)



EDs and suicide death

- Anorexia—18x (Keshaviah et al., 2014)
- Bulimia—7.5x (Preti et al., 2011)
- OSFED—4x (Crow et al., 2009)

- Depression, 20x; Bipolar, 15x
  (Harris & Barraclough, 1997)



Arcelus et al., 2011

Risk factors for elevated suicide risk in EDs

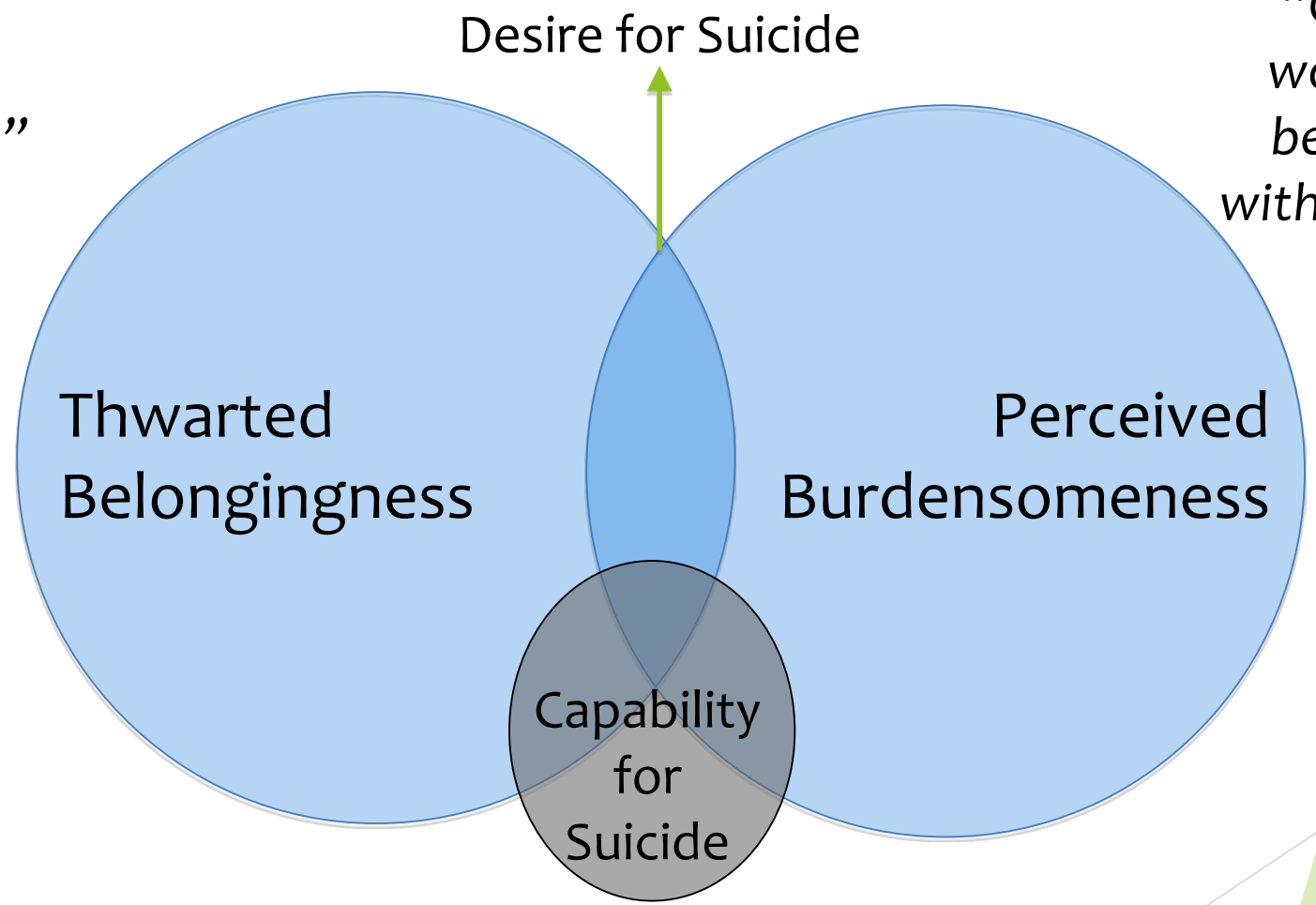
- Comorbid depression and substance in AN (Franko et al., 2004)
- History of substance use in BN (Franko et al., 2004)
- Interoceptive deficits (Dodd et al., in press; Smith, Forrest, Velkoff, in press)
- Cluster B personality symptoms (Milos, et al., 2004)
- Childhood emotional and sexual abuse in BN (C. E. Smith et al., 2015)

Frameworks for understanding ED-suicide link

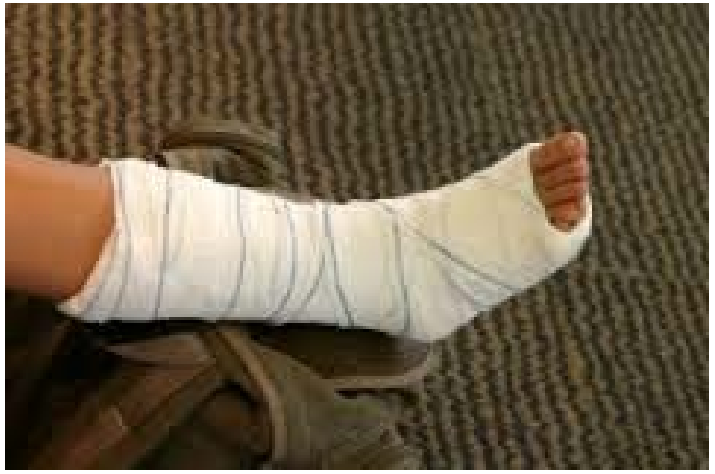
- The Interpersonal Psychological Theory of Suicide (Joiner, 2005; Van Orden et al., 2010)

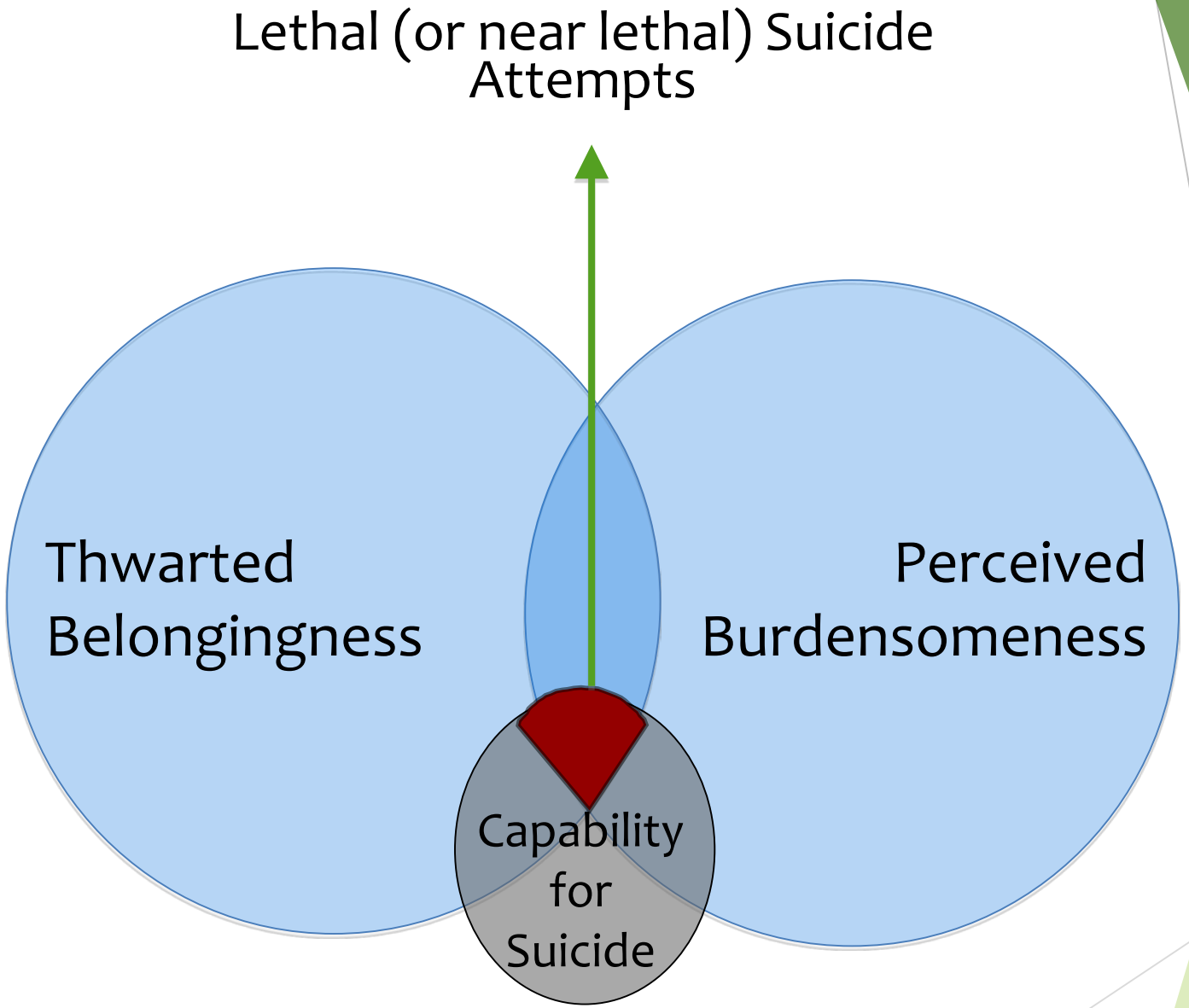
"I don't belong anywhere."

