Vol.6
Is.2
2022

DBT BULLETIN

DBT BULLETIN
www.dbtbulletin.org

Editor's Letter

EVER SINCE I was a bright-eyed graduate student, I've had a dream of one day creating a grassroots, zine-style newsletter for the therapy community. This was likely coming from the punk rock high schooler still in me (who you better believe I still actively channel with my teen DBT clients). In 2017, during a research meeting with Lynn McFarr she brought up her dream of one day starting a proper DBT journal, and the first conversation about the DBT Bulletin emerged. Five years later and more work than I ever anticipated, I am thrilled to see where this journey has taken us. This project has connected me in so many unexpected ways with the broader DBT community, and it truly feels like my heart's work. This issue is especially near to my heart because we first launched our debut issue of the DBT Bulletin publication at the last ISITDBT conference that I attended in person, pre-pandemic, in 2018. So much has changed for us all since that time. The following year I lost my first client to suicide, and shortly after the world shut down.

In this current issue, we are honored to feature an article on postvention practices. This issue also aims to uphold our commitment to anti-racism work in DBT and includes articles on how to do anti-oppressive work in private practice settings, as well as guidelines for cultural adaptations of DBT. We are also excited to include DBT perspectives on contingency management and DBT teams. Further, we have continued our tradition of lending a voice to creative considerations for both skills via a fabulous table on a DBT skills master handout, as well as clinician perspectives on self-dysregulation in Borderline Personality Disorder. Finally, I am beyond thrilled to announce that we have not one but three extraordinary student spotlight awards this year. 10,000 gold stars go to Christine Bird, Yoel Everett, and Sarah McHugh. I sincerely hope you enjoy this issue, and I have been honored to serve the community as your resident punk rock zine collaborator. Here's to another five years and seeing where the DBT Bulletin takes us next.

-Hollie Granato


SCAPE
CAN
GNE
ACH

Cultural Adaptations of Dialectical Behavior Therapy: Clinical Recommendations

Sinclaire M. O'Grady[1], Stephanie L. Haft[1], Esme A. L. Shaller [1,2], and Nancy H. Liu[1]

[1]Department of Psychology, University of California, Berkeley, [2]Department of Psychiatry and Behavioral Sciences, University of California, San Francisco

Introduction

In recent years, clinicians and researchers have made substantial efforts to make existing evidence-based treatments more effective for clients of different cultural, racial, and/or ethnic backgrounds. These modifications, or cultural adaptations, have been found to increase the efficacy of interventions and lead to reduction of symptoms (Arundell et al., 2021). A recent systematic review found 18 studies that implemented cultural adaptations of Dialectical Behavior Therapy (DBT; see Haft et al., 2022). DBT studies have evolved from comprising primarily of white participants to include increasingly diverse samples in more recent studies (Harned et al., 2022). Based on this review, the authors summarize several recommendations for clinicians to improve the acceptability and efficacy of DBT for clients from different racial, ethnic, and cultural backgrounds. The present report expands upon those recommendations and offers DBT clinicians several tips in efforts to culturally adapt DBT in their practice.

Clinical Recommendations

Tip #1: Make efforts to deliver and obtain written materials in the client's native language.

When working with clients from different cultural groups, clinicians may need to adapt elements of language when implementing the treatment (e.g., by delivering therapy in a language other than English, matching handouts/worksheets/diary cards to the literacy level and dialect of clients). We recommend language consistency be maintained across all DBT treatment components to facilitate accurate communication of emotional subtleties that may be unique to each language (McFarr et al., 2014). In addition, translation of materials into the client's native language is critical and materials should be translated and back translated by multiple experts familiar with a target culture. Future research focusing on validation of DBT materials in different languages is critically needed, as is accessible dissemination of these materials. Behavioral Tech provides information on how to obtain permissions to translate DBT materials into other languages: https://behavioraltech.org/resources/dbt-in-foreign-languages/#Spanish.

Tip #2: Explicitly discuss identity-based prejudice when introducing the biosocial theory.

Discussing racism, discrimination, acculturative stress, and historical and intergenerational trauma with clients when discussing the biosocial theory is especially critical when working with clients from different cultural groups. For example, clinicians could collaboratively create a genogram of the client's family in order to identify family members who may be means of support or stress, as well as visualize systemic problems in a culture and community (e.g., Kohrt et al., 2017). At present, racism is not mentioned as a factor that interferes with skillful behavior in any DBT skills training handout (Pierson et al., 2021). Observing and describing common methods of invalidation (e.g., from lower severity of empathic failure up to systemic (see Pierson et al., 2021) may help shift the client away from shame, build trust between client and clinician, and move the client from self-blame towards a more dialectical understanding of the causal and maintaining mechanisms of their current distress. For example, the Minority Stress Handout for Affirmative DBT is a helpful model that acknowledges common experiences of LGBTQ+ people (Chang & Cohen, 2022; Cohen et al., 2021).

Tip #3: Provide psychoeducation and tools for clients to cope with cultural stigma.

Stigma of seeking mental healthcare, especially for self-harmful behaviors, is rampant in many cultures, and needs to be addressed to prevent treatment drop out. Examples of addressing cultural stigma in treatment include framing DBT skills use as applicable to anyone regardless of meeting criteria for mental illness, addressing myths related to suicide and self-harm, incorporating family into treatment orientation and training family members to provide psychoeducation themselves about treatment, renaming groups, and holding treatment in culturally-supportive locales, such as community centers, religious centers, or local schools (Arunagiri et al., 2021; Choi et al., 2019; Kinsey, 2014; Ramaiya et al., 2017). Developing a cope ahead plan for skills the client can use when they confront stigma, either self-stigma or community stigma, such as Pros and Cons of being in treatment, Check the Facts on stigma-associated emotions such as shame, self-validation, and acknowledgement of causal reasons for current distress may be helpful. Understanding the factors that are stigmatizing to each client/culture can inform treatment delivery modifications and improve treatment acceptability and feasibility.

Tip #4: Use flexibility within fidelity with the diary card.

DBT clinicians likely already modify the diary card to fit the needs of their individual clients. Certain tailored formats may be more culturally normative and acceptable to certain individuals. In particular, simplifying diary cards to include non-numeric ratings (e.g., using pictorial representations) for clients with low literacy may reduce barriers to compliance (McFarr et al., 2014; Ramaiya et al., 2018). For clients who express symptoms somatically, physical sensations might be used instead of or in addition to tracking emotion words and urges (Arunagiri et al., 2021; Mercado & Hinojosa, 2017). Finally,

reinforcing diary card completion using culturally relevant contingencies is recommended (e.g., a Mexican Bingo Rewards Card (La Loteria Mexicana Tarjeta de Recompensa) where the client with the best compliance rate receives a small reward (e.g., a $10 gift card to a local bakery; McFarr et al., 2014).

Tip #5: Increase attention to cultural context in the interpersonal effectiveness module.

The interpersonal effectiveness module may require the most tailoring for clients of color and those from non-Western cultures. For example, using traditional assertiveness (e.g., DEAR MAN and FAST) skills may violate female role norms and even be dangerous (e.g., resulting in physical and emotional harm) for female clients in the context of a patriarchal society (Ramaiya et al., 2018). We recommend increased focus on interdependent relationships (e.g., hierarchical relationships and power differentials) when teaching these skills to clients from non-White and non-Western cultural contexts. Utilizing DBT skills manual worksheets such as Interpersonal Effectiveness Worksheet 1 ("Pros and Cons of Using Interpersonal Effectiveness Skills") and Interpersonal Effectiveness Worksheet 7 ("Troubleshooting Interpersonal Effectiveness Skills, Part 6: Is the environment more powerful than my skills?") may be useful in increasing attention to these issues (Linehan, 2014). Furthermore, although possible in Western contexts, more clients may identify with goals of increasing social harmony or supporting group goals rather than the other two DBT interpersonal effectiveness goals of keeping respect and getting an objective met (Cheng & Merrick, 2017; Ramaiya et al., 2018). In teaching skills to clients, describing differences between interpersonal relationships in different cultures may help frame interpersonal effectiveness skills depending on individualistic versus interdependent cultural values (Cheng & Merrick, 2017). Group therapy—or therapy involving wider familial and community networks—may be more common and accepted in certain countries and cultures (Hays, 2009; Koç & Kafa, 2019). Accordingly, adding group-based components beyond traditional skills training to treatment may increase the acceptability of DBT for certain clients. Practicing Loving Kindness (Mindfulness Handout 8: Practicing Loving Kindness to Increase Love and Compassion) could also be used to increase social connectedness (Linehan, 2014).

Tip #6: Adopt additional components into DBT teams.

