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Editor's Letter

THIS ISSUE OF THE DBT Bulletin is dedicated to ISITDBT 2021. If ISITDBT, the annual conference put on by the International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISITDBT), taught us anything this year, it is that the need is great, our resources are low, and sometimes ill prepared to be truly validating, and we lost a hero. COVID has made that all worse.. and better. At the same time, DBT continues to be well poised to address all of these concerns, except the hero part. Let me start with Dr. Seth Axelrod. The tribute in this issue is nothing short of joyously heartbreaking. For anyone who knew Seth Axelrod, heard of Seth Axelrod, or ever considered a secondary target or the Yale BPD conference, please take the time to read this article. He was the true definition of a mensch, a luminary in DBT, and I am honored to have worked with him in the small capacity I did.

Jumping to the articles, I am sure I am not alone in a large influx of clients trying to get into DBT in the Covid era. Managing the waitlists and turning people away is less than ideal. However, the Portland DBT team do a fantastic job of addressing two access issues, waitlists and coleaders for group. As ever, they are forward thinkers in maximizing access while staying true to the model. Their data support this. The questions they pose for DBT skills groups co-leaders are excellent questions for any interviewer and I found myself jotting some down for future use. Speaking of data, I think the finding of non-reacting mindfulness mediating outcome for DBT to be pretty fascinating (if I do say so myself). I think it points to the idea that being mindful really is the core skill of DBT. The article on the I'M SORRY skill fills a gap I hadn't even thought of (sorry!), but spend too much time teaching free form, so I can't wait to use it.

How many times have you been in team brainstorming how to help your client get more validation and commitment from their family members? I am sure I am not alone trying to get buy in from parents and family members post hoc. The pre-treatment for families article beautifully addresses these challenges head on, with a thoughtful, disciplined plan to address commitment from the family in pretreatment. If you have not seen the role play, by all means check it out on isitdbt.net.

Under do better, try harder, and be more motivated, I couldn't be more delighted to see three articles, addressing diversity, equity, and inclusion. This includes the moving consumer article by Haley Lilling, poignantly bringing home the impact of an invalidating environment on gender dysphoria. In my head I was mapping her experience onto the knockout minority stress handout from Chang and Cohen. I appreciated how the authors clearly outlined concrete interventions to addressing minority stress in DBT. Likewise, the recommendations for Antiracism Competency building reminded me of the principles that DBT therapists can fail, and that the therapy can fail even if the therapist didn't. Nowhere is this more true than in dealing with systemic racism. Fortunately, the authors, using the ABLE approach, help readers develop a clear actionable plan for their teams. Thank you to all of the authors for helping to create another interesting, challenging, and hopefully helpful issue of the bulletin. Happy Reading!

Lynn McFarr
CBT California

At the Heart of the Dialectic: Knowing, Connection, and Joy – Seth Axelrod, Ph.D., 1971 – 2022

Andrea L. Gold, *Brown University*
Suzanne E. Decker, *VA Connecticut Healthcare System*
Emily B. Cooney, *University of Otago*

SETH RICHARD AXELROD, PH.D., died on January 25, 2022, three days after Thich Nhat Hanh's passing. Seth was Director of DBT Services at Yale-New Haven Hospital, Associate Professor of Psychiatry at Yale School of Medicine, and the 2019 Cindy Sanderson Outstanding Educator Award recipient. In these, and his many other impactful roles, he embodied DBT's dialectic of acceptance and change, and the paradox of a synthesis being greater than the sum of its parts.

Seth's precision in assessment and formulation was formidable. His DBT conceptualization work extended Dr. Marsha Linehan's dialectical dilemmas, which he connected with her original secondary targets and therapist characteristics/stances to develop targeted micro- and macro- interventions. This includes a novel protocol for working with dialectical dilemmas and secondary targets, the Acceptance and Change Protocol under preparation for publication. His conceptualization work rested on rigorous assessment, his unerring sense of clarity, and meticulous observation. As any trainee who worked with him can attest, he modelled and expected precision in chain analysis, getting to the heart of the matter, and plunging in where angels fear to tread… and all of this with movement, speed, and flow, in a seven-minute interaction! His larger work in psychology and psychiatry training, developing and continuously improving his DBT summer seminar, and his work as a BTECH trainer are further examples of his relentless focus on change and growth for our field.

His journey living with cancer demonstrated the challenges of the path in front of him, the intense pain, sadness, and frustration that arose, and the acceptance that he returned to over and over again (https://www.cancerhealth.com/article/radical-acceptance-dialectical-behavior-therapy-cancer-profile-seth-axelrod; https://charlieswenson.com/living-with-cancer-1-of-4-episode-64/). As unrelenting and focused on change as he could be, Seth had, and continued to develop, tremendous capacity for acceptance. Seth chose to document this, to share radical acceptance with his family, friends, colleagues, and the world. His Facebook profile image was a visual pun on radical acceptance (Figure 2). Reflecting his characteristic synthesis of acceptance, irreverence, and creativity, he adopted an extended Iron Man metaphor to acknowledge the multiple surgical repairs done to his body and to integrate humor in describing his experiences.

As his friends, former trainees (S.E.D. & A.L.G.), and colleagues (E.B.C.) who had the pleasure and gift of doing DBT with Seth for over a decade (Figure 1), we agree that the syntheses at the heart of the acceptance and change dialectic for Seth were knowing, connection, and joy. Seth's many gifts included his ability to see the essential goodness and the potential for growth in others, long before they themselves could see it and especially when they couldn't. Seth applied his unparalleled "observe" and "describe" mindfulness skills to notice and label those talents. He helped others to assess their own wise mind values and to identify and shape necessary goal-directed behaviors in the service of those values, which he celebrated with them. When Seth taught DBT states of mind, he described emotion mind as "I feel" or "I want," reasonable mind as

Figure 2. Celebrating Seth Axelrod receiving the 2019 International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISITDBT) Cindy Sanderson Outstanding Educator Award in Atlanta, GA. Seth wrote, "I was completely shocked and deeply humbled to receive what I consider the highest honor for a clinician educator …. I'm so proud of all the incredible things my students give back to the world through their clinical care and leadership, research, and community service and advocacy to help individuals move out of suffering and towards fulfilling lives. Thank you for letting me contribute to your growth." Pictured from left to right: Suzanne Decker, Andrea Gold, Seth Axelrod, Emily Cooney.

"I think," and wise mind as "I know." Seth cared deeply about knowing as a process, and he would teach how wise mind integrates knowing that is both intuitive and based on one's experiences. Seth exemplified this synthesis and approached the process of knowing with compassion, curiosity, non-judgmental stance, and pleasure.

Another synthesis at heart of the acceptance and change dialectic for Seth was connection. Many of you may know Seth from his activity on the DBT-L listserv or the annual Yale-NEA BPD conference, which he co-developed with the late, deeply missed, Perry Hoffman, Ph.D. Both illustrate how Seth built, deepened, and broadened connections in the DBT world, seeking to introduce us to one another to foster relationships, debate, and scientific growth. He put tremendous effort into the conference, putting out draft after draft of materials, ensuring that the very chairs the speakers sat in were both comfortable and visually appealing (numeric rating scales were used), and pulling in a small army of volunteers to ensure the day went off well. He took deep joy in connecting DBT colleagues, especially when he could introduce a junior person to a more senior one, as any trainee who attended a professional meeting with him can attest.

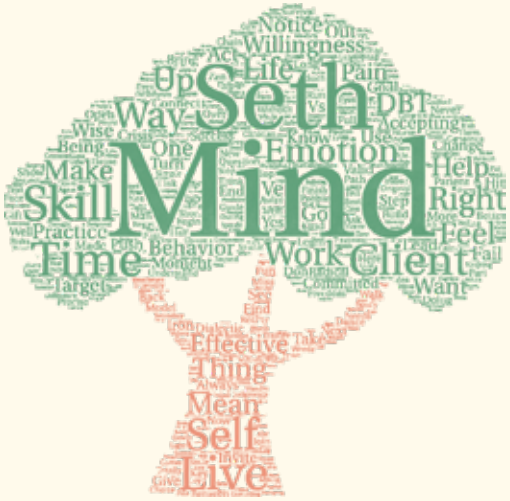

Figure 3. Word cloud created from the responses to the survey distributed to the DBT-L listserv and Seth's former trainees collecting wisdom learned from Seth.

Seth's passion for connection went hand in hand with his generosity. Seth was one of the most generous individuals we know, and he was particularly generous with his time and expertise. He consistently gave ideas, thoughts, solutions, advice, and effort to support someone (be they a student, a practitioner, someone with lived experience, or a family member), whether he knew them or not. He connected, encouraged, cajoled, shaped, and buoyed people up with seemingly boundless enthusiasm, thought, and energy. This generosity was relentless: he continued until he couldn't.

Finally, Seth's dialectic of acceptance and change brought him joy: his deep blast of delighted laughter when a client or trainee perfectly illustrated the problem at hand; his deep joy in being with the DBT community and "talking DBT"; and the tremendous joy, love, and pride he experienced with his family, friends, clients, trainees, and colleagues. Before he headed into his final surgery, he spent a long time giving messages to his wife, Rebecca: tell this person I love them, tell that person I'm proud of them. He mentioned family, friends, colleagues, former trainees. The list went on and on. As a nurse wheeled him across the hospital to the operating room, he kept telling her more and more people was proud of, ending at last with the nurse herself: "I don't think I am exactly qualified to tell you this, but I wanted to let you know you're doing a great job, and I'm proud of you, too."

In true dialectical fashion: while Seth's dialectic of acceptance and change brought him knowing, connection, and joy, his deep and broad capacity and skill for knowing, connection, and joy contributed to his ongoing dialectic of acceptance and change. Both of these are true, and, like Seth, they are greater than the sum of their parts. At Seth's memorial service, his family reflected on how deeply connected he

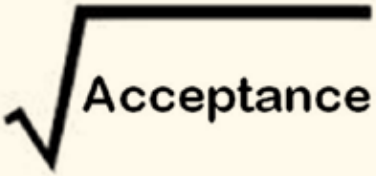

Figure 1. Seth Axelrod's Facebook profile image of a visual pun on radical acceptance.

felt to the DBT community. They commented on how fitting it was for Seth to excel in a field that requires you to bring your full self to the work. As we laughed and cried at his funeral, we also marvelled at how Seth brough his full work to his self, his family, his life. His family members spoke DBT terms such as dialectics, radical acceptance, and life worth living while sharing their memories of Seth. As DBT providers, we smiled at each other, knowing that his family "got it" when they spoke DBT terms.

We cannot imagine a better example of the "participate" mindfulness skill than watching Seth in action, whether it was teaching DBT, validating and coaching individuals with borderline personality disorder and emotional dysregulation, singing with his family and friends, or living with cancer and extending his Iron Man metaphor to cope. While living a life worth living, even when life includes cancer, Seth showed us how pain is inevitable and suffering is optional. We imagine his daily diary card skills ratings were filled with clear 5's ("tried, could use them, helped") and 7's ("didn't try, used them, helped"). His "participate" skill shone, as he threw himself completely into the current moment, became one with whatever he was doing, acted intuitively from his wise mind, and responded with spontaneity.

Another mentor said to one of us recently, "you'll still talk to Seth - and he'll answer. Just from a different place." Seth is gone, and, he is here - in the hundreds of clients he helped, in the former trainees who teach their mentees his work, the colleagues who he consulted with, and in the knowing, connection, and joy he found and nurtured in our DBT community.