"Others would be better of without me."



Fearlessness + pain tolerance





Fearlessness + pain tolerance

Why such a high suicide rate in eating disorders?

- Acquired capability
  - **Pain caused by disordered eating behaviors**

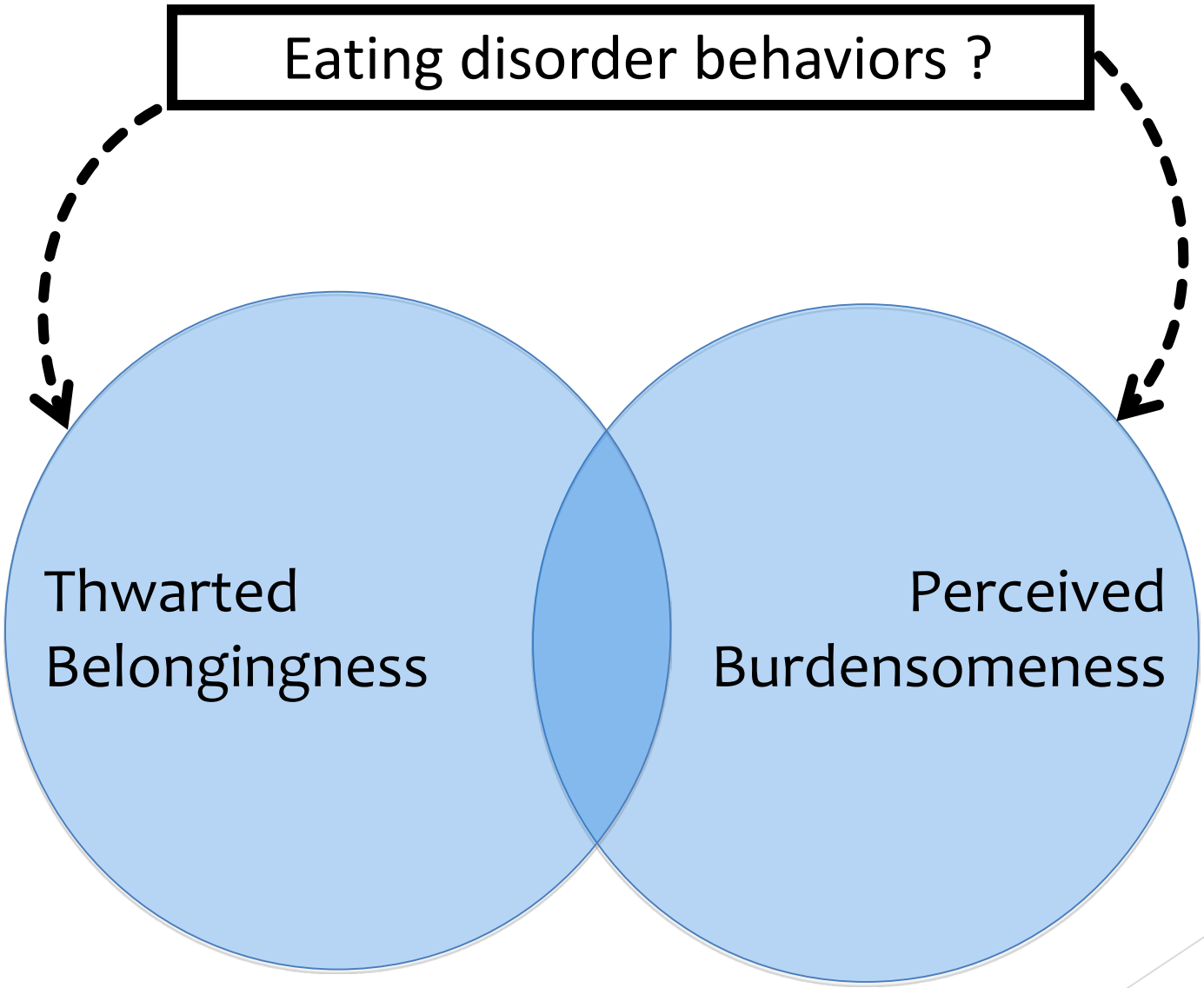
Capability for suicide and EDs

- **Case #7** was described as being socially isolated when she attempted suicide with an unknown quantity and type of pain medication and also opened her wrist arteries. This action led to some degree of unconsciousness, from which she awoke . . . She then threw herself in front of a train, which was the ultimate cause of her death.

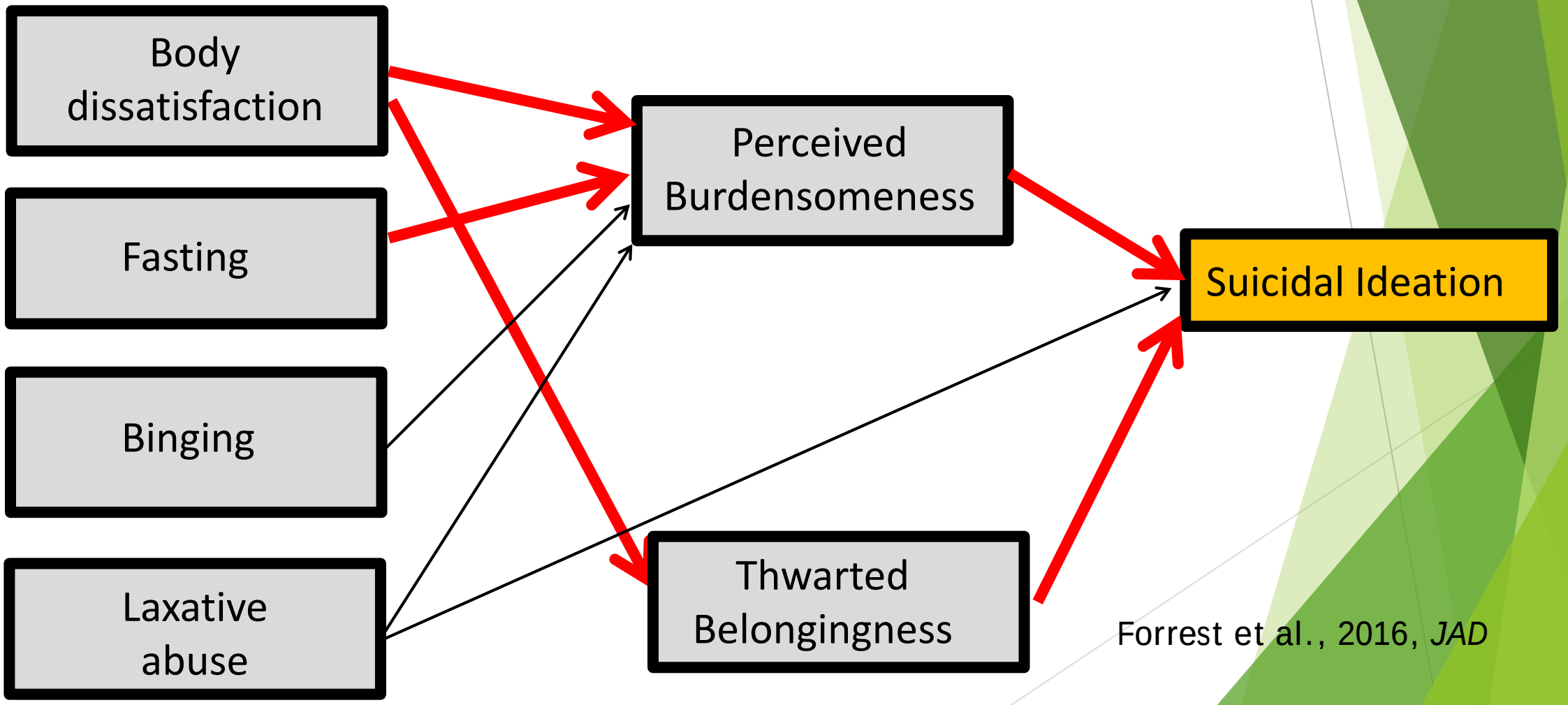
(Holm-Denoma et al., 2008)

Capability for suicide and EDs

- People with EDs have elevated pain tolerance (e.g., Lautenbacher et al., 2013)
- Over-exercise, vomiting, laxative use associated with self-reported capability (Smith et al., 2012; Witte et al., 2015)
- But, fearless about death was not higher in AN vs. other ED groups, and ED groups did not have higher fearlessness about death compared to controls, psychiatric inpatients (Smith et al., 2016)
- Restriction associated with attempts, not capability (Witte et al., 2010)