We suggest that DBT teams adopt the Antiracist Consultation to the Environment Agreement as described by Pierson et al. (2021): "At times when the problem is an intransigent, high-power environment, as is always the case when the problem is racism, we agree to actively seek out ways to support the client through antiracist advocacy. We agree to take a dialectical stance by ensuring that consultation to the environment is done in tandem with consultation to the client, so that environmental intervention does not fragilize or disempower the client. We agree to provide functional validation (i.e., responding with action) to racially marginalized clients by using our own resources of privilege and power to change racial inequities (p. 18)."

In addition, clinicians could also adopt the new Antiracist Therapist Agreement proposed by Pierson et al. (2021) which includes additional commitments towards consultation to their team regarding assessing and developing their own antiracist competencies. For resources, see Pierson et al., 2021 and the ISITDBT Antiracism Committee's evolving webpage (https://isitdbt.net/anti-racism/) for suggestions of skills to use to increase antiracist therapist competencies. Furthermore, DBT teams could also enhance observer agreements by adding observer tasks such as checking on microaggressions, as well as add weekly or monthly didactics related to culture and dismantling racism (e.g., a team member finds an article with a clinical application related to diversity).

Tip #7: Advocate for increased training of clinicians from different cultural contexts.

Incorporating members of the community into the treatment either through training counselors already in the community in DBT (e.g., through Train the Trainer methodologies; Frank et al., 2020), or through the addition of other treatment components with community leaders (e.g., adding traditional tribal or religious practices) may be helpful (Beckstead et al., 2015; Choi et al., 2019; Ramaiya et al., 2018). DBT clinicians can advocate for and invest in training for mental health professionals already integrated in racial, ethnic, or cultural communities by supporting scholarships to reduce barriers to attending DBT trainings (e.g., the DBT-LBC BIPOC Clinician Scholarship).

Conclusions

There are several ways clinicians can increase the acceptability and/or effectiveness of DBT for clients of color and/or different cultures. Synthesizing the tension of both training DBT clinicians to increase their cultural competence and humility while acknowledging that DBT itself has ethnocentric components requiring cultural adaptations is key. Empirical research evaluating the effectiveness of DBT for minority groups is critically needed, with significant findings used to inform potential systematic treatment adaptations for these groups (Harned et al., 2022). We encourage readers to consider ways in which we, as DBT clinicians and researchers, can

further promote more culturally responsive care in DBT beyond the practices identified in extant studies.

References

Arunagiri, V. (2021). Adapting DBT skills in a community center for south Asian women who have experiences with intimate partner violence [Dissertation Abstracts International: Section B: The Sciences and Engineering]. Hofstra University. https://www.proquest.com/dissertations-the ses/adapting-dbt-skills-community-center-south-asian/docview/2467639371/se-2?accountid=14496

Arundell, L. L., Barnett, P., Buckman, J., Saunders, R., & Pilling, S. (2021). The effectiveness of adapted psychological interventions for people from ethnic minority groups: A systematic review and conceptual typology. *Clinical psychology review*, 88, 102063. https://doi.org/10.1016/j.cpr.2021.102063

Beckstead, D. J., Lambert, M. J., DuBose, A. P., & Linehan, M. (2015). Dialectical behavior therapy with American Indian/Alaska Native adolescents diagnosed with substance use disorders: Combining an evidence based treatment with cultural, traditional, and spiritual beliefs. *Addictive behaviors*, 51, 84–87. https://doi.org/10.1016/j.addbeh.2015.07.018

Chang, C. J. & Cohen, J. M. (2022). Doing affirmative dialectical behavior therapy with LGBTQ+ people: clinical recommendations. *DBT bulletin*, 6, 11-15. https://static1.squarespace.com/static/62e933212ea2a15419c196cd/t/62e962b38771b028ddf1493b/1659462324157/DBT+Bulletin+Volume+6+Issue+1.pdf

Cheng, P.-H., & Merrick, E. (2017). Cultural adaptation of dialectical behavior therapy for a Chinese international student with eating disorder and depression. *Clinical case studies,* 16, 42–57. https://doi.org/10 .1177/1534650116668269

Choi, N. Y., Kim, H. Y., & Gruber, E. (2019). Mexican American women college students' willingness to seek counseling: The role of religious cultural values, etiology beliefs, and stigma. *Journal of counseling psychology*, 66(5), 577–587. https://doi.org/10.1037/cou0000366

Cohen, J. M., Norona, J. C., Yadavia, J. E., & Borsari, B. (2020). Affirmative Dialectical Behavior Therapy Skills Training with sexual minority veterans. *Cognitive and behavioral practice*, 28, 77-91. https://doi.org/10.1016/j.cbpra.2020.05.008

Frank, H. E., Becker-Haimes, E. M., & Kendall, P. C. (2020). Therapist training in evidence-based interventions for mental health: A systematic review of training approaches and outcomes. *Clinical psychology*, 27(3), e12330. https://doi.org/10.1111/cpsp.12330

Haft, S. L., O'Grady, S. M., Shaller, E. A. L., & Liu, N. H. (2022). Cultural Adaptations of Dialectical Behavior Therapy: A Systematic Review. *Journal of Consulting and Clinical Psychology*. Advance online publication. http://dx.doi.org/10.1037/ccp0000730

Harned, M. S., Coyle, T. N., & Garcia, N. M. (2022). The inclusion of ethnoracial, sexual, and gender minority groups in randomized controlled trials of dialectical behavior therapy: A systematic review of the literature. *Clinical psychology: Science and practice*, 29(2), 83–93. https://doi.org/10.1037/cps0000059

Hays, P. A. (2009). Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional psychology: Research and practice*, 40(4), 354.

Koç, V., & Kafa, G. (2019). Cross-cultural research on psychotherapy: The need for a change. *Journal of cross-cultural psychology*, 50, 100-115.

Linehan, M. (2014). DBT skills training manual. Guilford Press.

McFarr, L., Gaona, L., Barr, N., Ramirez, U., Henriquez, S., Farias, A., & Flores, D. (2014). Cultural considerations in dialectical behavior therapy. In A. Masuda (Ed.), Mindfulness and acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice (pp. 75–92). New Harbinger Publications. https://www.proquest .com/books/cultural-considerations-dialectical-behavior/docview/1710263976/se-2?accountid=14496

Mercado, A. & Hinojosa, Y. (2017). Culturally adapted dialectical behavior therapy in an underserved community mental health setting: A Latina adult case study. *Practice innovations*, 2, 80–93. https://doi.org/10.1037/pri0000045

Pierson, A., Arunagiri, V., & Bond, D. (2021). "You didn't cause racism, and you have to solve it anyways": Antiracist adaptations to dialectical behavior therapy for white therapists. *Cognitive and behavioral practice*. Online ahead of print. https://doi.org/10.1016/j.cbpra.2021.11.001

Ramaiya, M. K., McLean, C., Regmi, U., Fiorillo, D., Robins, C. J., & Kohrt, B. A. (2018). A dialectical behavior therapy skills intervention for women with suicidal behaviors in rural Nepal: A single-case experimental design series. *Journal of clinical psychology*, 74, 1071–1091. https://doi.org/10 .1002/jclp.22588

Doing Anti-oppressive Work in a Private Practice Setting: Sharing Our Ideas and What We Have Learned

Megan Schiferl and Kim Skerven
Center for Behavioral Medicine

AS A DBT COMMUNITY, we have responded to the call to engage in anti-oppressive work. Our investment is occurring on multiple fronts as we examine the structures, systems, and assumptions creating barriers to DBT for communities of color and other marginalized groups. These barriers include access to DBT treatment for clients and to DBT training for providers.

At our clinic, we asked ourselves: *What does anti-oppressive action look like in a clinic staffed by predominantly white clinicians who serve mostly white clients, delivering a treatment that has been under-studied with diverse populations?* This article will describe what we learned by taking up this question, knowing that other clinics are doing similar work. We share this in the spirit of growth and collaboration, from a place of humility and not of mastery. We hope that sharing our challenges, lessons learned, and accomplishments will spark ideas and encourage us all to work together taking anti-oppressive action as a DBT community.

Early Work: Honoring That We Don't Know What We Don't Know

Our clinic is located in a suburb of Milwaukee and our staff and clients skew toward a white, middle-class demographic. We made a commitment to increase attentiveness to diversity several years ago. At that time, we wrote a "diversity statement" to guide our work and started examining the network of insurance carriers we work with in an attempt to increase access to services (work that continues today). We did not, however, have an overall plan to guide our efforts. We decided to **work with an outside consultant**, an expert in anti-oppressive practice. She met with our team twice for several hours, helping us identify what we were missing so we could articulate a clear vision and create a cohesive plan. In writing this, we know some teams may not have access to such a consultant; **it may be useful for the DBT community to identify professionals trained in this type of consultation** and willing to connect with teams seeking to engage in anti-oppressive work.

