UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES

Meta-Competency 7-c: Distress Tolerance

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Meta-Competency 7-c: Distress Tolerance

Competency

- 7-c: Employ distress tolerance strategies including problem-solving and relaxation techniques to reduce the impact of acute stress on patient mental and behavioral health.

How to Use This Unit

This unit is designed to be a comprehensive guide in preparing bachelor's-level Behavioral Health Support Specialists (BHSS) to confidently manage and stabilize patient crises using a robust set of evidence-based skills. The goal of this unit is deeply practical: to transition the new practitioner from theory to applied competence in acute care settings, particularly when working within integrated care models where rapid stabilization is key. Distress tolerance, problem-solving, and relaxation strategies are salient because they equip the BHSS with the ability to address the entire spectrum of patient needs quickly. Distress tolerance provides the ability to anchor the patient during acute emotional crises, preventing issues that compromise patient safety. Relaxation strategies offer immediate, evidence-based physiological relief from stress, a common presentation in medical settings. Finally, problem solving is a brief, solution-focused intervention centered on life stressors that often exacerbate physical and mental health issues.

BHSS educators are strongly encouraged to move beyond didactic teaching and prioritize the activity examples, particularly the role-playing exercises, which simulate the intense emotional environments covered in LO-10 and LO-11. Instructors may choose to enrich the curriculum by adding case studies that reflect the cultural and historical contexts relevant to service areas or by incorporating specific agency protocols for risk assessment and referral. By emphasizing both the modeling of self-regulation and the structured delivery of skills like reframing and assertiveness, instructors will ensure the BHSSs are not only knowledgeable but also safe, composed, and highly effective anchors during a patient's moment of greatest distress.

Summative Competency Assessment Example for MC7-c: Distress Tolerance

This chapter covers several interventions related to the alleviation of acute stress. The summative assessment option provided is a practice and observation assessment. Given the breadth of material, a subject matter quiz on knowledge areas may also be appropriate. Instructors may choose to combine a knowledge-based quiz with a practice-based assessment for a selected intervention. Examples of additional assessments are provided.

Summative Assessment Example

Modeling an Emotional Regulation Technique

A BHSS student explains, models, and provides feedback for an emotional regulation technique to a role-play client. Examples of emotional regulation techniques are passive muscle relaxation, progressive muscle relaxation, or guided imagery exercises. The BHSS student invites the role-play client to join in the chosen practice after the role-play client indicates consent. While practicing the technique together,

the BHSS student provides both affirmations and gentle direction as needed to help the client engage appropriately in the technique. A third party observes and assesses the BHSS student practice within a 10-15 minute time frame.

- MC7-c Summative Assessment Example Activity and Rubric

Other Assessment Examples

- MC7-c Assessment Examples

Sample Readings/Resources for MC7-c: Distress Tolerance

Linehan, M. (2014). *DBT skills training handouts and worksheets* (2nd ed.). The Guilford Press.

Sample Learning Sequence

FOUNDATIONS	ADVANCED	PRACTICUM
LO-1 Define distress tolerance in psychological terms.	LO-6 Apply reframing techniques to promote adaptive ways of thinking.	
LO-2 List symptoms of acute stress that signal a crisis.	LO-7 Teach relaxation techniques grounded in evidence-based coping strategies.	
LO-3 Explain emotional regulation techniques.	LO-8 Teach problem-solving techniques grounded in evidence-based coping strategies.	LO-10 Model distress tolerance and use of healthy boundaries when facing patients' intense emotional experiences.
LO-4 Describe the link between cultural factors; historical factors; and expressions of stress, distress, and trauma.	LO-9 Teach assertiveness techniques grounded in evidence-based coping strategies.	LO-11 Assess immediate risk and make appropriate referrals to a higher level of care.
LO-5 Practice active listening and empathy to show compassion and nonjudgment of a person's acute stress.		

BHSS Foundations

LO-1 Define distress tolerance in psychological terms.

Key Terms and Concepts for LO-1

- **adaptive coping**: healthy and effective strategies that individuals use to manage stress, emotions, and challenging situations in a way that promotes well-being, growth, and positive outcomes.

- **distress:** a psychological and physiological response to a perceived threat, challenge, or difficult situation. It involves feelings of emotional pain, discomfort, or suffering, often accompanied by physical symptoms such as increased heart rate, tension, or fatigue. Distress can be caused by a wide range of factors, such as interpersonal conflicts, work pressures, health problems, or major life changes.
- **distress tolerance:** an individual's ability to withstand or cope with emotional distress and discomfort without resorting to maladaptive or harmful behaviors.
- **emotional discomfort:** unpleasant or distressing feelings that arise in response to challenging or stressful situations. It is a state of emotional discomfort that can range from mild unease to more intense feelings of distress. These emotions may include sadness, anxiety, frustration, guilt, loneliness, or anger and can be triggered by various factors such as personal conflicts, unmet needs, fears, or uncertainties.
- **impulsive behavior:** action taken without careful thought, consideration of consequences, or regard for potential risks. It is characterized by a sudden urge or impulse to act on a desire, emotion, or situation, often without pausing to reflect or plan. Impulsive behaviors are typically driven by immediate gratification or emotional reactions and may occur without considering long-term outcomes or potential harm.
- **resilience**: the dynamic process of adapting well and maintaining or quickly regaining psychological functioning in the face of adversity, trauma, stress, or significant sources of distress.

Key Teaching Points for LO-1

Distress Tolerance

- Distress tolerance is often measured by an individual's response to challenging emotional situations, and it can vary based on factors such as personality, past experiences, and current stress levels. Enhancing distress tolerance through psychosocial interventions can help individuals build resilience and improve overall mental well-being.
- Building resilience means that a person is more likely to accept reality than avoid it, to endure intense emotions rather than engage in impulsive reactions, and to use skills such as problem-solving and relaxation techniques to navigate crises.
- Distress tolerance is often cited in the work of Marsha Linehan and other researchers in the therapeutic field of dialectical behavioral therapy (DBT) (Linehan, 2015; Mazza, 2016; McKay, 2019).

Distress Tolerance Skills

- Distress tolerance skills help individuals to (a) accept distressing situations without judgment or escape, (b) delay impulsive actions that might worsen the situation or cause harm, (c) endure temporary emotional discomfort until it subsides naturally, and (d) use adaptive coping strategies to manage emotional pain, rather than unhealthy coping mechanisms like substance use or self-harm (Leyro et al., 2010).
- Often, distress tolerance is learned in childhood, pubescence, and adolescence. Ability can vary even among biological kin; research shows biological, psychological, and social factors all correlate with distress tolerance. Still, regardless of genetic predisposition, distress tolerance can be learned over time with coaching and reinforcement (Felton et al., 2019).

Sample Activities/Assessments for LO-1

Activity: Distress Tolerance Scale
Provide students with a distress tolerance scale to complete as a self-rating. The scale ought to measure one's reaction to a variety of situations. The averaged scores can provide a measure of comparison within the sample. After reviewing the rating, invite students to identify one area that might be a starting place to learn new skills or make improvements. See Resources LO-1 for visual example of a distress tolerance scale.

