DBT Bulletin

VOLUME 3, ISSUE 1 JUNE 2020

At DBT Bulletin, we want to make it clear that we stand in solidarity with the Black community, condemn racism, and believe Black lives matter. We have been reflecting and discussing on our board how we can do more as both a community and via our newsletter to dismantle racism and systemic oppression. To this end, our editorial team would like to outline action steps for the future of the DBT Bulletin: 1) We will be creating a scholarship program for trainees who will be presenting at ISIT/DBT with a priority for diversity related submissions. 2) We are recruiting for an additional board member who will lead the Diversity in DBT section of this bulletin. We are honored to provide this newsletter as a service to the DBT community and want to actively strive to increase our efforts to not only address social justice using our voice but to elevate the voices of diverse individuals in our DBT community. Please see the call to actions at the end of this newsletter for more information.

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Editorial Board

INSIDE THIS ISSUE:

Devil's Advocate

Devil's Advocate: DBT Gun Safety

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One thing that the last 13 years of being a DBT clinician has taught me is that the learning is truly never over. I have found that I am constantly having to lean on my DBT community, recognize that I don't know all that I think I do, and evolve my clinical skillset in order to meet the needs of my clients. It is because of this that in the Fall of 2018, I found myself once again embracing the fallibility agreement as I realized how little I really knew about one of the single largest predictors of suicide: firearms.

On November 17, 2018 I attended a panel discussion titled "Addressing Gun Violence in America Begins with a Focus on Suicide." The panel was comprised of leading researchers and innovators in the fields of firearm-related injury and public policy development. As someone who is passionate about suicide prevention and has dedicated the majority of her professional career to this cause, I left this discussion shocked at how little I actually knew about the relationship between firearms and suicide. While of course I would have been able to tell you that firearms are the most lethal of suicide means, I did not know that 85-90% of firearm suicide attempts prove to be fatal whereas only 5% of all other methods *combined* result in fatality (CDC, 2016). According to the CDC, suicides account for a whopping two-thirds of the total number of firearm-related deaths in the United States. The role of firearms is so significant that firearm ownership has proven to predict overall suicide rates, not simply firearm suicide rates (Kegler, Dahlberg, & Mercy, 2018; Hyejin, Khazem, & Anestis, 2016). And in fact, suicide is five times more common in households where a gun is present (R. I. Simon, 2007), a finding not attributable to elevated rates of mental health conditions, suicidal ideation, history of suicide attempts among gun owners, or other key demographic and cultural variables (Anestis & Houtsma, 2018; Miller et al., 2009). These results highlight how the very presence of a firearm independently and drastically increases one's risk for suicide.

To many, these findings may be somewhat jarring. Public opinion as well as the narrative often portrayed in the media is that firearm-related injuries are the result of person-to-person violence. When asked about this misconception, Director of Research Translation for the Educational Fund to Stop Gun Violence, Vicka Chaplin, explains "In public discourse, stigma and shame often prevent people from talking about personal experiences with suicide, while gun violence media coverage tends to be dominated by mass shootings. At the same time, and for far too long, we as a society have approached suicide solely as a mental health treatment issue, rather than a public health prevention issue: we focused on the "why" of suicide at an individual level instead of the "how" at a population level. Ultimately, it is important to treat suicidality while also reducing easy access to the lethal means -- i.e. firearms -- that make suicide attempts fatal."

Beginning to take note of the discrepancy between what is known on a population level and what is often discussed on a clinical level in relation to firearms, I set out on a humbling review of my own professional work to determine if I am targeting gun access and storage practices to the extent that I should be. I also began to wonder whether this blind spot may exist on a larger level as I considered the teams I have been a part of, listservs that I participate in, conferences that I have attended, and clinical discussions both large and small that I have had. It was at this point that I began to wonder about how often are we discussing firearms in the DBT community. In the spirit of always striving to understand "what is being left out," I along with my dear friend and colleague Dr. Lizbeth Gaona launched an informal survey of 195 CBT and DBT clinicians aimed at understanding firearm safety counseling practices among those who work with clients at elevated risk for suicide. The survey responses received were revealing in that they demonstrated a high degree of variability in the extent that providers assess for and clinically target gun access and storage behaviors. Some of the more noteworthy findings include: one in four clinicians reported having "no idea" as to the number of clients they have that possess or have access to a firearm, one in four clinicians

Devil's Advocate: DBT Gun Safety

Lauren Jackson, PsyD

reported that they ask about firearm access with only 25% of their clients, and one in five clinicians stated that they *never* ask their clients about firearm access. And interestingly, regression analyses suggested that the more confident a clinician is in their DBT skills knowledge, the less likely they were to explicitly ask about client firearm access (β= -.53, S.E. = .194, p<.01). These findings run parallel to a growing body of literature highlighting that firearms are largely being left out of important clinical discourse, despite the significant role they play in suicide.

After considering the relationship between firearms and suicide coupled with data illustrating that guns are not being adequately targeted in the clinical setting, we must ask the question: How do we begin to encourage systematic and comprehensive firearm safety counseling in the course of our work? And while firearm safety counseling interventions are in their infancy, DBT clinicians appear to be particularly well-suited for these types of conversations. Through adopting a dialectical stance where we are striving to balance acceptance and change, we as DBT providers are poised to both understand and validate the functions that firearms play in our clients' lives while also working to promote safety through psychoeducation and commitment strategies. We also have unique tools at our disposal including self-monitoring through use of diary cards and chain analyses, which can help us not only understand the function of storage-related practices, but also improve client buy-in by highlighting patterns surrounding mood-dependent behavior. In fact, the most significant growth edge we may face as a community is to simply recognize the importance of initiating a conversation about firearm access with *every* DBT client. Implementing this in routine practice perhaps has never been more important given that gun sales have surged in response to the COVID-19 pandemic. And so, let this be a call to all of us to review our understanding of the relationship between firearm access and suicide, evaluate any silent myths we may hold regarding the nature and prevalence of firearm-related deaths in the United States, validate ourselves while embracing the fallibility agreement if needed, and then ultimately lean into change.

Clinical Perspectives

Feel Your Fear and Do it Anyway: The Exposure Lifestyle

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I have a confession: I've become one of those sensation-seeking exposure fanatics (weirdos?) who searches for exposures every day. While sensation-seeking is optional, choosing to live the exposure lifestyle requires mindfully choosing to feel your fear and do it anyway, resisting urges to avoid or escape. This choice reflects my wise mind, my core values. It allows me to have integrity in the work I do with my clients and, even more, to live a flexible, value-driven life.

While exposure is an integral skills target across both DBT and CBT interventions, DBT and CBT providers traditionally use different terminology to describe exposure, which unfortunately obscures shared principles. Here, I use DBT terminology to describe exposure process and highlight shared principles across DBT and CBT traditions. I then describe DBT-specific extensions of exposure procedures, as well as common barriers that inhibit therapists' competence and confidence in exposure work. Finally, I discuss possible skillful solutions for each barrier.

DBT therapists often refer to exposure as "opposite action," one of two primary change skills taught in the emotion regulation skills module. This skill is designed to reduce the intensity of emotions when emotions do not fit the facts of the situation or when acting on the emotions' action urge is not effective. Opposite action reflects the emotion regulation capacities of CBT exposure techniques through the shared principle of changing emotional experiences by changing (or resisting) emotion-linked behavior. For example, I grew up with a severe fear of cats (my emotional experience). My fear prompted me to avoid cats at all costs, e.g., running out of my friend's room when her cat appeared (emotion-linked behavior). While in college and providing in-home therapeutic services to a boy with autism, I received the gift of an unplanned, naturalistic exposure. The boy urged me to play with his favorite neighborhood cat, named "Fat Boy" (as an aside, I believe this boy shared Marsha Linehan's nonjudgmental use of the term *fat)*.

Driven by my values to support the child, I acted opposite to my avoidance urges, *very* slowly increasing my exposure to Fat Boy (changing and resisting emotion-linked behavior). Initially, I pushed myself just to remain on the playground with the boy and Fat Boy, which felt scary but doable. I continued to gradually increase my exposure difficulty, from petting Fat Boy at a distance with my fingertips to eventually holding and snuggling the cat. Over a few weeks of gradual Fat Boy exposures and acting differently (i.e., resisting my fear-linked escape and avoidance behaviors), my fear of cats habituated. My interactions with Fat Boy illustrate how "the emphasis is on both exposure and acting differently" (Linehan, 1993, p. 344), a shared principle across both DBT and CBT exposure-based procedures.

From my experiences embracing the exposure lifestyle in my personal life and treating clients with severe emotion dysregulation co-occurring with OCD and anxiety disorders in my professional life, I have come to appreciate that opposite action is much more than a change skill. That is, exposure is not simply a change skill. Exposure is a dialectical skill, inviting a balance of both acceptance and chance. During exposures, we mindfully identify a core fear as an exposure target (e.g., fear of rejection or negative evaluation, fear of contamination, fear of uncertainty). We create a graded exposure hierarchy of stimuli that prompt each core fear. This first step reflects acceptance, using mindfulness and willingness skills to choose an effective exposure task that is challenging *and* doable. The second step requires change, as we approach, rather than avoid, stimuli that prompt our core fears, and continually act opposite to subsequent urges to avoid and escape. Next, we again apply acceptance skills, mindfully paying attention to and riding the wave of whatever emotions, thoughts, body sensations, and urges arise, exactly as they are. DBT acceptance skills that support this goal include mindfulness of the current emotion, thought, and other person, and radical acceptance. During this emotional experiencing (acceptance), we simultaneously resist our urges to submit to avoidance and escape rituals (change).