Seth Axelrod's ABCs of DBT

Following Seth's passing on 1/25/22, we invited the DBT community to share wisdom they learned from Seth. This is a curated list of the many responses, and one of the many ways that Seth will continue to teach and inspire others

A: **ABCs of behaviorism.** Antecedent, Behavior, Consequence. Seth always reminded us that at its core, DBT is a behavioral treatment.
B: **Benevolent demanding.** What is the behavior you'd like to see? Cut it in half, then cut it in half again.
C: **Choices.** Mindfulness allows us to be skillful and skills gives us choice. When we are being mindful, misery is a choice.
D: **Dancing.** Seth loved the metaphor that a DBT therapist is dancing with a client, and leading the dancel. It's our job to guide clients and lead the way. Seth taught us how to use the dialectical dilemmas to inform how to lead the dance.
E: **Eyes open** is how we practice mindfulness as it is how we live our lives.
F: **Freedom to Act** is the synthesis of full commitment to success and willingness to fail.
G: **Good enough** is the synthesis of doing my best and taking care of myself.
H: **Homework** is important. If you didn't do it, you do a missing links and recommit to doing it next time. Homework will change your life.
I: **Intention.** Seth lived his life with intention. He made mindfully focusing on one thing in each moment a repeated practice. He also frequently noted to clients and to trainees the importance of intentional and deliberate skills practice.
J: **Join.** When consulting to clients on how to navigate their environment, join in with them on understanding the struggle and solving the problem. Seth was constantly joining in and inviting others to do the same.
K: **Kindness** can look like an unwavering commitment to change. Be kind, always and relentlessly. Helping a client often means pushing a client past where they're comfortable, always in the service of their life worth living.
L: **Life worth living** as a guiding light in times of uncertainty. Leading your life worth living means finding what energizes you and fills you up instead of draining you. It involves accumulating positive emotions in the long-term in addition to the short-term, which includes tolerating short-term pain for long-term gain.
M: **Model** what you want your clients to do and learn.
N: **Non-judgmental stance.** Telling the specific truth in a way that invites understanding and problem-solving.
O: **One thing in the moment.** One breath at a time, one step at a time - you only have this present moment.
P: **Pain** + **non-acceptance** = **pain** + **suffering** (and stuck)
Pain + **acceptance** = **pain** (and the ability to move on).
Q: **Questioning or quarreling** with reality? Radical acceptance can help.
R: **Risks** are required to be a skillful and effective DBT clinician. Take risks, make mistakes, and repair when needed.
S: **Strike** when the iron is cold. Practice certain skills during lower-intensity moments to build mastery and work your way up to more difficult situations.
T: **Teflon mind** - push away nothing, cling to nothing.
U: **Unwavering centeredness** is "the quality of believing in oneself, in the therapy, and in the patient. It is calmness in the middle of chaos, much like the center of the hurricane. It requires a certain clarity of mind with respect to what the patient needs in the long run, as well as an ability to tolerate the intensity and pain experienced by the patient without flinching in the short run."3
V: **Variables.** Use behavioral chain analysis to understand and intervene on the controlling variables of target behaviors with precision.
W: **Willingness is an action.** What is the next willing step?
X: **Xenial.** Extending hospitality to strangers. Give people, especially our clients, the benefit of the doubt — assume that we and they are trying our best and want to improve.
Y: **Yes, and** …. When in doubt, think and respond dialectically.
Z: **Zen principle** of begin with the end in mind

COPE AHEAD

Skills Groups for Clients on the Waitlist

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Carson Robinson, *Harborview Medical Center*

Introduction

Recent work in the field of epidemiology has suggested lifetime prevalence rates for Borderline Personality Disorder (BPD) may be as high as 5.9% (Grant et al, 2008), with overrepresentation in forensic settings, emergency departments, and general clinical settings (SAMHSA, 2011). Dialectical Behavior Therapy (DBT) is held as an evidence-based "gold standard" for the treatment of BPD (e.g. SAMHSA, 2011). Learning DBT requires intensive training, posing a challenge to therapists in resource poor community settings (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). Challenges in maintaining staff training and competencies are reflected in the difficulty involved in keeping DBT programs running in the community (Swales, Taylor, & Hibbs, 2012) creating situations where agencies providing DBT find themselves in the unenviable position of maintaining long waitlists due to high demand and limited staff resources for individual therapy.

The current paper presents two implementations of skills-only protocols created using principles described in Linehan (2014, 2015) and uses a "adoption, not adaptation" approach. Both implementations draw from RCT and quasi experimental research demonstrating acceptability and efficacy of skills-only treatment for individuals with BPD (e.g. Linehan et al., 2015; McMain et al., 2017; Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2014), and both implementations focus on implementation of core treatment principles.

Case Studies

Case Number One: Portland DBT Institute, a free standing, private clinic

Portland DBT Institute (PDBTI) is a private, free-standing, group practice, offers full fidelity DBT, accepts private and public insurance, and has waitlists at times exceeding twelve months in duration. Due to wanting to serve a population in need and concerns regarding waitlists, the program created a standalone skills training program for individuals on the waitlist where skills treatment starts within a few weeks of the initial referral, and clients then transfer into full program services after coming off of the waitlist. Individuals could also choose to decline skills-only programming and stay on the waitlist.

For individuals electing to join a skills group rather than remain on a waitlist, the intake structure was modeled on standard clinic protocols for client assessment and payor authorization. During initial referral, administrative staff reviewed inclusion criteria for the skills-only program, which was the need for the individual to have a provider in the community who would provide crisis services. Materials related to the structure of the treatment are provided in a verbal format and in a "cheat sheet" format for clients.

General skills structure for adult clients followed standard protocols described in Linehan (2015). For adolescent clients, group followed protocols described by Rathus & Miller (2014). Specific descriptions of the skills-only components are as follows:

Skills Training Groups

Skills Training Groups are the core of the program and meet twice per week for one hour. One session consists of skills acquisition, and the next focuses on skills strengthening. The functions of skills group are identical to standard skills groups, except skills-only group is split across two sessions. This split maintains risk management practices (e.g. maintaining frequent contact with the individual) and allows for a second point of contact to maintain mindfulness to skills, similar to the manner in which an individual therapist would check in with a client regarding skills use during individual therapy.

Individual Check-In

Individual check-in consists of a bi-weekly check-in between the individual and the group leader. This session is exclusively focused on therapy-interfering-behaviors, increasing skill use, and commitment. The individual is referred to their outside provider if additional therapeutic issues arise, or if crisis intervention is required.

Crisis Management

Individuals in the skills-only program do not receive 24-hour coaching call coverage or crisis management while on the waitlist. Crisis management is provided by the individual's outside clinician, in conjunction with use of state and county crisis lines and other crisis resources.

Initial program evaluation data from adult and adolescent skills-only programs show rates of program completion and attendance meeting or exceeding rates of completion and program attendance for standard DBT services (e.g. skills with individual therapy) at the clinic. For example, in the teen program, families in the skills-only group had group attendance rates of 78%, while families who opted to wait and join full program services had group attendance

rates of 66%. Additionally, families who competed skills-only before moving to full program services had higher rates of full program completion than those who chose to wait to begin full program and not engage in skills only services (75% vs. 65%, respectively).

Case Number Two: DBT at Harborview Mental Health and Addiction Services, a community mental health clinic within a large academic healthcare system

The DBT program at Harborview Medical Center is the oldest continuously operating DBT program in the world. The program focuses on serving clients with pronounced suicidal behavior, and clients are fully discharged from the program after one year of treatment. While these factors help keep the front door open for new clients, Harborview's ability to bill public and private insurance makes it the only option for many clients. Additionally, the program is very small, culminating in a waitlist that can range from six to twelve months.

The long wait time causes significant distress for prospective clients and for clinicians eager to refer their imminently suicidal clients to more appropriate services. Among prospective clients and referring clinicians, there is a sense the length of the waitlist represents an injustice. Tragically, the team is aware of at least four clients who have died while waiting to enroll in the program.

In 2019, clinicians proposed the idea of a skills group for clients on the waitlist. The team considered advice from Sayrs and Linehan (2019): "Understand what the reinforcers are for the administrators". Clinic administration was highly motivated to reduce wait times for services across the clinic and had low concerns about liability, pointing out that providing some services to waitlisted clients may be preferable (both in terms of liability and the organization's mission) to providing no services at all. Since staffing was not available for adding an additional two-hour skills group, the new group was split into two one-hour appointments each week—one for teaching new content, and one for homework review. This format is identical to the one used at PDBTI, and the Harborview team shares the opinion this format enhances learning by providing multiple points of contact. Unlike PDBTI, the Harborview team decided against having co-leads in the waitlist group and decided against offering any form of between-session support, so that the group would require fewer clinician-hours from the team. These decisions helped the team implement the group with a minimal expense of time and energy.

The "Skills Jumpstart Group" has been successful in addressing the problem of the long waitlist in a sustainable manner. Clients begin attending the group months before they start standard DBT. We believe this jumpstart can help clients start standard DBT with reduced therapy-interfering behavior and be more active in generating solutions because of their expanded repertoire of skills. The team is now in the process of collecting data to substantiate these impressions.

Two additional benefits of offering a waitlist group are worth mentioning. First, clients who struggle with attendance can be given a behavioral test of commitment before enrolling in DBT. The team has asked clients with particularly inconsistent attendance to attend a certain percentage of Jumpstart sessions within a given time frame in order to be eligible to start DBT. This has helped some clients improve their attendance before starting DBT, while helping others decide they are not yet ready to commit to DBT. Second, skills trainers in the Jumpstart group get to know the client, which can inform individual therapist fit. Occasionally, clients request to work with one of the skills trainers from the Jumpstart group.

Suggestions for Effectiveness in Skills-Only Programming

Both programs used an iterative development method where information from participants and evaluation materials are fed back to improve outcomes and reduce barriers to care. Lessons learned from the implementations include:

Orient well: Create systems to ensure group members understand the structure of group and the need to get the most out of group and start applying skills rather than waiting.

Protect against drift: Create written treatment guides to help therapists stick to DBT principles while providing skills only treatment.

Skills within full-fidelity clinics: Use structures within full fidelity clinics to increase therapist effectiveness (e.g. consultation team, supervision structures).

Collect evaluation data: Existing data structures (e.g. Electronic Medical Records, diary cards, etc) are useful when engaging in process and outcome evaluation of programs.

Closing Observations

Providing services to individuals on waitlists has the potential to help individuals access evidence-based treatment sooner, give support when no other high-quality treatments options are available, and jump start skills training. The two presented implementations demonstrate potential methods for increasing the availability of skills-only treatment and increasing overall availability of DBT to communities in need. It is the hope of the authors that additional implementations, data collection, and dissemination of process and well as outcome evaluations will help the field to collaborate and move forward to expand treatment in this area.

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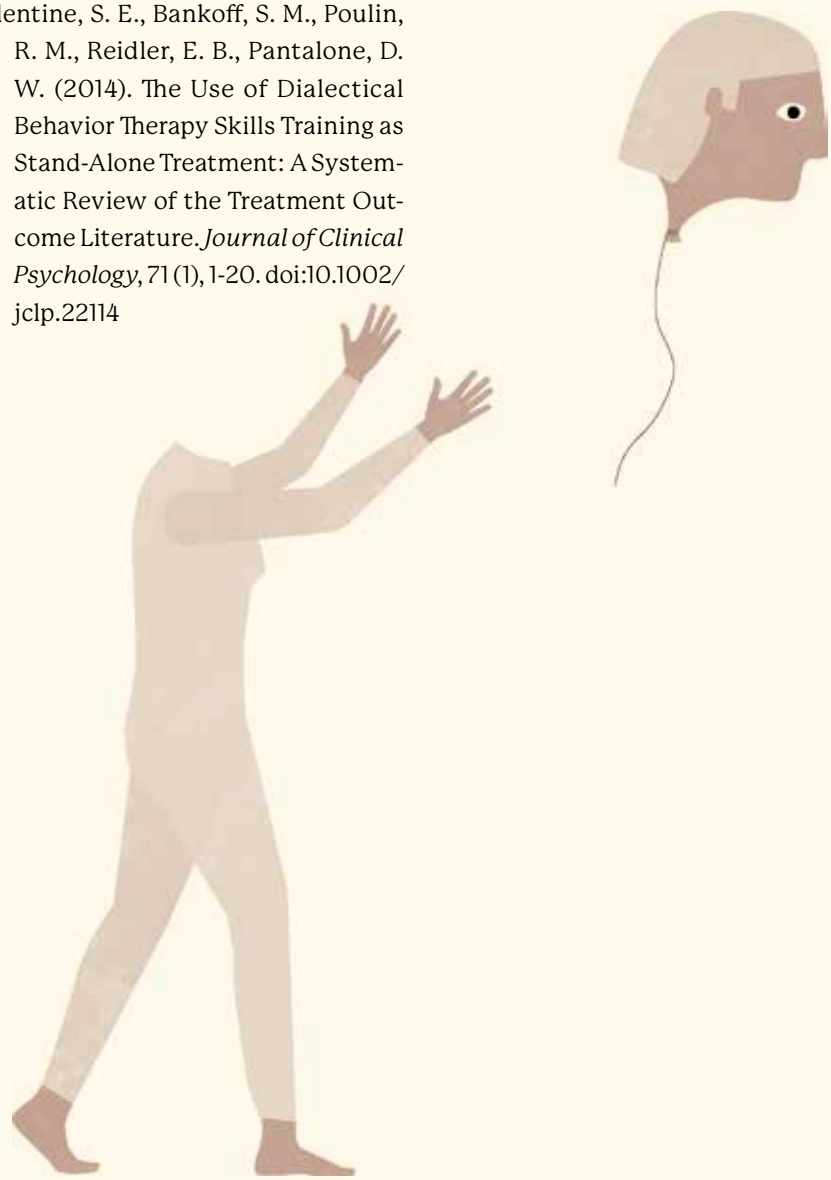

(BE) GENTLE

Doing Affirmative Dialectical Behavior Therapy with LGBTQ+ People: Clinical Recommendations

Cindy J. Chang, *Rutgers University*
Jeffrey M. Cohen, *Columbia University Irving Medical Center*

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, plus (LGBTQ+) people are at elevated risk for self-injurious thoughts and behaviors and disorders of emotional and interpersonal regulation (e.g., King et al., 2008). The mental health disparities that LGBTQ+ people face are often explained by the minority stress model (Brooks, 1989; Meyer, 2003; Testa et al., 2015). The minority stress model posits that LGBTQ+ people experience unique stressors due to cissexism and heterosexism that create an invalidating environment which disrupts psychological processes and confers greater risk for negative outcomes (Hatzenbuehler, 2009). Given that LGBTQ+ people experience elevated rates of the problems that Dialectical Behavior Therapy (DBT) aims to treat, it is unsurprising that sexual minority people are overrepresented in DBT trials (Harned et al., 2022).