Our time with the consultant highlighted that effectively adopting an anti-oppressive lens necessitates establishing a **strategic plan with specific goals**. This is in contrast to what had been happening, a pattern of initial energy and focus, then having it fall off the radar, observing that it fell off the radar, and then looping back around to enthusiasm once again. We needed an **internal workgroup** tasked with articulating desired outcomes, creating internal processes to reach them, guiding the work, and keeping focused on the goals even when feeling overwhelmed or distracted. We created our JEDI Council (Justice, Equity, Diversity, and Inclusion), a workgroup composed of staff members as well as students training at the clinic. This composition has been extremely helpful because staff members bring historical knowledge of the clinic while students bring new perspectives. Having a **regularly scheduled time** allows us to be one-mindful over time, breaking the aforementioned pattern of inconsistent attention. Finally, having this be **compensated time** for staff communicates the clinic's support of anti-oppressive action. Often, this work is done by dedicated people for little to no compensation. This devalues their contributions and creates a situation where the clinic does not have to make a full commitment to organizational change. Being intentional and explicit about the clinic's willingness to support structural change is critical to avoid falling into the trap of performative allyship and subsequent burnout.

Our Approach: Embracing Generative Discomfort

In DBT, we rely on dialectics to help us "walk the middle path" to keep moving forward. We know that this involves moments marked by dialectical tension that can be uncomfortable. At the same time, **dialectical tension creates opportunities for change.** This is generative discomfort. To facilitate this process, we engage in **dialectical assessment,** searching for what is missing and enabling us to see the bigger picture of the reality we are in. We relied heavily on these concepts as we carried our anti-oppressive work forward.

Just as we would encourage our clients to skillfully "lean into" discomfort, we challenged ourselves to do the same. An example of this that occurred on our team was during a consultation meeting where a client's race was an "elephant in the room." The team was discussing this client's behavior, yet nobody was directly talking about the client's race and how implicit biases could be informing our own interpretations of this client's behaviors. The team observed the "elephant" and the therapist seeking consultation shared that they were feeling defensive following that observation. Their disclosure of feeling defensive helped the team validate the therapist and move to a more dialectical position where we could simultaneously hold that the client's behavior needed to change and at the same time the team needed to be more attentive to their potential biases that may be influencing their interpretations of the client's behaviors. Situations like this call us to look at ourselves as individuals, as a team, and as an organization, to observe and describe what we see and to identify how our observations fit with our wise-minded values or deviate from them.

One strategy we found particularly helpful in harnessing the power of generative discomfort was when we asked

all team members to consider their own identities, their privileges, and how these inform their DBT work. This took the form of **formal reflective identity work** over the course of several weeks. First, each team member did personal reflection, writing about their own identities and their influence. Next, we divided the team into small groups to have multiple discussions about what was learned from the individual work. Finally, we gathered together as a team to discuss what we discovered through the prior sessions and how that could inform tasks we take up as a team. This helped the JEDI Council create an action plan embedded in our own understanding of where we were as a team and clinic as well as destinations we wanted to navigate toward.

Our Actions: Strategies We Have Implemented

An initial step was adopting "beginner's mind" by taking second looks at our internal systems. Anti-oppressive practice calls us to examine structures to identify systemic contributors to inequity. What were we missing as an organization that may be contributing to inequity? We conducted an **examination of our environment and processes,** which revealed work to be done. The needs we identified were broad and included auditing our documentation practices (particularly for clients with LGBTQ+ identities), re-envisioning our physical space to increase accessibility for those with a range of body shapes and sizes, ensuring restroom access for all through universal design, and getting all of our consent documents translated so they are available in English and Spanish. We also added a dedicated skills training group for LGBTQ+ adults.

Next, we determined that our systems to collect client demographic information made it difficult to understand our client base in order to learn who is and is not accessing our DBT services. Setting up **systems capable of collecting and analyzing accurate demographic data** is critical to identify gaps and detect whether implemented strategies are effective. To accomplish this, we changed intake paperwork to capture the data we needed. This included transitioning to an online/app based-diary card and data collection system that allowed us to aggregate data and increased assessment completion by removing behavioral barriers. Our JEDI Council also facilitated the update of intake paperwork and made recommendations to add signature lines for the name clients go by if different than their legal name, provide space for reflection on minority identity components and for adolescents to provide their experience of loved ones' acceptance of the name and pronouns they use.

We also noticed we were missing opportunities to recruit team members interested in helping us grow in our attention to anti-oppressive practice. It was something we cared about, and yet were not saying it "out loud" in our materials. We needed to **be explicit about our goals and our desire to recruit others interested in collaborating with us** to reach them. To this end, we added language to our student recruitment materials: "We seek to collaborate with students who are interested in making DBT accessible for diverse communities and populations." We also cultivated relationships with local training programs that serve a diverse student body. Subsequently, we noticed an increase in applicants talking about anti-oppression in their interviews and expressing enthusiasm about the work. Increasing training opportunities for students with diverse identities and backgrounds creates pathways for trainees to connect with DBT early in their careers, a priority for the DBT community overall.

Next, we addressed our tendency to focus on anti-oppression for periods of time and then drift away from it. We agreed it would be helpful to build in **intentional strategies to keep anti-oppressive action top of mind**. We started having a JEDI Council member regularly do a brief presentation during team meetings on segments of the American Psychological Association's (APA) **Inclusive Language Guidelines** (2021), which defines important terms and suggests language to use and not use. We have done **readings and discussions as a team** (e.g., Pierson, Arunagiri, & Bond, 2021) and in smaller breakout groups where we provided question prompts for structure. We share resources (e.g., webinars) and **gather in a central location articles and other documents** like APA Resolutions (e.g., Advancing Health Equity in Psychology, 2019) and practice guidelines (e.g., Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization, 2019). We also **monitor local and state-level legislation** (e.g., anti-trans policies; legislation that would create inequities in access to services for BIPOC clients) so we can be aware of structural issues impacting our clients and engage in advocacy when needed.

Finally, we launched a blog series as a mechanism for exploring how DBT connects with anti-oppressive practice. Members of the JEDI Council write posts that get disseminated on our website, through our email list, and to all of our clients. We have received positive feedback from clients feeling validated by being included. Examples of blog topics include: Bebe Moore Campbell National Minority Mental Health Awareness Month, the Juneteenth National Holiday, Transgender Day of Visibility, and National Hispanic Heritage Month.

Future Directions

We have learned so much from engaging in this work; we have accomplished a lot and there is much more anti-oppressive work to be done. To guide our next steps,

we talked as a team about priorities and identified the following: keeping our commitment strong over time, being active in challenging power structures on the team, and connecting with our surrounding community.

Keeping our commitment strong is critical as we move forward. As many teams have, we are considering adopting an anti-oppression team agreement. Beyond this, we have thought about either including this as part of the Observer's role or creating a second Observer dedicated to watching for microaggressions, inequities, marginalization, etc. For this to be successful, every team member must be willing to embrace opportunities for generative discomfort. This speaks to the importance of the aforementioned team agreement and also relates to the issue of power structures.

For our team, continuing commitment involves balancing the **dialectical tension between reflection and action**. Team members observed the danger of getting stuck in an overly reflective place (e.g., prioritizing reading, learning, small group discussion) at the risk of neglecting direct action to connect with diverse client populations or recruit BIPOC clinicians. On the other hand, there is danger in moving too quickly into action without having done internal work to address biases and power structures that can be oppressive for those individuals. This led us to consider ways to challenge power structures on the team.

Challenging power structures is twofold: experienced team members taking a step back while helping newer colleagues take a step forward. This involves experienced clinicians staying mindful of the goal of reducing power inequities on the team, not being the first to speak when a question is asked, and inviting input from others. To help newer team members take a step forward, we are considering having a mentor who is not the trainee's clinical supervisor for each trainee. This mentor would act as a consultant and cheerleader, helping their newer colleague contribute to difficult discussions on team and navigate dialectical tension.

Finally, we believe that **connecting with our surrounding community**, particularly communities of color, is needed to increase access to DBT treatment for clients and DBT training for clinicians. This aligns with our long-term goals and additional programming we plan to implement at the clinic.

We hope this paper provides ideas and encouragement for teams seeking to incorporate anti-oppressive action into their work and look forward to the continuing discussion of this important topic within the DBT community.

Note: We would like to express deep thanks to all members of our team, past and current, who have made contributions to our anti-oppression work. It has truly been a team effort!

References

American Psychological Association (2021). Resolution on Advancing Health Equity in Psychology. https://www.apa.org/about/policy/resolution-advancing-health-equity.pdf

American Psychological Association (2021). Inclusive language guidelines. https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines.pdf

American Psychological Association (2019). Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization. Retrieved from www.apa.org/about/policy/guidelines-low-income.pdf

Pierson, A. M., Arunagiri, V., & Bond, D. M. (2021). "You Didn't Cause Racism, and You Have to Solve it Anyways": Antiracist Adaptations to Dialectical Behavior Therapy for White Therapists. Cognitive and Behavioral Practice.