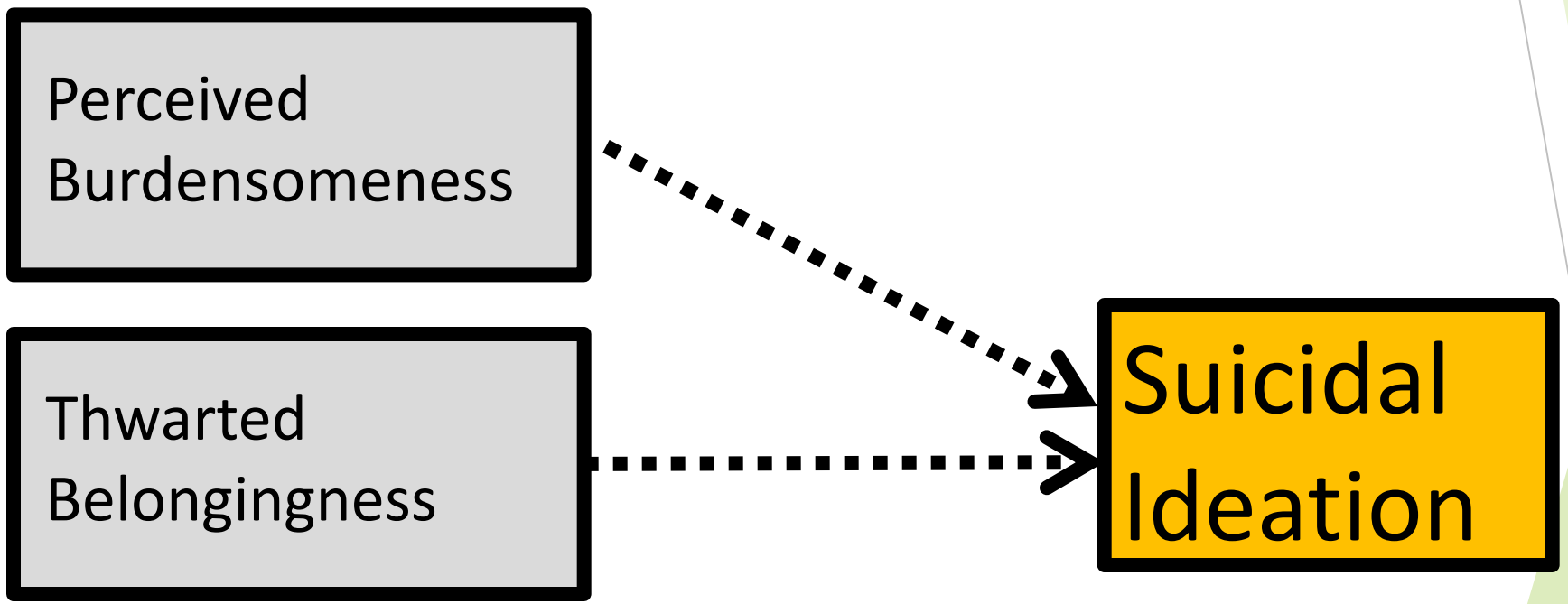

Eating disorder behaviors ?
Thwarted Belongingness
Perceived Burdensomeness

Further tests of the Interpersonal Psychological Theory in ED samples



Forrest et al., 2016, *JAD*

Further tests of the Interpersonal Psychological Theory in ED samples



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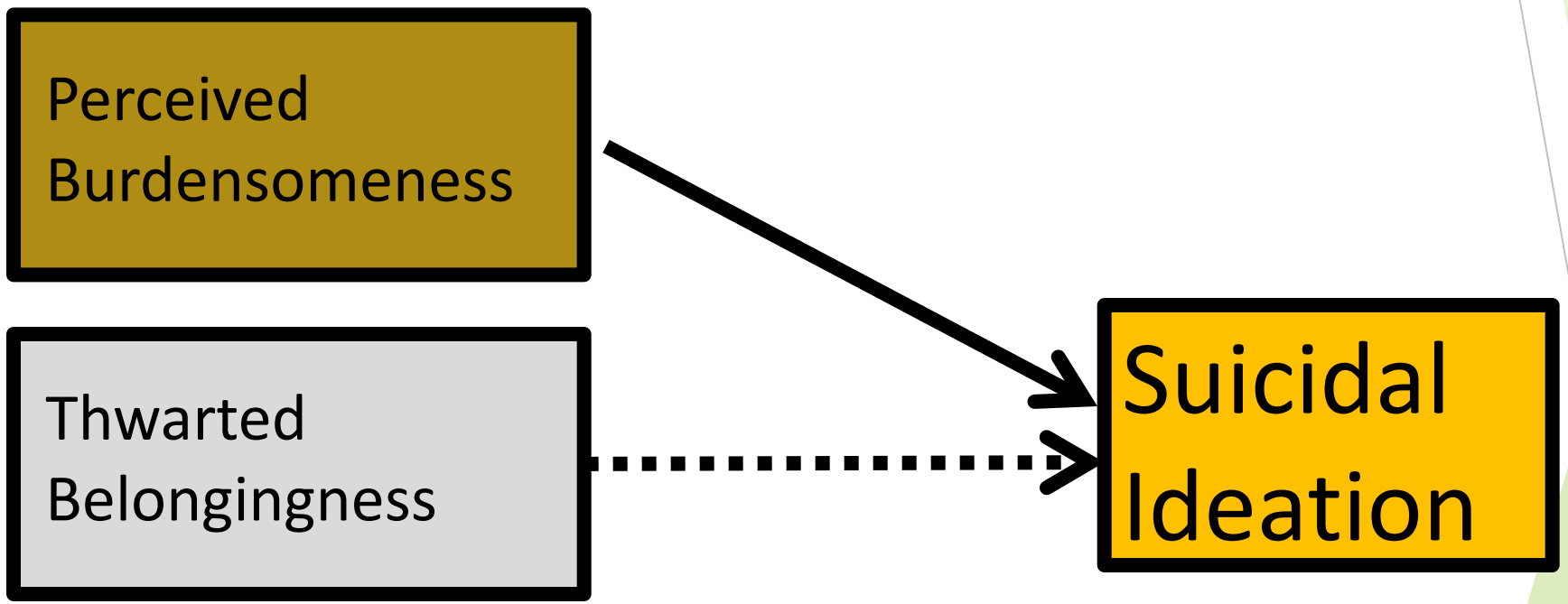
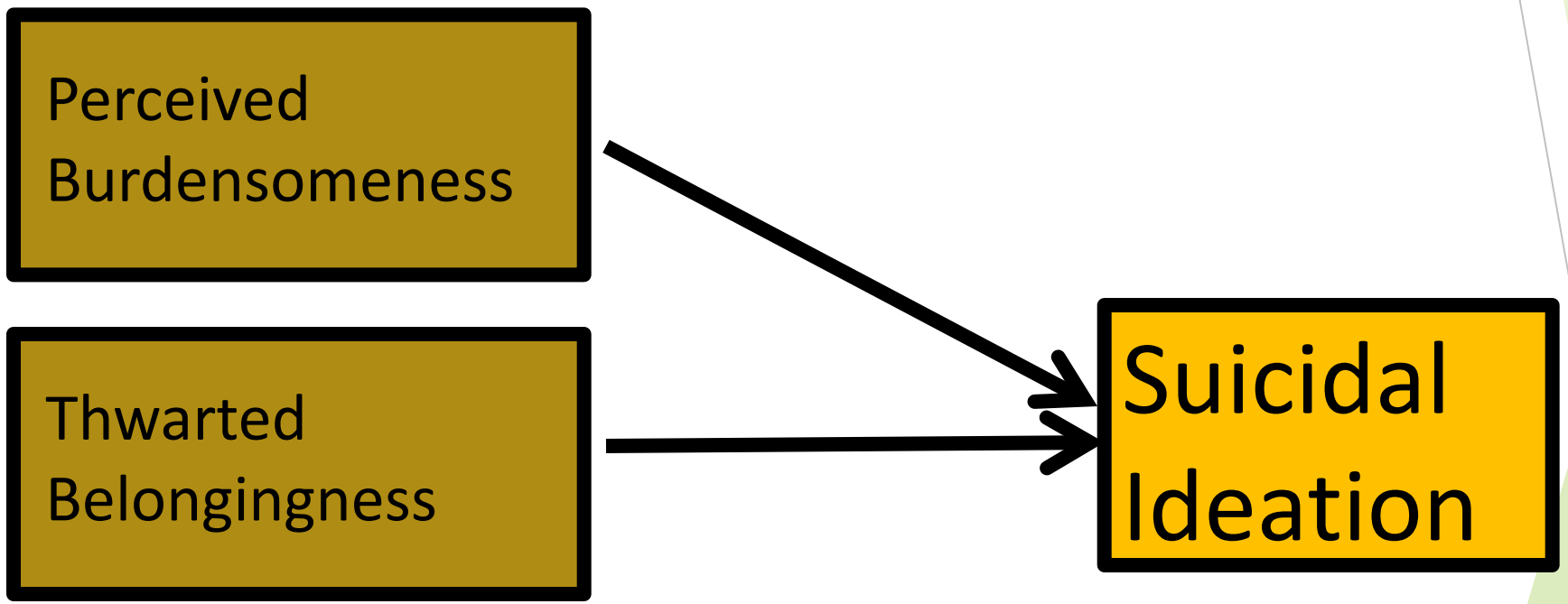


