DBT Skills: Distress Tolerance and Emotion Regulation

THE TALKING THERAPIES UK PRACTITIONER SERIES



DBT Skills: Distress Tolerance and Emotion Regulation

Surviving crises and changing emotions

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the DBT Skills: Distress Tolerance and Emotion Regulation course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 9 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This advanced practitioner course offers a rigorous exploration of the Distress Tolerance and Emotion Regulation modules within Dialectical Behaviour Therapy, designed to deepen clinical competence in managing acute crises and fostering emotional stability. Participants will engage with the full spectrum of distress tolerance skills, mastering crisis survival techniques such as TIP, self-soothing, and the ACCEPTS method to endure unbearable moments without exacerbating the situation. The curriculum also emphasises the critical practice of radical acceptance and turning the mind, providing a framework for peace when reality is immutable. In the emotion regulation section, learners will advance their understanding of emotional processing, learning to identify triggers, distinguish between emotions and thoughts, and reduce vulnerability through the PLEASE skills. The course details specific interventions, including Opposite Action to modify intense feelings and Checking Facts to challenge cognitive distortions. By addressing common clinical pitfalls and integrating these strategies into practice, this training empowers clinicians to guide clients effectively towards a balanced life, ensuring they possess the practical tools necessary for sustainable recovery. This module is essential for professionals seeking to refine their therapeutic approach and improve client outcomes in high-stress environments.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Teach crisis-survival skills: STOP, TIP, distraction and self-soothing, with rehearsal
- Teach radical acceptance and willingness against wilfulness
- Coach the emotion-regulation model: prompting events, interpretations, responses and after-effects
- Teach vulnerability reduction with PLEASE and pleasant-events scheduling
- Coach opposite action with correctly identified emotions and urges
- Judge which module a moment calls for: tolerating this crisis or regulating the pattern

PART 1

Core Distress Tolerance and Crisis Survival Skills

This module introduces foundational crisis survival and reality acceptance strategies to help clients manage overwhelming distress in daily life.

CHAPTER 1

Crisis survival skills

Crisis survival skills occupy a distinctive niche within Dialectical Behaviour Therapy (DBT). They are not designed to resolve the underlying problem, to process the painful narrative, or to restructure maladaptive beliefs; rather, they are engineered to keep the client alive and intact long enough for the more change-oriented modules of DBT to be brought to bear. The theoretical foundation for this approach rests on Marsha Linehan's biosocial model, which posits that emotional dysregulation emerges from the interaction of a biologically vulnerable emotional system and an environment that invalidates the person's emotional experience. When the emotional system is driven to a high-intensity state, the risk of acting on self-destructive urges rises sharply, and the therapist's immediate task is to provide a set of skills that can bridge the client across the peak of the crisis. The central premise, set out in Linehan's (1993) skills training manual, is that the goal in a crisis is to get through the moment, not to solve the problem in that moment. This premise must be communicated to the client in clear, concrete language, often using the metaphor of a railing that supports a person while they cross a dangerous bridge; the railing does not carry them across, but without it the fall would be certain.

The first clinical decision point is to determine whether the situation truly qualifies as a crisis. In DBT terminology, a crisis is characterised by three convergent criteria: the intensity of distress is high enough to threaten the client's safety or the safety of others; the client experiences a strong, often urgent urge to engage in a behaviour that would be harmful in the longer term (such as self-harm, substance use, reckless driving, or suicide attempts); and the problem that precipitated the distress cannot be resolved in the present moment. The therapist repeatedly asks the client the threshold question, "Can this be dealt with now?" If the answer is yes, the client is guided to employ the emotion regulation or problem-solving skills that are appropriate for that context. If the answer is no, and the urge is escalating, the crisis survival skills are activated. This decision-making process is taught repeatedly until it becomes automatic, because misapplication of the skills—using them as a permanent avoidance strategy—undermines their

credibility and can reinforce the very patterns they are meant to interrupt.