Suicide Postvention: Guidelines for Dialectical Behavior Therapy Consultation Teams

Jessica A. Renz,[1] Alec L. Miller,[2,3] and Kelly B. Graling[3]

[1]MindWell NYC, [2]Montefiore Medical Center/Albert Einstein College of Medicine, [3]Cognitive and Behavioral Consultants

Abstract

Objective: There is a lack of information regarding how DBT teams should manage a suicide and how to best support the individual therapist and consultation team.

Method: Due to the lack of information, the goal of this paper is to provide a clinical and administrative roadmap of steps for teams to help manage the crisis before and after it occurs.

Results: We present trauma-informed strategies for clinicians including setting limits, managing coverage, and utilizing support. In addition, we provide consultation team and administrative guidelines.

Conclusion: The use of these guidelines should increase support for clinicians and consultation teams during an emotional and potentially traumatic event.

According to The Centers for Disease Control and Prevention (CDC, 2019), suicide is currently the 10th leading cause of death across all ages and the 2nd leading cause of death among those 15-34 years old. After a pattern of declining numbers, rates of suicide have risen in specific population groups from 1999 through 2018, with greater increases occurring after 2006 (Hedegaard, Curtin, & Warner, 2020). Of particular concern to the adolescent DBT community, rates of suicide for females ages 10-14 has increased the most of any group, tripling between 1999 and 2014 (Heron, 2016). Suicidality is a common feature of individuals with Borderline Personality Disorder (BPD) who are often treated with DBT. In people with BPD, rates of suicide have been found to be 50 times greater than in the general population (American Psychiatric Association, 2001).

Although rates of suicide have risen, many mental health professionals see suicide as an aberration and are therefore unprepared to manage suicide when it does occur (Gutin, McGann, & Jordan, 2011). This is unfortunate, as statistics highlight the number of clinicians who can be affected. In 2017, the number of suicide deaths in the US was 47,173 (CDC, 2019). Of suicide decedents in 2010, 31% were found to be receiving mental health treatment (Parks, Johnson, McDaniel, & Gladden, 2014). Given the number of suicides as well as the number of those receiving mental health treatment, about 13,452 clinicians may lose clients to suicide on an annual basis (Tan, White, Homan, & Dimeff, 2017). Due to the aforementioned increase in suicide rates, DBT's focus on work with clients who are suicidal or exhibit suicidal behavior, and the increasing use of DBT by mental health clinicians, the management of suicide must be given serious clinical consideration (Curtin, Warner, & Hedegaard, 2016; Miller, Rathus, & Linehan, 2007).

DBT is an evidence-based behavioral treatment that has been found to reduce the frequency of suicide attempts and self-harm as well as decrease depression in adults (Panos, Jackson, Hasan & Panos, 2014) and lead to a reduction in suicidal ideation, depression, hopelessness, and borderline personality symptoms in adolescents (Mehlum et al., 2016; Cook & Gorraiz, 2015). Although suicidal behavior is often addressed on DBT therapist consultation teams and much attention is given to managing suicidal crises, the effects of suicide on DBT teams has yet to be carefully examined. Linehan provides brief postvention and confidentiality guidelines intended to help therapists from a DBT perspective (Linehan, 2000-2015). Additional suggestions have been made including the components of a suggested case review (Tan et. al, 2017). However, literature remains sparse in the DBT world on specific dilemmas and suggestions for teams. It is hoped that after reviewing this article, DBT teams discuss and implement a post-suicide plan of how to manage clinical considerations for their therapists and team, speak openly about dialectical dilemmas that may arise, and review how to effectively manage administrative responsibilities. In this article, we will refer to treating the clinician as individual, group, and/or parenting therapists who had frequent direct contact with the client and who may need additional support.

Impact on Clinician

In general, suicide is considered a traumatic loss with bereavement features that may be similar to the mourning process after an unexpected death that was not a suicide. The suicide bereavement process may include additional stressors specific to this type of loss such as stigmatization and experiencing a death that is sudden and/or violent in nature, both of which may impact the surviving clinician (Gutin et al., 2011). Clinician survivors of suicide may experience symptoms that are consistent with acute stress, particularly if they are in training or are more junior in their career (Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004). Symptoms of acute stress may include intrusion symptoms, negative mood or dissociative symptoms, avoidance, and arousal symptoms (American Psychiatric Association, 2015). Therapist grief reactions and distress following a suicide may last well into a year after the loss (Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000). In addition to managing a challenging and traumatic loss, Plakun and Tillman (2005) describe a twin loss after a client dies by suicide that clinicians experience on both a personal and professional level. This twin loss includes mourning the death of the client and person as part of a personal grief reaction in addition to a loss or shift in professional identity and clinical work.

Guidelines for Clinicians

Short-term considerations.

Immediately after a clinician experiences a death by suicide of a client, it is important to provide support from the DBT consultation team. Given the challenging nature of the grief reaction in addition to the possible long-term duration of post-suicide experiencing by the clinician, suicide loss may make managing therapist consultation team and other clinical responsibilities more

difficult. Clinicians may not be functioning optimally if they are experiencing post-traumatic emotional states and these states are more likely to be triggered by work with other suicidal clients (Gutin et al., 2011). While it is important not to assume that a clinician will experience a grief reaction that impairs their functioning, guidelines are given for client care based on the APA Ethics code, taking both therapist and client well-being into account. Supervisors or DBT team leader should check in with the clinician and assess how they are coping emotionally and functioning. Many clinicians after a loss may not require any reduction or change to their responsibilities. Preemptively, it may be useful for teams to develop a handout or set of written guidelines following a suicide on team so that this is not be determined in the aftermath but rather has been previously discussed and thought out as a team and/or organization.

If therapists are experiencing impairment following the death by suicide of a client, they may not be able to provide effective therapy in the short term. The Ethics code is clear that if personal problems are impairing a psychologist's ability to function "competently," appropriate measures must be taken to remediate the problem. While client well-being should be of primary focus in a therapeutic setting, a therapist who recognizes that they are not able to function competently working with suicidal clients may need a modification of that role. If clinicians do change their caseload or require a temporary reprieve, we suggest minimizing the difficulty for the client by transferring them to a clinician they are familiar with from other DBT modalities (e.g., skills group or coaching). We also recommend that the time away from clients be as minimal as possible.

In the immediate and short-term time period after a suicide, we encourage teams to give clinicians the following options if needed to reduce burden, decision making, and stress on the treating clinician while minimizing impact on the client. These options may also be functionally validating to the clinician. Other members of the team may also request similar supports as needed.

- Senior team members (STM) or supervisor can offer to call clients and cancel (or provide coverage) for the day of/week/desired time period after the suicide in order for treating clinicians to get support as needed. The clinician can decline this offer if they so desire. We encourage supporting the treating clinician's decisions and preferences throughout this process.
- If the clinician would like, identify a STM or supervisor to cover their coaching calls for the immediate future. This is to minimize disruption to clinicians' sleep and schedule and to decrease the possibility of concurrent exposure to coaching calls that may include suicidal ideation, suicidal or self-harm behavior, or other crises. In addition, it is possible that a clinician coping with a recent suicide may not provide the most effective and balanced coaching to other clients, with an urge to possibly react in a more fear-based way. As previously mentioned, we suggest providing these options as possibilities and clinician can accept these offers if they so desire. The clinician can role play with other team members how to speak with existing clients about a change in coverage if needed.
- Find coverage for group co-leadership roles as needed if desired by clinician.

Numerous factors must be considered regarding clinical care at this juncture. While it is important STM/supervisors convey confidence and a non-blaming stance towards the clinician, it is recommended that the treating clinician be provided an option to not assess or treat suicidal clients. There may be an immediate readiness for some clinicians and it may take more time for others. It is up to the clinician and their supervisor to determine when they feel equipped to assume responsibilities as normal. If needed, team members can be assigned to cover cases and groups with life threatening behaviors as needed during the interim. In addition, the treating clinicians is encouraged to identify and observe limits around their clinical capabilities during this time as they would during any other personal or professional crisis, particularly if they are unable to provide treatment effectively. If the treating clinician would like coverage of their clinical work, this can be supported and managed empathically by the team. While the clinician who most closely worked with the client who completed suicide may be most vulnerable to grief and stress, all team members should monitor their reactions to the loss. Clinicians who are experiencing grief reactions should be encouraged to ask for additional support or assistance during this process (discussed further below).

Medium to longer-term considerations.