Activity: Distress Tolerance Comparison
Compare a child's level of distress tolerance to that of an adult or parent. This activity is related to the work of Eric Berne, who authored transactional analysis as a psychological theory. Per Berne's theoretical model, adolescents and adults possess elements of a child, a parent, and an adult in responding to their environment. In some instances, an adult behaving like "a child" may be healthy and positive in terms of a sense of wonder, curiosity, and playfulness. Behaving like "a child" as an adult can also be damaging, such as yelling instead of talking, avoiding instead of confronting, and using violence when rejected. Create a table with columns for child, parent, and adult. Provide a situation such as "learning about a poor grade on a paper" or "hearing that a peer does not like you." Instruct students to generate ideas about how a child might react, a parent, and an adult. A role of a parent is to teach children to self-soothe, so that as adults, they are able to call upon a number of tools to lower their own stress levels. Even adults from generally healthy backgrounds can "forget" how to calm themselves and self soothe.

Activity: Short Answer Composition
Invite students to write a short response to the following prompt: "Describe three ways a person's cultural background might influence their expression of distress." Evaluate answer for thoughtful examination of the intersection of culture and behavioral expression.

Activity: Learning the TIPP Acronym from DBT
Invite students to explain what each letter of the TIPP acronym in DBT means and how it is used to help quickly regulate a person's body chemistry during a crisis. See Temperature, Intense Exercise, Paced Breathing, and Progressive Muscle Relaxation in resources for a visual example.

Specific Resources for LO-1

Resource: Distress Tolerance Scale Validity
Scale: Peer reviewed article presents empirical validity for the distress tolerance scale example.

- Alfonsson, S., Mardula, K., Toll, C., Isaksson, M., & Wolf-Arehult, M. (2022). The self-efficacy in distress tolerance scale (SE-DT): A psychometric evaluation. *Borderline Personality Disorder and Emotion Dysregulation*, *9*(1), Article 23. https://doi.org/10.1186/s40479-022-00195-9

Resource: DBT Skills Training Manual
Skills Manual: A comprehensive guide to teaching and learning self-help strategies, including distress tolerance techniques.

- Pederson, L., & Pederson, C. S. (2017). *The expanded dialectical behavior therapy skills training manual: DBT for self-help, and individual and group treatment settings* (2nd ed.). PESI Publishing & Media.

Resource: Temperature, Intense Exercise, Paced Breathing, Progressive Muscle Relaxation
TIPP: This webpage outlines the acronym used for a set of crisis survival skills designed to help individuals quickly reduce intense emotional arousal.

- DialecticalBehavioralTherapy.com. (2024). *T10: TIPP.* https://dialecticalbehaviortherapy.com/distress-tolerance/tipp/

LO-2 List symptoms of acute stress signaling a crisis.

Key Terms and Concepts for LO-2

- **acute stress**: a short-term reaction to a specific stressful event or situation, such as a deadline, conflict, or unexpected problem. While it is a normal response to stress, if left unmanaged, it can lead to problematic physical, emotional, and behavioral symptoms. The symptoms of acute stress can occur immediately or within a few hours of the triggering event and typically subside once the stressor is resolved or managed (Cleveland Clinic, 2023).
- **chronic stress**: if acute stress is not properly addressed or if stressors continue to accumulate, it can lead to chronic stress, which has serious long-term health consequences.
- **coping**: using strategies like deep breathing, relaxation techniques, or physical activity to help alleviate the symptoms of acute stress.
- **duration of stress**: the length of time distressful symptoms are present and interfering with day-to-day functioning.
- **crisis**: a period of acute psychological disequilibrium during which an individual's usual coping mechanisms fail, leading to significant distress and impaired functioning.

Key Teaching Points for LO-2

Observing Acute Stress Reactions

- Acute stress reactions may be categorized as physical, emotional, cognitive, behavioral, or social symptoms. See Stress Domains and Accompanying Symptoms in LO-2 Resources for a visual example.
- When someone is under acute stress, their cognition may be temporarily impaired. A BHSS may share an observation: "I see you are having trouble breathing and that you are trembling." It is important to rule out physical causes such as withdrawal from a drug, a drop in blood sugar, or other physiological factors. In integrated care settings, the medical chart will alert the clinician to known patient conditions. In non-integrated care settings, the clinician may need to ask, "Do you have any medical diagnoses, or is there another reason that you might be having trouble breathing or trembling?"
- If physiological causes are ruled out by a qualified medical provider or by evidence in the patient's records, then the BHSS may proceed to consider psychosocial interventions as a next step.

Treatment of Acute Stress Reactions

- In the clinical environment, acute stress reactions are usually successfully treated with emotional regulation techniques (Bryant, 2016).
- In some circumstances, acute stress symptoms that worsen (e.g., disorientation, loss of contact with reality, self-harm risk) or are unresponsive to behavioral intervention may require a higher level of care (e.g., crisis stabilization, emergency department, or psychiatric consultation). Knowing the signs and symptoms is important for decisions related to intervention. Review Item #9 on the Patient Health Questionnaire-9 (PHQ-9) and screen further for suicidal ideation. Refer

to MC5 for application of the PHQ-9; Generalized Anxiety Disorder-7 (GAD-7); and suicide screening, assessment, and management.

Role of the BHSS in Acute Stress Reactions

- Observe, document, and communicate acute symptoms clearly to clinical supervisors or team members.
- Use calm tone and brief language to orient and reassure the patient.
- Normalize the stress response, e.g., "Your body is reacting to a lot of pressure right now; let's slow your breathing together."

Sample Activities/Assessments for LO-2

Activity: Acute Stress Identification Exercise
The purpose of the activity is to train observation and categorization skills. Students review case vignettes, then identify and list all acute stress symptoms by domain (physical, emotional, cognitive, behavioral, social). This categorization may be done independently or in small groups. Afterward, students discuss how to differentiate stress-related symptoms from possible medical issues. Assessment of this activity may be pass/fail or, if a score is required, students identify a minimum of two correct symptoms per domain, including a description of an appropriate next step.

- Acute Stress Case Vignette Activity Instructions

Activity: Role Play of Crisis Observation and Response
This activity is a partner role play whereby one student portrays a patient under acute stress, the other a BHSS. The BHSS observes, names, and responds to the patient using grounding language and supportive statements (i.e., active listening). As a class, discuss what symptoms are observed in the role play, how they are addressed, and which follow-up steps are most appropriate. This may work well as a small group activity whereby several students serve as observers, then switch roles.

Activity: Stress Symptom Journal
Invite students to record personal examples of stress responses (physical sensations, thoughts, or actions) over a one-week period. Students reflect on which coping strategies helped alleviate distress and which did not. This activity may work well in triads, if possible, in private chat rooms hosted in the learning management system (LMS) so that an instructor may observe. In this example, students record a three-minute reflection video or audio with opportunities for peers to respond to their observations.

Specific Resources for LO-2

Resource: Stress Domains and Accompanying Symptoms
Stress Domains: An educational tool for understanding the scope of stress.

- Jin, J. (2025). *Stress domains and accompanying symptoms.* University of Washington. https://uwnetid.sharepoint.com/:w:/r/sites/og_bhss_program2/_layouts/15/Doc.aspx?sourcedoc=%7BF2140F9E-2857-421F-BDE4-A9ECC42727D3%7D&file=Stress%20Domains%20and%20Accompanying%20Symptoms.docx&action=default&mobileredirect=true&share=cQqeDxTyVygfQr3kqezEJyfTEgUAattG8On6AJfIka7rMXCaOg

Resource: Stress
Understanding Stress: Information from Harvard Medical School on acute and chronic stress.

- Harvard Medical School. (2024). *Stress.* Harvard Health Publishing. https://www.health.harvard.edu/topics/stress

Resource: Acute Stress Reaction vs. PTSD
Acute Stress: A description of similarities and differences between acute stress and symptoms of post-traumatic stress disorder.