Distraction is the first and often most intuitive of the crisis survival tools. Linehan (1993) introduced the acronym ACCEPTS to organise the range of distraction techniques. The components of ACCEPTS are Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, and Sensations. Each component offers a distinct pathway for redirecting attention away from the painful affect and toward a neutral or mildly pleasant stimulus. Activities involve engaging in an absorbing task that demands both hands and full concentration, such as a puzzle, a video game, or a vigorous household chore. Contributing shifts the focus outward by performing a helpful act for another person, thereby challenging the internal narrative of worthlessness. Comparisons, when used judiciously, invite the client to recall a past episode of intense distress that they survived, or to note that others may be experiencing greater hardship, thereby providing a relative perspective without fostering shame. Emotions encourages the client to deliberately invoke a contrasting emotional state, for example by watching a comedy clip when feeling enraged. Pushing away is a mental technique of deliberately postponing the problem, visualising it placed in a box to be opened at a later, safer time. Thoughts involve filling the mind with cognitive tasks such as counting backwards by sevens, reciting the alphabet in reverse, or naming world capitals. Sensations refer to deliberately seeking strong, safe sensory input, such as holding an ice cube, taking a cold shower, or snapping an elastic band against the skin. Two procedural safeguards are essential: the client must name the skill they are employing as they begin, distinguishing purposeful distraction from dissociative drift, and they must set a time limit, typically ranging from five to fifteen minutes, after which they reassess the intensity of the urge.

Self-soothing follows distraction in the hierarchy of crisis skills because it addresses the deeper need for comfort that is often denied by an invalidating environment. The five senses provide a structured framework for self-soothing. Visual self-soothing may involve gazing at a calming photograph, a candle flame, or a nature video. Auditory soothing can be achieved through a playlist of soothing music, nature sounds, or a guided relaxation recording. Olfactory soothing leverages the powerful connection between smell and the autonomic nervous system; a favourite scented candle, a particular soap, or freshly brewed coffee can serve as a cue for safety. Gustatory soothing involves slowly savouring a small, pleasant taste,

such as a piece of dark chocolate or a sip of herbal tea, paying full attention to texture and flavour. Tactile soothing includes wrapping oneself in a soft blanket, taking a warm bath, or petting a dog. The biosocial theory predicts that many clients will initially resist self-soothing because they have internalised messages that comfort is a sign of weakness or that they do not deserve kindness. The therapist therefore frames self-soothing as a skill that directly counteracts the invalidation, and encourages the client to schedule brief, non-negotiable self-soothing moments each day, gradually building tolerance for receiving comfort from oneself.

Improving the moment, organised under the acronym IMPROVE, offers a suite of techniques that aim to shift the client's internal experience without necessarily removing the distressing stimulus. Imagery invites the client to visualise a safe place or to mentally rehearse navigating the crisis successfully, thereby creating a neural rehearsal of coping. Meaning draws on Viktor Frankl's existential logotherapy, encouraging the client to locate a sliver of purpose or value within the painful experience, without demanding that the pain itself be justified. Prayer or, for secular clients, a form of spiritual surrender, allows the client to place the crisis in the hands of a larger entity, reducing the sense of personal responsibility for the intensity of the emotion. Relaxation involves systematic muscle relaxation, diaphragmatic breathing, or progressive tension-release, capitalising on the bidirectional relationship between the body and mind. One thing in the moment is a mindfulness technique that narrows attention to a single, present-centred action—such as feeling the texture of a stone or the rhythm of one's breath—thereby anchoring the client in the here and now. Vacation creates a brief mental or physical break from the problem, granting the client permission to step away for a defined period, often visualised as a mental holiday. Encouragement is a form of compassionate self-talk, deliberately countering the internal critic with affirmations such as "You have survived this before, you can survive it again". Each of these strategies is taught with an emphasis on rehearsal during calm periods, so that the client can retrieve them automatically when the crisis peaks.