Managing absence of the client in group while managing privacy concerns. Numerous additional clinical challenges may occur after a suicide. We encourage team discussion about how to manage the absence of a client in group while managing privacy concerns. This may be handled differently based on the stage of treatment of the individual who died by suicide and their level of involvement in the clinic or practice. In groups including Adult Skills Group, Adult Graduate Group, adolescent Multi-Family Skills Group, or Adolescent Graduate Group, it is encouraged that clinicians first speak with the client's family to get their permission before informing group members of the loss. Clinicians and family can discuss the language the family would like to be used to inform others (e.g., died, suicide). If the family and/or clinicians prefer that group members are not informed of the suicide, clinicians can inform other members that the client and/or family will no longer be participating without providing information that would violate privacy. In the case of adolescent Multi-Family Skills Group,

if the client was an adolescent and the parents also participated in group, it is also possible that family members may want to attend a group session to inform others. Teams can identify what might be most appropriate for their setting. Team members must be prepared for managing reactions of other clients and families in the practice and the possible increased risk for NSSI or suicidal behavior. Primary therapists need to be alerted and ready for risk assessment and possible contagion. In addition, treating psychiatrists and involved school mental health providers should be alerted as well, with permission from the family.

Assigning and providing client support or coverage as needed. It is possible that the treating clinician may want or need to make short-term additional support or changes to their caseload. In these instances, based on the treating clinician level of impairment (if any) as well as their needs and wants, several options are possible. Therapists can be provided with extra supervision if needed or wanted. Additional assistance can be given in the form of having a co-therapist cover coaching or individual sessions. Many clinicians may not experience impairment after a suicide and can continue to see their caseload as usual. At minimum, we recommend that consultation team member check in with the clinician more often.

We suggest that the team embrace decisions about clinical work following a suicide nonjudgmentally and with compassion. If the treating clinician has the desire to transfer clients with life threatening behavior or to continue seeing their current caseload, it can be helpful to discuss the pros and cons of this decision in team. We recommend that decisions regarding clients and caseload be recorded and written down in team so it can later be updated as needed and no cases are left without a coverage plan.

Helping the treating clinician return to work with suicidal clients when appropriate. As previously mentioned, a treating clinician may want to obtain short-term coverage as needed for suicidal clients. If coverage is sought and the caseload changed, it can be difficult to determine when the clinician may be interested in or prepared to return to this clinical work. The choice may relate to the nature and level of the clinician stress response, time they have had available to process the loss, physical rest and strength to resume coaching responsibilities and manage calls appropriately, trauma history, level of interest or motivation to participate in this type of work, and participation in their own therapy. In order to navigate this decision-making process which could possibly be an emotionally vulnerable and personal experience for clinicians, it is recommended that the treating clinician receive (at least) an hour of weekly supervision with another team member. This time can be used to process the loss as needed or desired and to discuss when to return to working with clients with life threatening behaviors. In addition to providing a nonjudgmental space for support, utilizing this supervision structure will allow another team member to learn about the treating clinician's level of functioning, which may allow them to make recommendations regarding alterations of clinical practice. Schultz (2005) recommends that supervisors facilitate contact for the clinician with others who have also experienced suicide loss. Supervisors may also consider making a recommendation for individual therapy if warranted.

When clinicians return to work with DBT clients who engage in NSSI or suicidal behavior, we suggest that the treating clinician and their supervisor discuss how to reintegrate this type of clinical work into their caseload. For some, it may be useful to return to taking clients with lower levels of risk (either NSSI or SI) and then resume work with clients with both NSSI and SI. This may require coordination with one's intake or screening clinicians and clients may disclose life threatening behavior in session, despite screening procedures. We suggest that the treating clinician notify the team that they are going to begin this type of work so other team members can be available to provide additional support as needed. In addition, we recommend that clinicians reach out to past supervisors or mentors for additional support during this process as needed and that this be supported even if these providers are outside of the clinician's current place of practice.

Post-suicide meeting as a small team of supervisors, treating clinician, and administrators. Clinical programs may want to meet with a group of supervisors, treating clinician, and administrators to review the case and course of treatment. We recommend that this occurs at a time when clinicians have sufficient memory for the event and at a time when they are emotionally prepared to engage in a discussion that will most likely involve more people than their regular supervision. The goal of this meeting is to bring information together that was gathered by team members and to identify things that were learned from the event, provide support to one another, as well as conduct a formal chain analysis on the suicide. Due to the potentially stigmatizing nature of a suicide loss even for mental health clinicians, we caution teams to be mindful of using language that could be considered blaming. At the same time, the meeting may actually help clinicians recall information that can help them to conceptualize the case in a less blaming way. This meeting can also provide information to clinicians that can be used in the future with suicidal clients as well as feedback for the team on how they handled postvention.

Impact on Consultation Team

Suicide on a DBT team is a unique type of clinical loss as the care of clients and responsibility for their treatment is shared by all members of the consultation team. Thus, after a suicide, team members, to different extents, are likely to experience responses to the suicide that may impact both their personal and professional functioning (Gutin et al., 2011). These experiences are likely to be

intensified when clinicians are exposed to other clients who exhibit suicidality, which is a likely and expected occurrence on consultation teams. Given the challenging nature of managing emotional responses as well as clinical duties on the team after a suicide, we suggest that teams be mindful of the needs of the treating clinician as well as team members' needs (e.g., assessing each team members' burnout ratings in an ongoing way and treating accordingly).

Addressing Dialectical Dilemmas

Dialectical dilemmas specific to the experience of client suicide may arise on the consultation team after a client's death by suicide and should be identified and navigated during the process of treating the clinician and team. The specific dilemmas noted here were identified based on the clinical experiences of our team after a client died by suicide and some or all dilemmas are hypothesized to appear on other teams as well. These dilemmas include excessive team emotion vulnerability versus emotional inhibition/avoidance, fragilizing versus assuming competence, and rigid problem-solving versus hopeless passivity.

Excessive team emotion vulnerability versus emotional inhibition/avoidance.

Excessive team emotion vulnerability includes the tendency to experience and express intense emotions frequently and openly during team, either during portions of the team dedicated to emotional processing of the event or outside of it during other clinical consultation. Excessive team emotion vulnerability may manifest itself by the team becoming a routine place for an excess of emotion processing and exclusively focusing on the suicide to the detriment of other therapist issues and clinical problem solving. This may occur due to clinicians feeling that consultation team is the only time they can express these emotions, clinician emotional vulnerability, or, at its extreme, grief or trauma symptoms of clinicians' that have not been adequately addressed.

Team emotional inhibition/avoidance, on the other hand, may appear as the avoidance of discussing the suicide or emotional material on team. This can occur for many reasons including regularly having other items or client concerns present on weekly agendas, team members experiencing anxiety about bringing up the suicide, and concerns about judgment or stigmatization occurring on team. In addition, some team members may be less interested in and/or willing to discuss the loss around colleagues and other professionals due to perceived judgment.

Synthesis of this dilemma requires that team and meeting leaders as well as consultation team members observe and describe what is being discussed and prioritized on team to identify any polarization around emotionality that may be occurring. While doing so, we encourage teams to validate that extreme movement and/or polarization on this dialectical dilemma is to be expected, and then attempt to find a middle path that recognizes the emotionality inherent to this experience without allowing it to overtake team functioning. We also encourage teams to allow room for more concrete work or necessary tasks that may inherently include disengagement from emotional experiencing as needed. We suggest that teams validate the treating clinician's emotional experiencing regardless of where they are on the dialectic based on their needs at that point in time. Radical genuineness is encouraged.

Fragilizing versus assuming competence. The treating clinician, other team members, or the team as a whole may be prone to being fragilized after such a difficult event. The process of fragilizing the treating clinician occurs when team members assume that the treating clinician is unable to identify or solve difficulties, they may be experiencing related to the loss. This may include taking over responsibilities without getting feedback from the treating clinician about their needs, wants, or functioning. This may also include avoiding discussion of the suicide in particular contexts due to concerns about making things worse or upsetting the clinician. Fragilizing may occur due to the team wanting to relieve the treating clinician of potentially triggering clinical situations or administrative duties. At its extreme, this may lead to team members not acknowledging or addressing problematic or dysfunctional behaviors on the part of any team member or the team as a whole. While fragilizing clinicians often comes from the team's desire to protect and take care of team members, this may result in the treating clinician believing they are unable to manage these responsibilities, which can inhibit their personal and professional growth after a client's death by suicide. Fragilizing may lead clinicians to feel incompetent in their professional roles and to believe that their team members have lost confidence in their ability to make decisions independently or to do clinical work with high-risk clients.