- National Center for PTSD. (2025). *Acute stress disorder.* U.S. Department for Veterans Affairs. https://www.ptsd.va.gov/professional/treat/essentials/acute_stress_disorder.asp

Resource: Trauma-Informed Care (TIC) in Behavioral Health
Trauma-Informed Care: A manual explaining the framework for TIC and how to implement it within healthcare systems. Describes acute stress, chronic stress, and trauma reactions.

- U.S. Department of Health and Human Services. (2017). *A treatment improvement protocol: Trauma-informed care in behavioral health services: TIP 57.* Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/sites/default/files/sma14-4816.pdf

LO-3 Explain emotional regulation techniques.

Key Terms and Concepts for LO-3

- **emotional regulation:** managing difficult emotions, such as anxiety, sadness, frustration, or anger, in a way that does not lead to harmful consequences, either to oneself or others.
- **emotional regulation techniques**: strategies and practices that help individuals manage and modify their emotional responses to various situations. These techniques aim to reduce emotional distress, improve emotional balance, and enhance well-being by allowing individuals to respond more thoughtfully and effectively to their emotions. Effective emotional regulation helps people cope with stress, improve relationships, and make better decisions.
- **awareness and acceptance**: the ability to acknowledge and endure unpleasant emotions instead of trying to avoid or suppress them.

Key Teaching Points for LO-3

Emotional Regulation Techniques for Acute Stress

- *Deep breathing* is the conscious act of focusing on one's breath, visualizing the breathing process, and ignoring intrusive thoughts while concentrating on the activity. Deep breathing can be taught to anyone and practiced with patients in a short amount of time (Davooodi & Ghahari, 2017).
- *Emotion-focused journaling* is the act of writing down one's feelings and thoughts to create an opportunity for both insight into oneself and to cope with emotions.
- *Grounding* techniques are action-oriented processes that help focus a person on their present reality and environment while serving as a temporary distraction from overwhelming emotions. Examples include deep breathing, 5-4-3-2-1 sensory exploration, and using pressure in the extremities, such as pressing hands together in a prayer form or pushing feet to the floor in brief intervals. There are myriad examples of grounding techniques.
- *Mindfulness meditation* involves paying attention to the present moment without judgment. It may be practiced with any other emotional regulation technique or simply lying down and conducting a guided body scan. Mindfulness may lead to greater distress tolerance.

- *Physical exercise* is any regular movement (appropriate to a person's ability and health status) that releases endorphins in the body, helping improve mood and reduce stress.

Relaxation Strategies for Acute and Chronic Stress

- *Imagery* is a relaxation technique that uses mental visualization of calming, positive, or pleasant images to reduce stress and promote emotional well-being. The idea is to engage the mind in creating vivid sensory experiences—such as imagining a peaceful beach, a quiet forest, or another safe and comforting space—to trigger the body's relaxation response.
- *Passive muscle relaxation* is a stress-reduction technique where the individual focuses on releasing tension from muscle groups without actively tensing them first. Unlike progressive muscle relaxation, which involves a cycle of tightening and then relaxing muscles, passive relaxation skips the tightening phase and emphasizes awareness and letting go of existing tension. This strategy is often helpful when a patient has loss of sensation in certain parts of the body, has an acute injury, or is not ready for active engagement of muscle groups.
- *Progressive muscle relaxation (PMR)* is a stress management technique that involves systematically tensing and then relaxing different muscle groups in the body to reduce physical tension and promote relaxation. It was originally developed by Edmund Jacobson in the 1920s and is widely used in counseling, health psychology, and stress reduction programs.

Problem Solving for Acute Stress

- *Problem solving* involves exploring the root cause of a situation, brainstorming possible solutions to resolve the problem, assessing probable outcomes, choosing an action, and evaluating the results.
- *Reframing* is the act of changing how one thinks about a person, place, or thing to decrease the power of the object and lower any associated emotional distress.

Self-Compassion for Acute Stress

- *Self-compassion* involves treating oneself with kindness and avoiding harsh self-criticism. It may involve self-soothing, which are activities that a person finds comforting.

Social Support for Acute Stress

- This means reaching out to others for support in processing difficult emotions. It involves more than one person and may require initiative from the patient.

Sample Activities/Assessments for LO-3

Activity: Emotional Regulation Technique Practice and Reflection

Students pick one emotional regulation technique and commit to practicing the technique at regular intervals for one week. The student journals about each experience and provides a summary statement on the total experience, their rationale for choosing the technique, the original purpose of the technique, and whether they followed through with the goal. If the student does not follow through with goal, they provide an explanation for this decision. (See Brief Goal Planning in MC-7f Part II for an example of planning to implement an emotional regulation technique.)

Activity: Teach an Emotional Regulation or Relaxation Technique

For this activity, students choose and prepare to teach an emotional regulation or relaxation technique to another person, the "patient." While it is okay to choose physical exercise, the student needs to be mindful of the volunteer patient's abilities and health status. Chair exercises may be appropriate in certain circumstances. The psychoeducation session should last ten to fifteen minutes and include

modeling, replication, and debriefing. (See MC7-b for additional psychoeducation resources and information).

Specific Resources for LO-3

Resource: Therapist Aid
Worksheets: Therapist Aid is an excellent resource for explanations of numerous emotional regulation techniques and offers free worksheets to use with patients.

- Therapist Aid. (2025). *Home page*. https://www.therapistaid.com/

Resource: BYU Relaxation Recordings
Relaxation Recordings: This is an excellent resource for recordings that guide patients through deep breathing, imagery, visualization, and progressive muscle relaxation.

- BYU Counseling and Psychological Services. (n.d.). *Relaxation recordings.* https://caps.byu.edu/relaxation-recordings

Resource: Self-Compassion Defined
Self-Compassion: The author defines self-compassion and explains its benefits for coping with acute and chronic stress.

- Self-Compassion Institute with Dr. Kristin Neff. (n.d.). *What is self-compassion?* https://self-compassion.org/what-is-self-compassion/

Resource: Brief Action Planning (BAP)
BAP: This blog post provides an explanation and video on brief action planning.

- Logan, H. (2024). The planning task of motivational interviewing and brief action planning. *MI Center for Change.* https://blog.micenterforchange.com/the-planning-task-of-motivational-interviewing-and-brief-action-planning/

LO-4 Describe the link between cultural factors; historical factors; and expressions of stress, distress, and trauma.

Key Terms and Concepts for LO-4

- **cultural factors:** the shared beliefs, values, customs, behaviors, and traditions of a group of people. These factors dictate what is considered "normal" or "acceptable" behavior, which emotions can be openly expressed (e.g., stoicism vs. dramatic expression), and what constitutes help-seeking behavior.
- **historical factors:** the long-term, intergenerational impact of past events, particularly those involving systemic oppression, colonization, war, or forced migration. This includes the phenomenon of historical or intergenerational trauma, e.g., the lasting effects of slavery or the Holocaust on descendants of survivors.
- **trauma:** in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) chapter on trauma and stress-related disorders, trauma is generally defined as exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways (APA, 2022):
    - direct exposure to the traumatic event(s)
    - witnessing the event(s) as it occurs to others

    - learning that the event(s) happened to a close family member or friend (violent or accidental)
    - experiencing repeated or extreme exposure to aversive details of the traumatic event(s), such as through professional duties (e.g., first responders, police officers)
- **culture-bound syndromes (CBS):** recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a specific diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM). These syndromes illustrate how culture organizes the expression of distress (e.g., *susto* in Latin America or *ataque de nervios* in Latino communities).
- **somatic expression of distress:** the physical manifestation of psychological or emotional stress. Many cultures that discourage the open expression of emotions translate distress into physical complaints (e.g., headaches, stomach pains, fatigue), which patients may present to the BHSS as medical issues rather than emotional ones.