Feel Your Fear and Do it Anyway: The Exposure Lifestyle

Andrea L. Gold, PhD

In addition to sharing exposure principles with CBT, DBT extends and modifies exposure-based procedures in two key ways. First, whereas CBT -based exposure therapies traditionally target problematic fear, anxiety and related emotions, DBT extends opposite action and exposure procedures to other painful emotions, including shame, guilt, anger, sadness, envy, and love. Second, exposure-based procedures are used informally throughout DBT, such that no whole sessions are necessarily devoted to utilizing exposure exposures in an explicit manner. Instead, informal exposures permeate the whole course of DBT. For example, essential DBT strategies and procedures, including behavioral analysis, contingency and skills training strategies, mindfulness practice, and withdrawal of therapist supportive activities, all function as exposure opportunities when they follow five key steps: (1) they elicit emotions, such as shame, guilt, fear, anxiety, sorrow and anger, that (2) are not reinforced; (3) the therapist blocks emotion-linked behaviors functioning as maladaptive coping responses (e.g., escape/avoidance responses to fear/anxiety, hiding/withdrawing responses to shame, repair/self-punishment responses to unjustified guilt, hostile/aggressive responses to anger); (4) the therapist enhances the client's sense of control over the situation or oneself, promoting the collaborative and voluntary nature of exposures; and (5) they have sufficient duration and/or frequency to be effective (Linehan, 1993).

Thus, exposure principles guide the emotion regulation function of opposite action, which can both be used as a moment-to-moment skill to regulate the intensity of emotions, and, as indicated in any given case conceptualization, can be expanded into a larger intervention via more formal exposure work. Following DBT principles and priorities, formal exposure work may be integrated throughout the stages of treatment accordingly to address both primary behavioral targets (e.g., co-occurring mental health disorders that respond to exposure procedures, such as posttraumatic stress disorder, obsessive-compulsive spectrum disorders, panic, and social anxiety disorder) and secondary behavioral targets (e.g., increasing emotional experiencing, decreasing inhibited grieving).

Some may wonder why DBT promotes exposure as an emotion regulation tool. After all, don't DBT clients struggle with intense emotions? Why would exposure, an intervention that is intentionally designed to INCREASE distress in the moment, be recommended for a DBT client? DBT clients frequently avoid and escape emotional stimuli in dangerous ways. Given the potential for DBT clients to engage in life-threatening and treatment-destroying behaviors, therapists may understandably feel scared to coach our clients to do things that intentionally increase their distress (i.e., exposure)! If we believe that coaching exposure means adding gasoline to the fires of hell, of course we might avoid. Coaching high-risk clients through exposures can be incredibly scary and overwhelming. And, at the same time, exposure is the solution. When our clients are in hell, why would we willingly choose to walk through hell? Because, *the only way out is through.* Our mission as DBT therapists is to get our clients out of hell and building a life worth living. In order to do so, clients cannot afford to remain afraid and avoidant of strong emotions. We need to invalidate the invalid: skillful exposure therapy does not increase levels of danger or distress in the long-term. It can free clients to feel their strong emotions without inhibiting fear or the need to escape. Besides, clients frequently face naturalistic exposures and emotional flooding in their natural environments (and your office), prompting avoidance and escape behaviors. Exposure therapy offers an alternative by helping clients skillfully address the things they are already facing in a planful, effective way. Clinicians and clients collaboratively plan and agree upon exposure work in controlled, voluntary, and safe contexts, providing tools and control that clients don't yet have in their lives. Exposure is how we coach clients to reach the peak of their emotion, and how they learn that they can tolerate it. This is the path to reducing and resisting destructive avoidance urges in the long-term, help-

Feel Your Fear and Do it Anyway: The Exposure Lifestyle

Andrea L. Gold, PhD

ing clients to replace misery responses with skillful ones.

Unfortunately, clinical opportunities for exposure more often than not are missed and avoided, even among DBT therapists. Nonetheless, exposure, an emotion regulation skill, is intended to be at the core of DBT. Let me hold the hope for you, if necessary, that exposure works, and offer some skills coaching.

What gets in the way?

1. You don't know how: You don't have skills mastery of exposure in general, or for specific client populations and/or case conceptualizations. You don't know how to build an effective exposure hierarchy, or identify the core fear. You're unsure how to define avoidance or escape behaviors to resist, or how to coach clients to re-expose when they submit to avoidance or escape urges. You don't know how to troubleshoot failed exposures, or when to coach exposure versus other skills. **Solution**: Didactics and experiential skills training, including books, audio/visual resources, live trainings, professional consultation, and DBT consultation team. I recommend evidence-based exposure trainings for anxiety (e.g., websites: adaa.org, abct.org), posttraumatic stress (e.g., websites: pe.musc.edu, tfcbt2.musc.edu), and obsessive-compulsive disorders (e.g., website: iocdf.org) to deepen your foundation. Also (re-)reading the "exposure procedures" section of Linehan, 1993. Advanced DBT trainings, such as DBT PE intensive training (website: dbtpe.org), teach us to expand exposure practices within the DBT framework. Most importantly, learn by doing – practice, practice, practice.

2. Emotions get in the way: I just said "practice times three", but we all know that's easier said than done. Why? Fear and anxiety prompt us to avoid conducting exposures, and guilt and shame inhibit us from asking our colleagues for help or seeking training. **Solution**: This solution is meta: do an exposure on your fear of exposure work. This is the path to regulating the emotions blocking you from starting and sticking with your clients' exposures. We know the action urge of fear is to avoid and escape, so let's validate our emotions and their action urges, and activate wise mind. Do a pros and cons of doing exposure work, and revisit your pros and cons skill when avoidance urges re-emerge. If wise mind says the fear is unjustified, then emotion regulation skills tell us to act opposite to avoidance urges and do exposure all the way. I coach you to commit (and re-commit) to your own exposures to effectively coach your clients through theirs, with support and consultation from your team. This is what we would ask our clients to do, isn't it?

3. Thoughts get in the way: Judgments; worry thoughts ("what if they freak out?"); guilt thoughts ("I haven't been doing enough exposures."); shame thoughts ("Why is this so hard for me!"). This is but the tip of the iceberg. **Solutions:** Fortunately, lots of skills here. Examples include mindfulness of the current thought, dialectical thinking, check the facts, activating wise mind, self-validation, pros and cons decisional balance, and self-encouragement skills.

4. The environment does not support exposure: Perhaps the DBT consultation team does not push therapists to identify when exposures are missing or problem-solve barriers. Teams might fail to reinforce exposure efforts and successes. Relief negatively reinforces avoidance. **Solutions:** Discuss this with your consultation team (DEARMAN GIVE FAST practice opportunity!). Create a reinforcement schedule (trust me, exposures become self-reinforcing the more you do them, but external reinforcement might get you started). Role-play exposure techniques (Ooh - another exposure opportunity for those anxious about role-plays!). Seek feedback. Volunteer for a chain analysis with your team following sessions in which you avoided exposure work.

5. Forgetting: 'Nuff said. **Solutions:** Cope ahead of time. Add exposure as a topic on your DBT consultation team agenda, session agendas, and/or therapy note templates.

Feel Your Fear and Do it Anyway: The Exposure Lifestyle

Andrea L. Gold, PhD

My wise mind knows from experience that exposure works. Exposure decreases our suffering and sets us free to savor a full life. Above all else, isn't this what we want for our clients and their families, our loved ones, and ourselves? I believe in you and I challenge you to seek out the motivation, skills, social supports, consultation, and reinforcement to embrace the exposure lifestyle. Tell me about your exposures and I'll send you gold stars – after all, I am Dr. *Gold*.

On Becoming Marsha Linehan: A Review of Building a Life Worth Living

Scott Temple, Ph.D.

In 2017, I attended a Death and Dying retreat that Marsha Linehan led at her beloved Redemptorist Retreat Center outside of Tucson. We wrote our 'life lines' in colored markers on long sheets of paper, and took turns presenting our lives to the group. I began by talking about my mother's psychiatric hospitalization in 1940. She was 16, and the impact of that experience would prove devastating for her, and for everyone in her life subsequently. During dinner that evening, Marsha asked me what I thought allows some people to thrive after such tragedy, while others drown.

I've thought a lot about that conversation. Marsha's memoir provides some answers. It details how she went from a hellishly tormented teen to a world-renowned scientist and treatment developer; a Zen teacher and spiritual mentor; and an authentic American folk hero, á la Bill W. and Dr. Bob, the founders of Alcoholics Anonymous.

From the memoir, a few clues:

A core of spiritual passion: Marsha's spiritual quest has been central to her life, beginning with what she described as a vision of God at age 20. Her path from the Christian contemplative traditions to Zen is chronicled in the memoir, including touching descriptions of her relationship with her primary teacher, Willigis Jager.

Saying "yes" to life: From childhood, Marsha Linehan had a capacity to say a deep 'yes' to the joys and delights of being alive. The memoir repeatedly shows this capacity for delight, whether in her love of dancing, food and wine, parties, or her zeal for learning how to camp in the wilderness. Marsha's therapeutic stance is always aimed towards helping others say 'yes' to life.

Clarity of purpose: Marsha made a commitment following her psychiatric hospitalization to get herself out of hell and then return to get others out. This central purpose is a continual thread in her memoir. When the pull of a monastic life beckons, she remembered this purpose and returned to academia, and to the development and dissemination of Dialectical Behavior Therapy (DBT).

Persistence: If there were a poster child for persistence, she shows up in this memoir. The book offers reflections of Marsha as seen through the eyes of peers, mentors, friends and family members, nearly all of whom remember her as a person who never gives up, no matter what the inner or outer barriers. Her request of her department chair for more time in a monastery is both funny and indicative of the relentlessness of her quest.

Disciplined curiosity: The creation of DBT required Marsha to absorb and synthesize multiple domains of knowledge into a single, creative whole. This required a detailed inquiry into behaviorism, CBT, Zen, the philosophy of dialectics, and research methodologies. Marsha threw herself into study, embracing 'beginner's mind' while learning what she needed to create DBT.