On the other side of the dialectic, assuming competence may refer to team members assuming that the treating clinician is capable, as they were prior to the suicide, to validate themselves and others and problem solve effectively. This may include expecting the treating clinician to have no difficulty in identifying their needs and wants and communicating them effectively to the team. This may also include expecting the clinician to maintain their current caseload and administrative duties without assistance from consultation team members. Team members may fall on this side of the dialectic for benign reasons in an attempt to give clinicians full autonomy over decision making and give them a "vote of confidence" after a loss. For those experiencing grief reactions or other post-suicide symptoms or distress, this may feel invalidating, which can increase the urges of individuals to avoid team and instead process their emotions outside of team or in smaller groups. Over time, this may lead to feeling unheard or misunderstood on team, which may lead to problematic behaviors such as avoidance, burnout,

or re-experiencing trauma. Assuming competence may lead clinicians to feel punished for setting limits or asking for accommodations in the short or long term after a completed suicide.

To manage the potential for polarizations that may occur, we encourage both a thorough assessment of the affected clinician's current functioning as well as regularly scheduled team check-ins. We recommend that the team be aware of and assess the clinician's responsibilities that may need reassignment or adjustment. This may be a task best accomplished by first making a list of all clinician responsibilities and then ranking which duties are proving to be the most difficult in the presence of a validating and understanding colleague or supervisor. If necessary, we also encourage open discussion about using opposite action skillfully if the treating clinician is experiencing unjustified guilt or shame about making changes to their responsibilities. We suggest that the team and treating clinician be willing to fully participate nonjudgmentally in the experience of recognizing one another's limits and abilities in making decisions about changes in responsibilities. We recommend that team members do their best to not take control of decision making without the treating clinician's input and that the treating clinician does their best to keep the team's functioning in mind. Ongoing team check-ins are crucial to meeting team members' changing needs.

Rigid problem-solving vs hopeless passivity. After a completed suicide, it is natural (and helpful) that teams should ask questions like "why did this happen?" and "what can we do to prevent this from occurring again?" Questioning the series of events that led a client to die by suicide, examining the role of the clinician in the events leading up to a suicide, and attempting to piece together the event in question is a functional way to respond to a loss. However, teams may fall into the extreme of rigid problem solving, which may involve the inability to tolerate the (inevitable) uncertainty of a client's feelings, thoughts, and decision-making process, extreme questioning in accountability, and even blame for the clinician's role in the completed suicide. Rigid problem-solving at its extreme may lead to blaming or finger-pointing that is counterproductive and possibly traumatizing. More broadly, teams may make more extreme decisions to prevent a completed suicide from occurring again by enacting elaborate safety protocols, more thoroughly screening and excluding new clients on the basis of risk, or relying more heavily on environmental interventions (breaking client confidentiality or referring a client to a higher level of care when it may not be clinically indicated). While action should be taken to reduce the likelihood of suicide, rigid problem-solving may discount clinician judgment, which may lead to unnecessary protocols that interfere with effective treatment.

On the other extreme, team members may feel dysregulated and hopeless about the risk of working with suicidal clients. Hopeless passivity may lead to a reticence or resistance to examine the facts of a completed suicide because "nothing could have been done." This results from fear and concern about the inability of clinicians to effectively identify risk and stop clients' high-risk behavior. Teams as a whole may experience a loss of a sense of mastery or ability to intervene. Team members may lose faith in DBT as an effective intervention, leading to despair. At its extreme, hopeless passivity may lead clinicians to regret their choice to provide DBT therapy, to no longer actively participate in consultation team or the treatment, or decide to no longer practice DBT to avoid working with high-risk clients. Hopeless passivity may be more likely to occur on a team when clinicians are experiencing grief reactions that are not adequately being addressed.

Finding a synthesis between rigid problem solving and hopeless passivity requires a consultation team to hold both truths that our job as clinicians is to help clients build lives worth living while also acknowledging clients' individual free will and choice. A basic assumption of DBT posits that clients cannot fail in DBT, only clinicians or the treatment itself is responsible for failure (Linehan, 1993). At the same time, DBT assumptions ask clinicians to fully accept clients as they are while attempting to move them towards progress and change. On the one hand, attempting to control clients' behavior or any possible danger in the future is unrealistic (and impossible), while on the other, hopelessly acknowledging we have no control is also problematic. Sitting with these broader questions, allowing team members to discuss both sides of the dialectic, expressing fear about not being prescient, and sadness about the possibility of a future loss may be helpful ways for the team to come to a synthesis. Continually reminding ourselves of the assumptions of DBT as well as relying on the observer to acknowledge the other side of the dialectic is critical to finding a synthesis to this dilemma.

Impact on Trainees

In a survey of 292 psychology interns, 97% of them had worked with a suicidal client (Kleespies, Penk, & Forsyth, 1993). Hence, trainees who work in a clinical environment and participate on a DBT team may experience the suicide of a client. Given the unique status and demands of training, we make several additional suggestions for supervisors and consultation teams with trainees. It is particularly important that trainees are oriented to the possibility of suicide as well as the suggestions for teams outlined above during their DBT orientation process.

We encourage supervisors and consultation team members to validate the unique perspective of the trainee during this experience, particularly around their being new to the field. The experience of emotions and possible distress can be normalized. In addition to validating emotions and their perspective, it is important to monitor trainee response to suicide given their potentially limited amount of clinical experience. Trainees,

particularly those who are earlier on in the training process, may have had few past clients and a small number of clients on their current case load. Therefore, they may feel the loss of this client acutely and make generalizations about their clinical skills or practice. We suggest that supervisors and teams be sensitive to this possibility. We encourage supervisors to devote additional time to discussing the trainee's clients in supervision. We also encourage trainees to seek out additional support from their academic institution with professors or academic advisors who can be attuned to any changes in academic development.

Impact on Administration in a Clinical Setting

In addition to impacting primary treating clinicians, trainees, and the consultation team, suicide is likely to necessitate completion of particular tasks as part of administrative procedures. Members of the team, as well as members of the administration in one's organization, must be notified of the suicide. Numerous additional steps to clarify the post-suicide administrative processes are described below.

Administrative Protocol.

Immediately following suicide, it is encouraged that teams take the following administrative steps:

1. Treating clinician should immediately notify your team leader.
2. Team leader will notify the remainder of the team with names of clinicians involved in the case, preferably by phone or phone tree.
3. Team leader and/or clinic director will reach out to treating clinician to assist with documentation or administrative tasks that need to be completed.
4. Clinic director can call to cancel clients of the treating clinician as needed or desired. Clinic director can help treating clinician and other team members (as needed) identify high-risk cases they plan to see in the near future and give the option of having another clinician see the case or having another clinician present to assist.
5. Team leader can suggest having a team meeting in the next 1-2 days for any clinician who can be in attendance, especially for teams who may not have their next scheduled meeting for many days. Put this as agenda item 1 at next team meeting so the treating clinician does not need to schedule.
6. If a treating clinician does not have a direct clinical supervisor, the clinic director or team leader will assign a STM to them for ongoing additional support.
7. Participate in a morbidity and mortality review to provide feedback to treating clinicians and ensure that standard of care was followed. If not, review what specific adjustments need to be made to ensure standard of care will be followed in the future.

After reviewing these guidelines and suggestions, we encourage clinicians and teams to consider the culture and requirements of their own clinical settings and identify team-specific clinical and administrative guidelines to have in place as part of the underlying foundation and structure of the team preemptively. We encourage DBT teams to speak openly about suicide. Lastly, when orienting new members to the understanding that if a client dies by suicide, it is a suicide of the entire team, we would like teams to highlight that if a suicide does occur, there is a site-specific plan in place to support the treating clinician and team.

Conclusions and Future Directions

In this article, we present challenges and potential impacts encountered by the treating clinician, therapist consultation team, and administration after a client dies by suicide. In an effort to mitigate disruption and trauma to consultation teams, we present specific guidelines about how to manage these challenges. We also review dialectical dilemmas that may arise on the DBT consultation team after suicide and how to work towards finding a synthesis in a way that will not compromise the important therapeutic and support roles of the team. Fortunately, suicide is a low base-rate occurrence. However, when it does occur, it can have a serious and lasting emotional impact on the clinician, including therapists in training, as well as the therapist consultation team. This article strives to provide ideas to stimulate discussion and to assist with planning and implementation of structure on teams prior to a suicide event. Our hope is that by discussing and planning for suicide openly, you can decrease disruption and distress as well as provide support and guidance to your teams in the aftermath of suicide.