Key Teaching Points for LO-4

The Influence of Personal and Social Identity

- Personal identity factors (e.g., race, ethnicity, religion, gender identity, sexual orientation, disability status) significantly influence how a person perceives, interprets, and responds to stressful stimuli in the environment. For example, a microaggression perceived by one person as a minor inconvenience may be perceived by another, based on a lifetime of similar experiences, as a threat, triggering an acute stress reaction.
- In **collectivist cultures**, emotional expressions that might cause shame to the family (e.g., anxiety or depression) are often suppressed, leading to somatic complaints or indirect expressions. In **individualist cultures**, emotional expression is usually more tolerated but often framed around personal faults or failures.

The Enduring Power of Historical Trauma

- Historical factors create **intergenerational trauma**, in which the emotional, psychological, and physiological legacy of massive group trauma (e.g., genocide, forced assimilation) is passed down to later generations, affecting their stress response, resilience, and mistrust of institutions (like health care).
- **Context of mistrust:** Patients from historically marginalized or oppressed groups may express stress or trauma as suspicion, non-adherence, or hypervigilance toward behavioral health systems, which they may perceive as extensions of past oppressive systems. The BHSS must understand these historical contexts to avoid misinterpreting such behaviors as simple resistance to treatment.
- **Protective factors:** Conversely, cultural and historical factors also instill resilience, community cohesion, and adaptive coping mechanisms (e.g., spirituality, strong social networks) that can serve as potent protective factors against stress and trauma. The BHSS should identify and leverage these strengths.

BHSS Role: Observation and Cultural Humility

- The BHSS must move beyond a symptom checklist approach and adopt a stance of cultural humility, recognizing that their own cultural lens is one of many.
- The specialist should observe not only what is expressed but also what is *not* expressed (e.g., the patient discusses a major loss with a flat affect, which could signal a cultural norm of stoicism or dissociation in the face of grief).

- When an expression of distress seems unfamiliar (e.g., a culture-bound syndrome), the BHSS must ask open-ended questions to clarify what the expression means to the patient and family, rather than immediately pathologizing the behavior.

Sample Activities/Assessments for LO-4

Activity: Culture-Case Compare & Contrast
Provide students with two case vignettes that explore the relationship between culture and stress expression. Examples include (1) a patient whose culture encourages highly emotional expression (e.g., *ataque de nervios*) and (2) a patient whose culture mandates stoicism/somatic complaints (e.g., unexplained chronic pain). Students identify the relationship between cultural factors and stress expression. Evaluation is based on the student's ability to accurately identify the role of culture and propose two non-judgmental questions to ask the patient.

- Case Vignette Examples

Specific Resource for LO-4

Resource: Cultural Formulation Interview
Interview Questions: The interview template serves as a resource for identifying potential non-judgmental questions that help patients discuss the relationship between symptoms and cultural identity.

- American Psychiatric Association. (2013). *Cultural formulation interview.* https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/DSM-5-TR/APA-DSM5TR-CulturalFormulationInterview.pdf

LO-5 Use active listening and empathy to show compassion and nonjudgment of person's acute stress.

Key Terms and Concepts for LO-5

- **active listening:** receiving and processing verbal and nonverbal cues to attend to another person for the purpose of communicating understanding of their lived experience, expressing care or empathy, and avoiding premature problem-solving (Teniente & Guerra, 2011).
- **empathy:** the ability to understand, share, and respond to the feelings, thoughts, and experiences of another person. It involves putting oneself in someone else's shoes, not just recognizing their emotions but also connecting with them on an emotional level.
- **compassion:** feeling with the patient coupled with an unconflicted desire to remove suffering and to support patient-defined and -led treatment goals, intentions, prayers, or hopes.
- **nonjudgment:** approaching a patient's situation, feelings, or actions without assigning moral value or blame. For example, recognizing that telling a patient who is overwhelmed by news to "just stop it" is uncompassionate, judgmental, and ineffective as it misses the underlying function of the behavior.
- **boundaries:** an invisible demarcation between two people that protects both people physically, emotionally, and psychologically.

Key Teaching Points for LO-5

The Fundamentals of Nonverbal Communication

- **Body language (SOLER):** BHSS staff must model attentive nonverbal cues to convey acceptance and safety. The following acronym may help the BHSS recall attending skills when helping someone with an acute crisis (Stickley, 2011):
    - **S**quarely face the patient.
    - **O**pen posture (avoid crossed arms/legs).
    - **L**ean slightly toward the patient.
    - **E**ye contact (appropriate to culture).
    - **R**elaxed demeanor.
- **Tone and pace:** When a patient is in acute stress, the BHSS must use a calm, low, and even tone of voice and a slow pace of speaking. This physically helps regulate the patient's activated nervous system.
- **Flexibility:** While the attending skills described in the SOLER acronym are best practice for professional helpers, the BHSS ought to be responsive to the patient's needs. For example, if a patient is uncomfortable with a BHSS squarely facing the patient, the BHSS may ask the patient, "How may I position the chairs for you to be most comfortable in our session today?"

Active Listening: Processing and Reflecting

- Active listening involves three core techniques that communicate non-judgment:
    - Reflecting/paraphrasing: Restate the patient's content or feelings in your own words (e.g., "So, if I hear you right, you feel completely overwhelmed because the deadline was moved up"). The goal is to c*onfirm understanding and show you were listening.*
    - Validating statements: Acknowledge the patient's emotional experience as understandable *given their circumstances* (e.g., "That sounds incredibly difficult and stressful. It makes perfect sense why you're feeling so anxious right now"). Validation is the opposite of judgment.
    - Minimal encouragers: Give small verbal (e.g., "Uh-huh," "Go on," "I see") and nonverbal cues (e.g., nodding) that prompt the patient to continue without interrupting their flow or taking over the conversation.

Empathy During Acute Stress

- Empathy versus sympathy: Empathy is *feeling with* the patient (e.g., "I understand that must feel overwhelming"); sympathy is *feeling sorry for* the patient (e.g., "I'm so sorry. That's terrible"). BHSS staff must aim for professional empathy to maintain effective boundaries.
- Focus on function, not form: When a patient presents as "overwhelmed for benign reasons" (such as from excessive news watching), the BHSS must look beyond the *behavior* and show curiosity about the *function*. Instead of judging said news watching, the compassionate approach is to ask, "What does watching the news do for you right now?" or "What is the feeling you are trying to manage by staying informed?"

Sample Activities/Assessments for LO-5

Activity: Role Play Acute Stress & De-escalation

Students role play in pairs. One plays the patient and the other the BHSS. The "patient" presents a scenario of acute stress (e.g., tearful, agitated). The BHSS must use active listening techniques (paraphrasing, validation, and minimal encouragers) to de-escalate the acute emotion without attempting to fix the problem. The role play should last 5–7 minutes. The instructor or a third observing student rates the BHSS's successful performance of the following:

- Using validating language ("That sounds incredibly difficult") rather than judgmental language ("Why would you do that?").
- Body language (eye contact, posture, tone of voice) conveying a sense of acceptance.
- Refraining from interrupting the patient or trying to "fix" the problem immediately.
- Reflecting the patient's feelings accurately.
- Using validating statements at appropriate times.
- Demonstrating curiosity about the patient's perspective ("Tell me more about what that feeling is like for you").