Reaching out to people: Marsha had an uncanny knack for finding the right mentor at the right moment. The book displays her ever-growing awareness of her need for connection; and it ends touchingly in her description of her relationship to her adoptive daughter, Geri Rodriguez, Geri's husband, and their child, Marsha's grandchild.

A willingness to do what works: One of her most impressive skills is the ability to see herself with painful clarity, and to adjust her behavior in the service of being effective. When she prods therapists and patients to do the same, her ability to sell skills is clearly born of her own struggles. For example, Marsha repeatedly references her tendency to be a 'motor mouth'. She is remarkably candid about her tendency to be interpersonally insensitive at times. But the memoir describes any number of incidents in which she observed her own behavior's unworkability, and adjusted to be effective.

To quote the memoir: "If you're a tulip, don't try to be a rose; go find a tulip garden." DBT helps people decide who they are, where they belong, and how to get there. Marsha has said, "If I can do it, anyone can." Not everyone will; and for those who are willing, this memoir points the way.

Research Insights

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

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Introduction

Borderline personality disorder (BPD) is considered to be one of the most potentially lethal of all psychiatric illnesses with a prevalence of about 1 -2% in the general population (Bender et al., 2001; Lieb et al., 2004; Zanarini et al., 2012). Skodol, et al., (Skodol et al., 2002) examined several domains of impairment for 175 treatment -seeking individuals with BPD and found severe impairment in employment among 52%, global life satisfaction for 55%, social adjustment for 71%, and overall functioning for 47%, of the sample. Functional impairment was more severe for those with BPD than a comparison sample with major depression.

In a 2012 review (Sansone & Sansone, 2012) of 11 mostly small national and international studies representing the literature on employment in BPD since 1980, severe and long lasting impairment in employment and high rates of disability were reported. In a large US study, Zanarini, Jacoby, Frankenburg, Reich, & Fitzmaurice (2009) sampled 290 individuals with BPD during an inpatient psychiatric admission at McLean Hospital in Massachusetts and followed them for 10 years. Consistently over time, approximately half (41-52%) of the sample was receiving social security disability income (SSDI) disability benefits- three times the rate of the comparison group with other personality disorders.

The opposite of psychiatric disability is recovery. Zanarini, et al., (Zanarini et al., 2012) defined recovery as "remission from BPD, have at least one emotionally sustaining relationship with a close friend or life partner/spouse, and be able to work (including work as a homemaker) or go to school consistently, competently, and on a full-time basis" (p.2). Based on this definition and review of a 16-year follow-up period, rates of recovery for individuals with BPD were substantially lower and unstable compared to controls with other personality disorders. Employment and education outcomes have rarely been evaluated in clinical trials of BPD treatments. However, one large clinical trial evaluating the efficacy of Dialectical Behavior Therapy (DBT) vs. General Psychiatric Management (GPM), found that, at baseline, 40% of participants were working or in school and 40% received psychiatric disability. After a year of treatment and two years follow-up, 58% of the DBT and 40% of GPM participants were working or in school and 29% of DBT and 47% of GPM participants received psychiatric disability, non-significant differences (McMain et al., 2012).

Employment is a struggle for many individuals with BPD. However, this does not mean individuals with BPD do not want to work. Indeed, a qualitative study examining client goals for recovery found that 50% of the sample of clients with BPD identified the importance of practical achievements and employment as part of their recovery, and that making progress in pursuing career goals would lead to an increased sense of competence (Katsakou et al., 2012). These findings are supported by other qualitative studies of individuals with BPD (Cunningham et al., 2004) and psychiatrically disabled individuals with a variety of diagnoses (Killeen & O'Day, 2004; Underlid, 2005) who report a strong desire to work.

In response to clients' desire but inability to work, a team of DBT therapists at Harborview Medical Center in Seattle, WA developed a recovery oriented program for clients that have completed a year of standard DBT (SDBT) called DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES). DBT-ACES promotes living wage employment with the goal to reduce clients' dependency on disability payments, social services, family, and others for basic needs. DBT-ACES, like SDBT (Linehan, 1993), is an intensive one-year outpatient program that combines skills training focused on contingency management, skills training, and exposure strategies.

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

The feasibility of DBT-ACES was established in an evaluation of 30 consecutive SDBT graduates at the end of 1 year of DBT-ACES and after a 1 year follow-up (Comtois et al., 2010). From the end of SDBT to the end of DBT-ACES, there was a significant improvement in participants' odds of being employed or in school, working at least 20 hours per week, as well as subjective quality of life and sustained decrease in the frequency of psychiatric inpatient admissions. Since this initial evaluation, the Harborview DBT-ACES program has expanded its clientele to include those with commercial as well as public insurance. Also, the Medicaid expansion in Washington State under the U.S. Affordable Care Act increased the number of employed adults with insurance. In addition, two other sites developed DBT-ACES programs: Harbor-University of California Los Angeles (UCLA) Medical Center and Der Landschaftsverband Westfalen-Lippe (The Regional Association of Westphalia-Lippe; LWL) Klinik in Lengerich, Germany. All sites planned and coordinated observational program evaluations with the same outcome variables. The goal of this re-evaluation was to combine these evaluations to determine if initial DBT-ACES results could be replicated. In addition, this evaluation examined program costs, costs of inpatient use, and school and workplace benefits in order to estimate the net monetary benefit of DBT-ACES above and beyond those gained by SDBT alone.

Methods

This program evaluation was conducted at three settings: Harborview Medical Center, Harbor-UCLA Medical Center, and LWL-Klinik Lengerich in Germany. Harborview is a major medical center in downtown Seattle owned by King County and managed by the University of Washington as both the county hospital and a research and training facility. Harbor-UCLA is a major medical center in Torrance, CA that is a UCLA-affiliated county hospital and research and training facility. Both Harborview and Harbor-UCLA include large outpatient community mental health centers with long-standing outpatient DBT programs. LWL-Klinik Lengerich is a psychiatric and neurological specialty hospital in Lengerich, Germany, and the DBT-ACES program existed within a well-established standard DBT program in an ambulatory care clinic.

Participants

This study was conducted as program evaluation of ongoing clinical care in the three DBT programs. Enrollment in SDBT was based on BPD diagnosis on the SCID-II interview (First, 1997; First et al., 1995) in Lengerich, on life-threatening and therapy-interfering behaviors at Harborview, and either SCID II BPD diagnosis or a subthreshold diagnosis if combined with high target behaviors at Harbor-UCLA. Patients with low intelligence level (IQ < 70) were excluded for all programs. Lengerich also excluded clients with acute schizophrenic or manic illness, substance dependence (only in the case of permanent use and a necessary detoxification) and diagnosis of anorexia with BMI < 17.5. Harborview and Harbor-UCLA did not have these exclusions.

The 45 participants were clients consecutively admitted to each program. Data was collected by the teams as program evaluation so there were no research specific inclusion or exclusion criteria nor was a power analysis conducted. All sites have active SDBT programs from which pool clients for this study were drawn. Harborview included 21 participants consecutively entering the Harborview DBT-ACES program between 2011 and 2013. Harbor-UCLA included 8 clients consecutively entering the Harbor-UCLA DBT-ACES program between 2011 and 2016. LWL-Klinik Lengerich included 16 participants consecutively entering the Lengerich DBT-ACES program between 2010 and 2012. The 45 DBT-ACES participants represent only a subset of the clients in SDBT at the 3 sites: 24% of those starting SDBT entered DBT-ACES at Harborview, 22% at Harbor-UCLA, and 50% at Lengerich.

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES)

DBT-ACES is a manualized adaptation of standard DBT developed by the Harborview DBT program in collaboration DBT treatment developer, Marsha Linehan, PhD (Comtois et al., 2010; Hoeschel et al., 2011). The treatment is the same as comprehensive standard DBT, consisting of the same philosophy and strategies as well as individual, group, out-of-session contact, and consultation team modalities, but includes four modifications: pre-treatment, primary targets, specific career and employment contingencies, and the DBT-ACES skills curriculum. It is currently designed to occur when a client is near graduation from a full year of SDBT or after having completed that year.

Pre-treatment in DBT-ACES is a 2-4 month process during which a potential client is oriented to DBT-ACES through a process designed to mimic application processes for competitive employment (e.g., performance evaluation and interview) and college (e.g., entrance exams and short essays). The pre-treatment process provides valuable exercises through which clients develop career plans and use their SDBT skills to address barriers to competitive employment or college, including stopping self-harm and other significant behavioral dyscontrol.

DBT-ACES primary targets are called Recovery Goals and were developed by the DBT-ACES team in consultation with Marsha Linehan, PhD. The 30 Recovery Goals include career and living wage employment goals as well as goals for interpersonal and emotional skillfulness and for self-sufficiency. These goals are the focus of individual DBT-ACES sessions, serving as the primary quality of life targets within the DBT hierarchy.

The third modification of DBT-ACES is the addition of two graduated contingencies to facilitate living wage employment: "Career Activities" and "Work as Therapy." The Career Activities requirement is tied directly to the client's ambitions for living wage employment and reflects the most effective activities to achieve them. This can include paid employment, college, vocational training, internships, self-employment, etc. The contingency of Career Activities starts at 10 hours a week and increases to 20 hours by 8 months into DBT-ACES. To assure DBT-ACES clients have the skills to (a) find a job quickly and (b) keep a job even if they don't like it (a requirement of life off disability), the Work as Therapy contingency requires clients to find a standard job on the open market and work there for a minimum of 10 hours/week for at least 6 months. Both contingencies are requirements for continued participation in DBT-ACES. If they are not met for 4 weeks in a row, the client is suspended from the program (i.e., on DBT 'therapy vacation') until they are met. (Work as Therapy counts toward Career Activities so the maximum time required is 20 hours/week.)