Researchers and therapists have proposed that DBT is uniquely positioned to meet the needs of LGBTQ+ people (Cohen et al., 2021; Skerven et al., 2019; Sloan et al., 2017). First, DBT acknowledges the impact of an invalidating environment, which is easily extended to the societal invalidation that LGBTQ+ people experience. Second, the dialectic between change and acceptance allows for acknowledgement that LGBTQ+ people both live in a world in which stigma and prejudice exist and yet can make changes towards a life worth living (Cohen et al., 2021). Third, DBT is a transdiagnostic treatment, which can address transdiagnostic risk factors such as minority stress, making it well-suited for LGBTQ+ people, who are also more likely to have co-occurring difficulties (Pachankis, 2015).

Given that DBT offers a flexible and principles-based approach, delivering high-quality care to LGBTQ+ people largely depends on therapist ability to integrate LGBTQ-affirming principles into their DBT practice. Of concern, emerging evidence suggests that some sexual minorities may not benefit from standard DBT to the same extent as heterosexuals (Beard et al., 2017). This report offers several recommendations for DBT therapists to increase their effectiveness in working with LGBTQ+ people. Of note, the LGBTQ+ population is heterogeneous, and it is critical to consider intersectionality (i.e., how different social identities overlap and interact; Crenshaw, 2017).

Clinical Recommendations

Tip 1: Incorporate Minority Stress

We propose introducing minority stress targets in conjunction with the biosocial model, including a handout describing individual level psychological processes of internalized stigma, rejection sensitivity, and identity concealment. Explicitly describing minority stress as part of the invalidating environment functions to shift shame-related attributions away from personal shortcomings towards the more accurate burden of minority stress. By considering minority stress in case conceptualization, therapists can determine where DBT skills can help target minority stressors.

Given many LGBTQ+ people experience rejection based on minority status, it makes sense for an LGBTQ+ person to expect rejection. To address expectations of rejection, the skill of "Check the Facts" can help assess the probability of rejection occurring. For instance, if a person would like to disclose their identity and is unsure how others may react, they may "reality test" by mentioning an LGBTQ+ celebrity in conversation. If checking the facts suggests that rejection is unlikely, a person might act opposite to shame by disclosing. Conversely, if rejection is likely, the skill of "Problem Solving" can help the person identify alternative sources of support or engage in advocacy. Additionally, a "Cope Ahead" plan may be appropriate, given that four in ten LGBTQ adults report rejection by a family member or friend based on their sexual orientation or gender identity (Pew Research Center, 2013). All decisions must be guided by the person's values.

Tip 2: Amplify Resilience

Even though the mental health field highlights notable mental health disparities in LGBTQ+ people, it is also important not to lose sight of the strengths that this community demonstrates. DBT can help LGBTQ+ people build supportive relationships, develop community connections, and cultivate pride. Specifically, therapists may highlight unique strengths, as well as reinforce an individual's ability to overcome personal struggles. To amplify pride, we highlight how the opposite action of shame is to disclose to people who are likely to be accepting and also incorporate Pride-based celebrations in DBT skills group sessions. Therapists can also celebrate the unique strengths of the LGBTQ+ community such as by acknowledging

the activism and advocacy related to HIV/AIDS, marriage equality, and transgender rights.

In addition to highlighting individual strengths, fostering community connectedness can help buffer against the negative effects of minority stress (Rogers et al., 2021). This can include integrating LGBTQ+ specific resources such as community centers into skills such as "Pleasant Activity Scheduling." Additionally, DBT skills group may be considered a place to develop supportive relationships, so long as those relationships do not interfere with the group dynamics, consistent with Linehan's model (Linehan, 1993).

Tip 3: Center the LGBTQ+ Experience

To effectively work with LGBTQ+ people, DBT therapists must recognize how the larger sociocultural context impacts their practice. DBT therapists may not realize that they have been socialized to make assumptions about people's gender identities (e.g., assuming pronouns) or sexual orientation (e.g., asking a woman "Do you have a husband?"). Furthermore, DBT therapists who are not considering the sociocultural context may inappropriately pathologize justified emotions such as fear of realistic discrimination. These missteps are the result of existing in a cissexist and heterosexist society, and we must do better.

To increase their ability to provide LGBTQ-sensitive care, DBT therapists may take steps such as asking all patients about their gender identity, sexual orientation, and pronouns. We also encourage DBT therapists to center the LGBTQ+ experience by 1) focusing on the person's values as opposed to imposing values of the dominant culture and 2) analyzing the function of behaviors to avoid including your own judgments (e.g., assuming that having multiple sexual partners is maladaptive).

Tip 4: Advocate: Engage in Consultation to the Environment

The DBT Therapist Consultation Agreements include "consultation to the patient," which states that therapists must consult with their clients to help increase skillful means of navigating their own relationships and environment (Linehan, 1993). Yet, Linehan notes that environmental intervention may be appropriate when the problem is a powerful environment (Linehan, 1993). As such, Pierson and colleagues (2021) proposed the Antiracist Consultation to the Environment Agreement: "At times when the problem is an intransigent, high-power environment, as is always the case when the problem is racism, we agree to actively seek out ways to support the client through antiracist advocacy."

Other forms of oppression, such as heterosexism and cissexism, also require consultation to the environment. If DBT therapists are polarized to consulting to only the client, they may communicate the message that the client is solely responsible for solving these systemic problems. Instead, DBT therapists should provide functional validation (i.e., responding with action) by using our privilege and power to combat inequities without "fragilizing" the client. For example, therapists can consult to the environment by advocating for all gender bathrooms and responding when group members express cissexist and heterosexist sentiments.

Tip 5: Check Yourself: We are all Fallible & Contribute to Oppressive Structures

Consistent with the fallibility agreement (Linehan, 1993), DBT therapists can let go of having to prove their virtue. Given the reality of living in a heterosexist, cissexist, and racist

society, we are all fallible and contribute to oppressive structures. When (not if) you make a mistake, it is important to apologize without centering the apology on yourself (i.e., do not over apologize), commit to doing better, and do better. For example, if you mispronounce a person's name or misgender a person, make a commitment to using the correct name and pronouns in the future. Additionally, consistently invite clients to share feedback (e.g., "What have I missed?" "What can I do differently to be a more effective therapist for you?") and practice non- defensiveness when hearing the feedback.

Consultation team may help elucidate therapist therapy-interfering behaviors, including the ways we all contribute to oppressive structures. Therapists can also consider and discuss (by calling out the elephants in the room) the implications of existing structures, such as self-pay structure, lack of diversity among staff, and microaggressions within the DBT team. Additionally, didactics may include readings of anti-oppression literature such as "How to Be an Anti-Racist" by Ibram X. Kendi, including engaging with any discomfort that may arise such that avoidance does not hinder learning. By acknowledging our fallibility as individual people, teams, and organizations, we can let go of defensiveness and work towards a more just and equitable clinical practice.

Conclusion

As mental health therapists serving people across various intersecting identities, we have an ethical obligation to deliver LGBTQ-affirming care. DBT therapists may better serve LGBTQ+ people by incorporating minority stress into conceptualization and treatment, amplifying resilience, intentionally centering the LGBTQ+ experience, consulting to the environment, and acknowledging fallibility such that growth can occur. We hope that the recommendations offered in this article will help DBT therapists avoid becoming polarized to individual-level factors when systemic oppression exists.

We encourage readers to consider actions they can take to increase their effectiveness (e.g., asking all individual patients about their identities rather than assuming, practicing saying they/them pronouns on your own in order to foster your ability to use correct pronouns which you may be less familiar with). As a mental health therapist, what is one action you can commit to at this time?

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MINORITY STRESS HANDOUT

Stressors More Commonly Experienced by LGBTQ+ People

☐ Rejection Sensitivity

- ☐ When you fear rejection related to your gender identity or sexual orientation
- ☐ When you expect rejection related to your gender identity or sexual orientation
- ☐ Other: _____

☐ Internalized Stigma (e.g. Internalized Heterosexism/Transphobia)

- ☐ Buying into negative beliefs or stereotypes about LGBTQ+ people
- ☐ When you take on negative attitudes about LGBTQ+ people
- ☐ Other: _____

☐ Concealment & Impression Management

- ☐ When you hide your gender identity or sexual orientation
- ☐ Attempting to appear an identity that does not match your own identity (e.g. “straight acting”)
- ☐ Explicitly claiming an identity that does not match your own identity (e.g. saying “I’m straight”)
- ☐ Stress around impression management
- ☐ Other: _____

☐ Other: _____

Developed for Affirmative DBT by Jeffrey M. Cohen, 2021.

ONE THING AT A TIME

Finding, Training, and Implementing DBT Co-Leaders

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Introduction

Dialectical Behavior Therapy (DBT) skills training groups require two clinicians – a lead therapist and a co-leader – to deliver full-fidelity treatment (Linehan, 2015). While required for adherence, three real-world challenges interfere with clinics' ability to implement co-leaders. First, running DBT within managed care is complex; insurance companies typically reimburse for one skills trainer per group. Second, guidance on the implementation of co-leaders is limited in Linehan's skills training manuals, which focus primarily on the lead skills trainer. Third, the co-leader role encompasses diverse responsibilities, including maintaining overall group safety, facilitating skills acquisition and skills strengthening, and maximizing attendance and participation. Given that the co-leader performs critical functions in group, it is necessary that clinics provide co-leaders with adequate training and supervision. To address these concerns, clinics require operational strategies for recruiting, training, and implementing DBT co-leaders within existing financial structures. The present article outlines a model developed by Portland DBT Institute (PDBTI), a free-standing, full-fidelity outpatient DBT clinic accepting public and private insurance. Comprised of trainees from undergraduate to doctoral levels, PDBTI's coleader program offers training, supervision, and hands-on clinical opportunities for students seeking academic credit.

Review of the Co-Leader Role:

The skills group leader and co-leader model represents the synthesis of the primary treatment dialectic: change and acceptance. As per Linehan's 2015 skills training manual, the group leader is responsible for skills acquisition and behavioral change; this includes eliciting observations, providing feedback on homework, and presenting skills content. While the group leader maintains adherence to treatment structure, targets, and tone – i.e., procedure, the co-leader attends more closely to process, ensuring effective engagement from each participant. The co-leader embodies the acceptance end of the dialectic, mediating tensions that arise between clients and the group leader; in these moments of dialectical tension, the co-leader assumes the role of 'good guy,' expressing and validating the client's perspective, while the group leader serves as the 'bad guy,' enforcing group guidelines.

The co-leader attends to the individual needs of severe, multi-diagnostic clients, many of whom are targeting suicidal and self-harm behaviors. one of the most compelling reasons for the presence of a co-leader in skills group is logistical: two clinicians allow for uninterrupted clinical oversight should a client engage in therapy-destroying behavior (e.g., self-harm, extreme aggression). In these instances, co-leaders may either provide crisis coaching or facilitate group while the leader targets the therapy-destroying behavior. As such, it is crucial for co-leaders to feel supported and prepared to navigate challenging clinical interactions, provide in-vivo skills coaching, and manage their burnout.

The Co-Leader Program at PDBTI:

PDBTI operations and management staff created a co-leader program, which recruits co-leaders from the community and provides a comprehensive training and supervision system to ensure quality of services for clients, and training which benefits co-leader interns, and education for the community regarding evidence-based practice.

Recruitment of Co-Leaders:

Following site contract negotiation with the applicant's school, the recruitment process begins with a co-leader interview to assess applicants' clinical experience and interests, self-care behaviors, and motivation to provide equitable and non-pejorative care.

Items regarding clinical experience assess the applicant's experience working with high-risk behaviors and personality disorders, and confirm that the applicant understands the nature of the co-leader role. These items serve a dual function of assessing goodness of- fit, i.e., does this internship provide them relevant clinical experience, as well as eliciting attitudes towards the clinic's client populations.

Questions regarding self-care and burnout management help the interviewer determine readiness and identify resources the co-leader may need during their internship.

Discussions regarding equity and stigma elicit examples of when applicants sought information about systemically oppressed populations and steps they took to integrate learning, as well as their reactions to and awareness of social and provider stigma. These discussions provide further insight into the applicant's attitudes towards our client populations and awareness of their own limitations, social identities, and motivation to serve oppressed populations.

Criteria for strong applicants include: clinical experience (or

alternatively, if the applicant lacks clinical experience, how they effectively approach unfamiliar clinical work), strong soft skills, awareness of existing biases, prejudices, and clinical limits, and an absence of "red flag" behavior, which include defensiveness, pejorative language, and passive responses to questions related to equity.

Initial Training and Ongoing Supervision of Co-Leader Cohorts:

Prior experience with DBT is not required; as such, training is necessary to ready students for co-leading. At PDBTI, training is comprised of didactic presentation and experiential, role-playing opportunities, preparing co-leaders to begin providing effective skills coaching and client advocacy in their first group. Role-play examples include: coaching a client to attend group and providing skills coaching for a dysregulated client.