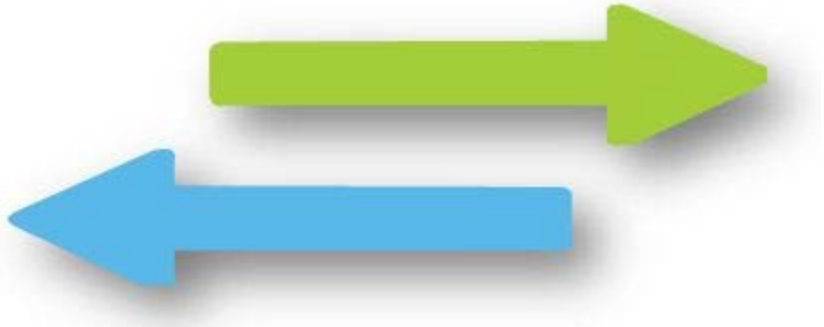
Smith et al., 2016, *IJED*

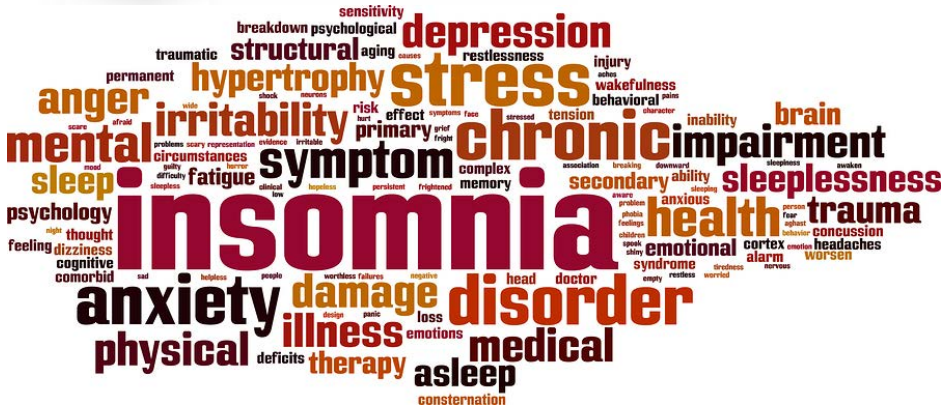
Further tests of the Interpersonal Psychological Theory in ED samples



Pisetsky et al., 2017, *IJED*

Summary, caveats, and future directions





- Cross-sectional
- Directionality?
- Comorbidities

Assessment and Targeting of Suicidal and ED behaviors

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Case Western Reserve University
and Private Practice

Don’t ask don’t tell

“If you don’t ask the question: they wont tell you”

But also remember that much communication is indirect (behavioral vs. verbal)

Best practice: *ask* the suicide question

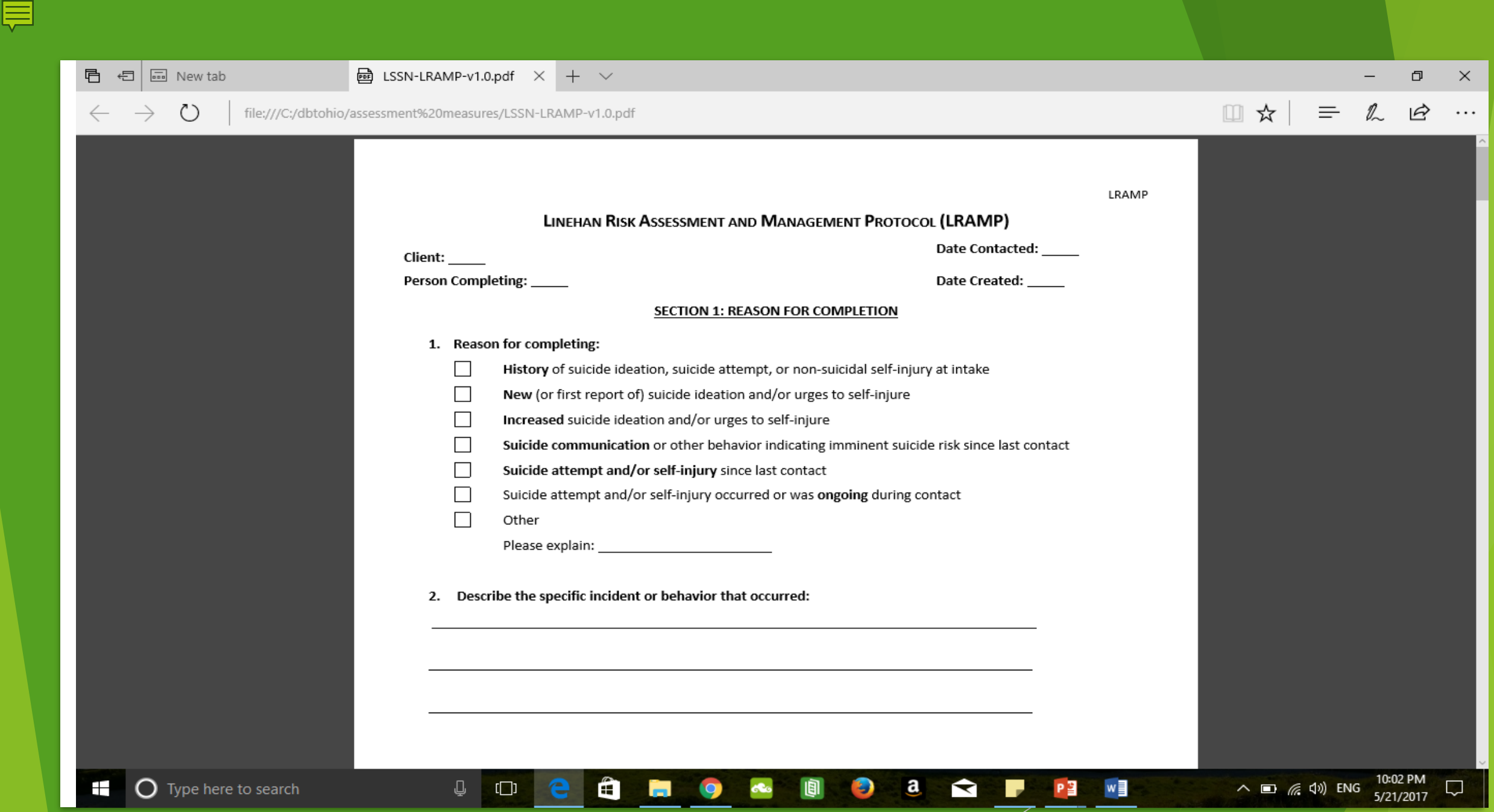
Be	Be direct. Ask them.
Use	Use specific words like “commit suicide,” “kill yourself,” “take your life”
Listen	Listen for hesitation, reluctance to answer
Do	Don’t necessarily accept the first “No” response (put it in context)

Specific questions

- Are you afraid you might do something rash? That you might regret?
- Are you thinking about hurting yourself?
- Are you thinking about killing yourself?
- Should I be worried?

- Do you have a specific plan?

- What do you hope will happen if you die?



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LINEHAN RISK ASSESSMENT AND MANAGEMENT PROTOCOL (LRAMP)

Client: _____ **Date Contacted:** _____

Person Completing: _____ **Date Created:** _____

SECTION 1: REASON FOR COMPLETION

1. **Reason for completing:**
   - ☐ **History** of suicide ideation, suicide attempt, or non-suicidal self-injury at intake
   - ☐ **New** (or first report of) suicide ideation and/or urges to self-injure
   - ☐ **Increased** suicide ideation and/or urges to self-injure
   - ☐ **Suicide communication** or other behavior indicating imminent suicide risk since last contact
   - ☐ **Suicide attempt and/or self-injury** since last contact
   - ☐ Suicide attempt and/or self-injury occurred or was **ongoing** during contact
   - ☐ Other