The fourth modification is a DBT-ACES skills curriculum that was developed with a focus on the key skills and strategies for successful employment and self-sufficiency including goal-setting, problem-solving, troubleshooting, perfectionism, time management, and reinforcement of themselves and others.

DBT-ACES uses all SDBT strategies, with a strong focus on contingency management and exposure. Contingency management is reflected in the work requirements described above as well as constant attention to reinforcing adaptive behavior and teaching clients to do so for themselves. Anxiety and shame are predominant emotions that interfere with returning to work and functioning self-sufficiently, based on an assessment of DBT-ACES applicants' self-reported barriers to achieving these goals (Carmel et al., 2018). Therefore, exposure is a dominant treatment strategy in DBT-ACES – primarily in vivo as well as in-session informal exposure. (Detailed information on the DBT-ACES program can be found at dbtaces.com.)

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

Clients received 1 year of comprehensive SDBT according to the treatment manuals (Linehan, 1993, 2015b, 2015a). All site clinicians were trained in SDBT by Marsha Linehan and expert clinicians that had been offering comprehensive SDBT for many years. Clients interested in participating in DBT-ACES completed DBT-ACES pre-treatment in their final four months of SDBT or after completing the program. Clients started one year of DBT-ACES when their applications were completed and accepted. DBT-ACES was provided according to the treatment manual at all sites as trained by the first author and treatment developer (KAC).

Procedures

For the US sites, the information from this unfunded program evaluation was obtained by a combination of therapist interview and record review by the authors as members of their respective DBT programs. Individual therapists in Lengerich interviewed their clients with standardized interviews translated into German which were then used to determine study outcomes matched to those collected in the US. All participants who entered the DBT-ACES program were included in the outcome analyses regardless of whether they completed DBT-ACES. At Harborview and Harbor-UCLA, this program evaluation was not determined to be research by their university IRB and thus not in need of IRB review. Ethik-Kommission der Ärztekammer Westfalen-Lippe und der Westfälischen Wilhelms-Universität Münster (Ethics committee of the medical chamber Westfalen-Lippe and the Westphalian Wilhelms-University Münster) confirmed the Lengerich evaluation was part of clinical quality control and no need of ethical review.

Measures

Employment and Schooling

Employment includes only competitive employment – that is, a job for pay that is available on the open market for people with or without a disability. School was defined as a matriculated program such as college, General Educational Development (GED) program, or a vocational-technical or business certificate program. As minimum hours of both employment and school are required as part of DBT-ACES participation, this information was well known and tracked by the clients and therapists using the DBT diary cards to monitor hours of employment. Therapists were aware of the need for this information for the program evaluation.

Cost-Benefit Measures

Costs included for the cost-benefit analysis were any associated with inpatient stays that occurred during the 1 year prior to admission to the SDBT program (Pre-SDBT), 1 year after the SDBT program (Pre-ACES) and the 1 year after the DBT-ACES program (Post-ACES). Potential benefits associated with the program were also assessed by valuing (i.e., estimating the monetary value of) hours spent working or in school for each of these time periods. All dollar values were converted to 2015 values using the Consumer Price Index. Missing values were all due to baseline (Pre-SDBT) non-response as opposed to being censored as a result of loss to follow-up. All missing-non-response values pertaining to the number of inpatient stays reported at baseline were assumed to be zero. Also, missing-non-response educational-attainment values reported at baseline were assumed to imply a level of "less than high school." Given the drastic drop in inpatient visits and the increase in hours worked that occurred from pre-SDBT to pre-ACES (see below), the assumptions employed here with regard to number of visits and educational attainment most likely serve to diminish the predicted cost offset associated with the intervention.

Inpatient Stays

Each inpatient stay was valued according to the average 2010 cost for the 18-44 age group reported by the Agency for Healthcare Research and Quality ($9,910) (Pfuntner et al., 2013). This estimate was derived from the Healthcare Cost and Utilization Project

(HCUP) National Inpatient Sample (NIS), which contains information representative of all discharges from U.S. community hospitals, except rehabilitation and long-term acute care hospitals, regardless of payer and has the advantage

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

of estimating actual costs incurred by the hospital (as opposed to charges billed).

Workplace and Educational Productivity

Workplace productivity was valued according to the reported number of hours worked and the median weekly earnings associated with the clients' reported level of educational attainment, obtained from the Bureau of Labor Statistics (BLS) (Bureau of Labor Statistics, n.d.-a). Educational benefits were based on the reported number of hours spent in school-related activities, and were valued according to the estimated return for a year of schooling in the United States (Card, 1999), applied to the lifetime earnings for individuals between the ages of 30 and 34 years (Max et al., 2004). For this age group in the United States, a year of education is estimated to increase the present value of lifetime earnings by $61,570. The portion of this total for a DBT-ACES client was estimated by their hours of school activities relative to a standard full-time school year estimated as 145 eight-hour academic days.

As the purpose for the economic evaluation was to inform "real-world" decisions, generalizable unit cost estimates were used instead of real costs for the specific programs. The average annual cost of the SDBT and DBT-ACES programs was estimated using a modified version of the Drug Abuse Treatment Cost Analysis Program Instrument (DATCAP)(French, 2003; French et al., 1997). The DATCAP is a widely-used, customizable instrument used to estimate the resources required to deliver a program. A unit costing method was used to assign values to these resources. The costs associated with the DBT programs included the cost of a licensed psychiatrist at 20% FTE and four mental-health practitioners (one at 60% FTE and three at 80% FTE); computers, furniture and office space for each individual; a printer; and miscellaneous supplies and materials. In the interest of generalizability, mean salary and benefit information for SDBT/ACES personnel was obtained from the BLS (Bureau of Labor Statistics, n.d.-b). The per-client annual cost of the program was estimated at $10,872.

Data analysis

Data were collected for three time points – the beginning of SDBT (Pre-SDBT), the beginning of DBT-ACES (when the individual had completed 1 year of SDBT; Pre-ACES), and the end of DBT–ACES (Post-ACES). Longitudinal data analysis was conducted using generalized estimating equation (GEE) which appropriately models clustered data, can accommodate non-normal outcome distributions, and leverages outcome data from all individuals including those with partial follow-up data. The outcome variables were (1) hours of competitive employment plus enrollment in school and (2) working or attending school at least 20 hours per week. Gaussian and binomial GEE models were used for continuous and binary outcome variables, respectively. Each outcome variable was regressed on site and time in separate GEE models. The site variable was divided into two simple contrasts using Harborview as a reference group: i) UCLA-Harbor vs. Harborview and (ii) Lengerich vs. Harborview. The time variable was divided into two planned contrasts: (a) Pre-ACES versus Pre-SDBT and (b) Post-ACES versus Pre-ACES.

For the Gaussian GEE model of the hours of employment outcome, which was non-normally distributed, a sensitivity test was conducted using the rank-transformed outcome in order to provide a non-parametric test of statistical significance (Fan & Zhang, 2017). The *P* values derived from the rank GEE analyses were consistent at $p < .01$ with those derived from a Gaussian GEE approach. Consequently, the effect sizes from the results assuming normal distribution are reported for ease of interpretation. Other possible confounders such as age and presence/absence of BPD diagnosis, which appeared to differ between sites, were included in the sensitivity analyses. Results were consistent with these covariates so they were not included in the analyses reported here. GEE was conducted using the *gee* and *aod* packages in R (Carey et al., 2015; Lesnoff & Lancelot, 2012; R Core Team, 2014).

The authors conducted a preliminary analysis of the costs and cost-offsets associated with DBT-ACES relative to SDBT. The person-period was modeled using individual multivariable generalized linear models (GLM) for each resource category; that is,

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

inpatient costs, and workplace and educational benefits. In the DBT-ACES study period, there was only missing work and school data for two participants who had dropped out. The missing data was accounted for using inverse probability weighting in the GLM regressions (Seaman & White, 2013). Standard errors and p-values were calculated using non-parametric bootstrapping techniques to help control for sampling uncertainty (Glick et al., 2007).

Results

Demographic and clinical characteristics of the three samples are provided in Table 1. The Harbor-UCLA sample had a higher mean age (M = 42) as compared to Lengerich (M = 27) and Harborview (M = 34). Not all participants graduated the DBT-ACES program (although all are included in the results presented). Dropout was highest at Harborview (n=8, 38.1%) then Harbor-UCLA (n=2, 25%) and lowest in Germany (n=1, 6.3%).

Table 1 Demographic and Clinical Characteristics

	UW-Harborview (N = 21)		Harbor-UCLA (N = 8)		Klinik Lengerich (N = 16)	
Age						
Mean	34.1		42.5		26.9	
SD	9.3		10.8		10.6	
	N	%	N	%	N	%
Female	20	95.2	8	100.0	14	87.5
Ethnicity						
White	17	81.0	6	75.0	16	100.0
Black	0	0	1	12.5	0	0
Latino/a	1	4.8	1	12.5	0	0
Asian-Pacific Islander	0	0	0	0	0	0
Mixed	3	14.3	0	0	0	0
Highest Education						
Some high school or less	2	9.5	2	25.0	2	12.5
High school or GED	5	23.8	2	25.0	7	43.8
Some college	6	28.6	1	12.5	1	6.3
College graduate	6	28.6	2	25.0	6	37.5
Post-graduate education	2	9.5	1	12.5	0	0
Marital status						
Single, never married	16	76.2	7	87.5	12	75.0
Married	1	4.8	1	12.5	3	18.8
Divorced or separated	3	14.3	0	0	1	6.3
Homeless	2	9.5	0	0	0	0
Borderline personality disorder diagnosis	20	95.2	8	100.0	16	100.0
Primary Axis I diagnosis						
Depressive disorder	15	71.4	6	75.0	13	81.3
Anxiety disorder	5	23.8	2	25.0	1	6.3
Comorbid Axis I diagnoses						
Mean	2.4		1.2		1.	
SD	.97		1.0		1.08	

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

Workplace and Educational Outcomes

Figure 1 illustrates the results of this study. Hours of work or school increased over time, from an average of 5.8 hours/week at Pre-SDBT to 13.7 at Pre-ACES and 30.3 hours/week at Post-ACES. The percent of clients competitively employed or enrolled in school at least 20 hours/week was at 15.6% (n=7) at Pre-SDBT and increased to 33.3% (n=15) at Pre-ACES and to 83.7% (n=38) at Post-ACES.