Specific Resources for LO-5

Resource: Every Choice Has Opportunity
ECHO: These slides from the University of Chicago describe reflective listening.

- Education Lab. (n.d.). ECHO connect cards: Empathy and reflective listening. *University of Chicago.* https://educationlab.uchicago.edu/wp-content/uploads/sites/3/2025/12/ECHO-Connect-Card-Empathy-and-Reflective-Listening.pdf

Resource: How to Practice Active Listening
Active Listening: An article detailing active listening, purpose, and methods to practice.

- O'Brien, A. (2022). How to practice active listening: 16 examples and techniques. *PositivePsychology.com*. https://positivepsychology.com/active-listening-techniques/

BHSS Advanced

LO-6 Use reframing to promote adaptive ways of thinking.

Key Terms and Concepts for LO-6

- **reframing (cognitive restructuring):** a cognitive technique that involves changing the way a person views a situation, relationship, or thought to alter its meaning and decrease its emotional intensity (Haley, 1992). It is not about denying reality, but about finding alternative, more helpful interpretations. Reframing has roots in multiple traditions: as a cognitive technique in the work of Beck and Ellis and as a systemic intervention in the work of Milton Erickson, Jay Haley (strategic therapy), and Salvador Minuchin (structural therapy) (Corey, 2013; Gladding, 2002).
- **cognitive distortions:** exaggerated or irrational thought patterns that are believed to perpetuate psychological distress. Reframing is the primary tool used to challenge these distortions (e.g., all-or-nothing thinking, fortune telling, catastrophizing). The concept of cognitive distortions stems from the foundational work of Albert Ellis in rational emotive behavior therapy (REBT) and Aaron Beck in cognitive behavior therapy (CBT), and it was further developed and popularized in the CBT literature by authors such as David Burns (2024).
- **maladaptive thinking:** thought patterns that are rigid, negative, unrealistic, and interfere with a person's ability to cope effectively, solve problems, or achieve goals.

- **adaptive thinking:** flexible, realistic, and constructive thought patterns that promote emotional resilience, problem solving, and positive behavior.
- **wise mind:** a concept from dialectical behavior therapy. It is a state of mind that balances the emotional mind (feelings-driven) and the reasonable mind. The reasonable mind exists in state of logic, facts, and rational thinking; decisions are made on evidence, planning, and problem-solving.

Key Teaching Points for LO-6

The Rationale and Mechanics of Reframing

- Bridging thought and emotion: The BHSS must understand that emotions are often triggered by *thoughts* about an event, not the event itself. Reframing helps the patient change the thought, which then changes the emotional response.
- *Example:* Failing a test leads to the thought, "I am a total failure," which leads to the emotion of high despair. A reframed thought could be "I failed this time, but I can study differently next time," which might evoke the emotions of moderate frustration alongside motivation.
- Focus on possibility and controllables: Effective reframing shifts the patient's focus from what is fixed, negative, and uncontrollable to what is possible, neutral or positive, and within their control.
- The BHSS role of guiding, not telling: The BHSS does not *tell* the patient what to think. Their role is to use Socratic questioning to guide the patient in finding the alternative frame for themself.

BHSS Best Practices for Reframing

- Validate first: Always start by validating the patient's original feeling ("It makes total sense you feel like a failure right now"). Attempting to reframe without validation may ignore the patient's perception and experience.

1. Challenge the thought, not the patient: Use gentle language ("Let's check the facts on that thought..." or "Is there any other way to look at this?") to separate the person from the distorted thought.
2. Use metaphors: Help the patient visualize the shift with imagery (e.g., viewing a diamond from a different side or switching lenses).

Sample Activities/Assessments for LO-6

Activity: Cognitive Distortion and Reframing

This activity was designed to help the BHSS identify common cognitive distortions and practice generating adaptive reframe questions. The instructor provides a list of common cognitive distortions, e.g., catastrophizing, should statements, all-or-nothing thinking (see Cognitive Distortions in LO-6 Resources for a visual example). For each distortion, the instructor provides a patient statement (e.g., "I got a B instead of an A, so I shouldn't bother going to college at all"). The distortion statements can be generated with help from artificial intelligence (AI) language models to better conform to character identity preference. Students work in pairs or small groups to match the example to a type of cognitive distortion, then generate a reframing question or response.

Specific Resources for LO-6

Resource: Cognitive Restructuring Techniques for Therapists

Treatment Guide: describes the therapeutic process of identifying and challenging negative and irrational thoughts.

- Therapist Aid. (n.d.). *Cognitive restructuring techniques for clinicians.* https://www.therapistaid.com/therapy-guide/cognitive-restructuring

Resource: Cognitive Distortions
Worksheet: Helpful tool to explain cognitive distortions. May be useful with accompanying psychoeducation about distortions, including their benefits and liabilities in communication.

- Therapist Aid. (2023). *Cognitive distortions*. https://www.therapistaid.com/therapy-worksheet/cognitive-distortions

Resource: The Power of Reframing Thoughts
Cognitive Restructuring: A helpful tool for understanding the process of cognitive restructuring and methods of intervention, including reframing.

- Ackerman, C. (2025). Cognitive restructuring: The power of reframing thoughts. *PositivePsychology.com.* https://positivepsychology.com/cbt-cognitive-restructuring-cognitive-distortions/

LO-7 Teach relaxation techniques grounded in evidence-based coping strategies.

Key Terms and Concepts for LO-7

- **parasympathetic nervous system (PNS):** the part of the autonomic nervous system responsible for the body's "rest and digest" functions. Relaxation techniques (e.g., deep breathing) are evidence-based because they are designed to activate the PNS, counteracting the stress-induced "fight or flight" response.
- **diaphragmatic (belly) breathing:** a deep breathing technique that involves fully engaging the stomach, abdominal muscles, and diaphragm when breathing. This is the most effective way to slow the heart rate and activate the parasympathetic nervous system intentionally.
- **progressive muscle relaxation (PMR):** an evidence-based technique of systematically tensing and then relaxing specific muscle groups throughout the body. The goal is to create a deep sense of physical relaxation and increase awareness of the difference between tension and calm.
- **guided imagery (visualization):** a technique in which a patient is verbally guided to imagine a peaceful, relaxing place or scene. This engages the senses to promote emotional and physiological calm.

Key Teaching Points for LO-7

The Evidence-Based Rationale

- Physiological effect: Relaxation techniques are not just "feel good" activities; they are proven interventions for reducing physical symptoms of stress, such as high blood pressure, muscle tension, and rapid heart rate (Sheehan, 2022; Toussaint et al., 2021). The BHSS should explain this mind-body connection to patients to increase buy-in.
- Daily practice versus crisis use: Distinguish between using relaxation techniques as a daily wellness habit to prevent chronic stress versus using them as an acute stabilization tool (e.g., taking three quick deep breaths before responding to an urge).
- Titration and pacing: When teaching a technique, the BHSS must ensure the patient is comfortable and consents to learn and practice it. Some patients may feel anxious or dizzy when

they first learn deep breathing. Start with short intervals and encourage a slow, comfortable pace.

The BHSS's Role in Teaching Relaxation

- Preparation and rationale: Briefly explain why the technique works (PNS activation) and when to use it.
- Modeling: The BHSS should model the technique first (e.g., demonstrate deep breathing or tensing and relaxing a muscle group).
- Instruction and coaching: Guide the patient through the steps using a calm, slow, and soft tone of voice. Provide encouraging, supportive feedback (e.g., "Good, I see your shoulders relaxing now").
- Replication and practice: Have the patient practice the technique and provide real-time coaching.
- Debriefing: Ask the patient what they noticed (sensations, feelings) and how they plan to use the skill in their daily life.