Future directions include conducting qualitative work to gather information about the emotional experience of team members, including trainees, after a suicide. Feedback from treatment clinician's experience on DBT teams during suicide postvention will be critical to further shape and articulate short-term and long-term efforts to provide emotional and concrete support. These guidelines will be further improved by considering a broad range of clinical settings across a full continuum of care, client presenting problems, and cultural considerations. Additionally, the dialectical dilemmas proposed here are hypothesized as potential polarization, and more needs to be learned about the dialectical dilemmas that may emerge on a team and how syntheses were achieved. It is critical we learn more about how to support clinicians during an emotional and potentially traumatic experience.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct

(2002, Amended 2016 and 2016). Retrieved from https://www.apa.org/ethics/code/ethics-code-2017.pdf

Centers for Disease Control and Prevention (CDC). (2019). 10 Leading Causes of Death by Age Group, United States — 2014. Retrieved from https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2014-a.pdf

Centers for Disease Control and Prevention (CDC). (2019). Deaths: Leading Causes for 2017. Retrieved from https://www.cdc.gov/nchs/nvss/leading-causes-of-death.htm#publications

Cook, N.E. and Gorraiz, M. (2016), Dialectical behavior therapy for non-suicidal self-injury and depression among adolescents: preliminary meta-analytic evidence. *Child Adolescent Mental Health*, 21: 81-89. doi:10.1111/camh.12112

Curtin, S. C., Warner, M., & Hedegaard, H. Centers for Disease Control and Prevention. (2016). Increase in suicide in the United States, 1999-2014 (241). Washington, DC: National Center for Health Statistics. No DOI found

Gutin, N., McGann, V. L., & Jordan, J. R. (2011). The impact of suicide on professional caregivers. In J. R. Jordan & J. L. McIntosh, (Eds.), Grief after suicide: Understanding the consequences and caring for the survivors (93-111). New York, NY: Routledge. No doi found.

Hedegaard H, Curtin SC, Warner M. Increase in suicide mortality in the United States, 1999–2018. NCHS Data Brief, no 362. Hyattsville, MD: National Center for Health Statistics. 2020. https://www.cdc.gov/nchs/products/databriefs/db362.htm

Kleespies, P.M., Penk, W.E., & Forsyth, J.P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact and recovery. *Professional Psychology: Research and Practice*, 24, 3, 293-303. http://dx.doi.org/10.1037/0735-7028.24.3.293

Hendin, H., Lipschitz, A., Maltsberger, J. T., Haas, A. P., & Wynecoop, S. (2000). *Therapist's reactions to patients' suicides*. American Journal of Psychiatry, 157, 2022-2027. https://doi.org/10.1176/appi.ajp.157.12.2022

Heron, M. U.S. Department of Health and Human Services. (2016). Deaths: Leading causes for 2013 (Volume 65, Number 2). Washington, DC: Public Health Service.

Hu, G., Wilcox, H. C., Wissow, L., & Baker, S. P. (2008). Mid-life suicide: An increasing problem in U.S. Whites, 1999-2005. *American Journal of Preventive Medicine*, 35, 589-593. http://dx.doi.org/10.1016/j.amepre.2008.07.005

Linehan, M. M. (1993). Cognitive-behavioral treatment of Borderline Personality Disorder. New York, NY: The Guilford Press. No DOI found.

Mehlum, L., Ramberg, M., Tørmoen, A. J., Haga, E., Diep, L. M., Stanley, B. H., Miller, A. L., Sund, A. M., & Grøholt, B. (2016). Dialectical behavior therapy compared with enhanced usual care for adolescents with repeated suicidal and self-harming behavior: Outcomes over a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55, 295-300. http://dx.doi.org/10.1016/j.jaac.2016.01.005

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). Dialectical behavior therapy with suicidal adolescents. New York, NY: The Guilford Press. No DOI found.

Panos, P. T., Jackson, J. W., Hasan, O., & Panos, A. (2014). Meta-Analysis and Systematic Review Assessing the Efficacy of Dialectical Behavior Therapy (DBT). *Research on social work practice*, 24(2), 213—223. https://doi.org/10.1177/1049731513503047

Parks, S. E., Johnson, L. L., McDaniel, D. D., & Gladden, M. (2014). Surveillance for Violent Deaths - National Violent Death Reporting System, 16 States, 2010. 63(SS01), 1-33. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Plakun, E. M., & Tillman, J. G. (2005). Responding to clinicians after a loss of a patient to suicide. *Directions in Psychiatry*, 25, 301-310. No DOI found.

Ruskin, R., Sakinofsky, I., Bagby, R. M., Dickens, S., & Sousa, G. (2004). Impact of patient suicide on psychiatrists and psychiatric trainees. *Academic Psychiatry*, 28(2), 104-10. http://dx.doi.org/10.1176/appi.ap.28.2.104

Schultz, D. (2005). Suggestions for supervisors when a therapist experiences a client's suicide. In K. M. Weiner (Ed.), Therapeutic and legal issues for therapists who have survived a client suicide: Breaking the silence (59-69). New York, NY: Haworth Press. https://doi.org/10.1176/ps.2006.57.7.1050

Tan, E., White, A., Homan, J., & Dimeff, L. (2017, November). Clinic Management and Recovery from Suicide. Workshop presented at the annual meeting of ISITDBT, San Diego, CA.

Identity Disturbance: Clinical Implications for DBT Treatment of Self Dysfunction in BPD

Lauren Bonavitacola[1,2] and William Buerger[1]

[1]Cognitive & Behavioral Consultants of Westchester and Manhattan, [2]Bonavitacola Psychological Associates, LLC

Introduction

IDENTITY DISTURBANCE is one of nine symptoms of Borderline Personality Disorder (BPD). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes identity disturbance as a "markedly and persistently unstable self-image or sense of self," (American Psychiatric Association, 2013). In Dialectical Behavior Therapy (DBT), the problem area of self-dysfunction, of which identity disturbance is a part of, is targeted by its listed antidote, the skill set of mindfulness. Outside of the acquisition and application of mindfulness skills, the DBT therapist is left with minimal direction for how to target this arguably primary and integral aspect of the BPD constellation of symptoms.

The authors provide guidance on how identity can be operationalized and assessed within a DBT model. Our intention will be to acknowledge ways that this concept is already understood and addressed within DBT and to suggest additional ways that we can apply a DBT frame to more specifically target identity disturbance in DBT. The LIVE skill will be presented as a novel skill addressing this problem area that therapists and clients can use.

What is Identity and Identity Disturbance, and How Can We Behaviorally Define It (Better)?

Little has been written on how to strategically and specifically target identity disturbance in DBT, which may be in part due to its unclear definition. Constructs that are harder to observe, such as "identity," can be difficult to operationally define, posing a challenge for behavioral treatments. Given that identity disturbance is indeed a symptom of BPD for which DBT is designed to treat, this question of how to measure identity and the disturbance of it is not theoretical; it is clinical. If we are to help our patients find a "life worth living," presumably we must also help them clarify who it is, i.e., their identity, that is living this life.

Although identity disturbance is not easily defined, Dr. John Gunderson, a prominent BPD researcher involved in further defining the BPD diagnosis for the DSM IV, defined this construct as frequent and suddenly changing goals, beliefs, vocational aspirations and/or sexual identity where people may also feel as if they are assuming the identity of other people to whom they are close (Gunderson, 2008). Linehan's original 1993 text posits that identity disturbance is a natural side effect of labile emotions that interfere with our ability to recall, regulate, and experience identity-related behavior and cognitions. Specifically, Linehan suggests that heightened emotion may result in a failure of memory during affective events, as well as in dysregulated behaviors and cognitions, making it difficult for patients and those around them to discern patterns that might characterize an identity. It is important to note that this dysregulation includes both heightened emotions and also its dialectical polar opposite, emotional numbness.

Taking into consideration the above, we propose defining a stable identity as a collection of interests, values, and mood states that persist across time and can integrate with others (i.e., can be impacted by others opinions, interests, values, etc., while not shifting entirely and impulsively based on them). Based on this definition, we can determine what we are actually measuring (e.g., interests, values, and mood states) to mark change, or consistency, over time.

Which DBT Skills Address Identity Disturbance?

The idea that emotion dysregulation plays a central role in identity disturbance and chronic feelings of emptiness is also supported by empirical research, which suggests focusing on mindfulness and emotion regulation skills when targeting these symptoms. In a study of participants with BPD who completed a 12-month comprehensive DBT program, overall DBT skills use was associated with significant reductions in various BPD symptoms, including identity disturbance as measured by the identity problems subscale of the Personality Assessment Inventory-Borderline Features Scale (PAI-BOR) (Stepp et al. 2008). When controlling for each module of DBT skills, only Mindfulness and Emotion Regulation skills significantly predicted a reduction in the identity problems subscale scores over time. In another study of a 12-week inpatient DBT program, Roepke et al. (2010) found that self-concept clarity (i.e., identity), as measured by the Self-Concept Clarity Scale (SCC), significantly improved from pre- to post-treatment in comparison to the waitlist control group. Their hypotheses as to which DBT skills most directly target this construct include validation, behavioral chain analysis, dialectical thinking, and mindfulness.