Figure 1 Examination of DBT-ACES Outcomes by Setting

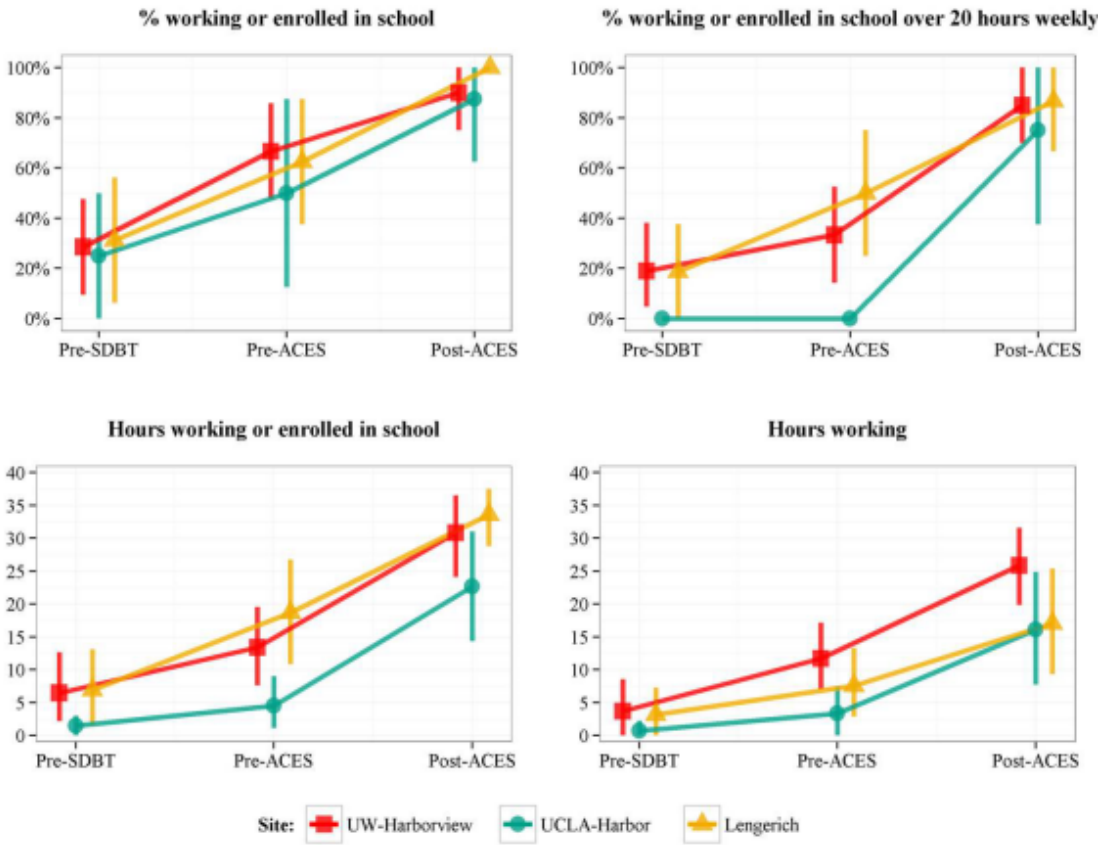

Figure 1 and Table 2 illustrate employment and school descriptive information for each setting and at each time point. Comparing the sites, clients at Harbor-UCLA were slower to engage in work and school and rarely did so during SDBT (i.e., before DBT-ACES) in comparison to clients at Harborview and Lengerich. It is also apparent that clients in the new clinics were more likely to attend school than Harborview clients.

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

Table 2 Examination of DBT-ACES outcomes by setting

	UW-Harborview			Harbor-UCLA			Klinik Lengerich		
	Pre-SDBT	Pre-ACES	Post-ACES	Pre-SDBT	Pre-ACES	Post-ACES	Pre-SDBT	Pre-ACES	Post-ACES
Competitive Employment									
% Any	14.3%	61.9%	85%	12.5%	25%	75%	18.8%	37.5%	66.7%
% Greater than 20 hours/week	9.5%	28.6%	80%	0	0	37.5%	6.3%	18.8%	46.7%
Hours/week									
Mean	3.7	11.7	25.9	0.8	3.4	16.1	3.2	7.6	17.1
SD	10.7	12.9	14.5	2.1	6.3	13.2	8.3	11.3	15.8
Matriculated Education									
% Enrolled	14.3%	9.5%	20%	12.5%	25%	75%	18.8%	43.8%	53.3%
Hours/week									
Mean	2.8	1.7	5.0	0.8	1.1	6.5	3.8	11.1	16.5
SD	7.8	6.6	10.5	2.1	2.2	4.3	9.2	15.2	18.0
Employment or School									
% Any	28.6%	66.7%	90%	25%	50%	87.5%	31.3%	62.5%	100%
% Greater than 20 hours/week	19%	33.3%	85%	0	0	75%	18.8%	50%	86.7%
Hours/week									
Mean	6.5	13.4	30.9	1.5	4.5	22.6	6.9	18.7	33.6
SD	12.3	14.3	14.0	2.8	6.0	12.9	12.6	17.4	9.1

Figure 1 illustrates the results for hours of competitive employment plus enrollment in school. Controlling for differences by setting, clients increased their time engaged in employment or school by 7.96 hours/week between the beginning and end of SDBT (Pre-SDBT to Pre-ACES) ($Z = -2.97$, $p = .003$). Controlling for differences by setting, clients increased their time in competitive employment or enrolled in school by 16.65 hours/week between the beginning and end of DBT-ACES (Pre-ACES to Post-ACES) ($Z = 6.02$, $p < .001$).

One of the biggest differences between the SDBT and DBT-ACES is whether clients achieved at least 20 hours per week of competitive employment and school enrollment (as can be seen in Table 2 and Figure 1). Controlling for differences by setting, clients were 63% less likely to be working or attending school at least 20 hours per week at the beginning of SDBT than at the start of DBT-ACES (Relative Risk [RR]=0.37, 95% CI: 0.18-0.75). Controlling for differences by setting, clients were 11.6 times more likely to be working or attending school over 20 hours per week at the end compared to beginning of DBT-ACES (RR=11.6, 95% CI: 4.78-28.30).

Cost-Benefit Outcomes

Tables 3 and 4 contain descriptive statistics for the cost-benefit measures obtained at each time point, as well as the

associated raw and predicted cost figures. Inpatient visits fell from an average of 2 measured over the 1 year prior to entering SDBT (pre-SDBT), to an average of 0.05 after SDBT (Pre-ACES), which was unchanged for the year after DBT-ACES (Post-ACES). The mean predicted cost differential for the Pre-ACES versus Pre-SDBT period was -$16,491 (SE=6,119; p=0.01); see Table 4. The mean predicted cost differential for Post-ACES versus Pre-SDBT was very similar at -$17,187 (SE=6,281; p=0.01). Thus, the predicted cost differential for the Post-ACES vs Pre-ACES period was statistically insignificant ($-696; SE=392; p=.08), due to no further change in the use of inpatient care during the DBT-ACES year. However, the predicted monetary benefit differential for school and workplace benefits during the Post-ACES vs Pre-ACES period was $546 (SE=123; p<0.001) demonstrating that the school and workplace benefits continued to increase.

The estimated increase in value due to reduced inpatient stays and increased school/workforce participation did not significantly offset the estimated per-client cost of the intervention. The per-client cost of the intervention would have to drop to approximately $4,500 before the estimated offset would produce a statistically significant net-monetary benefit.

Table 3. Descriptive Statistics and Costs by Time Period

	Pre-SDBT	Pre-ACES	Post-ACES
Inpatient Visits – Mean (SD)	2 (5)	0.05 (.21)	0.05 (.21)
Hours Worked – Mean (SD)	3 (9)	9 (12)	21 (15)
Hours in School – Mean (SD)	3 (8)	5 (11)	9 (14)
Predicted Inpatient Costs – Mean (SE)	16,649 (6,114)	403 (245)	254 (363)
Predicted School and Workplace Benefits – Mean (SE)	246 (82)	492 (114)	1,038 (131)
Raw Total Cost – Mean (SD)	16,451 (40,443)	-142 (1,901)	-658 (1,775)
Predicted Total Cost – Mean (SE)	16,402 (6,125)	-89 (290)	-784 (386)

Table 4. Predicted Cost Differentials

	Total Costs		Inpatient Costs		School & Workplace Benefits	
	Mean (SE)	P-value	Mean (SE)	P-value	Mean (SE)	P-value
Pre-ACES vs. Pre-SDBT	-16,491 (6,119)	0.01	-16,246 (6,122)	0.01	246 (100)	0.02
Post-ACES vs. Pre-SDBT	-17,187 (6,281)	0.01	-16,395(6,267)	0.01	792 (138)	<0.001
Post-ACES vs. Pre-ACES	-696 (392)	0.08	-149 (351)	0.67	546 (123)	<0.001

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

Discussion

This study was an observational evaluation of DBT-ACES in three routine care outpatient settings. Results replicated the earlier findings (Comtois et al., 2010) with somewhat higher rates of employment and school enrollment achieved in the Harborview and Lengerich settings and slightly lower rates at Harbor-UCLA. School enrollment was lower for the Harborview clients than for clients from Harbor-UCLA and Lengerich. There are a variety of potential explanations for this difference. In Lengerich, education is more accessible and affordable compared to the United States. California also has a number of educational programs to assist clients in returning to work, such as the CalWORKs program that funds many clients' treatment at Harbor-UCLA. In contrast, there are no particular supports nor incentives for attending school in Washington State and thus Harborview DBT-ACES clients and therapists likely focused more attention on increasing employment.