The final component of the crisis survival toolkit is the pros and cons analysis, which differs from the standard decision-making matrix used in other DBT modules. In the crisis context, the grid contains four cells: the pros of acting on the urge, the cons of acting, the pros of tolerating the urge, and the cons of tolerating. The therapist guides the client to complete this

analysis in a state of relative calm, encouraging honest articulation of the perceived benefits of the self-destructive behaviour—such as immediate relief, a sense of control, or a feeling of being heard. This honest acknowledgement validates the client's experience and often proves to be the most therapeutic element of the exercise. The completed card is then stored in a readily accessible location—such as a wallet, phone lock screen, or bathroom mirror—so that it can be consulted in the heat of the moment when rational deliberation is otherwise unavailable. Writing the pros and cons in advance is meant to make it more likely that clients will pause before acting on urges, providing a window for other crisis skills to take effect (Linehan, 2015).

The practical implementation of these skills requires careful attention to the function of the client's self-harm or other high-risk behaviour. For a client whose cutting reliably reduces unbearable affect within ninety seconds, a simple distraction such as scrolling through social media may be insufficient unless it has been rehearsed to the point of automaticity. The therapist therefore works with the client to develop a personalised crisis kit, placing the most effective distraction items (for example, a set of coloured pencils, a small puzzle, or a list of favourite songs) in the environment where the crisis typically occurs. The kit is reviewed after each real-world use, with the therapist asking two reflective questions: what was reachable, and what actually moved the intensity rating on the client's self-report scale (often a visual analogue scale from zero to ten). This iterative process refines the kit, ensuring that the most potent tools are the most accessible.

To illustrate the integration of these concepts, consider the case of a 27-year-old woman named Mia who presents with recurrent episodes of self-injury following interpersonal conflicts. Mia scores a nine out of ten on her distress visual analogue scale after a heated argument with her partner. In the session, the therapist first confirms that the problem (the argument) cannot be resolved in the immediate moment and that Mia's urge to cut is intensifying. The therapist guides Mia through the threshold question, and together they decide to activate the crisis survival skills. Mia selects the distraction component of ACCEPTS, choosing an activity: she begins a crossword puzzle she has kept on her bedside table. While completing the puzzle, she names the skill she is using, "I am using distraction through activity," and sets a timer for ten minutes. After five minutes, the intensity of her urge drops to a six. She then moves to self-soothing, selecting the tactile

sense: she wraps herself in a weighted blanket she has identified as comforting. She focuses on the pressure of the blanket, describing the sensation to herself, which further reduces the urge to a four. Next, Mia employs the IMPROVE technique of Imagery, closing her eyes and visualising a quiet beach where she feels safe and in control. The mental rehearsal of a safe place stabilises her affect. Finally, she consults the pros and cons card she prepared in a previous session. She reads aloud the pros of cutting—"It will stop the pain now, it will make me feel in control"—and the cons—"It will leave a scar, it will increase my shame, it will not solve the argument"—as well as the pros of tolerating—"I will stay alive, I can talk to my therapist later"—and the cons of tolerating—"The pain will continue for a while". The honest acknowledgement of the pros of cutting validates her experience, and the balanced view of tolerating reinforces her commitment to survive the moment. After completing the card, Mia feels a renewed sense of agency and decides to call a trusted friend, which further reduces her urge to a two. She eventually falls asleep, having survived the crisis without self-harm. In the subsequent therapy session, the therapist and Mia review the episode, noting which components of the kit were most effective, and they adjust the kit accordingly, adding a new sensory item (a scented lavender oil) that Mia reports as particularly soothing.

The evidence for crisis survival skills comes from trials of DBT as a whole. In a randomised trial, women with borderline personality disorder who received DBT were half as likely to attempt suicide as those treated by non-behavioural experts (Linehan et al., 2006); in another, DBT and general psychiatric management produced similar and lasting improvements, including in self-harm (McMain et al., 2012); and a Cochrane review found DBT more effective than treatment as usual for parasuicidality and anger (Stoffers et al., 2012). Skills training appears to matter: in a component trial, the interventions that included it reduced non-suicidal self-injury more than DBT individual therapy without it (Linehan et al., 2015). The underlying mechanisms are thought to involve the strengthening of behavioural repertoires that can interrupt the chain of events leading from emotional escalation to self-destructive action, thereby increasing the client's perceived self-efficacy and reducing the likelihood of impulsive behaviour.