Ongoing clinical supervision consists of a twice-monthly supervision group. As co-leader trainees do not attend therapist consultation team meetings, the co-leader supervision group provides a structured space for skills didactics, discussion, and validation from facilitators and other co-leaders. This group functions to increase co-leader commitment by reducing burnout, standardizing and increasing access to training, and highlighting and promoting effectiveness in skills groups. The co-leader supervision group is modeled after standard full program skills groups — mindfulness practice, homework review, and a brief skill didactic with opportunity for consultation questions and role-play. Co-leader homework assignments promote acquisition and generalization of skills relevant to effective co-leading. Trainees are encouraged to utilize DBT skills in their personal lives, allowing them to provide relevant examples in group and better understand the application of specific skills during coaching calls. Thorough training, and ongoing supervision ensure that co-leaders adhere to the key functions of the co-leader role — maximizing participation and minimizing therapy-destroying and therapy-interfering behaviors.

Co-leader materials are oriented around fundamental aspects of the co-leader role Co-leaders are provided with a set of 'core competency' handouts: (1) 'Crisis Management,' which provides a reference sheet for common crisis survival skills for coaching encounters, (2) 'Applying a Dialectical Stance,' which outlines three behaviorally-specific strategies for modeling dialectics, and (3) 'Coaching Clients to Attend Skills Group,' which offers guidance on providing in-vivo coaching to increase attendance and participation. A 'co-leader diary card' is also presented to co-leader trainees as a means of tracking and reinforcing skillful behavior in skill training groups; diary card items are anchored around the core competencies, and supervision group homework assignments emphasize intentional rehearsal of skills.

Implementation of Co-Leaders in DBT Skills Groups:

Co-leaders may begin co-leading in skills training groups once they have completed the orientation training and onboarding (including a background check). The current co-leader protocol is modeled after core-structures in the original Linehan protocols and incorporates as many behaviorally-specific cues as possible. Co-leaders use a checklist of steps to accomplish before group, during group, during the break, and after group. These procedures, along with the co-leader core competency handouts, overview responsibilities and highlight what tasks are not within the purview of the co-leader role.

At the start of group, the co-leader is focused on attendance; co-leaders are responsible for contacting absent clients who do not have a pre-planned reason to miss group. As clients have access to co-leaders' contact information, it is vital to clearly delineate the role of the co-leader to clients (i.e., co-leaders are not to be contacted for crisis coaching outside of group), and co-leaders are encouraged to determine and observe their own limits regarding client contact.

Co-Leader Feedback, Evaluation, and Next Steps:

PDBTI aims to routinely obtain satisfaction and program evaluation data from its co-leader cohorts to review the efficacy of our program. Two assessment tools are used: a co-leader feedback form, which aims to solicit suggestions for improvement, and a 30-minute co-leader exit interview, which assesses confidence in and willingness to treat individuals with borderline personality disorder and life-threatening behaviors.

Initial data from PDBTI's Eating Disorder Intensive Outpatient Program demonstrates the clinical benefits of co-leaders in DBT skills groups: attendance significantly improved following the implementation of a co-leader. There was an 82.5% attendance rate for the 6 months prior to the introduction of co-leaders (n = 20), and a 97% attendance rate for the 6 months following (n = 21). Of note, these increases in attendance occurred within the transition to telehealth due to COVID-19 pandemic, further supporting the utility of the co-leader within skills groups. However, there is a potential confounding variable present, given the approximate co-occurrence of co-leader introduction and the remote format of group skills training due to the pandemic.

PDBTI's co-leader program was iteratively developed and has been modified throughout the clinic's history. The current iteration includes telehealth adaptations, and the co-leader supervision group now places a significant emphasis

on skills didactics and behavior tracking (versus unstructured clinical consultation). PDBTI's model is just one potential solution for mediating DBT programs' clinical and financial needs. Implementing student trainees is not a viable option for all clinics, though components of the recruitment, training, supervision, and implementation process may be relevant. In particular, co-leader training materials and resources offer a succinct yet thorough guide to enacting the co-leader role; the model of three primary co-leader competencies may provide an accessible means of quickly and efficiently disseminating DBT training to both clinical and non-clinical populations interested in providing DBT or DBT-informed care.

For the aforementioned co-leader program materials, please contact Eric Matsunaga at *ematsunaga@pdbti.org*.

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RADICAL ACCEPTANCE

Antiracism Competency Building in DBT Teams

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Antiracism Competency Building in DBT Teams

"I can't believe what you say, because I see what you do" (Baldwin, 1966, p. 738).

Linehan's DBT assumptions for skills training include the dialectic that people are doing the best they can, they want to improve, and they need to do better, try harder, and be more motivated to change (Linehan, 2014). To develop an antiracist practice of DBT, our behavior must reflect the intention of dismantling White Supremacist institutions. To verbally renounce racism without behavioral evidence of a commitment to fighting racism (also referred to as virtue signaling) risks harmful, functional invalidation (e.g., Khazanchi, 2021; Sherman & Goguen, 2019). It is proposed that the onus of this effort for behavioral change is best placed on stakeholders of power and privilege within the DBT community, which disproportionately lies in the hands of White therapists.

This paper summarizes the key points made in the ISITDBT 2021 panel discussion that offered recommendations for how White clinicians can adopt an antiracist practice of DBT (Pierson, Arunagiri, & Bond, 2021a). Recommendations made here focus on implementing antiracist competency building in the setting of a DBT consultation team. The consultation team is referred to as "therapy for the therapist," (Linehan, 1993) and provides an ideal setting for DBT practitioners to support each other with the often-uncomfortable task of examining and changing one's own racist beliefs, attitudes, and behaviors (Pierson, Arunagiri, & Bond, 2021a).

Dialectical Stance on Fighting Racism

Pierson, Arunagiri and Bond (2021) recommended that DBT consultation teams commit to taking a dialectical stance on fighting racism by acknowledging what we don't yet understand as individuals or as a clinical-research community. This includes acknowledging our responsibility to correct gaps in self-awareness, knowledge, and racist behaviors that perpetuate racial inequities. A dialectical stance on fighting racism in DBT acknowledges that, on one hand, more research is needed to understand whether DBT needs to be adapted to better meet the needs of people with racially marginalized identities; and at the same time, DBT clinicians and researchers must change their own beliefs, attitudes, and behaviors to better develop their skills and competencies for an antiracist practice of DBT. This perspective shifts the focus away from a deficit view of the client, and instead places the responsibility onto the DBT therapist to identify their own shortcomings and needs for growth in providing the treatment (Pierson, Arugagiri, & Bond, 2021).

Pierson, Arunagiri and Bond (2021) recommended that therapists use tools from the DBT technology to change behaviors and better equip themselves for fighting racism in the context of therapy. When identifying which specific DBT skills and coping strategies to apply, four main objectives for building antiracism competencies are recommended: (1) increasing awareness of one's own racial identity, race-related biases, attitudes, and behaviors, (2) building knowledge about the history of racism, White privilege, and White supremacy, (3) developing, strengthening, and generalizing skills for changing racist beliefs and behaviors, including avoidant racist behaviors that maintain a status quo of White privilege, (4) engaging in advocacy that promotes change to racist policies and practices within the systems that one operates (Pierson, Arunagiri, & Bond, 2021).

These four objectives are derived from a multicultural competency framework referred to as AKSA, which was originally created by Sue et al. (1992) and further developed by the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2015). The AKSA framework represents multicultural and social justice competencies for counseling theories, practices, and research, including: (1) a therapist's race-specific awareness of their values, beliefs, and attitudes; (2) knowledge; (3) skills; and (4) advocacy (AKSA; Ratts et al., 2015; Sue et al., 1992). For ease of remembering these four main objectives for developing antiracism, teams may consider using the acronym "ABLE" to represent: Awareness, Building knowledge, Learning skills, and Engaging in advocacy. Therapists can use these four main objectives to assist them with selecting the most effective DBT coping strategies for tailoring a solution analysis to address their main objective in building antiracism competencies. *Table 1* provides suggestions for clinicians to consider when tailoring a skills plan for targeting a specific antiracism competency domain with ABLE (Pierson, Arunagiri, & Bond, 2021).

Antiracism Therapist Agreement

Linehan's set of six DBT therapist agreements is a tool that facilitates therapists in monitoring their fidelity to the DBT model (Linehan, 1993). Therapists are encouraged to make these commitments

Table 1. Targeting Therapist Treatment-Interfering Racism with ABLE

Deficit Area	Competency Building Goal	DBT Skills	Examples
Awareness	Reframe experience within context of racial identity	Observe, describe, beginner's mind, level 4 validation	Add observer task to highlight missed opportunities for considering context of racial identity during consultation; explore areas lacking awareness during client intake process
Build knowledge	Define systematic racism, situate relative position	Problem solve, willingness	Ongoing team book club; monthly didactics and journal club; conducting chains on willingness to participate; regularly attend workshops/trainings on anti-racism by experts in the field and offer in-house if possible
Learn skills	Ongoing racial identity development	Distress tolerance, radical acceptance, emotion regulation	Role play addressing microaggressions with clients on team; hire a diversity specialist/consultant; practice distress tolerance and mindfulness of your own emotional experience when talking about race
Engage in advocacy	Dismantle racist systems	Accumulating positives in the long term, middle path, interpersonal effectiveness	Fundraise; offer free or low fee trainings to the community; engage in community work to build ties with black communities

to themselves and explain them to their clients at the outset of entering into the therapeutic relationship. An additional antiracist therapist agreement is proposed that includes the following:

Therapists must assess their competencies in antiracism prior to beginning treatment with clients or as soon as possible once they enter the therapeutic relationship. This is advised for work with clients of any identity and background, and is absolutely required as preparation for working with racially marginalized clients. This agreement is incumbent on White DBT therapists without exception, and is encouraged for all DBT therapists. Therapists will make every reasonable effort to increase their competencies in antiracism, including but not limited to: engaging in consultative discussion, openly receiving feedback from others about racist behavior, completing self-reflective exercises about race-related values, attitudes, and beliefs, increasing race-specific knowledge through educational activities, completing homework assigned by consultation team members in order to foster growth in specific anti-racist competencies, and making repairs to team members and/or clients when therapist racist behavior is identified (Pierson, Arunagiri, & Bond, 2021, p. 6).

An important step in incorporating the anti-racist therapist agreement is for teams to make a commitment together to actively address this issue. This includes not only incorporating the agreement into written agreements that your team uses but consistently reading and discussing it, allocating time for training or exercises that reflect on racial identity and identify racist or anti-racist behaviors and having goals for changes that the team and program will be making to move towards being anti-racist in its practice. It is recommended that therapists conduct a self-evaluation of their competencies within the four antiracism objectives captured by ABLE: namely, evaluating their attitudes and beliefs about race; knowledge of racism and White Supremacy; skills for tolerating distress and changing ineffective emotions that block ongoing racial identity development, interfere with changing racist behaviors, or impede progress with dismantling White Supremacy systems; engaging in advocacy that works toward changing racist policies and practices at a systems-level. There are many resources now available for self-reflective exercises that build antiracism competencies by developing greater awareness of White racial identity and related power and privilege. Examples may include exercises such as sharing a self-evaluation of attitudes and beliefs about race, developing and sharing a self-conceptualization of racial identity (see Singh, 2019 for an example of a guided exercise about development of racial identity), or using DBT tools such as a missing links analysis and behavioral chain analysis to identify the function of a therapist racist behavior and develop a solution analysis.

These are important exercises to explore, as the first step to making any behavioral change is an acceptance of the problem and a commitment to put

in the effort to change. We also recommend that program directors attend trainings and hire consultants to advise them with their ongoing development of anti-racist practices. This will avoid burdening individuals, especially people of color, to take on the responsibility to lead these initiatives or educate and correct White therapists. It is also a step forward to invest financially in these initiatives, which signals a strong commitment to the rest of the team.

Call to Action

It is recommended that DBT teams make an explicit commitment to antiracist development in their DBT practice by answering the following questions:

1. How much time are you willing to allocate to your own self-study of racial identity?
2. What thoughts, emotions, and behaviors might interfere with developing your self-conceptualization of racial identity? Which DBT skills can you use to cope with those barriers?
3. What DBT strategies are you willing to employ to facilitate ongoing awareness of power and privilege connected with White racial identity?

The present discussion aims to provide White clinicians and their teams with ideas for how to assess and build antiracism competencies in the context of DBT practice. It is strongly recommended that White clinicians commit themselves to antiracism competency building. We advise that the highest priority in this process is for White clinicians to engage in self-reflective and self-evaluative exercises that guide them in examining their attitudes, thoughts and emotions related to White racial identity development. Just as you make time each day to engage in your own mindfulness practice, are you also willing to allocate time to a self-study of your White racial identity?