Despite these differences, the results are comparable across all sites and with the previous study. Although the rate of drop out in the current study (6.3 - 38.1%) was less than the previous feasibility study (44%), our findings largely replicate those of the earlier study, which found that with adequate support, behaviorally stable clients entered the workforce and enrolled in school at higher rates than in prior naturalistic longitudinal studies of treatment seeking individuals with BPD (Sansone & Sansone, 2012; Zanarini et al., 2009, 2012; Zimmerman et al., 2012). In the clinical trial that examined employment outcomes, 58% of DBT and 40% of GPM participants were working or in school at two year follow-up (McMain et al., 2012), compared to 87.5-100% at the end of DBT-ACES in the current study. While we cannot be sure DBT-ACES caused this effect without a control group, our results indicate that meaningful recovery is feasible and attainable for individuals disabled by BPD who are invested in living wage employment.

The cost-benefit analysis found substantial savings of the program of over $17,000 per client compared to the year prior to SDBT. The cost offset during the SDBT program was primarily driven by the decrease in inpatient stays. However, evidence of significant school and workplace benefits were also observed in both the SDBT and DBT-ACES years compared to the year prior to SDBT with the latter over three times the former.

It is critical to note that, like the original evaluation study (Comtois et al., 2010), these DBT-ACES programs only enroll individuals with BPD who have completed a SDBT program and want to pursue living wage employment. This is deliberate as DBT-ACES is a voluntary program; it is not designed to motivate individuals to want to work if they don't want to, nor to help clients who do not like nor benefit from DBT. That being said, this is a selection bias that must be taken into account when understanding the results. As described above only 24% of Harborview, 22% of Harbor-UCLA, and 50% of Lengerich clients who started SDBT entered DBT-ACES. While some clients had successful employment outcomes in SDBT and therefore had no need for DBT-ACES, many more were uninterested in or did not feel ready to work toward living wage employment, getting off of psychiatric disability or being financially independent.

This re-evaluation of DBT-ACES has several other limitations. First, this information was collected at the American sites from clinicians and medical records rather than by independent assessors with standardized measures. The data collection differences as well as differences in DBT-ACES program size and structure, could have led to variability of the findings. This limitation is offset by the objective nature of the outcome variables which were calculated the same way at each site. Second, this study included no comparison condition and cannot rule out regression to the mean or natural change. Nor can we rule out that the effects are due to a second year of any DBT based intervention. An additional limitation was the lack of data collected to determine the varying extent to which each partici-

DBT-Accepting the Challenges of Employment and Self-Sufficiency (DBT-ACES) Effectiveness: A Re-Evaluation in Three Settings

Comtois, Carmel, McFarr, Höschel, Huh, Murphy, Benson, & Höschel

pant utilized the intervention resources. Indeed, we calculated per-participant costs based on the estimated annual cost of operating the program as conducted at the original DBT-ACES site so outcomes cannot be directly generalized to sites with different structures or caseloads.

Despite these limitations, there are several strengths of this evaluation. External validity is high. All three settings implemented DBT-ACES in existing programs using existing funding and staff with no clinical procedures changed for the purposes of this evaluation. The Lengerich and Harbor-UCLA sites received limited training in DBT-ACES and thus developed and conducted their DBT-ACES programs independently. Results from independent sites lend weight to the program effectiveness as these results replicated the original evaluation (Comtois et al., 2010). A clinical trial or other methodology with stronger controls against threats to internal validity is clearly the next step.

The current study provides additional evidence that DBT-ACES may assist clients in terms of increasing both the likelihood and amount of competitive employment as well as school enrollment. Moreover, our results indicate that DBT-ACES programs are capable of generating a large net monetary benefit to insurers and society. Findings yield additional support for the generalizability of DBT-ACES, which was fully implemented in another DBT program in the United States as well as one in Germany. Finally, this replication validates the benefits of work for those with mental health conditions. It provides further hope to individuals with BPD that they can recover not only from the symptoms and crisis of BPD but also become gainfully employed and financially independent.

List of Abbreviations

Abbreviation	Description
DATCAP	Drug Abuse Treatment Cost Analysis Program Instrument
BLS	Bureau of Labor Statistics
BPD	borderline personality disorder
IRB	Institutional Review Board
DBT	Dialectical Behavior Therapy
DBT-ACES	Dialectical Behavior Therapy – Accepting the Challenges of Employment and Self-Sufficiency
GEE	Generalized Estimating Equation
GED	General Educational Development
GLM	Generalized Linear Models
LWL	Der Landschaftsverband Westfalen-Lippe (The Regional Association of Westphalia-Lippe)
SDBT	Standard Dialectical Behavior Therapy (as described in treatment manuals)
SD	Standard Deviation
SE	Standard Error
UCLA	University of California, Los Angeles
WA	Washington State, USA

Find References Here

Diversity in DBT

Contextualizing DBT for Sexual and Gender Minorities: A DBT Skills Training Group including Stigma Management

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Using an ecological framework, influences from the microsystem through the macrosystem are shaped by diversity. In DBT, we are interested in the transaction between an individual and their social environment, particularly those invalidating transactions that can become internalized (i.e., self-invalidation). In her text, Linehan (1993) posits that cultural sexism can function as an invalidating environment, integrating an ecological perspective into the theoretical model that grounds DBT. She lists "prototypic invalidating experiences" (Linehan, 1993, p. 52) rooted in sexism including cultural ideals for women and bias against proclivities deemed "feminine" as examples.

Because DBT is a principle-driven treatment, it can be oriented toward clients' unique contextual landscapes. The authors are interested in how heterosexism, cissexism, and structural stigma (e.g., unequal legal protections for transgender people, religious messages denouncing homosexuality) contribute to an invalidating environment and subsequent self-invalidation for sexual and gender minorities (SGMs). Transactions between SGMs and these invalidating environmental factors can produce enacted stigma (e.g., misgendering someone) and felt stigma (e.g., shame) (Herek, et al., 2009). Ultimately, the invalidating interactions may become self-directed (e.g., internalized stigma). [For examples of stigma levels and how they may emerge in therapy see Skerven et al., 2019]. Minority stress theory (Meyer, 2003; Hendricks & Testa, 2012) reminds us that chronic exposure to stigma like this can increase risk for a variety of mental health problems and may function as a source of traumatic stress (Nadal, 2018). This brief paper will describe how the authors incorporated skills for managing stigma into a standard DBT group for SGM veterans, DBT including Stigma Management (DBT-SM).

The Intervention

To understand how DBT may be contextualized for SGMs, the authors conducted a DBT skills training group for SGM veterans at a VA Medical Center. These veterans were referred for outpatient DBT and screened to be appropriate for DBT. The VA Medical Center offers both comprehensive DBT as well as a "skills only" track where veterans participate in weekly skills training group; veterans are given a choice between the two tracks with input provided by the DBT therapist conducting the initial screening. For this intervention, SGM veterans seeking to participate in the "skills only" track were given the option of either the standard group or the DBT-SM group. As a pilot intervention, the DBT-SM group followed the 13-week skills training schedule described by Linehan (2015) augmented by two sessions focusing on minority stress (Meyer, 2003) and types of stigma (Herek et al., 2009). Some of the SM materials were adapted from a similar group that was conducted at a different VA (described in Cohen & Newman, 2019). The format was a standard DBT skills training group.

The Stigma Management Material

Information about common experiences of SGMs was included to increase validation and self-validation and to guide the use of DBT skills to manage stigma. Two didactic handouts were created for this purpose. The first describes types of stigma: structural (e.g., laws or policies that communicate non-acceptance), enacted (e.g., direct expression of stigma), felt (e.g., emotional reactions to experiencing enacted stigma), and internalized (e.g., negative attitudes toward self). The second handout describes stressors that are unique to SGMs such as being sensitive to rejection due to one's gender identity, gender expression, or sexual orientation and having urges to conceal these aspects of oneself.

Teaching about these concepts serves two purposes. First, it is validating and can facilitate self-validation. Just as a client may relate to the concept of "emotional invalidation" and think, "Oh…that's what that is," an SGM client may have an "ah-ha" moment when they learn about microaggressions. Microaggressions are commonplace experiences carrying stigmatizing messages to the recipient (Sue & Sue, 2013). Examples include being misgendered or hearing the phrase "That's so gay!" that equates non-

Contextualizing DBT for Sexual and Gender Minorities: A DBT Skills Training Group including Stigma Management

Skerven, Shaw, Mirabito, & Kirkman

heterosexual identities with something negative (i.e., communicates judgment).

The second purpose of providing didactic information about stigma is to facilitate problem-solving. When microaggressions occur, observing and describing ("That was a microaggression") can help an SGM person understand what is happening and then determine which skills might be effective in responding. For example, when being misgendered, skills such as identifying one's interpersonal effectiveness goal, moderating one's emotional response, checking the facts, and/or using opposite action to request the wise-minded correction using DEAR MAN may be called for. Teaching about dimensions of minority stress creates opportunities for skillfully locating wise mind in challenging contexts and engaging in effective use of problem-solving strategies. This dialectical approach to managing stigma (Sloan, Berke, & Shipherd, 2017) has the potential to disrupt the process of stigma internalization and help the individual move toward their life-worth-living goals.