In practice, the therapist must maintain a stance of radical acceptance while simultaneously encouraging the client to employ the crisis survival skills. This dialectical stance mirrors the broader DBT philosophy: the therapist

validates the client's current emotional experience and the rationality of the urge, while also gently nudging the client towards behaviours that preserve life and health. The therapist's language should reflect this balance, for example: "I hear that the pain feels unbearable and that cutting would bring you immediate relief. At the same time, I also hear that you want to stay safe and keep your body intact. Let's use the skills we have practised to give yourself a chance to see whether the urge passes without harming yourself."

Finally, the construction of a crisis kit should be a collaborative, client-centred process. The therapist asks the client to identify two distraction activities that reliably capture their attention, one self-soothing item for each of the five senses, and two IMPROVE strategies that feel personally resonant. The client then drafts a pros and cons card in their own words, ensuring that the language used is authentic and non-judgemental. This kit is reviewed at the start of each session, and any modifications are made based on the client's lived experience of using the kit in real crises. The iterative nature of this process underscores the DBT principle that skills are not static prescriptions but dynamic tools that evolve with the client's growth.

In summary, crisis survival skills are a meticulously structured set of interventions designed to bridge clients across the most perilous moments of emotional intensity. By clearly delineating when the skills apply, teaching distraction through the ACCEPTS framework, guiding self-soothing via the five senses, expanding the repertoire with IMPROVE techniques, and cementing decision-making through a four-cell pros and cons analysis, the therapist equips the client with a robust, evidence-based safety net. The ultimate aim is not to resolve the underlying problem in the heat of the crisis, but to ensure that the client emerges from the episode unscathed, ready to engage in the subsequent emotion-regulation and problem-solving work that will promote lasting change.

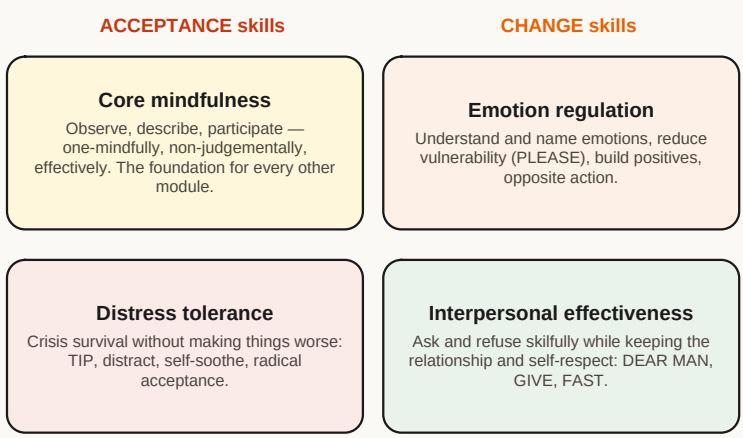


FIGURE 1.1 The four DBT skills modules

Linehan's skills curriculum balances acceptance and change. Mindfulness and distress tolerance teach how to be with experience as it is; emotion regulation and interpersonal effectiveness teach how to change it. Core mindfulness underpins all three of the others.

Points worth keeping

- When crisis survival skills apply
- Distraction and self-soothing
- Improving the moment
- Pros and cons of tolerating versus acting

PRACTICE TASK

Build a personal crisis survival kit of six concrete actions.

CHAPTER 2

Reality acceptance skills

The capacity to live with what is, rather than to be forever caught in the battle against it, is the cornerstone of the Distress Tolerance module in Dialectical Behaviour Therapy (DBT). After the crisis-survival skills have steadied the emotional tide, the learner is invited to move from the question of "how do I get through this hour?" to the deeper, more enduring inquiry of "how do I live with what is true?" This shift is not a concession to defeat; it is an invitation to cultivate a stance of reality acceptance that allows the client to conserve emotional energy for the actions that can truly change the situation. The reality-acceptance skill set comprises Radical acceptance, Turning the mind, and the distinction between Willingness versus wilfulness, each of which is taught with a precise definition, a clear behavioural component, and a grounding in the evidence base that underpins DBT.