     Please explain: _____

2. **Describe the specific incident or behavior that occurred:**

_____

_____

_____

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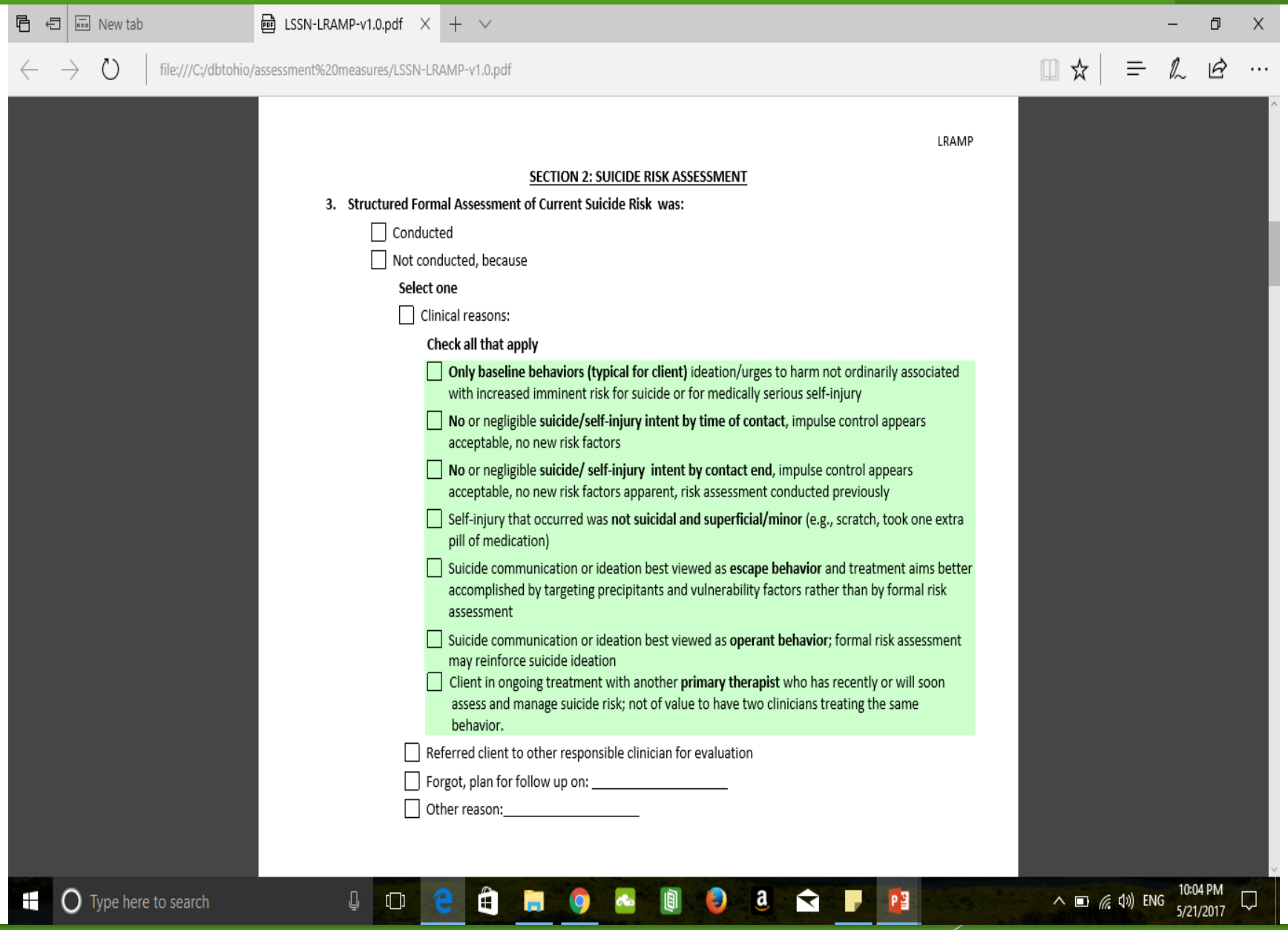
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LRAMP
SECTION 2: SUICIDE RISK ASSESSMENT
3. Structured Formal Assessment of Current Suicide Risk was:
Conducted
Not conducted, because
Select one
Clinical reasons:
Check all that apply
Only baseline behaviors (typical for client) ideation/urges to harm not ordinarily associated with increased imminent risk for suicide or for medically serious self-injury
No or negligible suicide/self-injury intent by time of contact, impulse control appears acceptable, no new risk factors
No or negligible suicide/ self-injury intent by contact end, impulse control appears acceptable, no new risk factors apparent, risk assessment conducted previously
Self-injury that occurred was not suicidal and superficial/minor (e.g., scratch, took one extra pill of medication)
Suicide communication or ideation best viewed as escape behavior and treatment aims better accomplished by targeting precipitants and vulnerability factors rather than by formal risk assessment
Suicide communication or ideation best viewed as operant behavior; formal risk assessment may reinforce suicide ideation
Client in ongoing treatment with another primary therapist who has recently or will soon assess and manage suicide risk; not of value to have two clinicians treating the same behavior.
Referred client to other responsible clinician for evaluation
Forgot, plan for follow up on: _____
Other reason:_____
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4. Select Acute Suicide Risk Factors

ACUTE RISK FACTORS	Not Reported/ Not Observed	No	Somewhat	Yes	Comment
Current suicide intent, including client belief that he/she is going to commit suicide or hurt self	☐	☐	☐	☐	
Current suicide plan, rehearsals and/or preparation	☐	☐	☐	☐	
Preferred method currently or easily available	☐	☐	☐	☐	
Access to lethal means	☐	☐	☐	☐	
Perceived burdensomeness to others	☐	☐	☐	☐	
Current severe hopelessness or pessimism	☐	☐	☐	☐	
Diminished concentration and impaired decision-making	☐	☐	☐	☐	
Alcohol intoxication (currently or likely to be)	☐	☐	☐	☐	
Severe loss of interest or pleasure (anhedonia)	☐	☐	☐	☐	
Recent discharge from psychiatric hospital	☐	☐	☐	☐	
Currently or will be isolated or alone	☐	☐	☐	☐	
Recent stressful life events (e.g. recent interpersonal losses, disciplinary and legal crises)	☐	☐	☐	☐	
Recent diagnosis of a mental disorder	☐	☐	☐	☐	
Recent diagnosis of chronic and/or life threatening physical illness (e.g., cancer,	☐	☐	☐	☐	

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5. **Suicide protective factors**

PROTECTIVE FACTORS	Not Reported/ Not Observed	No	Somewhat	Yes	Comment
Hope for the future	☐	☐	☐	☐	
Confidence in ability to solve or cope with problems	☐	☐	☐	☐	
Attachment to life	☐	☐	☐	☐	
Responsibility to children, family, or others, including pets, who client would not abandon	☐	☐	☐	☐	
Social support or connectedness	☐	☐	☐	☐	
Attached to therapist, counselor, or other service provider	☐	☐	☐	☐	
Fear of suicide, death and dying	☐	☐	☐	☐	
Fear of social disapproval of suicide	☐	☐	☐	☐	
Belief that suicide is immoral	☐	☐	☐	☐	
Frequently attends religious services	☐	☐	☐	☐	
Client motivated to over-report risk	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

SECTION 3: SUICIDE RISK MANAGEMENT

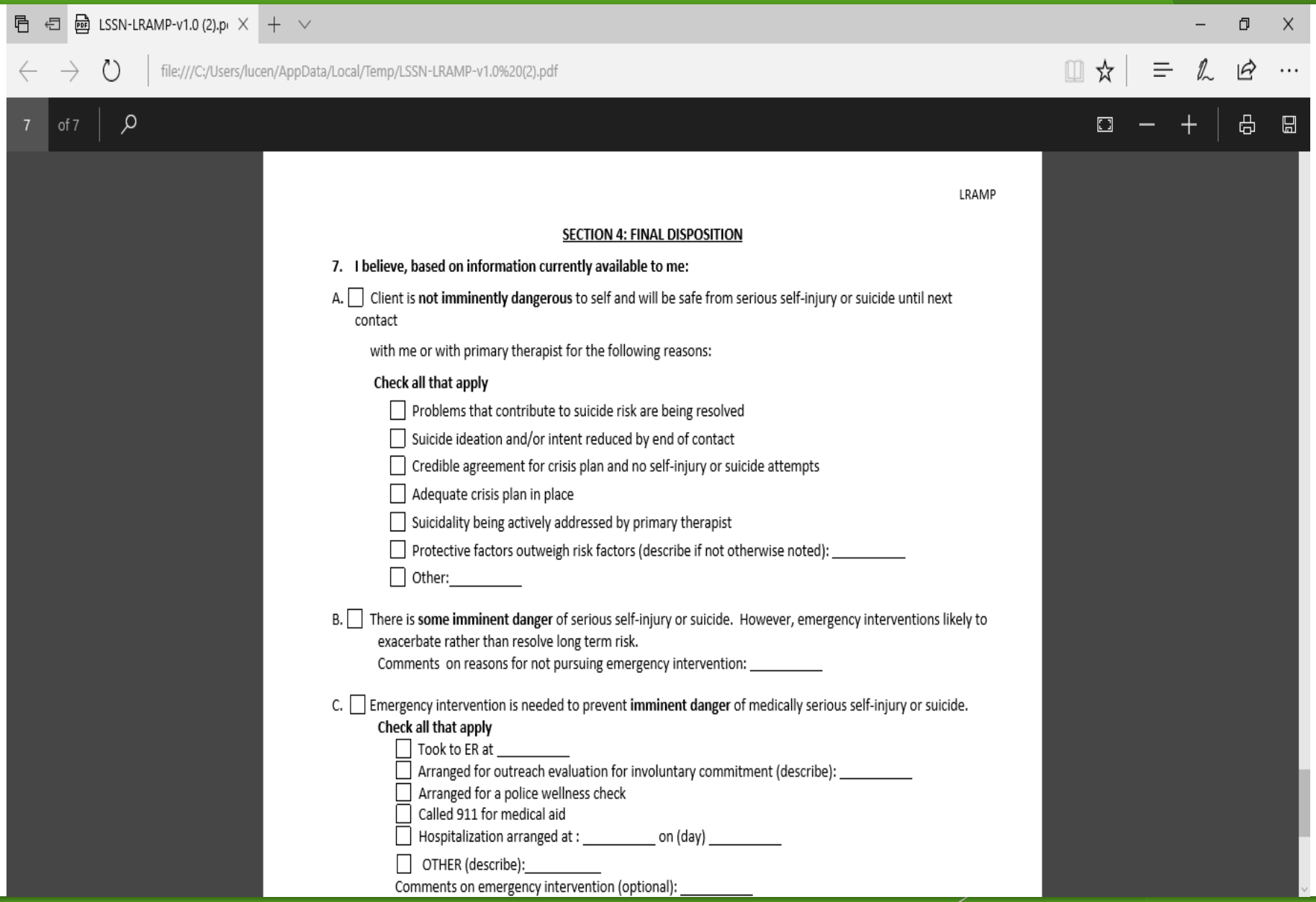
6. Treatment actions aimed at suicidal/self-injurious behaviors: (Check All that apply)