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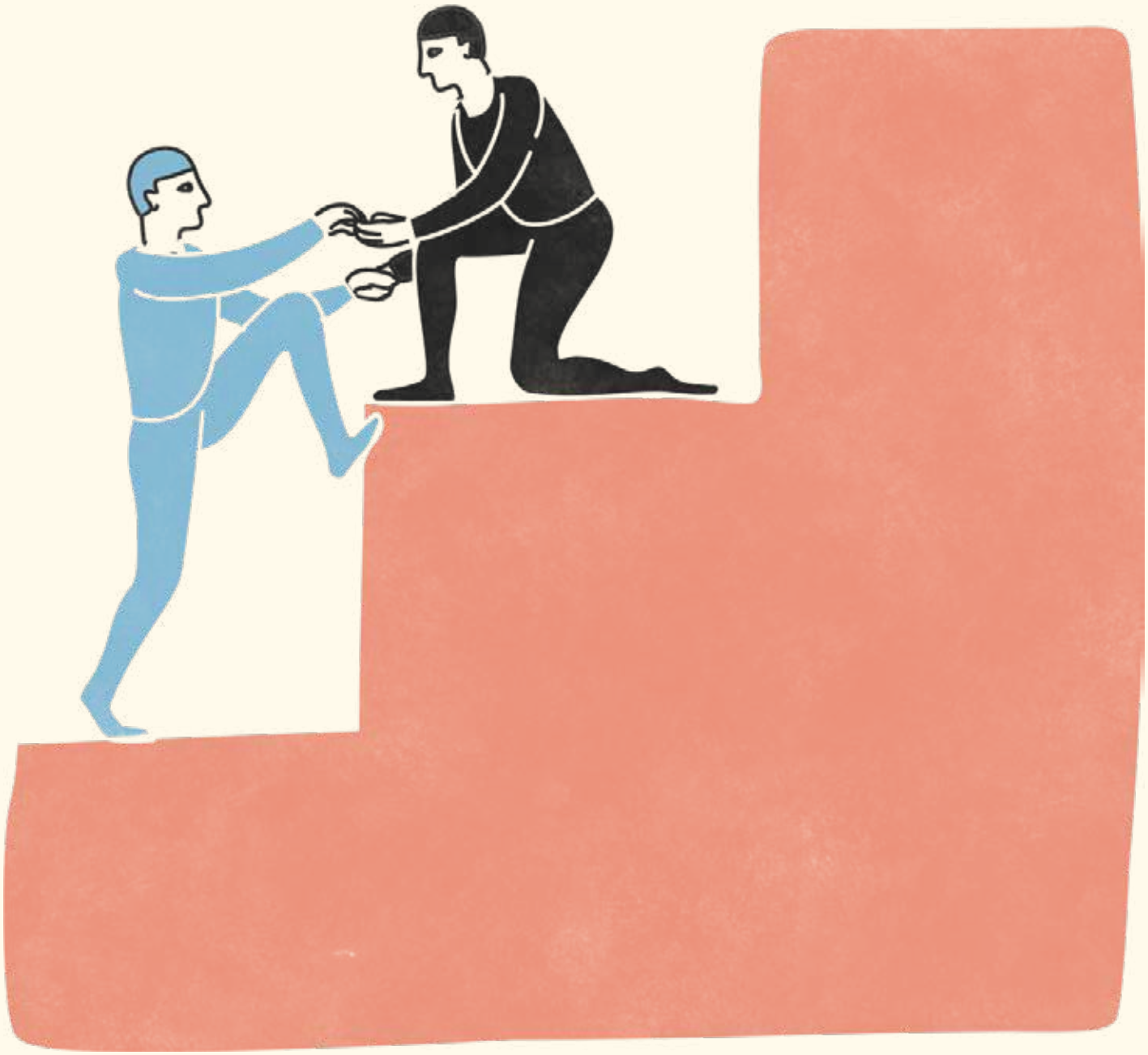

CONTRIBUTING

Preparing the Environment for Change: Pretreatment with Families

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Introduciton

Pretreatment is a crucial stage of adherent dialectical behavior therapy (DBT) that carefully and strategically elucidates goals, communicates expectations, and prepares individuals and clinicians to partner together to build a life worth living (Linehan, 1993). Typically, adult and adolescent DBT pretreatment focuses largely on the identified client; family interventions, if available, are often considered supplemental. Given the importance of family members in our clients' interpersonal worlds, directly incorporating them into pretreatment can build and maintain clients' commitment, motivation, and dedication to change during a standard course of DBT.

Authors first provide an empirical and theoretical rationale for integrating families into pretreatment and then outline practical strategies for how to do so. Systematic considerations for teams when implementing family-based care in DBT are also discussed.

Research Evidence

Existing research indicates that DBT-based interventions for family members reduce burden, grief, and anxiety and depressive symptoms, while increasing well-being and empowerment (Ekdhal, Idvall, & Perseius, 2014; Hoffman et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007; Flynn et al., 2017; Liljedahl et al., 2019). More recent literature suggests that providing DBT-based interventions to caregivers improves family relationships and outcomes for adolescents, without including the adolescent in treatment (Fruzzetti et al., 2020; Payne & Fruzzetti, in preparation).

DBT-based intervention for family members can improve outcomes at the caregiver, client, and relationship level. The DBT transactional model, a relational extension of Linehan's (1993) biosocial theory, provides a theoretical understanding of these empirical findings (Fruzzetti, Shenk, & Hoffman, 2005). It also offers clinicians a nonjudgmental frame from which to assess and orient families to how their often painful, ineffective familial relationship patterns can be understood and changed. This understanding helps to reduce blame, build hope, and increase family member commitment to DBT.

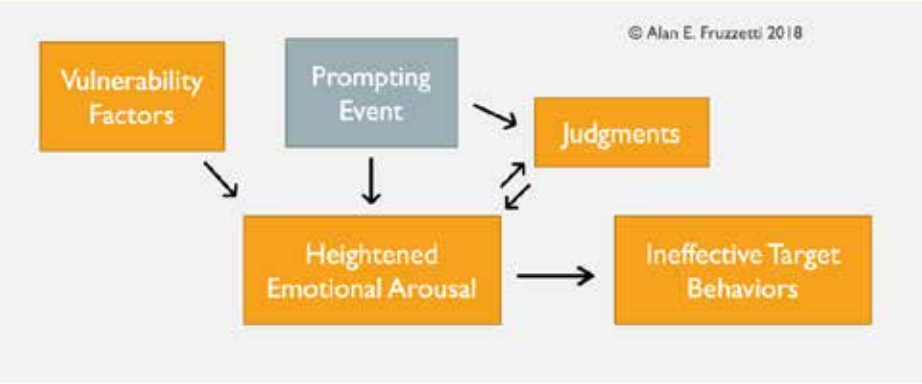

Figure 1. Part 1 of DBT Transactional Model

Theoretical Considerations: The DBT Transactional Model

The DBT transactional model (Fruzzetti et al., 2005) explores a specific interpersonal interaction or pattern occurring between family members. Understanding and utilizing this model with family members are central to DBT Family Therapy and an important part of pretreatment with families. In addition to guiding a clinician's case conceptualization, orienting families to the transactional model in intake, pretreatment, or early family therapy sessions lays the foundation for future interventions and can enhance caregiver motivation and commitment.

For the purposes of description, the transactional model is separated below into four interrelated parts:

1. Abbreviated behavior chain prior to transaction
2. Beginning of the transaction: Accurate or inaccurate expression
3. Response to expression: Validation or invalidation
4. Consequences of in/accurate expression and in/validation
5. Long term transactional patterns as vulnerability factors: Pervasive history of invalidation

Below, these parts of the transactional model are discussed and supplemented with a clinical example of 17-year-old Erica and her mother.

To see the ISITDBT 2021 role play of a DBT-A pretreatment family session where the therapist uses this model alongside the strategies discussed here, please go to www.isitdbt.net to access a recording of the conference.

Part 1 of the DBT transactional

model resembles a DBT behavior chain for an identified client (Figure 1). This establishes the various links for the client that precedes interacting with a family member. Erica's prompting event includes a friend not responding to an invitation to hang out. This leads to increased emotional distress and judgments. Erica's vulnerability factors include not feeling well and being tired after staying up late to study. These links leave Erica in a heightened emotional state and more vulnerable to engaging in self-harm.

Part 2 includes the beginning of the interaction – Erica saying or doing (or not saying or doing) something. In

Figure 2: Steps to accurate expression.

the transactional model, this is termed accurate or inaccurate expression (for an in-depth explanation, see Fruzzetti, in preparation). Accurate expression requires various steps and using numerous DBT skills layered together (Figure 2). Accurate expression is particularly challenging in the presence of heightened emotions. If steps are missed, it often results in inaccurate expression. This may look like a wide variety of behaviors including, target behaviors, shutting down/avoiding, or acting impulsively.

In our example, Erica's mom calls her to come to dinner. At this point in her chain, Erica is quite distressed and responds with inaccurate expression, yelling: "LEAVE ME ALONE!" Accurate expression may have included Erica expressing her disappointment and vulnerabilities to her mom.

Part 3 of the transactional model includes another person's words or actions (or lack thereof) in response

Figure 3: Steps to validation.

to their family member. Ideally, this involves validation, which is also comprised of steps that include numerous DBT skills (Figure 3). Without accurate expression, however, validation is difficult. In our example, Erica's mom responds with invalidation: "I don't have time for your attitude – get down here. NOW!"

Part 4 of the DBT transactional model involves the consequences of inaccurate expression and invalidation. Figure 4 highlights the transactional links of the client's inaccurate expression (gold box) with the family member's invalidation (dark orange). It further outlines how this triggers a cycle (circular arrows: inaccurate expression leading to invalidation, to arousal, to more inaccurate expression, etc.).

For example, Erica's emotional arousal increases secondary to her mother's demand that she come to dinner immediately. This triggers more judgments, arousal, and inaccurate expression: "Ugh, I HATE YOU! This is why I always want to KILL MYSELF!"

This comment increases Mom's judgments and arousal, resulting in more invalidation: "It's ALWAYS my fault - quit being so DRAMATIC! Get down here, or I'm taking the car!" In this transaction, Erica's valid experience of disappointment and heightened vulnerabilities are not expressed and subsequently not validated. Erica's mother's own judgments and emotions make it difficult for her to respond in a validating way. Additionally, Erica is also now at greater risk of engaging in ineffective target behaviors.

Part 5 adds the prevalent interactional pattern that many DBT families experience: repeated cycles of inaccurate expression and invalidation that

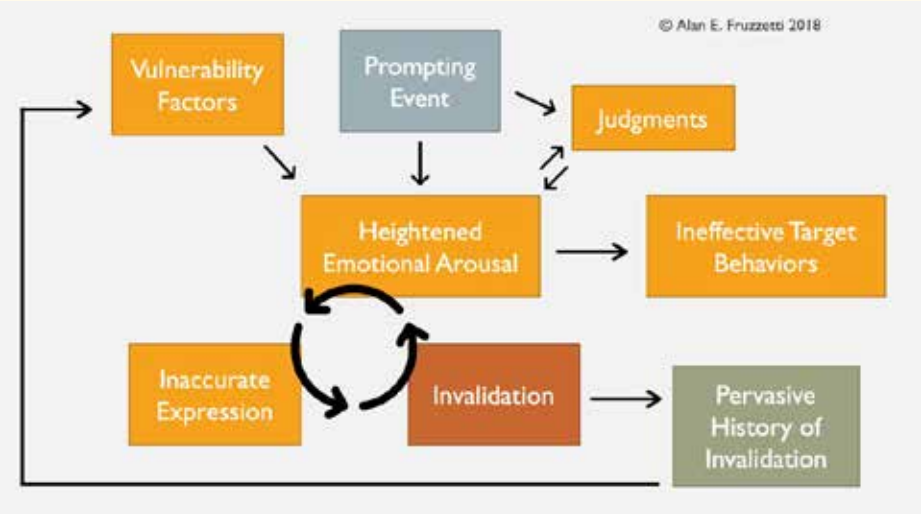

Figure 4. Complete DBT Transactional Model.

eventually turn into pervasive histories of invalidation between family members (Figure 5, green box and arrow). These histories, in turn, become vulnerability factors for future transactions. Erica and her mom frequently have conflicts that escalate quickly and include hurtful statements. As a result, their arousal (fear) rises and judgments ("Here we go again") often start as soon as they see each other.

This transactional model helps to explain the above research findings: changing one part of a transaction directly impacts the transaction itself and therefore the others involved. It also serves as the foundation for and highlights the importance of DBT family and couple's interventions. Strategies for generating more effective transactions (i.e., DBT two-step model) are discussed below. Integrating families into DBT first requires building family members commitment and motivation to participate during the pretreatment stage.

Practical Strategies

Integrating DBT Family Skills. As in all stages of DBT, pretreatment with families includes blocking ineffective behaviors and coaching effective ones. Because DBT family work conceptualizes behaviors transactionally, therapists also block ineffective and coach effective transactions. To do so, therapists use the two-step model (Fruzzetti, in preparation). The goal of the two-step is for the client to increase accurate expression while the family member simultaneously increases validation of the client's experience. The two-step model helps to interrupt ineffective transactions and learning patterns and replace them with more effective cycles of accurate expression and validation.

In the context of a pretreatment session with Erica, the therapist may teach the transactional model, using a relevant example, and then guide the family through the two-step. In session, the therapist helps Erica identify and express the emotion she was experiencing (i.e., accurate expression of disappointment) and helps Mom identify a different response based on understanding Erica's experience (i.e., validation).