Radical acceptance, as Marsha Linehan (1993) describes it, is the complete and total acceptance of reality as it is, without judgement and without fighting or denying it. The definition is deliberately narrow because the therapeutic impact hinges on the client's ability to separate acceptance from approval, forgiveness, resignation, or passivity. Acceptance is a stance, not a feeling; it is a deliberate choice that can be made even when the accompanying emotions are painful. The arithmetic that the module repeatedly emphasises – pain plus non-acceptance equals suffering – captures the essence of the skill. Pain, in this formulation, is the inevitable levy of loss, illness, or injustice; suffering is the additional charge imposed by the mental struggle against the fact. When a client refuses to accept a diagnosis of multiple sclerosis, for example, the ongoing internal war adds layers of anxiety, anger, and self-criticism that amplify the original pain. By embracing Radical acceptance, the client acknowledges the reality of the diagnosis, thereby halting the second, unnecessary war and freeing emotional resources for constructive coping.

It is essential to delineate what Radical acceptance is not, because the distinction often becomes the source of misunderstanding. First, it is not approval. One can accept that a storm has ruined a picnic without approving the storm's existence. Second, it is not passivity. Acceptance is the

pre-condition for effective action; one cannot change a circumstance that is denied. The dialectic of acceptance and change at the heart of DBT (Linehan, 1993) underlies this stance. Third, acceptance is not forgetting or forgiving. Those are separate processes that may follow, but they are not required for the acceptance itself. Finally, acceptance is not a feeling that magically replaces distress; rather, it is a deliberate mental posture that often allows the underlying sadness or grief to surface, signalling that the skill is functioning as intended.

Turning the mind is the operational mechanism that transforms Radical acceptance from a single, daunting decision into a repeatable practice. The mind, like a steering wheel, can be turned repeatedly toward acceptance each time the client notices a drift back into argument or denial. Linehan (1993) describes it as choosing acceptance again each time one notices that one has gone back to fighting reality. The skill is taught as a series of micro-steps: first, the client names the moment of resistance (e.g., “I am fighting the fact that I lost my job”); second, the client acknowledges the resistance without judgment; third, the client consciously turns toward acceptance, using a phrase such as “I am choosing to accept what is”. The repetition of this process builds a mental muscle that can be deployed in low-stakes situations – a traffic jam, a rainy day – before being summoned in higher-stakes contexts such as a relationship breakup or a serious health diagnosis. By framing acceptance as a series of turns rather than a singular achievement, the client learns to count each turn as a success, thereby dismantling the belief that “I tried acceptance and it did not work”.

The distinction between Willingness versus wilfulness provides the posture that underlies the turning process. Wilfulness is the somatic and cognitive refusal to play the hand that has been dealt; it manifests as crossed arms, clenched fists, a set jaw, or the mental narrative of “this cannot be true”. It is a defensive posture that maintains the internal war and, paradoxically, exhausts the client’s emotional reserves. Willingness, on the other hand, is the open-handed, body-aligned stance of entering the reality as it stands, ready to act from that point. The module encourages clients to notice the physical cues of wilfulness and to replace them with the opposite somatic signals – relaxed shoulders, palms open on the lap, a softening of the facial expression. Research on embodied cognition (e.g., Damasio, 1994) supports the notion that bodily posture can influence emotional experience, and DBT integrates this insight by pairing the mental shift of Turning the mind with a

concurrent bodily shift towards willingness.

A graded approach ensures that the skills are trainable rather than aspirational. The learner begins with trivial realities – accepting a red traffic light, the taste of a bitter medicine, the inconvenience of a delayed train. These low-stakes repetitions allow the client to experience the turning process without the threat of overwhelming emotion. Once competence is demonstrated, the client progresses to moderate challenges – a cancelled appointment, a critical comment from a supervisor, the onset of a chronic pain flare. Finally, the client may approach the epicentre of their suffering – a traumatic loss, a diagnosis, a history of abuse – but only after the turning muscle has been sufficiently conditioned. This hierarchical exposure mirrors the principles of exposure therapy (Foa et al., 2007) and respects the client's capacity for emotional regulation.