A. ☐ Suicidal ideation and behavior **not explicitly targeted** in session (Check reasons)
- ☐ Client is **not imminently dangerous**
- ☐ Same reasons as for not conducting structured formal suicide risk assessment
- ☐ Risk assessment was sufficiently therapeutic.
- ☐ Other: _____

B. ☐ Did **behavioral analysis** of previous suicidal ideation and behaviors.

C. ☐ Analyzed **chain of events** leading to and consequences of current suicidal/self-injurious ideation and behaviors
- ☐ Vulnerability Factors _____
- ☐ Prompting Events _____
- ☐ Behavior
  - ☐ Suicide Attempt
  - ☐ Non-suicidal self-injury
  - ☐ Increased suicide ideation and/or urges to self-injure
  - ☐ Suicide threat
  - ☐ Other (specify) _____
- ☐ Consequences _____
- ☐ Comments (Optional) _____

D. ☐ Focused on **crisis intervention** and/or **problem solving** (Check all used):
- ☐ **Validated** current emotions and wish to escape or die (emotional support)
- ☐ **Identified** events that have set off current crisis response _____
- ☐ **Formulated** and summarized problem situation with client _____
- ☐ Worked to remove, remediate **prompting events** _____
- ☐ Gave advice and **offered solutions** to reduce suicidality _____
- ☐ Challenged **maladaptive beliefs** related to suicide/self-injury _____
- ☐ Coached to **use skills** client is learning in therapy _____
- ☐ Clarified and **reinforced** adaptive client responses



SECTION 4: FINAL DISPOSITION

7. I believe, based on information currently available to me:

A. ☐ Client is **not imminently dangerous** to self and will be safe from serious self-injury or suicide until next contact

with me or with primary therapist for the following reasons:

Check all that apply

- ☐ Problems that contribute to suicide risk are being resolved
- ☐ Suicide ideation and/or intent reduced by end of contact
- ☐ Credible agreement for crisis plan and no self-injury or suicide attempts
- ☐ Adequate crisis plan in place
- ☐ Suicidality being actively addressed by primary therapist
- ☐ Protective factors outweigh risk factors (describe if not otherwise noted): _____
- ☐ Other:_____

B. ☐ There is **some imminent danger** of serious self-injury or suicide. However, emergency interventions likely to exacerbate rather than resolve long term risk.
Comments on reasons for not pursuing emergency intervention: _____

C. ☐ Emergency intervention is needed to prevent **imminent danger** of medically serious self-injury or suicide.
Check all that apply

- ☐ Took to ER at _____
- ☐ Arranged for outreach evaluation for involuntary commitment (describe): _____
- ☐ Arranged for a police wellness check
- ☐ Called 911 for medical aid
- ☐ Hospitalization arranged at : _____ on (day) _____
- ☐ OTHER (describe):_____

Comments on emergency intervention (optional): _____

Assessment of Ideation

- Active or passive
  - Have you ever felt so bad, you didn't want to be alive? (wished you wouldn't wake up?)
  - Do you want to be dead?
  - Have you thought about killing yourself?
- Chronic vs. acute
  - Have you ever felt like killing yourself in the past?
  - What did you do when you felt like this?
  - Do you always kind of wish you were dead?

Pull out all the stops (while maintaining the relationship)

But when someone has a life-threatening ED *and* chronic suicidality…..

- rt?

Targeting in DBT

- A process - transforms the clients' goals
  into specific behaviors to increase and decrease
  in order to reach those goals
- When the client has a single problem that if solved will meet his goals
  - that problem is **the target**
  - **and you are a lucky therapist!**
- When there are multiple behaviors to increase or decrease
  - there has to be a **mechanism to determine what is treated** as a part of the overall case conceptualization
    - And in each session

Why Target?

- Targeting gives a means to sort behavior when multiple behaviors presented during the week and in session
- Behaviors that are not targeted do not change

How does DBT target behaviors?

- In sessions and conceptually
- Target I: life threatening
- Target II: therapy interfering
- Target III: quality of life interfering

Target 1 behaviors

- Suicidal behaviors
- Non-suicidal self injury
- ED behaviors *when medically unstable*

Imminently Life Threatening Conditions in ED Clients

- Bradycardia
  - Heart rate (e.g., < 40) generally warrants hospitalization (Sachs et al, 2016)
- Prolonged QTc
  - >470 needs daily ECG (Sachs et al, 2016)
  - >500 requires hospitalization

Imminently Life Threatening Conditions in ED Clients

- Electrolyte Abnormalities (Mehler & Walsh, 2016)
  - Hypokalemia (serum potassium <3.6)
  - Hyponatremia (serum sodium <120-125)
  - Metabolic alkalosis (bicarbonate >28)
- Chronic Ipecac Abuse
- Mallory-Weiss Tear
- Diabetic Keto-Acidosis

Strategies from DBT for managing self-harm and suicide risk

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University of California San Diego Eating Disorder Center

Adult Program Manager

Primary DBT Interventions for life-threatening behaviors

1. Assess frequency, intensity, and severity of suicidal behavior (LRAMP)
2. **Conduct a comprehensive chain analysis (Behavioral Analysis)**
3. **Relate current behavior to overall patterns (Diary Card)**
4. Validate the patient's pain
5. **Focus on negative effects of suicidal behavior (Behaviorism)**
6. **Reinforce non-suicidal responses (Contingency Management)**
7. **Discuss solving problem vs. distress tolerance (Skills Coaching)**
8. Obtain commitment to a non-suicidal behavioral plan

Behavioral Chain and Solution Analysis

Behavioral Chain Analysis

- The concept of the functional analysis can be traced to the work of B. F. Skinner (1957), who sought to understand how behavior is maintained through environmental contingencies (e.g., rewards, punishers).

- Identify and break up learned behavioral sequences that precede clients dysfunctional behaviors, identify effective behaviors to replace problem behavior and remove reinforcers for these problem behaviors. Teach others how to remove reinforcers where needed.

- The chain analysis is often taught in visual form, as both therapists and clients alike can generally understand the sequential aspect of the chain when presented this way.

Behavioral definition of the problem behavior:

behavioral excess
(unwanted behavior)

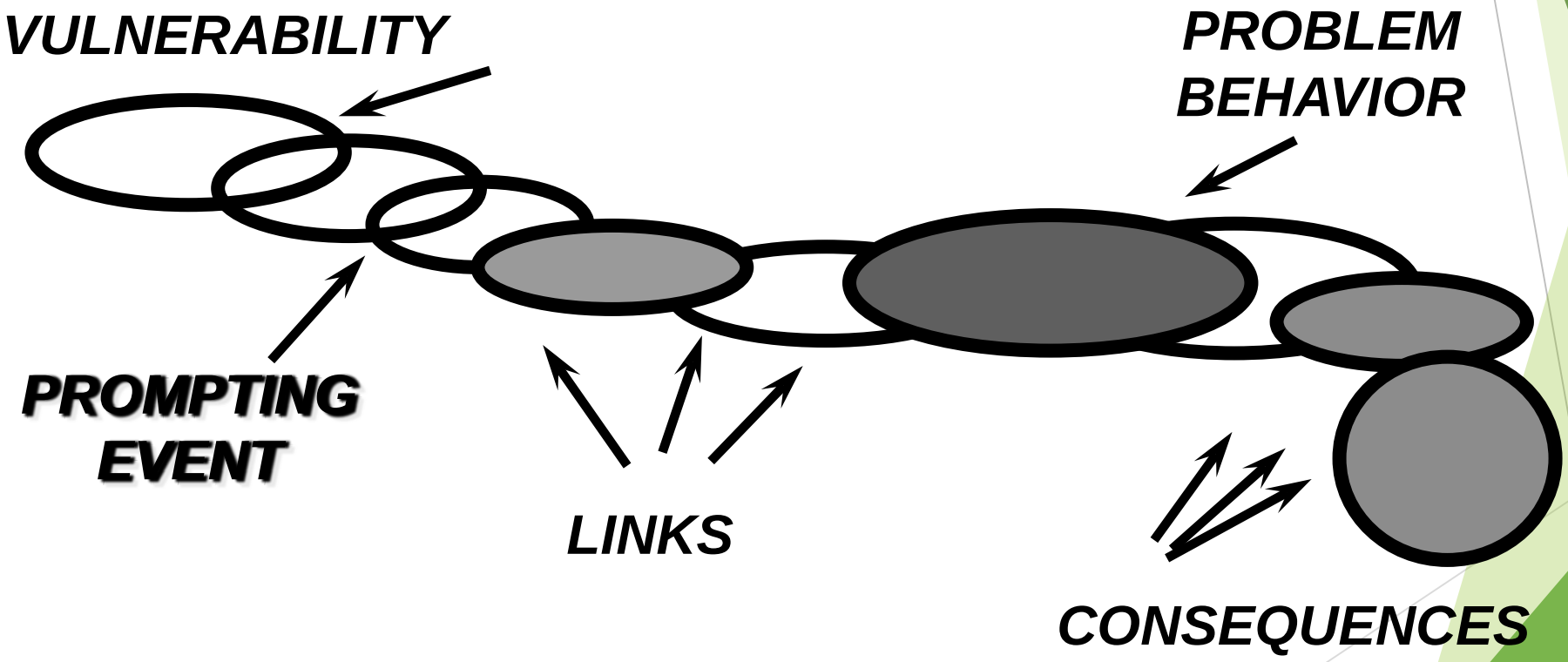
or

behavioral deficit
(desired behavior missing)