Focus Technique: Progressive Muscle Relaxation (PMR)

- Systematic tensing and relaxing: PMR involves deliberately tensing specific muscle groups for a few seconds and then releasing the tension to promote relaxation.
- Body awareness: It helps individuals notice the difference between tension and relaxation, increasing awareness of physical stress.
- Stress and Anxiety Reduction: By reducing muscle tension, PMR can lower physiological arousal and alleviate symptoms of stress and anxiety.
- Structured Sequence: Typically practiced in a guided order (e.g., starting from feet and moving upward), ensuring full-body relaxation.

Sample Activities/Assessments for LO-7

Activity: Teach-Back Session—Coaching Progressive Muscle Relaxation
This activity may help assess the student's ability to deliver clear, paced, and supportive instructions for a complex physical relaxation technique. Students work in pairs: one acts as the BHSS/coach and one as the patient. The coach's task is to conduct a 10-minute session to teach the patient the basic steps of PMR, focusing on the hands, arms, and shoulders. This activity can be graded as a self-assessment or by the instructor or another peer's observation. The assessment should evaluate the BHSS's successful demonstration of the following:

- Introducing PMR and its goal (tension/release awareness).
- Using a slow, calming voice and pace.
- Guiding the patient through tensing and releasing at least three different muscle groups (e.g., hands, forearms, biceps).
- Asking the patient for feedback ("What did you notice?").

Specific Resources for LO-7

Resource: Relaxation Techniques: What You Need to Know
Relaxation: The National Institutes of Health (NIH) provides information on different types of relaxation techniques and how they benefit both physical and mental health.

- National Center for Complementary and Integrative Health. (2021). Relaxation techniques: What you need to know. *National Institutes of Health.* https://www.nccih.nih.gov/health/relaxation-techniques-what-you-need-to-know

Resource: Relaxation Techniques
Handouts and Worksheets: The Therapist Aid website has many additional resources on relaxation techniques to use for psychoeducation and coaching or as homework for BHSS students.

- Therapist Aid. (2025). *Relaxation techniques*. https://www.therapistaid.com/therapy-worksheet/relaxation-techniques

LO-8 Teach problem-solving grounded in evidence-based coping strategies.

Key Terms and Concepts for LO-8

- **problem-solving therapy (PST):** An evidence-based cognitive behavioral approach focused on equipping individuals with skills to identify, define, and effectively resolve life problems that may contribute to psychological distress (Renn et al., 2020; Scott et al., 2010; Zhang et al., 2018).
- **controllable problem:** a stressor or difficulty for which the patient could take direct action on to change the situation (e.g., a debt, a poor schedule, an unread email). Problem solving is only appropriate for these types of problems.
- **uncontrollable problem:** a stressor or difficulty that cannot be altered by the patient's direct action (e.g., the weather, another person's emotions, past events). For these types of problems, the BHSS should guide the patient toward distress tolerance or emotional regulation skills instead.
- **brainstorming:** a structured technique used in the problem-solving process to generate a large number of potential solutions without judgment or immediate critique of any proposed ideas.

Key Teaching Points for LO-8

The Rationale and Timing for Problem Solving

- Problem solving is an evidence-based coping strategy for managing chronic or recurring stressors that are controllable for adults (Zhang et al., 2019) and adolescents (Metz et al., 2023). It should only be attempted after acute distress has been managed (i.e., after using relaxation or grounding techniques). Patients cannot effectively problem solve while in the emotional mind.
- The BHSS acts as a coach and guide when problem solving, ensuring the patient stays focused on the steps, does not skip ahead, and generates solutions relevant to their life. The BHSS does *not* provide the solution.

The Six-Step Problem-Solving Model (Structured Instruction)

- The BHSS may teach patients this structured approach:
- Define the problem (be specific): Clarify the problem in concrete, factual terms. Focus on *what* is happening and *who* is involved. *(Example: "My landlord called and said my rent is due a week earlier than I thought.")*

- Generate solutions (brainstorm): List every possible solution, no matter how impractical or silly. Suspend all judgments**.** *(Example solutions for missing rent: Pay it late, ask a friend, sell my phone, ask the landlord for an extension.)*
    1. Evaluate solutions (pros and cons): Select the top 2–3 most promising solutions and analyze the potential positive and negative consequences for each. This helps move a patient from the emotional to the reasonable mind.
    2. Choose a solution (develop an action plan): Select the best solution and write out a clear step-by-step plan for implementation (the *who, what, when, where*).
    3. Implement the plan (action): The patient carries out the action plan.
    4. Review the results (feedback): Assess whether the plan worked. If it did not, return to Step 3 and choose the next best solution.

Sample Activities/Assessments for LO-8

Activity: Problem-Solving Coaching Role Play
Facilitate a role play of a BHSS guiding a patient through the first four steps of the problem-solving model without providing the solution. Students work in pairs as the patient and the coach or BHSS. The patient presents a controllable problem (e.g., “I'm always late for my appointments because I oversleep” or “I'm overwhelmed by the number of bills I have to pay”). In a 10 to 15-minute session, the coach guides the patient through Steps 1–4 of the problem-solving model. For the self-assessment or observational assessment, evaluate the BHSS’s demonstration of the following components:

- Validating at the start the patient's stress related to the problem
- Ensuring the problem is defined specifically (Step 1)
- Guiding the patient to generate at least five different solutions (Step 2)
- Coaching the patient to select one solution and identify its pros and cons (Step 3)

Specific Resources for LO-8

Resource: Solution-Focused Problem-Solving Worksheet
Worksheet: A useful tool for guiding a patient through a problem-solving process.

- Universal Coach Institute. (n.d.). *Solution-focused problem-solving worksheet.* https://www.universalcoachinstitute.com/wp-content/uploads/2025/02/Solution_Focused_Problem_Solving_Worksheet.pdf

Resource: Problem Solving
Worksheet: An alternate example of a tool to guide a patient through a problem-solving process.

- Therapist Aid. (2016). *Problem solving*. https://www.therapistaid.com/therapy-worksheet/problem-solving

Resource: Six Step Problem-Solving Process
Six Steps: This is a worksheet to share with patients that helps guide them through the structured approach to problem solving.

- NYS & CSEA Partnership. (n.d.). *Six-step problem solving process.* https://nyscseapartnership.org/document/six-step-problem-solving-process

LO-9 Teach assertiveness techniques grounded in evidence-based coping strategies.

Key Terms and Concepts for LO-9

- **assertiveness:** a communication style that involves expressing one's thoughts, feelings, and needs directly, honestly, and appropriately while respecting the rights of others. It is the middle ground between passivity and aggression.
- **passive communication:** a style characterized by failing to express one's needs or feelings, often leading to others violating one's rights. This can result in resentment, unfulfilled needs, and increased distress.
- **aggressive communication:** a style characterized by expressing one's needs in a demanding, hostile, or dominating manner that violates the rights of others. While one's needs are expressed, they are done so in a way that leads to conflict, broken relationships, and guilt.
- **interpersonal effectiveness:** a core DBT skill module that focuses on how to meet one's needs, maintain self-respect, and build and maintain positive relationships. Assertiveness is central to this.
- **"I" statements:** assertions that are framed around the speaker's feelings and observations, rather than the listener's actions (e.g., "I feel frustrated when..." instead of "You always make me feel..."). "I" statements are a foundational assertiveness technique.