Using their existing DBT tools paired with transactional conceptualizations of behavior, therapists guide families though two-step transactions starting in pretreatment. Therapists may block or redirect inaccurate expression and invalidation with irreverent and reciprocal communication strategies. This work highlights where and how all family members can use skills, reduces feelings of blame, and generates hope.

Individual, Behaviorally Specific Goals.

Identifying behaviorally specific DBT treatment goals is a crucial step in pretreatment. With families, it is important that these goals are individually defined for each family member. This includes rephrasing general or client-centered goals (e.g., Help Erica stop cutting) to focus on their own skills deficits (e.g., Learn how to validate when Erica shuts down). Orienting families to the transactional model can help individuals nonjudgmentally identify their own skills deficits and treatment targets.

DBT Commitment and Stylistic Strategies. Pretreatment with families in DBT is, at its core, still DBT pretreatment. The DBT commitment strategies (Linehan, 1993) are directly applicable in interactions with family members and employed throughout all communication with families. Similarly, stylistic strategies (Linehan, 1993) are interwoven to name ineffective transactions and solicit movement from family members stuck in ineffective emotions.

Systematic Considerations

Integrating family members into pretreatment requires several key systematic considerations. Teams must address their own commitment and barriers to providing family-based DBT. This may include targeting willingness, feasibility, and additional training needs.

Once committed and with the necessary tools, teams must clearly establish the expectations for family involvement. Integrating families into pretreatment may require adding additional pretreatment sessions for the identified client. This pretreatment work may also be integrated into intake or early family therapy sessions, depending on a provider's limits and resources. Additional considerations include: How often are family sessions conducted? Who is expected to participate? What contingencies are in place to support these expectations? Teams should decide how, when, and by whom these expectations will be communicated and implemented.

As with any component of DBT, teams must also discuss how to maintain their own motivation and commitment to integrating families into DBT. Family work involves additional time, energy, and resources. Making sure adequate training, consultation, and supervision is available to navigate added challenges is critical.

Some ideas to promote sustainable integration of families into DBT and pretreatment include:

- Continually and consistently communicate with families about expectations for their involvement.
- Use group-based, caregiver-only skills "bootcamps" that focus on the transactional and two-step models.
- When possible, use trainees for non-billable, caregiver psychoeducation.
- Use existing DBT family therapy resources (e.g., Family Connections™ materials, www.borderlinepersonalitydisorder.org).

Conclusions

Integrating family members into DBT has robust empirical and theoretical support and begins with pretreatment. This includes providing targeted psychoeducation, including the DBT transactional and two-step models; identifying individual, behaviorally specific goals; and getting clear commitment from all family members. While this work often requires additional systematic resources, it can expedite transformation of family transactions and maximize the effectiveness of DBT.

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I'M SORRY: A New DBT Skill for Effective Apology

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OUR TEAM at the University of Oregon proposes a new DBT skill for effective apology. We review the limited teaching of apology in the current edition of DBT skills (Linehan, 2014), the dialectical relevance of apology to DBT clients, and the research supporting five components of effective apology. This review culminates in the development of a new DBT skill —acronym and all!— and presents initial support for its acceptability.

Current Teaching of Apology Within DBT

Apology is briefly mentioned within the DBT skills manual. DBT clients are encouraged to apologize when they experience guilt that "fits the facts" (see Emotion Regulation Handout 13 regarding justified guilt). Conversely, clients are discouraged from apologizing when practicing Opposite Action for shame and from over-apologizing when asserting their needs through the FAST skill (Linehan, 2014). Aside from these references to apologizing, DBT skills provide no additional guidance to clients for determining the appropriateness of an apology in a given situation. Further, guidance for how to deliver an apology that is effective and consistent with clients' interpersonal goals and values is absent.

Why Learning More About Apology May Help DBT Clients

Apology is particularly relevant to the lives of DBT clients, who seek treatment for behaviors stemming from emotion dysregulation that are prone to negatively impact their interpersonal relationships (Linehan, 1993). When these behaviors cause conflict or hurt others (e.g., yelling, aggression, withdrawing, or other behaviors that co-occur with emotion dysregulation), apology may be warranted. In fact, apology is likely crucial to the repair efforts that comprise the last step of Chain Analysis in DBT (Linehan, 2014). However, effective apology is often a tall order, as apology itself requires the ability to skillfully regulate and tolerate negative emotions. While offering an apology, a client may experience shame or guilt regarding the offense, anxiety about the recipient's reaction, lingering anger at the recipient, and/or sadness related to loss. Although many of these emotions are likely justified, they pose barriers to offering an effective apology (Lerner, 2017) or engaging in repair (Linehan, 1993). Even when clients apologize, the apology may be perceived as insincere, or lack the content that facilitates interpersonal healing and repair.

Paradoxically, DBT clients also likely over-apologize for basic needs and/or apologize when they have done nothing wrong. The histories of chronic other- and self-invalidation from many DBT clients' childhoods may cause intense levels of shame, guilt, and/or fear (Linehan, 1993), which when not challenged or regulated, may lead to excessive apology or self-beratement. Frequent apology may temporarily serve clients as they seek reassurance, yet may also backfire by creating long-term tension in relationships and decreasing self-respect. Thus, DBT clients may at times over-apologize, and at other times, struggle with apologizing effectively when warranted or when it fits the facts.

Including detailed and flexible guidance on apology in DBT would be beneficial because 1) apology behaviors — both too often or not enough — may be particularly relevant to DBT clients' lives and their presenting difficulties with emotion dysregulation and interpersonal conflicts, and 2) apologizing is a complex, yet essential, interpersonal skill, comprising multiple components that may be a fruitful avenue for behavioral skill acquisition and rehearsal.

New Apology Skill: I'M SORRY

As such, we propose a new skill that draws from overarching DBT principles as well as empirical literature regarding effective and useful apologies. This new skill is named **I'M SORRY** — **I**- Identify if an apology is warranted, **M**- (stay) Mindful, **S**- say Sorry, **O**- Own your mistake, **R**- Recognize their feelings, **R**- Repair, **Y**- say whY you won't do it again (find the full handout, worksheet, and teaching materials at: https://osf.io/fnd45/?view_only=01fe44d05d2f48abbc56c3b82177370b).

The first part of this skill (**I'M**) draws upon existing DBT skills to help clients determine whether an apology is warranted. The first step, Identify if an apology is warranted, prompts clients to Check the Facts for their emotions and to consult their Wise Mind to determine if an apology is justified and goal-serving. If they are experiencing guilt, remorse, or shame that fits the facts and/or they want to repair a relationship, they may proceed with the rest of the skill. The second step, stay Mindful, builds from the core Mindfulness skills. Clients are encouraged to

use their Observe and Describe skills to notice and become aware of their thoughts, emotions, and urges to avoid painful emotions (e.g., downplaying the seriousness of the offense) or, alternatively, taking all the blame.

The latter half of the skill, **SORRY**, provides an outline for the content ("what") of an effective apology. Regarding what constitutes an effective apology, much of the literature converges on five key elements: explicit expressions of regret (e.g., "I'm sorry," "I apologize"; Smith & Harris, 2011); explicit expressions of responsibility (e.g., "I did something that was wrong"; Newman & Kraynack 2013); an acknowledgment of the transgressed person's emotions or suffering (Lazare, 2004); an offer of repair or reparation for the harm (Howell et al., 2012; Lewicki et al., 2016; Scher & Darley, 1997; Schmitt et al., 2004); and a commitment to not make the same mistake again (Howell et al., 2012; Lazare, 2004; Scher & Darley, 1997).

SORRY maps onto these five components directly. Specifically, say Sorry directs clients to apologize genuinely and to describe the action that they are sorry for. Own your mistake suggests that clients label their action as wrong, unfair, or unjust, and identify themselves as the actor (as opposed to passively stating that "unkind words were said"). Recognize their feelings instructs clients to acknowledge the recipient's feelings and hurt by leaning on their previously established Validation skills. Repair proposes that, where appropriate, the client make an offer of repair or reparations. This could include monetary compensation (e.g., in the case of destruction of property), or their time or favor. Finally, say whY it won't happen again advises clients to articulate why the same offense will not happen again. Chain Analysis and Cope Ahead skills may support this step. These five steps comprise the content of a comprehensive and effective apology within DBT. Although research indicates that the greater number of elements included in an apology enhances its effectiveness (Lewicki et al., 2016), we aim to achieve a balance between practicality and flexibility with **SORRY**. Each of the five elements is encouraged, but not all elements may be applicable to a specific situation or relationship. Each client's Wise Mind guides the process.

To refine the structure and content of the skill, the first author presented the skill and training materials to a group of clinical psychology doctoral students enrolled in a DBT Skills practicum at a training clinic at the University of Oregon. After receiving feedback from this presentation, the first and third authors, who had prior experience leading DBT groups, introduced the skill in a supplemental session of an adult telehealth DBT Skills group during the spring of 2021. Clients were alerted that this skill was exploratory, and they were eager to try it. Clients were asked to provide feedback on the skill after the group session. Overall, the reaction to the skill was positive, and clients gave strong and consistent feedback that the skill was understandable and fit within the DBT frame. Clients actively participated and specifically enjoyed discussing their own experiences of receiving apologies, as well as how the elements may be modified or adjusted to particular circumstances. This initial client feedback suggests that **I'M SORRY** may be an acceptable addition to current DBT skills content. Future research is needed to empirically test the acceptability and effectiveness of **I'M SORRY** in varied clinical settings and with diverse clinicians and clients.

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INTERPERSONAL EFFECTIVENESS HANDOUT X

(Interpersonal Effectiveness Worksheet X)

Guidelines for Apologizing Effectively (I'M SORRY)

A way to remember these skills is the term **I'M SORRY**

Identify if an apology is warranted
(Stay) Mindful

Say sorry
Own your mistake
Recognize their feelings
Repair
(Say) whY it won't happen again

Identify if an apology is warranted

Identify if an apology is warranted. Apologies *may* be warranted when 1) you feel an emotion (guilt or shame) about your past behavior *that fits the facts* or 2) someone confronts you about or discloses to you that your past behavior has hurt them. Ask Wise Mind if apologizing in this instance is justified and effective, and reflect on your goals (objective, relationship, and self-respect). I'M SORRY is most useful when your first priority is to repair the relationship. If an apology is NOT warranted, engage in opposite action and/or the FAST skill.

(Stay) **M**indful

Stay Mindful throughout. Observe your thoughts and emotions. If you feel guilty or ashamed about your behavior, observe the urge to avoid painful emotions, shift blame, or – alternatively – take *all* the blame and over-apologize. If someone is confronting you, observe any defensiveness, judgment, anger, or willfulness. Observe the urge to downplay the seriousness of the offense, change the topic, or lie.

Say sorry

Say sorry genuinely. Apologize with not just your words, but your tone, body language, and facial expression. Name what you are sorry for using your describe skill.

"I am sorry that I yelled and said that 'you're a jerk.'"
Avoid the use of conditionals (e.g., "I'm sorry *IF* my words offended you").

Own your mistake

Own your mistake and take accountability. Acknowledge that *you* did something hurtful, unfair, or unjust. Focus on the impact of your actions, rather than your intentions. Do not take responsibility for others or things outside of your control.

"What I said was wrong and unfair."
Avoid passive voice (e.g., "Unkind words were said").

Recognize their feelings

Recognize their feelings and their suffering. Empathize with their perspective and express concern about their feelings. Use validation skills. However, do not let your emotions overwhelm theirs.

"I can see that what I did really upset you, and I care about your feelings."
"I understand why you thought that what I did was unfair."

Repair

Repair by offering reparations or restitution, if appropriate. Offer concrete ideas of how you can make amends for the specific offense. Ask them for their suggestions.

"I know it cost you a lot of time and money when I scratched your car, so I will take it to the auto repair shop for you and pay for the damages."
"What can I do to make this up to you?"

(Say) wh**Y** it won't happen again

Say whY this behavior will not occur again. Identify the causes of this behavior. Discuss how you will commit time, effort, and resources to avoid making the same mistake in the future. Follow through with promised behavior. If the pattern of behavior is recurrent, it may be helpful to state that you will continue to think about what you did and/or take the initiative to bring up the topic again.

Other ideas: _____
_____
_____
_____
_____

ONE-MINDFULLY

Mindful Mechanisms of Change in DBT: Nonreactivity and Nonjudging

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Introduction

Mindfulness is a key component of Dialectical Behavioral Therapy (DBT; Linehan, 1993a; Linehan, 1993b). A commonly accepted definition of Mindfulness is paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally (Kabat-Zinn, 2015). DBT teaches mindfulness in order to increase self- and situation-awareness, which in turn facilitates better decision-making and coping ability (Robins, 2002). Researchers have identified five facets of mindfulness (Baer et al., 2006): Observing, Describing, Acting with Awareness, Nonreactivity, and Nonjudging (see Table 1).