or

faulty stimulus control
(behavior occurs in wrong situation or fails to occur in right situation)

Analyze the chain of events over time



Behavioral Chain Example

Action, Body Sensation, Cognition, Event, Feeling

E (vulnerability factor): lack of sleep, restricting

F (vulnerability factor): feeling incompetent at work

E (prompting event): body comment from co-worker

F: anxious, sad, frustrated

C: “She thinks I can’t do this job because of my weight”

C: “I am worthless”

F: overwhelmed, hopeless

C: “I can’t stand this”

F: numb

C: “I just want to feel differently and can’t get through the day without cutting right now”

A: locked self in bathroom

A (problem behavior): Cutting

F: Felt surge of relief

F: Guilt, shame

Solution Analysis Strategies

- Identify goals, needs, and desires
- Generate solutions
- Evaluate solutions
- Choose a solution to implement
- Troubleshoot the solution

Behavioral chain example with skills analysis

E (vulnerability factor): lack of sleep & restricting

F (vulnerability factor): feeling incompetent at work

E (prompting event): body comment by coworker

F: anxious, sad, frustrated

C: "She thinks I can't do this job because of my weight"

C: "I am worthless"

F: overwhelmed, hopeless

C: "I can't stand this"

F: numb

C: "I just want to feel different and can't get through the day without cutting right now"

A: locked self in bathroom

A (problem behavior): Cutting

F: Felt surge of relief, guily and shame

- PlEASE skills & cope ahead
- Practice non-judgmentally
- Use interpersonal effectiveness
- Self-soothe, distract
- Mindful of catastrophizing

- Non-judgmental
- Mindfulness of emotion
- Wise Mind

- Mindfulness of emotion

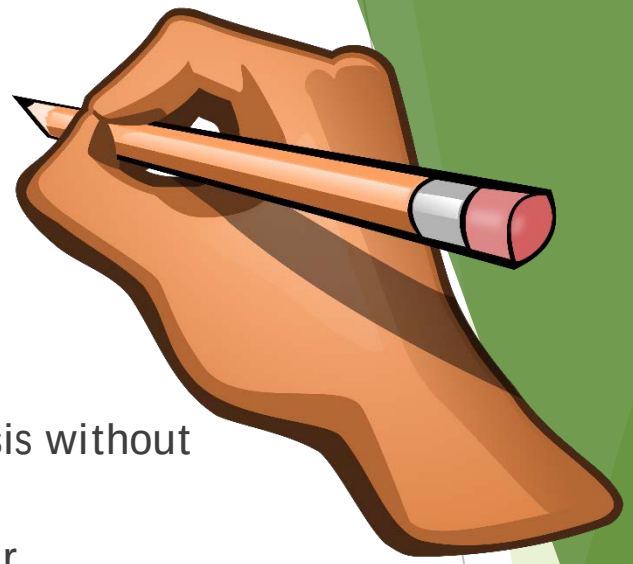
- Pros & cons

- Opposite action

- Effectively

Function of Diary Cards for suicide risk & self-harm

Diary Cards



- Patient fills out daily and brings to session
  - Allows the therapist to track self-harm and suicide risk on a daily basis without reinforcement
  - Provides an opportunity for the therapist to reinforce skillful behavior
- Record of goals for treatment and progress towards them
  - Tracking days without engaging in life-threatening behaviors
  - Highlighting skills to help resist strong urges
- Use to set agenda: Talk about life-threatening behaviors/urges, then treatment-interfering, then quality of life
  - Helps decide the behavior(s) to behaviorally chain
- Use to highlight patterns of emotion or behavior over time

Diary card, Week of:_____

Emotions

Urges

Actions

Skill Usage

Goals

** EMOTIONS **	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Sad							
Anxious							
Guilt/Shame							
Anger/Frustration							
Confident/Proud							
Content/Joy							
Motivated (to recover)							

** URGES **	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Restrict							
Binge							
Purge							
Weigh myself							
Lie/omit							
Isolate							

** ACTIONS **	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Restrict							
Binge							
Purge							
Weigh myself							
Lie/omit							
Isolate							

IMPORTANT EVENTS that may have contributed to my ratings:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

Skill Usage (check off each skill you used)	*DBT Handout #*	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Wise mind	*M 2*							
APES or Mastery activity	*ER 10-13*							
Radical Acceptance	*DT 8-10*							
PLEASE (Balanced sleep, etc)	*ER 14*							
Encouragement (affirmations, rewards, etc)								
Mindfulness of Emotion	*ER 16*							
Attend to relationships (Call/text or social)								
Willingness	*DT 12*							
For urges:								
Pros and cons (writing them up or reviewing them)	*DT 4*							
Express urges (to someone)								
Self-soothe	*DT 5*							
IMPROVE the moment	*DT 6*							
Distract	*DT 7*							
Opposite Action	*ER 5*							
Urge surf	*M 6*							
Other skills: DEAR MAN, Nonjudgmentally, Alternate Reb, etc)								
Other_____								

My goals for treatment and life:	Progress this week (0-5)
1. Build a life (identity, activities, etc) outside my ED—[set specific goals around this]	
2.	
3.	

Targeting life-threatening behavior in session

- Patient must bring diary card to every session.
- Use diary card to decide what behavior to focus on.
- The first time there is no diary card, therapist responds non-judgmentally and asks, “What happened?” Regardless of response, “Remember we cannot proceed without a completed diary card. So I am going to ask you to fill out this blank one, and we will talk when you are done”. Therapist does deskwork and refrains from interaction with patient until she is done.
- Second time no dc, do a detailed behavior chain analysis. May apply aversive consequence

Contingency Management

Key concepts in contingency management of life threatening behaviors

- Natural vs. Arbitrary Reinforcers
  - Withdrawing warmth after a patient self-harms
- Satiety or Satiation of a Reinforcer
- Discriminative Stimulus
  - Identifying events that increase the likelihood of life-threatening behaviors
- Fixed (steady) vs. Intermittent Reinforcement
- Escape Behavior
- Reinforcement or Punishment Gradient

Phone Coaching: Targeting life-threatening behavior in the moment

Primary functions of phone coaching

- First function: Call before engaging in behavior
  - With suicidal clients or nonsuicidal self-injurious clients, important goal= reduce the risk of a completed suicide while not simultaneously reinforcing future suicide behaviors
  - They must call when they are able to receive feedback and benefit from skills coaching. No new learning can occur when emotional arousal becomes too high (Baddeley 2007)
- Second function: Assist with skills generalization
  - During intense crisis, clients often have difficulty accessing and applying information taught in a therapy context to the real world. Phone coaching helps with this!
- Third function: Make a repair in the relationship & celebrate successes

Phone coaching and behavioral principles

- Phone coaching outside of session allows us to maximize the principles of behaviorism
  - Opportunity for clients to gain additional skills that they can practice in the moment, rather than after the fact.
  - Skills coaching increases positive outcomes of using skills and the connection between skillful behaviors are more likely to become temporally linked.
  - Skills are also more immediately reinforced!

- Encourage trying skills before calling
  - Phone coaching and skills use can be shaped!
  - Clients use AT LEAST 2 skills before reaching out for coaching.
  - Ask “what skills have you tried so far” to start the coaching call (or text)

The 24 Hour Rule

- While instructing to client to call prior to the crisis is designed to reinforce skillful behavior, the 24-hr rule exists to extinguish unskillful behavior.