Key Teaching Points for LO-9

The Assertiveness Continuum

- Assertiveness is a critical coping strategy because it reduces interpersonal stress by ensuring the patient's needs are heard without resorting to conflict or self-negation (Omura et al., 2017). Teaching this skill involves helping the patient identify where they fall on the communication continuum and guiding them toward assertiveness. Assertiveness training is highly effective for both adults and adolescents (Avşar & Ayaz Alkaya, 2017; Caplan et al., 1992).
- Distinguishing styles:
    - Passive: I lose, you win (ignoring one's own rights)
    - Aggressive: I win, you lose (violating the other person's rights)
    - Assertive: I win, you win (mutual respect; compromise is possible)

Teaching Structured Instruction with the DESC Script

- One structured assertive communication model BHSSs can teach patients is the **DESC script**, short for *Describe, Express, Specify, Consequences*:
    - **D**—Objectively **describe** the situation or the behavior that is causing the problem, sticking only to the facts (avoiding judgment). *(Example: "When you arrive 20 minutes late to our meetings...")*
    - **E**—**Express** your feelings about the situation using an "I" statement. *(Example: "...I feel frustrated and anxious because...")*
    - **S**—Clearly and concretely **specify** the desired change in behavior or the solution. *(Example: "...I need you to call or text me if you'll be more than five minutes late.")*
    - **C**—Explain the **positive consequences** of cooperation or the **negative consequences** of noncooperation (stated calmly). (*Example: "If you call, we can adjust the agenda and stay on track," or "If you continue to be late without notice, I will have to start the meeting without you.")*

BHSS Coaching Best Practices

- Role play is essential. Assertiveness must be practiced out loud. The BHSS can facilitate role play and provide immediate feedback on the patient's body language, voice tone, and word choice.

- Start small. Coach patients to practice assertiveness in low-stakes situations first (e.g., ordering food, asking a friend for a small favor) before applying it to high-stakes conflicts (e.g., talking to a boss or partner).

Sample Activities/Assessments for LO-9

Activity: Coaching and Observation Session
A coach (BHSS) teaches a patient (peer) the DESC model for assertive communication. The coach guides the patient through application of DESC to a benign situation (e.g. setting boundaries with an in-law over the holiday or declining to take on a low performing employee's workload). For a self-assessment or observation, evaluate the following:

When the patient practiced assertiveness, did the coach help guide the patient to:

- Stick to the facts?
- Express their feelings using "I" statements?
- Identify whether the desired change was specific and realistic?
- State consequences calmly?

Specific Resources for LO-9

Resource: DESC Model of Assertiveness Training
DESC: This website provides information on the DESC model as a helpful tool for individuals and teams.

- Agency for Healthcare Research and Quality. (2023). Tool: DESC. *U.S. Department of Health and Human Services.* https://www.ahrq.gov/teamstepps-program/curriculum/mutual/tools/desc.html

BHSS Practicum

LO-10 Model distress tolerance and use of healthy boundaries when facing patients' intense emotional experiences

Key Terms and Concepts for LO-10

- **emotional contagion:** the psychological phenomenon in which a person's emotions and related behaviors quickly and automatically trigger similar emotions and behaviors in other people. During a patient crisis, the BHSS must actively resist emotional contagion to remain an anchor of calm.
- **provider safety:** the physical, psychological, and emotional well-being of the BHSS. In the context of intense patient emotion, this includes the provider protecting oneself from verbal aggression, physical harm, and secondary traumatic stress.
- **healthy boundaries:** professional, invisible limits that define the appropriate and safe interaction between the BHSS and the patient. These protect both parties by ensuring the relationship remains therapeutic, predictable, and focused on the patient's goals.
- **self-care:** the continuous act of combining reflective practice with opportunities for recreation to achieve balance between work and one's personal life.

- **DEAR MAN:** the acronym describing a DBT technique: Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate. It can be used for effectively making or refusing a request.

Key Teaching Points for LO-10

Modeling Distress Tolerance (The "Anchor" Role)

- Physiological grounding: The BHSS's first job in a crisis is to regulate their own body to avoid escalating the patient's emotion (to reduce any emotional contagion). The BHSS should mentally or physically employ a brief distress tolerance skill (e.g., *paced breathing* or a quick *5-4-3-2-1* grounding check) before speaking or acting.
- Composure and tone: Modeling composure means maintaining a calm, low, and even tone of voice and a nonreactive, open posture, even when the patient is yelling, crying, or highly agitated.
- Nonjudgmental stance: The BHSS must internally practice radical acceptance of the patient's intense emotion (LO-1) to avoid reacting with personal offense, fear, or frustration.

Setting and Maintaining Healthy Boundaries

- Boundaries = safety: Healthy boundaries ensure the therapeutic relationship is safe and professional. In a crisis, boundaries are about maintaining physical distance and asserting limits on behavior, not emotion.
    - Acceptable boundary: "I understand you are angry, but I need you to lower your voice if we are going to continue this conversation." (Putting limits on behavior)
    - Unacceptable boundary: "You need to calm down or I will leave." (Invalidating; attempting to control emotion)
- Immediate action for safety: If a patient's intense emotion transitions into a physical threat or clear verbal abuse, the BHSS's immediate priority is safety. This requires using a clear boundary statement and following established safety protocols (e.g., requesting backup, calmly moving to an exit, using the DEAR MAN technique to assert a need to step away).
- Post-session self-care: Following an emotionally intense session, the BHSS should use a self-care strategy (e.g., deep breathing, consultation with a supervisor) to decompress from the emotional experience, preventing burnout and compassion fatigue.

Sample Activities/Assessments for LO-10

Activity: Crisis Role Play with Focus on Provider Self-Regulation

Students may work in groups of three: one as a patient who is highly emotional, one as a BHSS, and another as an observer (the instructor may also observe). The patient presents an intense emotional state (e.g., crying uncontrollably, pacing, yelling nonspecific and angry demands). The BHSS spends 5–7 minutes attempting to de-escalate the patient without becoming personally distress. The BHSS should internally check their breathing and, if necessary, set one clear boundary. This activity may be done virtually rather than face to face and student consent for participation is necessary. A "fishbowl" structure may be more appropriate for certain groups. For a self-assessment or observation, evaluate the BHSS's demonstration of the following:

- Using a slow, regulated voice throughout the scenario.
- Using a validation statement to acknowledge the patient's pain.

- If the patient's behavior is unsafe or abusive (e.g., moving too close, swearing), asserting one firm, professional boundary (e.g., "I will stay here with you, but I need you to please sit back down/keep your voice down").

Specific Resources for LO-10

Resource: How to Say "No"
Setting Boundaries: A worksheet for therapists on boundary setting that may benefit both the therapist and patient.

- Therapist Aid. (2023). *Setting boundaries: How to say "no."* https://www.therapistaid.com/therapy-worksheet/setting-boundaries

Resource: How to Build Psychological Capacity
Mastering the Inner Skills of Psychotherapy: A deliberate practice manual on building psychological capacity.

- Rousmaniere, T., & Jin, J. (2026). *Mastering the inner skills of psychotherapy: A deliberate practice manual on building psychological capacity* (2nd ed.). American Psychological Association. https://www.apa.org/pubs/books/mastering-inner-skills-psychotherapy-second-edition

LO-11 Assess immediate risk and make appropriate referrals to a higher level of care.