DBT has been found to be effective for a wide range of mental health disorders (Panos et al., 2014); however, the specific role of mindfulness as a mechanism of change in DBT is not well understood. Certain facets of mindfulness have been associated with differential treatment outcomes in DBT (Peters, 2013; Mitchell et al., 2018). But more research is needed to confirm and deepen our understanding of how individual facets of mindfulness are related to treatment outcomes, especially in outpatient settings. To explore this topic, we conducted a naturalistic study in an outpatient setting with adult DBT patients examining the relationships between the five facets of mindfulness and various treatment outcomes. Prior research by Mitchell and colleagues found that increases in the Nonjudging and Acting with Awareness facets were associated with improved treatment outcomes in BPD (2018). Therefore, we hypothesized that Nonjudging (H1) and Acting with Awareness (H2) facets would mediate changes in depression, anxiety, borderline symptoms, emotional dysregulation, and rumination from baseline to post-test for adult clients enrolled in outpatient DBT.

Methods

Procedure

This study was a naturalistic study of adult patients at an outpatient private practice and teaching center in Southern California. As part of the practice's measurement-based care, patients received assessments including a battery of validated outcome measures at regular intervals throughout treatment. DBT Patients receive assessments at intake and after each of the three 8-week modules of DBT treatment over the course of 6 months. Patient data were included in this study for adult patients who completed the intake assessment and at least one additional assessment after a minimum of two months of treatment.

Statistical Analysis

Within-subjects mediation analysis was performed using the MEMORE macro for SPSS (Montoya, 2017) to assess the significance of the indirect effects of the intervention, DBT, on validated measures of depression, anxiety, borderline symptomatology, rumination, and emotion regulation through each of the five facets of mindfulness. MEMORE uses percentile bootstrapping to estimate a 95% confidence interval for the indirect effect of X (the intervention) on changes in the outcome variable (Y) through changes in the mediator (M) for two-instance repeated measures designs. Figure 1 demonstrates an example of the conceptual mediation pathway.

In Figure 2, the unstandardized statistical pathways are described. The a path is the presumed effect of the intervention (X) on the mediator variable (M), and is found by subtracting the mean of the mediator at pre-intervention (M1) from the mean at post-intervention (M2). The b path is the effect of the mediator (M) on the outcome (Y) while controlling for the effect of the intervention (X). The c path is the total effect of the intervention (X) on the outcome (Y) without controlling for other variables. The c' path is the direct effect of the intervention (X) on the outcome (Y) controlling for the mediator (M). The c' path is made interpretable by controlling for d, the mean-centered average of the mediator. Finally, the indirect effect of the intervention (X) on the outcome (Y) is found by multiplying the a and b paths.

Missing Data

Analysis of the data demonstrated that approximately 14.9% was missing. Following recommended guidelines for missing data handling in clinical research (Sterne et al., 2009), multiple imputations were conducted. As is common practice, 5 imputations were generated with 10 iteration cycles each (Heymans & Eekhout, 2019). The final full imputed data set was produced by drawing randomly from each of these five imputed data sets.

Results

Participants

The total sample size was 62. The mean age of the sample was 30.1 years old, and 69% were female. Almost half of the participants (46.8%) declined to state their ethnicity. Of those who did report ethnicity, 84.8% were White, 3.0% Black, 3.0%, Latino/a, and 9.1% reported "Other". Approximately 45.2% had a confirmed diagnosis of BPD. The

Table 1. Definitions and Examples of The Five Facets of Mindfulness

Mindfulness Facet	Definition	Example	Related DBT Skills
Observe	Noticing both external and internal experiences	I can see the steam come out of my coffee	"What" skills
Describe	Mentally labeling external and internal experiences	This coffee is warm to the touch and has a bitter taste	"What" skills
Acting with Awareness	Consciously responding in a non-automatic way	I drink my coffee, look outside, and ignore everything else	"How" skills, Wise mind
Nonreactivity	Allowing thoughts and feelings to arise and pass without acting impulsively on urges or ruminating on negative emotions	I feel angry, but I will not throw my coffee to the ground	"How" skills
Nonjudgment	Noticing experiences (thoughts, sensations, feelings) without evaluating them	I see that I am angry, but I allow the feeling to come and leave	"How" skills

average time in treatment was 7 months, with a minimum of 2 months and a maximum of 12 months.

Treatment Outcomes

Participants reported significant improvement in all 5 treatment outcomes from baseline to post-treatment. There were also significant improvements in overall mindfulness (FFMQ total score). For the FFMQ facets, there were significant improvements in Acting with Awareness, Nonjudging, and Nonreacting, but not in Observing or Describing. Treatment outcomes are reported in Table 2.

There were significant indirect effects of DBT on each of the five outcomes variables mediated through the FFMQ total score. The results for these analyses are presented in Table 3.

FFMQ Facet Mediation Analyses

In partial support of our first hypothesis (H1), increases in Nonjudging from pre- to post-intervention significantly mediated reductions in anxiety, borderline symptoms, rumination, and emotion regulation, but not depression. Contrary to our second hypothesis (H2), increases in Acting with Awareness from pre- to post-treatment significantly mediated reductions in depression, but no other outcomes. Additionally, increases in Nonreacting from pre- to post-treatment significantly mediated reductions in depression, anxiety, borderline symptoms, and rumination, but not emotion regulation. As expected, Observing and Describing did not significantly mediate reductions in any of the five treatment outcomes. Significant results are presented in Table 4.

Discussion

The purpose of this study was to explore the relationship among the five facets of mindfulness and five clinical treatment outcomes, including depression, anxiety, borderline symptomatology, rumination, and emotion regulation, in a sample of adults participating in outpatient DBT. The hypotheses that mindfulness would mediate changes in treatment outcomes was supported for Nonjudging (H1), but not for Acting with Awareness (H2); additionally, Nonreacting was unexpectedly found to be a significant mediator of treatment

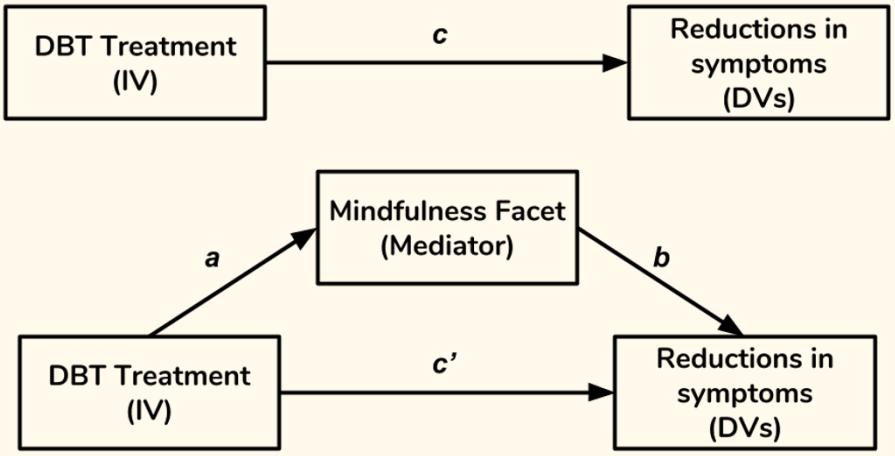

Figure 1. Conceptual diagram of mediation analysis.

Measure	Construct	Number of Items (total score range)	Sample Item	Citation
Five Facet Mindfulness Questionnaire (FFMQ)	Mindfulness; higher scores indicate greater mindfulness	39 (39 - 195)	"When I have distressing thoughts or images, I am able just to notice them without reacting" (Nonreacting)	Baer et al., 2016
Patient Health Questionnaire (PHQ-9)	Depression symptom severity; higher scores indicate greater depression severity	9 (0-27)	"Feeling bad about yourself or that you are a failure or have let yourself or your family down"	Kroenke et al., 2001
General Anxiety Disorder (GAD-7)	Anxiety symptom severity; higher scores indicate greater anxiety severity	7 (0-21)	"Worrying too much about different things"	Spitzer et al., 2006
Borderline Symptoms List (BSL-23)	Borderline Personality Disorder symptoms severity; higher scores indicate more severe symptomology	23 (0-92)	"My mood rapidly cycled in terms of anxiety, anger, and depression"	Bohus et al., 2009
Difficulties in Emotion Regulation Scale (DERS)	Emotional regulation and dysregulation; higher scores indicate more difficulty in emotion regulation	36 (36 - 180)	"When I'm upset, I become out of control"	Gratz & Roemer, 2004
Ruminative Response Scale (RRS)	Rumination; higher scores indicate higher levels of ruminating tendencies.	22 (0 - 88)	"think 'Why can't I get going?'"	Treynor et al., 2003

outcomes and, as predicted, Describing and Observing were not. How might we understand this pattern of results?

Previous investigations have found that increases in Nonjudging were significantly associated with improvements in BPD symptoms and other DBT treatment outcomes (Perroud et al., 2012; Mitchell et al., 2018), and our findings align with these studies. The research by Mitchell and colleagues also suggested that Acting with Awareness would follow a similar pattern, yet our study found that increases in this facet mediated improvements in only one of the five treatment outcomes, depression. Research by Peters and colleagues (2013) may provide an explanation. These researchers found that the relationship between Acting with Awareness and some features of BPD depended on the level of Nonjudging. For example, Acting with Awareness was associated with reduced anger rumination only for participants with high levels of Nonjudging. In other words, in order to benefit from Acting with Awareness, participants needed to hold a less judgmental stance toward their internal experiences. It is

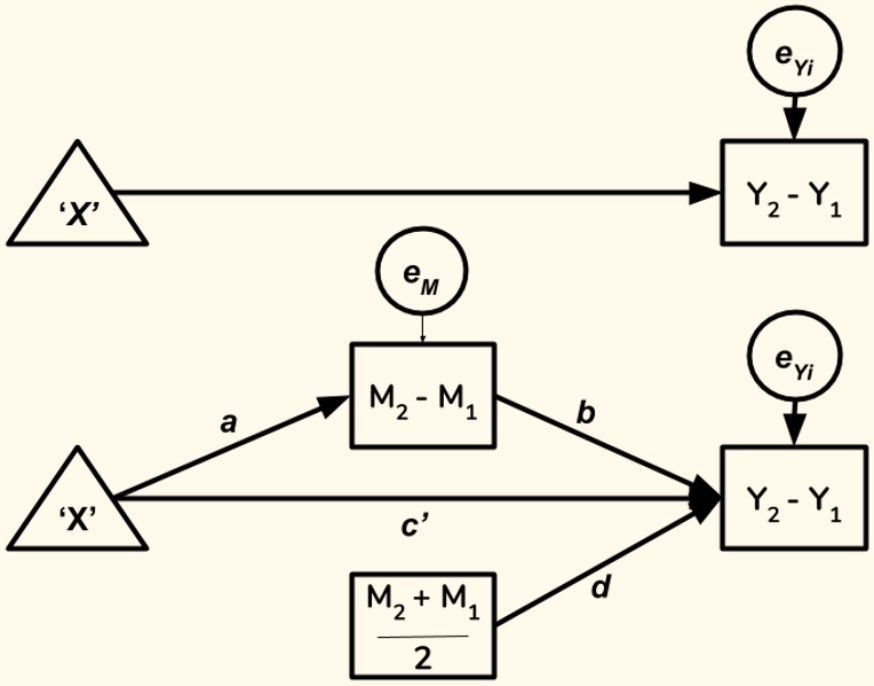

Figure 2. Statistical diagram of within-subjects repeated measures mediation analysis.

possible that our sample, which included clients who had not yet completed treatment, had not learned how to use a nonjudgmental stance to support their ability to act with awareness. The mean increase in Acting with Awareness was half as large as that reported for Nonjudging, offering further support for the idea that our sample may not have developed sufficient skill in acting with awareness to significantly impact treatment outcomes.

Unexpectedly, our study also found a significant relationship between Nonreacting and DBT treatment outcomes. Mitchell and colleagues (2018) did not observe a relationship between Nonreacting and DBT treatment outcomes; however, the authors noted that the lack of this relationship in their research was surprising, "given the emphasis in DBT on learning to respond mindfully and to reduce automatic, impulsive reactions to prompting events" (pg. 9). It is possible that the small sample size (N = 35) and other variability in their data may have prevented them from detecting this effect.

Finally the facets of Observing and Describing did not significantly mediate treatment outcomes. In our sample, this may be explained in part by the fact that patients did not improve their self-reported mastery of the Observing or Describing over the course of treatment. Given the lack of significant change in these subscales over time, there could be no association between improvements in these subscales and treatment outcomes. Unfortunately, we can only speculate on the reasons why these skills did not improve; perhaps they were not emphasized by clinicians or practiced regularly by patients. Additional research, perhaps including qualitative elements, would be required to understand this finding.