It is crucial to maintain the boundary that Radical acceptance applies to facts, not to ongoing abusive situations. In a case of current domestic violence, the therapist does not ask the client to accept the violence itself; rather, the client is guided to accept the fact that the violence is occurring. This acceptance removes the denial that often impedes safety planning, thereby enabling the client to take decisive protective action. The skill is thus paired with the principle of "accept what you cannot change, change what you can" – the client accepts the present reality while simultaneously working to alter the circumstances that are within their control.

To illustrate the integration of these concepts, consider the case of Michael, a 45-year-old electrician who suffered a severe hand injury at work, rendering him unable to perform his trade. Initially, Michael entered a period of wilfulness lasting two years, characterised by relentless litigation fantasies, self-pity, and a refusal to engage with vocational rehabilitation. He described his situation as "an injustice that will never be righted" and his body mirrored this stance: arms crossed, jaw clenched, voice edged with bitterness. In therapy, Michael was first asked to practice Turning the mind with trivial realities – accepting the rain on his commute, the delayed bus, the taste of his prescribed analgesic. Over several weeks, he began to notice the moment when his mind drifted back to the narrative of "the system has failed me" and deliberately turned towards acceptance, using the phrase "I am choosing to accept what is".

When the therapist introduced the distinction between Willingness and

wilfulness, Michael was guided to notice his somatic resistance and to experiment with an open-handed posture while filling out a retraining application form. He placed his palms flat on the table, took a slow breath, and, despite tears, completed the form. The act of writing the application with willing hands, even while grieving the loss of his previous career, marked the first concrete turn towards acceptance. Michael later described the experience as "the first day since the accident that happened to me rather than at me" – a subtle but profound shift in perspective. The grief that followed was not a sign of failure; it was the natural emotional response that acceptance had allowed to surface. Over the ensuing months, Michael engaged in a structured vocational programme, eventually qualifying as a health and safety officer – a new professional identity that grew out of his willingness to accept the present reality and act from it.

The lesson concludes with a practice plan that operationalises the three components. The client selects one trivial daily reality to accept (e.g., the taste of a bitter tea), writes down the Turning the mind sequence for a moderate challenge (e.g., a criticism from a colleague), and identifies a wilfulness signature in the body (e.g., clenched fists) to be replaced with a willingness posture (e.g., open palms). By committing to these rehearsals, the client builds the turning muscle, the somatic openness, and the cognitive flexibility required for the more demanding applications of reality acceptance. The next module will build upon this foundation, moving from the acceptance of distressing emotions to the regulation and transformation of those emotions, thereby completing the dialectical balance of tolerating what is and changing what can be changed.

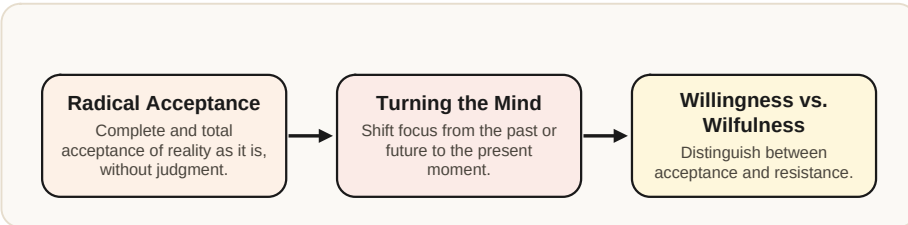


FIGURE 2.1 Reality Acceptance Skills
The flow of reality acceptance skills to cultivate a stance of acceptance. This flow can be repeated as needed, with the mind turning again and again to the present moment.

Points worth keeping

- Radical acceptance
- Turning the mind, again and again
- Willingness versus wilfulness
- Acceptance is not approval

PRACTICE TASK

Identify one situation you could practise radical acceptance towards.