Acceptability to Participants

Feedback indicated that participants appreciated that the group was only open to SGM members. They talked about feeling open to share homework examples on topics such as experiencing microaggressions, knowing that others would validate and resonate with the experience. One member remarked that having only SGMs in the room "…keeps the group within the tribe." Many homework assignments were completed on events related to stigma: being addressed with the wrong pronoun, rejection by family members, feeling afraid for one's physical safety in certain places, and managing shame related to one's identity. As the authors reflected, all agreed that examples shared in the DBT-SM group were not occurring in other DBT groups they have facilitated. As skills trainers also identified as SGMs, they were able to use personal examples illustrating concepts and skills use. Real-life experiences related to heterosexism, cissexism, and stigma were easy to share and included examples of being misgendered and inaccurately labeled as heterosexual.

Moving Forward

The authors are currently evaluating emotion regulation difficulties, DBT skills use, and distress from stigmatizing experiences with the group members. The authors plan to use this information to improve DBT-SM, continuing to assess its effectiveness, and will share outcomes along with the didactic material we developed with those who are interested.

Find References Here

Trainee Voices

Trainee's Voices on DBT Teams

Kathleen Camacho, Psy.D., Postdoctoral Fellow, NYU Child Study Center

During my fourth year of graduate training, I had the privilege of participating as an extern within a comprehensive DBT outpatient program at Cognitive Behavioral Consultants of Westchester and Manhattan. I was simultaneously eager to learn from an incredibly skilled group of clinicians and terrified of being "outed" for not knowing DBT. While neither Alec Miller nor his team would ever make such invalidating statements, the "struggle was real," as they say, as it was still difficult to speak up during team meetings. I found the tension between my high motivation to learn and my equally strong urges to hide to be the central dialectical challenge on team for me. I wanted myself, and in turn my clients, to benefit from the collective wisdom of the consultation team. This inevitably meant practicing quite a bit of opposite action to fear by adding consultation items to the agenda in an effort to build mastery toward the effective delivery of DBT. My supervisor also encouraged trainees to provide suggestions to more senior clinicians, which compounded my anxiety. Fortunately, the team cultivated an environment in which trainees' feedback was valued, which made it easier to speak up. Nevertheless, the dialectical challenge was present, and it required opposite action to fear to overcome these barriers to learning.

Now as a postdoctoral fellow on another comprehensive DBT outpatient program at NYU Child Study Center, I continue to utilize opposite action to my fear when requesting consultation, and especially when providing suggestions to fellow team members. Several factors within both of the comprehensive teams I've participated on have strengthened my DBT skills and my competencies in being an active member of a consultation team as a trainee. Firstly, each team's ability to model vulnerability has been especially validating and normalizing of the challenges experienced at all levels of practicing DBT. Since self-invalidation related to professional competency as a trainee may interfere with practicing vulnerability, this was greatly appreciated. In the spirit of the fallibility agreement, seeing exceptionally skillful clinicians voice their challenges with burnout, motivation, empathy building, amongst other things, has allowed me to also practice being vulnerable and radically genuine. Secondly, the embedded structure of consultation team that requires trainees to participate in all of the capacities within team provides several opportunities for trainee exposure in practicing opposite action. It also creates more opportunities for team members to provide encouragement, feedback, as well as to reinforce participation on DBT team. The very active approach required of trainees is what has continued to push me outside of my comfort zone and into the territory of skills strengthening and professional development.

In sum, I urge trainees to practice opposite action to their fears and speak up- to mindfully express victories and challenges alike in addition to being vulnerable and seeking consultation when stuck. You may have trouble with building empathy for a patient after several consecutive 3 AM phone calls while also navigating numerous patients in high distress, or have difficulty with radically expressing that things went awry in the last session and a repair is in order. On the flip side, it may be difficult to share good news that a client coped with a breakup without engaging in self-harm. In the end, it is our responsibility to practice what we preach ("O.A. all the way") and learn from those around us despite how uncomfortable it can be. For the teams I've had the privilege of being on, I appreciate trainees being treated as valuable team members, having models of vulnerability and fallibility, and being given space to develop our own style while adhering to the model.

Finding the Middle Path Between Dependence and Autonomy: Recent Trainee Experiences in Dialectical Behavior Therapy Supervision

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Dialectical Behavior Therapy (DBT; Linehan, 1993; Linehan, 2014) is a principle-based, third-wave cognitive behavioral therapy originally designed to treat individuals with high levels of suicidality and shown to be efficacious with Borderline Personality Disorder (BPD) – a disorder of pervasive emotion dysregulation. Given the multi-modal nature of the treatment (Lungu & Linehan, 2016) and the acuteness of the clients for which it was designed, learning DBT as a psychology trainee can be a daunting task, as it requires trainees to learn a new treatment *and* also to manage one's own emotional reactions to treating high-risk clients (Yang & Linehan, 2017). Importantly, recent research suggests that psychology trainees can effectively deliver DBT, with client outcomes that were comparable to study therapists in a large-scale randomized controlled trial (Rizvi, Hughes, Hittman, & Oliviera, 2017). High quality supervision is essential for psychology trainees to conduct effective DBT with a high-risk, complex client population. In fact, the very structure of DBT incorporates supervision for therapists of all experience levels through weekly therapist team consultation. Supervision is not an adjunct to DBT; rather, it is an essential component of the treatment itself (Fruzzetti, Waltz, & Linehan, 1997).

At the core of DBT lies the concept of dialectics – the idea that truth exists in opposite positions, and that growth occurs from honoring the truth in both positions in order to find a synthesis or "middle path" between them (Linehan, 1993). Dialectics pervade all elements of the treatment, including supervision of trainees (Fruzzetti et al., 1997; Waltz, Fruzzetti, & Linehan, 1998). The central dialectic in DBT is balancing acceptance and change – accepting the client for who they[1] are currently, while simultaneously working to replace ineffective behaviors with new, skillful behaviors. Thus, a core dialectical assumption is that all clients are, at each moment, doing the best they can, *and* that they can do better. This dialectic is also present in DBT supervision (Waltz et al., 1998): DBT trainees need to feel validated, supported, and guided by their supervisors while simultaneously learning how to be more effective therapists.

As we, the authors, reflected on our own training experiences in DBT – as practicum students, interns, and postdoctoral fellows – we recognized another critical dialectic, embodied by our supervisors, that helped us to fully engage in learning DBT and to feel competent working with high-risk clients (Figure 1). This dialectic was based on how we believe our supervisors perceived us and behaved towards us as DBT trainees. At one extreme, supervisees may be treated as dependent on their supervisors, incapable of working with complex clients. Supervisors who view trainees from this pole may feel the need to "protect" trainees, treat

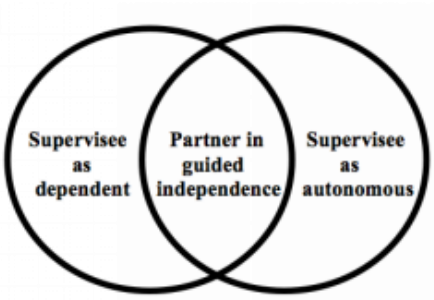

Figure 1. Dialectical View of Supervisee

them as fragile, and may micromanage their clinical decision-making. As a result, trainees may become increasingly insecure, question their treatment decisions, perhaps believing that they are fragile, and become fearful about making mistakes. At the opposite pole, supervisors may treat their

[1] For the purpose of gender inclusivity and maintaining client confidentiality in all case examples, we will refer to individual clients as "they".

Finding the Middle Path Between Dependence and Autonomy: Recent Trainee Experiences in Dialectical Behavior Therapy Supervision

Valenstein-Mah, Yang, Staples, & Neilson

trainees as wholly autonomous. From this position, supervisors may be too distant and trainees may feel anxious, lost, and unsure about how to make clinical progress, or simply not receive sufficient critical feedback to improve as needed. Likely, in either extreme, trainees are not learning the skills necessary to become competent, confident DBT therapists. The middle path, then, positions supervisees as partners in the process of guided independence; trainees are treated as fundamentally capable of effectively delivering DBT while simultaneously provided appropriate oversight and guidance in learning new therapeutic strategies and skills that are tailored to the client's clinical needs and trainee's developmental stage. While this dialectic may not be unique to supervision in DBT, we believe it is especially crucial given the emotional demands on both trainees and supervisors when treating high-risk, complex clients while learning a challenging, principle-based treatment.

In this paper, we share three illustrations of this dialectic in action and specific supervisory interactions in which we believe supervisors found this middle path. We describe three supervisory experiences in the four different modes of DBT – skills group, individual therapy, phone coaching, and consultation team – and how they made a significant impact on our development as clinical psychology trainees, as well as broader lessons that can be taken away from these formative supervisory experiences.

Skills Group Supervision. As I (Elizabeth Nelson) entered my fourth year of graduate school, I was anxious as I began leading a skills group for adults in a full-model outpatient DBT clinic. I was worried I would not effectively teach the material and I would not skillfully draw out effective behaviors from clients and manage ineffective behaviors as they arose within the group. My supervisor was aware of my anxiety in this new role, and she exemplified guided independence by providing support without fragilizing me. While she arrived at all of my supervision appointments having prepared detailed notes on the video recording of my last skills group, she set the expectation that I create the agenda for our supervision. She asked me to reflect upon my own adherence to DBT in the previous group, to ask questions before receiving feedback, and to take the lead in planning for the next group. Research has found that trainees find it helpful to critique their own session tapes before receiving feedback from their supervisors, as this allows them to provide suggestions for their own clinical skill development and to more openly and non-defensively receive corrective feedback (Sobell, Manor, Sobell, & Dum, 2008). Thus, while I always felt that my supervisor had a wealth of DBT knowledge, she trusted that I could self-identify areas of growth and development to effectively teach DBT skills.