- During phone coaching orientation, clients are informed that they are explicitly forbidden to call their therapist after a nonsuicidal self-injurious act until a 24-hour time period has elapsed.
  - Can be flexible after eating disorder behavior depending on client need

- Contingency management for life-threatening behaviors

Discussion

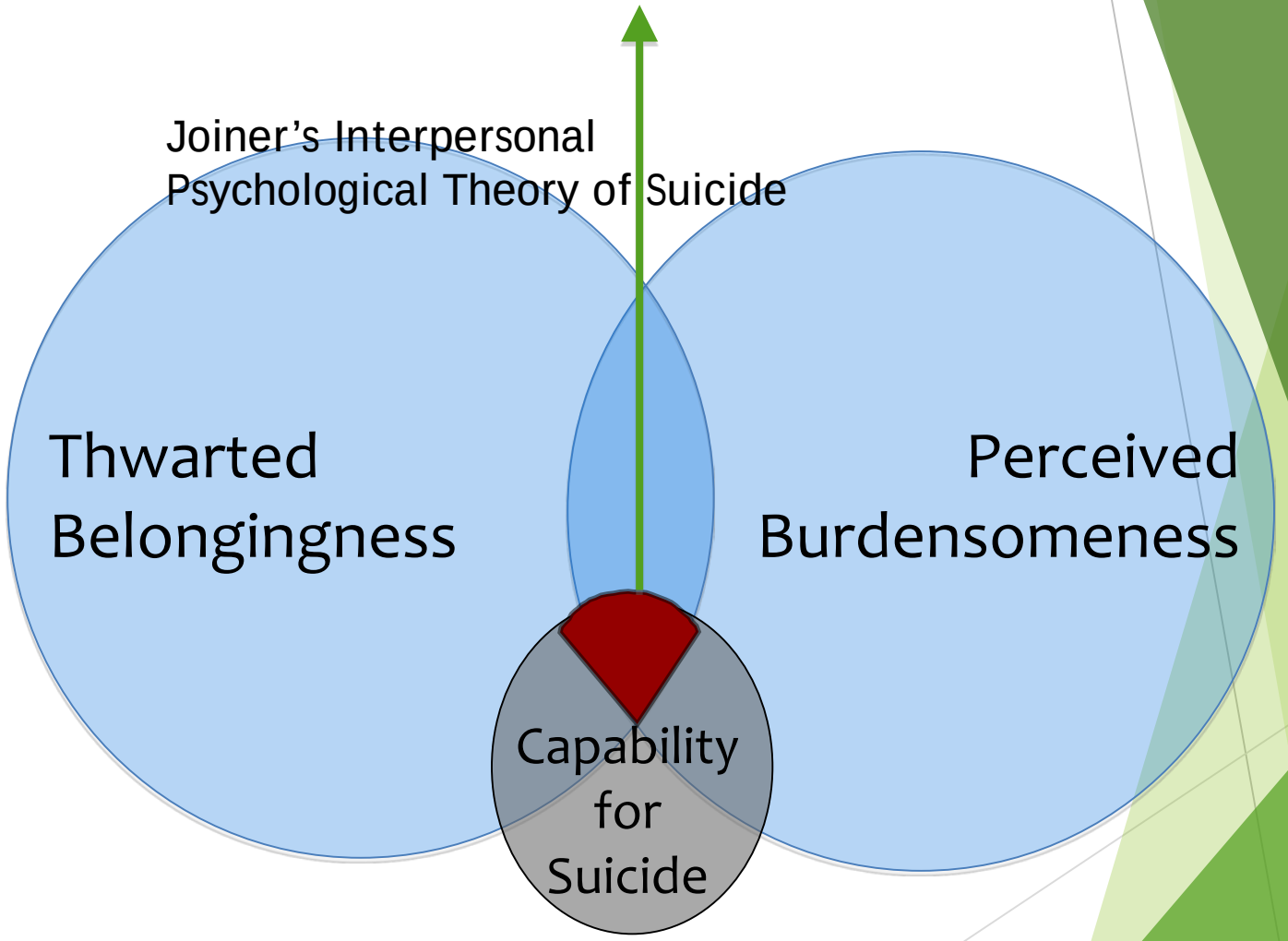
Leslie Karwoski Anderson, Ph.D.

UC San Diego Eating Disorders Center for Treatment and Research

Therapist Fears

- Treating individuals at chronic high risk for suicide is scary and often leads to therapist burnout!
- Therapists may react with excessive fear, anger, hostility OR excessive empathy

Intro to Suicidality in Eds, April Smith



Fearlessness + pain tolerance

Avoiding Burnout

- Self-Care
- Consultation team
- Skills Use
- Education

Assessment and Targeting of Suicidal and ED behaviors, Lucene Wisniewski

LINEHAN RISK ASSESSMENT AND MANAGEMENT PROTOCOL (LRAMP)

Client: _____ Date Contacted: _____

Person Completing: _____ Date Created: _____

SECTION 1: REASON FOR COMPLETION

1. Reason for completing:
   - ☐ **History** of suicide ideation, suicide attempt, or non-suicidal self-injury at intake
   - ☐ **New** (or first report of) suicide ideation and/or urges to self-injure
   - ☐ **Increased** suicide ideation and/or urges to self-injure
   - ☐ **Suicide communication** or other behavior indicating imminent suicide risk since last contact
   - ☐ **Suicide attempt and/or self-injury** since last contact
   - ☐ Suicide attempt and/or self-injury occurred or was **ongoing** during contact
   - ☐ Other

     Please explain: _____

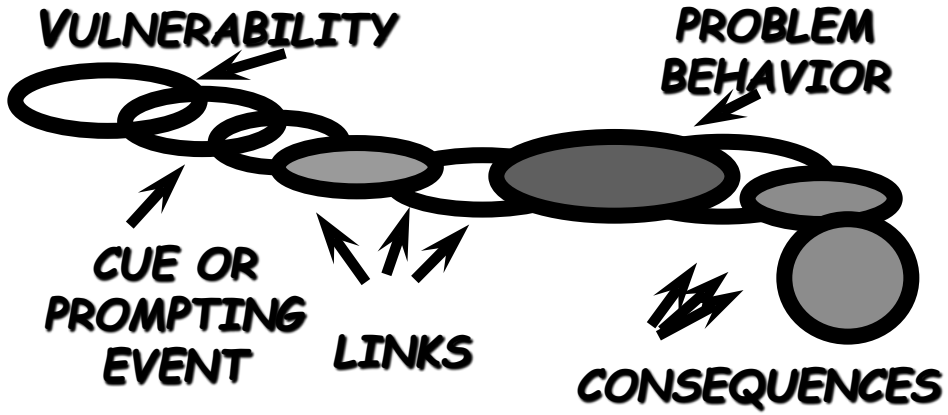
2. Describe the specific incident or behavior that occurred:

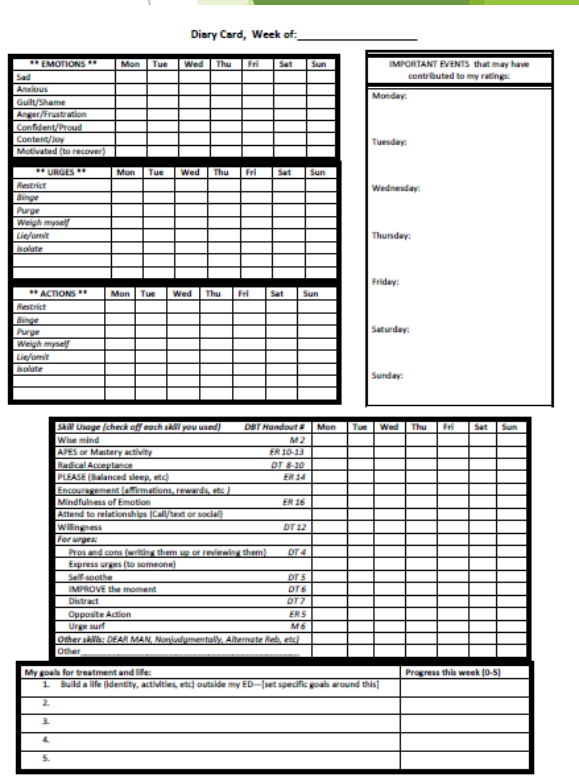
_____

_____

_____

Strategies from DBT for managing self-harm and suicide risk, Anne Cusack





Diary Card, Week of:_____

** EMOTIONS **	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Sad							
Anxious							
Guilt/Shame							
Anger/Frustration							
Confident/Proud							
Content/Joy							
Motivated (to recover)							

** URGES **	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Restrict							
Binge							
Purge							
Weigh myself							
Lie/omit							
Isolate							

** ACTIONS **	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Restrict							
Binge							
Purge							
Weigh myself							
Lie/omit							
Isolate							

IMPORTANT EVENTS that may have contributed to my ratings:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

Skill Usage (check off each skill you used)	DBT Handout #	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Wise mind	M 2							
APES or Mastery activity	ER 10-13							
Radical Acceptance	DT 8-10							
PLEASE (Balanced sleep, etc)	ER 14							
Encouragement (affirmations, rewards, etc.)								
Mindfulness of Emotion	ER 16							
Attend to relationships (Call/text or social)								
Willingness	DT 12							
For urges:								
Pros and cons (writing them up or reviewing them)	DT 4							
Express urges (to someone)								
Self-soothe	DT 5							
IMPROVE the moment	DT 6							
Distract	DT 7							
Opposite Action	ER 5							
Urge surf	M 6							
Other skills: DEAR MAN, Nonjudgmentally, Alternate Reb, etc)								
Other								

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4.	
5.	