Key Terms and Concepts for LO-11

- **immediate risk:** a situation where a patient poses a clear and present danger to themselves (suicidal behavior) or to others (homicidal behavior or violence). This requires a time-sensitive intervention.
- **safety plan:** (also known as a "crisis response plan"): a living document that outlines personal warning signs, coping strategies, and resources to use during a crisis.
- **ideation, plan, and means (IPM):** the core components of suicide risk assessment. Ideation involves thoughts of death or suicide; a plan includes a specific method, time, and/or place; and means is having the method or weapon readily available. High risk is indicated by a specific plan with readily available means.
- **higher level of care:** clinical services that offer greater structure, supervision, and intensity than standard outpatient care. Examples include crisis stabilization units, emergency departments, psychiatric inpatient hospitals, or intensive outpatient programs (IOP).
- **duty to protect:** in the United States, the duty to protect is rooted in the Tarasoff decision (Tarasoff v. the Board of Regents of the University of California, 1976) in which the California Supreme Court ruled that behavioral health providers ought to hold privileged communication for their patients except when maintaining privacy threatens the life of another person. Subsequently, other states have passed laws that further detail when and how a behavioral health provider must act to protect others. The duty to protect involves careful assessment of a situation so that any breach of confidentiality does not cause more harm by failing to accurately assess the circumstances. The duty to protect leads to the duty to warn.
- **duty to warn:** In 1976, in Tarasoff v. the Regents of the University of California, the California Supreme Court ruled that the persons involved in the patient case (college counselor, supervisor, and campus police) ought to have breached confidentiality and warned Tatiana

Tarasoff that her estranged boyfriend intended to harm or kill her. This case laid the foundation for other states to pass laws that require certain professions or citizens to take steps to warn a person if they are in danger. Over time, the duty to warn has been extended to those who may be within the vicinity of the person at risk for lethal harm.

Key Teaching Points for LO-11

Components of Immediate Risk Assessment

- **Ask directly and nonjudgmentally.** The BHSS should know how to ask clear, direct questions about suicide and violence. The questions should use simple language: *"Are you having thoughts of killing yourself right now?"* or *"Are you planning to hurt anyone?"*
- Suicide risk assessment in the BHSS role: The BHSS is typically tasked with gathering facts to inform the licensed clinician's final decision. Key information to gather includes:
    - **Ideation.** Are the thoughts current and frequent?
    - **Plan.** Is the plan specific (does the patient know when, where, how)?
    - **Means.** Does the patient have access to the means (e.g., pills, weapon)?
    - **Intent.** How likely is the patient to act on the plan?
    - **History.** Has the patient attempted suicide before? (This is a major risk factor.)
- **Prioritize safety over comfort.** A patient may become angry or upset when asked about risk. The BHSS must tolerate this distress and complete the risk assessment to ensure safety.

Decision Making and Referral Protocol

- High risk: If the patient has a specific plan and accessible means, or if they are actively showing symptoms of psychosis, the BHSS must immediately contact their supervisor and/or emergency services (911/crisis team). Never leave the patient alone. The appropriate referral is usually the emergency department for medical clearance and psychiatric evaluation.
- Moderate risk: If the patient has ideation but no immediate plan or means, the BHSS should initiate a safety plan collaboratively with the patient (if trained) and immediately consult with a supervisor to discuss a warm hand-off to a higher level of outpatient care (e.g., IOP) or intensive case management.
- The BHSS must understand that they do not have the authority to make the final determination to hospitalize a patient. Their role is to gather information, maintain safety, and follow the agency's established protocol for contacting the licensed clinical supervisor or medical staff.

Sample Activities/Assessments for LO-11

Activity: Crisis Triage and Protocol Simulation Exercise
Students work in pairs or small groups. The instructor provides three case vignettes with varying risk levels (one high, one moderate, one low) and a copy of a fictional agency's crisis protocol and referral flowchart. For each vignette, students identify the level of immediate risk (high, moderate, low) and list the three most important risk questions to ask the patient. Then, using the protocol flowchart, they identify the next immediate step to take (e.g., contact supervisor, call 911, schedule follow-up) and the most appropriate referral to a higher level of care (e.g., ED, IOP, Crisis Line).

UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES

Unit Summary

This unit establishes the foundational skills necessary for a bachelor's-level Behavioral Health Support Specialist (BHSS) to manage and stabilize patients experiencing acute distress. The curriculum progresses from defining core concepts like distress tolerance and recognizing acute stress symptoms to the practical application of stabilization skills, including emotional regulation and relaxation techniques. BHSS trainees also develop critical cognitive and interpersonal competencies, learning to address the influence of cultural and historical factors, employing active listening and empathy skills, coaching patients on reframing, facilitating problem solving, and teaching assertiveness. The final objectives emphasize the professional role, including the necessity to model personal distress tolerance and boundary maintenance during crisis and to assess immediate risk and make appropriate referrals to ensure patient and provider safety. Through frequent role play and skill practice across these objectives, the BHSS should achieve a genuine belief in their capacity to stabilize, support, and safely refer patients in crisis.

Annotated Bibliography

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- This systematic review of 11 studies published between 2006 and 2017 examines how interventions targeting distress tolerance (i.e., the capacity to endure and effectively respond to negative emotional states) may support self-management in individuals with chronic conditions. The review finds high heterogeneity in how distress tolerance and self-management behaviors were defined and measured across studies; only one study assessed goal-oriented problem solving as a specific outcome. The authors conclude that, while theoretically promising, current evidence is limited, and more rigorously designed, theory-driven interventions with explicit mechanisms (i.e., how distress tolerance leads to problem solving which leads to self-management behavior) are needed. For instructors teaching stress-management strategies, this review underscores the importance of cultivating distress tolerance skills (in addition to stress reduction ones).

Rogerson, O., Wilding, S., Prudenzi, A., & O'Connor, D. B. (2024). Effectiveness of stress management interventions to change cortisol levels: A systematic review and meta-analysis. *Psychoneuroendocrinology*, *159*, 106415. https://doi.org/10.1016/j.psyneuen.2023.106415

- This systematic review and meta-analysis evaluates the effectiveness of various stress management interventions, such as relaxation techniques, mindfulness, and cognitive behavioral approaches, on physiological stress markers, specifically cortisol. Across 58 randomized controlled trials, the researchers found that these interventions produced a medium overall effect in reducing cortisol levels, suggesting a measurable impact on the body's stress response. Among intervention types, relaxation and mindfulness showed the strongest influence on cortisol regulation, while talk therapies and general mind-body exercises had smaller effects. This article provides a robust, evidence-based foundation for explaining how psychological techniques can alter physiological stress responses. It highlights the biological

underpinnings of stress and supports incorporating relaxation training, mindfulness practices, and guided breathing into classroom activities.

Malouff, J. M., Thorsteinsson, E. B., & Schutte, N. S. (2007). The efficacy of problem solving therapy in reducing mental and physical health problems: A meta-analysis. *Clinical Psychology Review*, *27*(1), 46–57. https://doi.org/10.1016/j.cpr.2005.12.005

- This meta-analysis of 31 studies to evaluate the effectiveness of problem-solving therapy (PST) on mental and physical health outcomes. Results indicated that PST significantly reduced symptoms of depression, anxiety, and stress-related conditions, with larger effects compared to no-treatment controls and moderate effects versus treatment-as-usual. The analysis highlighted that PST is particularly effective when delivered in structured, time-limited formats and when focused on real-life problems. For instructors teaching stress management strategies, this article provides strong empirical support for integrating problem-solving skills as a coping intervention, demonstrating that structured problem-focused approaches can mitigate psychological distress and support adaptive functioning across a range of mental and physical health contexts.

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