This approach was exemplified when navigating a particularly challenging situation with one DBT skills group member. For several weeks, a member of our skills group made regular statements to my co-leader and me that they intended to engage in self-harm behaviors following group. They also refused to engage in skills coaching, including a refusal to reach out to their individual DBT therapist. We were unsure how to respond to the client's self-harm statements. In supervision, rather than immediately providing an answer and assuaging our anxieties, the supervisor asked me and the other leader what DBT principles we should consider. We discussed the principles we believed to be relevant, namely consultation to the client versus an environmental intervention, our conceptualization of the function of the client's behavior, and ideas on how to respond. Our supervisor responded with praise regarding our conceptualization, highlighting that it did not fragilize the client and clarified the lead role of the client's individual therapist and our role as skills group leaders to increase effective behavior. Our supervisor reinforced that the client was capable of being reoriented regarding whom to contact for coaching and that we were capable of providing an environment conducive to the client learning new skills while simultaneously setting limits around addressing self-harm. Rather than treat me as too novice to address this serious problem or too anxious or fragile to come up with solutions, my

Finding the Middle Path Between Dependence and Autonomy: Recent Trainee Experiences in Dialectical Behavior Therapy Supervision

Valenstein-Mah, Yang, Staples, & Neilson

supervisor, consistent with guided independence, encouraged me to apply what I learned and provided me with additional feedback she thought would help. This was very helpful in responding to the client, whose behavior radically changed once we implemented our plan. This interaction instilled in me the principle that DBT does not treat either its therapists or clients as fragile or incompetent to solve high-risk problems. Rather, both clients and trainees, with therapists and supervisors serving as touchstones and guides, can make more progress than they believe they can.

Individual Therapy and Phone Coaching Supervision. My (Joyce Yang) DBT supervisor impressed upon me that there didn't need to be, and indeed wasn't, anything fragile about me, even though I was a trainee. She conveyed that each individual, from graduate student to treatment founder, was a critical member of our DBT Consultation Team, which emphasized supporting one another as people and therapists. One way we demonstrated support was to provide phone coaching as back-up therapists for team members who were out of town, not only to provide clinical coverage but also to validate their need for relief from 24-hr phone coaching.

A pivotal moment in my development as a DBT clinician occurred the first time I served as back-up therapist for my supervisor's client with chronic suicidality. The day she left the client called me in anticipatory distress that their therapist had left them in my hands for several days. They experienced a feeling of abandonment, compounded by their partner's work-related absence. They feared being home alone at night and reported a significant increase in their suicidal thoughts and self-harm urges. They insisted upon either being hospitalized or for my supervisor to return to their assistance. Although I knew the client in my capacity as their skills group leader and had reviewed the client's case conceptualization and treatment plan with my supervisor before she left, I was not yet familiar with their interpersonal style on the phone or while acutely distressed. As my own anxiety ramped up, I considered a) the client's physical safety (perhaps pointing me towards agreeing to initiate hospitalization), b) what was clinically indicated (knowing this client's perception of themselves as fragile, their history of using hospitalization as an escape, and research that completed suicide is highest immediately post-discharge from inpatient hospitalization) and c) my own internal pressure to do a "good job" in the eyes of my supervisor, which meant, at the very least, keeping her client alive while she was away. As I attempted to sort through these thoughts, I fumbled my coaching on the phone and the client hung up on me.

Based on my supervisor's previous encouragement, I did not hesitate to reach out to her for guidance. Prior to her departure, she had instructed me to call her as needed, explicitly telling me not to worry about disturbing her. While developing procedures for emergency situations is an important element of orientation to supervision, particularly in a supervision contract (APA, 2015), I believe encouragement to call her for additional supervision was essential, given the high-risk nature of the client. It reassured me that the client's safety was the top priority and she was committed to providing me necessary support. On the phone with her, when I stated doubt about my risk assessment skills, my supervisor began first by acknowledging the validity in my concerns (Linehan, 1993): not even the most seasoned clinician can assess risk in a way that predicts the future 100%. My anxiety and worry served a clear purpose of letting me know that I care about my clients, and reminded me of the real levels of danger associated with their suicidal ideation and attempts. This acknowledgement reminded me to find the validity in the client's emotions: they felt alone because people they cared about were away and feeling alone is often scary. After validating, my supervisor encouraged me to share my impressions based on my assessment prior to giving her own impressions, thereby communicating trust in my clinical abilities. She also guided me to undertake a functional assessment in addition to the topographical assessment of the client's behavior, which allowed me to conceptualize the function of the

Finding the Middle Path Between Dependence and Autonomy: Recent Trainee Experiences in Dialectical Behavior Therapy Supervision

Valenstein-Mah, Yang, Staples, & Neilson

client's suicidal and self-harm thoughts as serving an escape from a situation they believed they couldn't tolerate. This conceptualization allowed me to generate and successfully coach the patient to choose more adaptive escapes behaviors (such as distraction through watching an engaging movie) as well as increasing distress tolerance to survive being alone for the night. Importantly, this plan did not involve extensive suicide risk assessment, which we conceptualized as further reinforcing the escape function in thinking about and planning for suicide and self-harm.

Rather than bypassing me to call the client herself and coach them directly, my supervisor's willingness to spend the extra time to supervise me through assessment and coaching of her client and encouraging me to continue to call her with questions and updates, communicated both belief in my ability as a clinician and that I was not alone in delivering the treatment, holding the middle path of guided independence. By allowing me to coach her client while also not leaving me to autonomously make treatment decisions, my supervisor allowed me to demonstrate to the client that they were able to stay safe on their own (without a hospital) and that they actually were not alone, with me a phone call away. In this way, my supervisor modeled for me the power in not treating someone as fragile, and in the same way, I learned to not treat my clients as fragile.

Therapist Team Consultation. I remember anxiously observing the team dynamics during my (Jennifer Staples) first DBT consultation team meeting, gathering clues to understand my role as a trainee team member and trying to formulate an articulate and insightful contribution. These team experiences often provoke that familiar "imposter syndrome" and increase awareness of unavoidable power dynamics which leave trainees – and particularly young women trainees – feeling silenced. Fortunately, I did not encounter the competitive pecking order that I anticipated. I was impressed by the genuine respect and consideration afforded to trainees' ideas and suggestions.

One particular interaction exemplifies the concept of guided independence during my experience of DBT supervision within a team context. In my internship year, during one weekly consultation team meeting that was part of an outpatient, full-model DBT program, two of the staff psychologists – one of whom served as my direct supervisor – became locked in a struggle about how to accurately conceptualize a client's recent suicidal behavior. They continued to fervently express their differing positions, and there was noticeable tension in the room. In an attempt to address other items on our agenda, and perhaps to dispel the tension, the group changed topics without resolution. I remembered the DBT team agreement to accept a dialectical philosophy that caught between two conflicting opinions, to look for the truth in both positions and to search for a synthesis. Debating whether or not it was my place as a trainee to highlight tension between two supervisors, I decided to name the "elephant in the room" and requested that the team revisit the dialectic between the two team members and attempt to find a synthesis. Immediately, I was behaviorally reinforced when my supervisor expressed appreciation, confirmed that he was still feeling frustration related to the client's conceptualization, and the team proceeded to work toward a synthesis.

Following team, my supervisor approached me individually and praised me for addressing the dialectical tension in the room. He asked about what that experience was like for me as a trainee and, when I expressed my uncertainty and nervousness, expressed genuine appreciation for the chance to resolve the situation and highlighted my adherence to the DBT team agreements and consultative role.

I was grateful for my supervisor's support in the moment, further appreciative that he checked in with me afterward and allowed for the opportunity to debrief, and proud that I took a risk to uphold my consultative role and grow as a trainee. Indeed, research suggests that supervisors' skills in applying different roles (e.g., teacher, consultant, counselor, and evaluator), forming a strong working relationship with the supervisee,

Finding the Middle Path Between Dependence and Autonomy: Recent Trainee Experiences in Dialectical Behavior Therapy Supervision

Valenstein-Mah, Yang, Staples, & Neilson

and expressing appropriate affective responses is predictive of trainees' reports of their needs being met (Eisenhard & Muse-Burke, 2015). In this interaction, my supervisor allowed me to serve as consultant to him on a difficult clinical issue. He also strengthened our supervisory relationship by showing his genuine appreciation for my intervention. This example is just one of many experiences in DBT where I felt that my supervisors successfully attained a synthesis of guided independence, promoting competence while providing a foundation of support.

Discussion

In this paper, we provided three examples of our supervision experiences in DBT, in which our supervisors took a dialectical approach to supervision, and we as trainees felt empowered to work with high-risk, complex clients while still being able (and required) to ask for and receive guidance when needed. In other words, our supervisors allowed us to become partners with them in a process of guided independence.

Importantly, the dialectical balance between dependence and autonomy may differ based on trainees' developmental level. More novice trainees may require more didactic, "hands-on" supervision to develop their competence in delivering a treatment, whereas more advanced trainees may need a more "hands-off" supervisor who takes on a consultant-like role and actively encourages the trainee to function more independently. A thorough assessment of a trainee's skill level in the beginning stages of supervision is important for determining the appropriate balance (APA, 2004). However, we believe that a spirit of support and belief in the trainee's capability to become a skilled therapist must still pervade the supervisory relationship, no matter the trainee's current stage of development.

While research on psychological supervision is increasing, there remains a need to understand which specific supervisory behaviors enhance supervisee confidence and skill acquisition. Supervision in DBT is no exception. While we provide anecdotal evidence for supervisory behaviors we found helpful for our development as DBT therapists, research on DBT-specific supervision (e.g., use of dialectical strategies with supervisees) and their impact on both therapist and client outcomes is lacking.

In conclusion, we believe it is important for DBT supervisors to have confidence that their supervisees can effectively deliver the treatment; fortunately, evidence suggests this is the case (Rizvi et al., 2017). Equally important is for DBT supervisors to communicate this belief through their supervisory behaviors, while simultaneously providing the appropriate oversight and guidance necessary for supervisees to continue their clinical skill development. In turn, we believe that trainees will begin to trust in their own capacity to work with high-risk, complex clients, providing effective treatment to those in need.

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