Limitations

This study has several limitations. The first and most critical is the lack of a control group, which prevents us from drawing any strong causal conclusions from these results. The improvements could be due to numerous other factors besides treatment itself, including the mere passage of time, regression to the mean, or changes in medication. Second, these analyses cannot provide insight into the temporal relationship between these variables. For example, while improvements in nonjudging were associated with reductions in borderline symptoms, we cannot identify whether one preceded the other, as we were only able to examine two time points, baseline, and post-test. Future studies may explore more temporally rich data to provide more granular insight into the trajectory of change for treatment outcomes. Finally, we conducted a large number of statistical tests, which increases the risk of type I error

Table 2. Mean Change in Treatment Outcomes from Intake to Post-treatment*

Variables	Mean Time 1	Mean Time 2	Change in mean	95% CI Lower	95% CI Upper	Std. dev. diff	Std. error diff	t	df	p value
PHQ9 Total	12.59	9.57	-3.03	-1.23	-4.83	7.10	0.90	3.360	61	0.001
GAD7 Total	11.40	7.64	-3.76	-2.29	-5.23	5.79	0.74	5.107	61	<.001
BSL Total	65.58	51.94	-13.65	-7.91	-19.38	22.56	2.87	4.762	61	<.001
Rumination Total	59.39	52.78	-6.61	-2.98	-10.25	14.32	1.82	3.636	61	0.001
DERS Total	113.25	97.91	-15.35	-8.33	-22.37	27.64	3.51	4.372	61	<.001
FFMQ Total	68.97	78.59	9.62	13.55	5.69	15.48	1.97	-4.894	61	<.001
FFMQ Observe	12.96	13.73	0.78	1.66	-0.10	3.45	0.44	-1.775	61	0.081
FFMQ Describe	17.28	17.83	0.55	1.74	-0.63	4.67	0.59	-0.930	61	0.356
FFMQ Act Awareness	14.83	16.46	1.64	2.98	0.30	5.28	0.67	-2.443	61	0.017
FFMQ Nonjudging	13.13	16.42	3.29	4.58	1.99	5.12	0.65	-5.057	61	<.001
FFMQ Nonreactivity	10.78	14.15	3.37	4.52	2.22	4.52	0.57	-5.875	61	<.001

*Not all participants completed a standard 6-month course of treatment. Average time in treatment = 7 months; minimum 2 months

Table 3. FFMQ Total: Estimates and 95% Confidence Intervals for significant ab paths between FFMQ total and outcomes

Mediator	Outcome	Indirect Effect (ab)	95% CI	Std. Error	p-value
FFMQ Total	PHQ-9	1.93	[.86, 3.13]	0.65	0.003
FFMQ Total	GAD-7	1.64	[.61, 2.66]	0.53	0.002
FFMQ Total	BSL-23	7.77	[4.56, 11.20]	2.19	<.001
FFMQ Total	RRS	3.08	[.94, 5.19]	1.25	0.014
FFMQ Total	DERS	5.26	[1.41, 9.48]	2.37	0.026

or false-positive results. As such, some of the significant relationships reported here may have arisen by chance and not reflect true or stable effects. Therefore, all these results should be considered exploratory.

Clinical Implications and Conclusion

This naturalistic study is one of the first to explore the relationship between different facets of mindfulness and various treatment outcomes in outpatient DBT and highlights the potential importance of Nonreactivity and Nonjudging skills for clinical improvement. As noted, these results are exploratory, and thus we discourage drawing any strong clinical recommendations from our study. That said, if these results are eventually found to be robust, they may suggest that clinicians emphasize the teaching and practice of Nonjudging and Nonreacting skills and stances with their patients, as they appear to be the most strongly related to clinical improvement. However, Nonjudging and Nonreacting can be particularly difficult to learn and master (Solhaug et al., 2016), and therefore it may be worth exploring whether and how clinicians can effectively support their clients in the development of these more complex skills. Labelle and colleagues (2015) found that early improvement in nonjudging mediated later improvements in nonreacting during Mindfulness-Based Cognitive Therapy. This suggests that clinicians may benefit by focusing initially on helping their clients develop a nonjudgmental stance which they can later deploy to facilitate nonreactivity.

Future research into the relationship between mindfulness facets and treatment outcomes in DBT could benefit from more temporally rich data (e.g., time-series, or ecological momentary assessment), measures of actual DBT and mindfulness skills usage throughout the course of treatment, larger and more diverse samples, as well as controlled experimental designs. Such research could deepen our understanding of how and why clinical change occurs in DBT, and support the further refinement of this important treatment.

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Table 4. FFMQ Facets: Estimates and 95% Confidence Intervals for significant ab paths between FFMQ facets and outcomes

Mediator	Outcome	Indirect Effect (ab)	95% CI	Std. Error	p value
AA	PHQ9	1.99	[.18, 1.93]	0.49	0.035
NR	PHQ9	1.90	[.64, 3.34]	0.72	0.008
NR	GAD7	1.77	[.60, 3.03]	0.59	0.003
NR	BSL-23	8.87	[5.21, 13.28]	2.39	<.001
NR	RRS	3.28	[.64, 5.86]	1.43	0.021
NJ	GAD7	1.17	[-.33, 2.48]	0.51	0.022
NJ	BSL-23	5.18	[.61, 9.96]	2.03	0.01
NJ	RRS	2.73	[-.019, 5.31]	1.26	0.03
NJ	DERS	5.72	[1.97, 10.32]	2.45	0.019

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ADAPTING DBT FOR GENDER DYSPHORIA: A PERSONAL ACCOUNT FROM A DBT CLIENT

Haley Lilling

AS A TRANSGENDER WOMAN with borderline personality disorder, bipolar II, and a history of psychiatric hospitalizations, I've found success with DBT in both my recovery and my transition.

While DBT has been helpful for my gender dysphoria, I've found that DBT currently lacks an established framework for the treatment of gender dysphoria. I strive to lay the foundation for this framework. In this article, I give a brief summary of my adaptations of DBT for gender dysphoria, and an example of them in use.

I find my dysphoria to be an interactive collection of triggers and emotion narratives.

Emotion narrative - *an emotion along with its accompanying thoughts, urges, and physical state.*

These triggers and emotion narratives combine to form trigger trees.

Trigger tree - *a collection of triggers and emotion narratives all occurring in one episode.*

Dysphoria Triggers:

1. Personal triggers
    a. Remembering, expecting to have, or having a negative perception of myself
2. Social triggers
    a. Misgendering (memory of, expectation of)
    b. Believing others are/will/have misgendered me even if they have not

Dysphoria Emotion Narratives

1. Personal emotion narratives
    a. Despair, dissociation, panic, shame, self-hatred, anger
2. Social emotion narratives
    a. Anxiety, self-consciousness, paranoia, anger, jealousy
    b. Traumatic invalidation
        i. Every time I get misgendered, it invalidates my womanhood
3. Transition anxiety
    a. Anxiety related to transition tasks

Next I want to introduce my **normals**. They are a set of skills that are preventative, proactive, and guiding. They are my goals.

First are my **essential normals**, composed mostly of the PLEASE skill. These are essential to manage every day, both for prevention, and for returning to baseline from a trigger tree.

Next are my **extended normals**, composed mostly of short and long term goals, building mastery, and forming and maintaining relationships. They're preventative and proactive, but also guiding. Extended normals guide the effective actions steps that I take at the end of a trigger tree.

Dysphoria normals operate like extended normals. They're preventative and proactive relative to dysphoria trigger trees, and they guide my effective action.

Dysphoria Normals

1. Transition
    a. Hormones, laser hair removal, surgery, name change, etc.
2. Appearance, voice, and mannerisms
    a. Adapting my fashion, appearance, voice, and mannerisms to match the woman that I am
3. Corrections
    a. Correcting others when they misgender me
    b. Operate as trigger prevention by reducing misgendering and expectation of misgendering
    c. Operate as positive self-language by validating my womanhood to myself

Solving a Trigger Tree with my *Point Skill Tree*: A Prototypical Chain and Solution Analysis Prompted by Misgendering:

Throughout the following example, I will use my **point skill tree**, which is the set of skills that I use to combat trigger trees in the moment. The skill tree is divided into three objectives:

1. Returning to baseline
2. Modulating my self-language beliefs
3. Acting effectively

Trigger Tree:

At work, a colleague refers to me as 'he' to one of his friends. I fail to correct him and walk away.

(thoughts) *'He sees me as a man. Everyone else in here is staring at me and sees me as a man too. I have to quit. I can't work until after my surgeries. The thing on my neck is huge and everyone is looking at it and I look freaking disgusting and my face is so masculine. Even if I get my trach shave the thing is too big, they won't be able to make it go away.'*

'This dysphoria will never go away and there's nothing I can do. Look at Rose and Jen, they literally have they/them on their name tags and everyone still misgenders them and they never correct people and they're still fine. Why am I freaking out so much?

It's impossible to correct him because he won't even know what I'm talking about and if I try to explain it he'll just look at his friend and laugh.'

(physical state) I feel the hot prickles. I'm getting stress-sweat and I can't focus on my work. My heart is racing. I feel tears coming.

(urges) Cry to Annie and embellish

everything so she comforts you and feels bad for you. Cry to Clark, embellish your pain, and quit. Stare at your face and the thing on your neck in the mirror and make yourself sob. Scratch your scars open.

(emotions) Self-consciousness, anxiety about getting misgendered, invalidation, self-hatred, despair, anger, transition anxiety about tracheal shave.

Point Skill Tree: Three Branches of Skills Solutions:

My point skill tree starts with returning to baseline and modulating my self-language beliefs. The goal of these two objectives is to put me in position to achieve objective three.

Returning to baseline (objective 1):

1. Use distress tolerance to get the hell out of that physical state.
2. Focus on my essential normals. Loss of essential normals is almost always an underlying cause of a trigger tree.

I just want to be mindful of my distress, not the details of my trigger tree. Trying to address those in a distressed physical state will only exacerbate things.

I go to the bathroom. It's darker, quieter, and I'm alone. I get a handful of cold water and drop it down the back of my neck and spine. It's a modified TIPP skill.

I go into the stall and sit down. My physical state is already drastically different. I can breathe normally. However, I'm still vulnerable. Any attempt to address triggers and emotion narratives will re-trigger me.

I realize that I had waited too long before taking my break, and I'm hungry.

I tell Clark that I got distressed, and that I'm going to need to take extra time on my ten minute break. I go to a private place and eat.

Modulating my self-language beliefs (objective 2):

I want to note two of my thoughts:

This dysphoria will never go away and there's nothing that I can do.'

'Rose and Jen never get triggered like you do. Why does this trigger you so much?'

These are not dysphoria thoughts. Instead, they represent self-language beliefs about my dysphoria. I've noticed that part of my pathology is the development of a set of engrained self-language beliefs about my emotions. I split these self-language beliefs into three categories:

1. Self-invalidation
2. Self-criticism/self-hatred
3. Hopelessness and helplessness

The first thought exemplifies hopelessness and helplessness. I am hopeless and helpless in relation to my dysphoria; it will never go away and there's nothing that I can do.

The second thought exemplifies self-invalidation. I'm not normal or valid to be as sensitive to triggers and react as intensely as I do.

I become mindful of these beliefs and modulate them with opposite language. I tell myself:

'You're doing so well with your transition! You're better than you were a few months ago and you're going to be even better in a couple of months. You have tools. You work hard. You can do this.' **(hope, confidence, and competence)**

'You're sensitive, you're intense, and it's okay! That's who you are, it's not supposed to be easy! Once you manage them, your powerful emotions are a gift that guide you forward.' **(self-validation)**

Note: The skills objectives do not flow in a strict hierarchy. Sometimes skills to return to baseline are more initially accessible, whereas other times, it's more initially accessible to modulate my self-language beliefs. Both are essential in setting the stage for objective three.

Acting effectively (objective 3):

Finally, I'm able to become mindful of the trigger tree itself. I strive to comb through the triggers and emotion narratives and build a plan for effective action. Skillfully acting effectively is crucial because it reinforces the idea that despite my distress, my emotions and dysphoria are valuable. They guide me forward in life. Returning to baseline and modulating my beliefs allow me to hear my emotions without panicking. In objective three, I listen to them and plan for effective action.

Now, my dysphoria normals guide me. They form my arsenal for effective action.

First, I focus on the initial social trigger. I must correct him. It's awkward, and I'm having anxious urges to avoid it, but the correction serves multiple roles. First, it reduces social triggers by reducing the likelihood that he will misgender me in the future. This reduces my anxiety about getting misgendered when I'm at work.

Second, it reverses the invalidation of my womanhood. When I tell him that I am a woman and he accepts it, he validates my womanhood. I also validate my womanhood out loud to myself.

I use check the facts, opposite action and DEARMAN. I approach him.

"Hey, you know I'm a woman right, because you referred to me as he before."

"Oh yeah, sorry, my bad."

"It's okay, I just wanted to make sure you knew I'm a woman."

"Yeah forsure."

I feel a wave of pride and validation. **(corrections)**

Second, the social trigger set off a tree of personal dysphoria and transition anxiety around the thing on my neck. I realize that I have been avoiding researching and making my tracheal shave appointment out of fear that it won't work. I know the program that I want to go with, but I've been avoiding making the call. I resolve to make the

call on my next off day. **(transition)**

Like with traditional emotions, managing my dysphoria is about finding balance in the dialectic of acceptance and change.

Once at baseline, becoming mindful of my dysphoria triggers and emotion narratives allows me to identify *what I want to change*. Then, my dysphoria normals guide me forward by helping me find how to change.

Since the beginning of my recovery and transition, I've asked myself how I can accept the things that I can't change. I haven't solved it, and I imagine it's different for everyone, but I'll close with something that I've found to be true for me, and that, as a coach, I've always told my players.

'If we do everything that we can do to get better, and we play our hearts out, we'll be proud of the result, win or lose. If we don't try our best, a loss will be tough to accept. We'll give it our all now and we won't regret a thing.'

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