While these studies offer broad suggestions for categories of skills to emphasize, they do not provide specific suggestions for ways to instruct patients to use said skills. To help clinicians and patients better understand and assess progress with this construct, we propose the LIVE skill: Locate, Identify, Validate, Expect. In addition to the descriptions of each step of this acronym below, please refer to Table 1 and the corresponding LIVE handout for more clinical suggestions.

Locate pleasant and mastery activities using mindfulness

Awareness building via the practice of **mindfulness** is recommended in order to increase identification and engagement with interests, values, and characteristics. Similarly, mindfulness of current emotions, both in the moment and in reflection via diary card data, can help to build awareness of a person's typical

Table 1. Prompts for Therapists When Using the LIVE Skill

L	How did you feel when you did X activity? (e.g, joined a local sports league? Went for a walk with your neighbor? Watched a new movie? Read that article about a particular political belief?)
	When have you felt most alive? Most yourself? The most centered and connected to yourself?
	When have you felt the least comfortable? The least like yourself? The least connected with yourself?
I	What value(s) do your interests align with?
	Are you living in line with your values?
	Are you honoring your values in the activities you engage in, the people you surround yourself with, the way you represent yourself?
V	Are you judging yourself for your interests or values? How can you practice self-compassion about aspects of your identity you tend to judge?
	Are you relying on others' validation in order to feel secure in aspects of your identity?
	Are you changing your identity to match the identity of others around you?
	How does it feel when you own an aspect of yourself without shame and without seeking approval?
E	When identity confusion arises, ask questions to further enhance self-awareness such as: • Do you still value that? Why? • How do you feel when living in line with that value? • Why did you choose to wear that outfit, say that thing, join that club, attend that event? What values of yours are those things in accordance with and which are not? • Have you been honest with yourself and others about your interests and perspectives? • Do you need to use your FAST skill to stand up for your wise mind values, even if this means disagreeing with someone?

patterns of emotions over time. Both of these applications of mindfulness provide data to the client and the therapist alike — i.e., how is a person spending their time and what is the impact of that (positively or negatively) on their emotional state? From there, with the continued use of mindfulness, the puzzle can start to be pieced together towards a more stable identity. This may require **opposite action to fear and/or shame** to explore new things and to face the emotions that may come when trying a new activity. Through discussion in therapy, therapists can drag out this self-reflection and help patients start to further develop their identity.**Identify underlying patterns of interest and values**

As mindfulness of one's experiences allows the patient to recognize the specific activities that lead to pleasant/desired emotions, they can begin to incorporate these activities more strategically and frequently into their repertoire a la **accumulating positives in the short term**. The goal here is not only to increase the patient's mood, but also affirm that these interests and values are something they can and will engage with repeatedly. Specific behavioral targets could be set within the patient's diary card, and the clinician and patient could monitor whether engagement is increasing over time.

Once a category of one's self-identity is established, assisting patients to connect these activities to the broader values that they fall into, a la **accumulating positives in the long term**, can help with further deepening one's identity. Once values are established, they can become a guiding principle that the patient returns to when feeling lost or disconnected from their identity.

Validate interests and values internally and externally

The need to practice **self-validation** becomes the critical next step in preventing a person from being inconsistent. Exploring one's interests and values, and self-validating these discoveries, can help provide a grounding frame to return to when a patient experiences intense emotions and cognitions that prompt feeling disconnected from their identity. Additionally, how we understand ourselves is in part shaped by how we are perceived

(or imagine we are perceived) by other people. Seeking others who will also adopt a nonjudgmental or ideally positive stance towards the interests and values that are shared by the patient will be an important part of embracing these aspects of identity, and building a community that will encourage their continued development.

As with all of DBT, **wise mind** will play a large role in discerning when and where to seek out this validation from others. Identity disturbance can sometimes lead those with BPD to shift their interests based not on their wise mind but on what those around them like or value. Additionally, some people are not always able or willing to validate all aspects of one's identity, and can negatively judge, ostracize, or otherwise hurt others for characteristics that they deem unacceptable or different. Therefore, it is important for patients to enlist their wise mind to discern when, where, and from whom to seek validation.

Expect and troubleshoot internal and external obstacles

The path that follows is often littered with obstacles. Many will have anxiety about whether they will be successful in their pursuits, or accepted on the other side of them. Others will wonder whether they deserve their vision of a life worth living, or can tolerate the distress that lies between them and that at times distant future. The nature and difficulty of these obstacles will vary from patient to patient, influenced by multiple internal and environmental factors. As such, the steps for this stage are highly idiographic, with the ultimate guidance being "**Cope ahead**, troubleshoot, and do DBT." This is an ongoing and collaborative process, in which patient and clinician work together to continually assess for obstacles to engaging with these interests and values, anticipating that these obstacles will change as the patient successfully takes steps forward.

Patient Illustration

Imagine a patient who loves to cook but often feels intense feelings of shame, anger, and sadness when interacting with her colleagues at work where she is a line cook. In response to the intense work environment, she may start to have thoughts such as "I suck at my job," and "I'm not cut out to be a chef," leading to her quitting her job due to her efforts to inhibit shame. This is now the third career path that she has started and abruptly stopped. The emptiness that now comes from the lack of a job and the intense emotions that the experience of working at the restaurant prompted lead this patient to the new belief of, "I never enjoyed cooking after all," and further reinforces a lack of identity.

Applying the **LIVE** skill with this patient could look like the following:

- **L**- Ask the patient to practice mindful observation and monitor on their diary card how they feel while participating in cooking when at work or when at home. What do they notice?
- **I**- If the patient realizes they truly enjoy cooking, they can start to plan meals they would like to cook each day. Over time and with consistency, this patient may start to self-identify as "a person who enjoys cooking." They may realize that this activity falls within the value of creativity and now this value becomes another integrated aspect of their sense of self.
- **V**- As this patient moves through life as a cook, self-judgment can interfere with maintaining stability in line with this value. For example, she may get a new job and make a mistake on an order, leading her to thoughts of self-doubt (e.g., "I'm an awful cook, I'm not cut out for this"), and subsequently urges to quit. In these moments, she can remind herself that she truly loves cooking and has worked hard to get to where she is as a cook, so as to not give up. She may also choose to surround herself with others who support this aspect of her identity, e.g., working with a chef who can act as a mentor.
- **E**- If this patient deviates from this aspect of their identity because, for example, they stop making fresh meals in service of going out to eat most nights per week because their new partner likes to dine out, this may erode their identity as a cook. A more dialectical approach for this patient would be going out to eat some days per week while also honoring that they are an avid cook and want to make meals at home several days per week too.

Final Thoughts

Identity disturbance is a historically ill defined, and therefore difficult to measure, concept. By operationalizing it, we hope to make this core diagnostic feature of BPD more understandable to clients and clinicians alike. By proposing a novel skill, other than just the previously prescribed intervention of mindfulness, we hope to make identity disturbance more targetable and therefore changeable. With the LIVE skill, DBT practitioners who treat individuals with BPD and identity disturbance more broadly can guide patients in a concrete and structured way towards developing a more stable identity. As patients grow in confidence in their developing identities, our hope is that this leads to them experiencing a more fulfilling and balanced life worth living.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Gunderson J. G., (2008). Borderline

personality disorder: A clinical guide, 2nd ed. Washington, D.C.: American Psychiatric Publishing.

Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: The Guilford Press.

Roepke et al. (2011). Dialectic behavioral therapy has an impact on self-concept clarity and facets of self-esteem in women with borderline personality disorder, *Clinical Psychology and Psychotherapy*, 18, 148–158.

Stepp, S. D., Epler, A. J., Jahng, S., & Trull, T. J. (2008). *Journal of Personality Disorders*, 22(6), 549–563. personality disorder. Guilford Publications.

Payne, L. G., & Fruzzetti, A. E. (in preparation). Effects of brief, intensive BT parent skills training on suicidal adolescents: A randomized trial.

IDENTITY HANDOUT

Guidelines for Addressing Identity Disturbance: Building a Life Worth Living (LIVE)

Locate pleasant and meaningful activities using mindfulness

- ❑ Monitor engagement with interests, values, and characteristics
- ❑ Use mindfulness to clarify which activities increase and decrease positive emotions

Identify underlying patterns of interest and values

- ❑ Increase engagement with identified activities via accumulating positives in the short term
- ❑ Identify and increase engagement with patterns of interest and values via accumulating positives in the long term

Validate interests and values internally and externally

- ❑ Self-validate by reorienting towards interests and values while experiencing intense emotions and cognitions
- ❑ Build community by seeking validation from others who can validate said interests and values

Expect and troubleshoot internal and external obstacles

- ❑ Anticipate internal (e.g. anxiety, shame, self-doubt) and external obstacles (e.g., invalidating environments, applications, financial costs)
- ❑ Cope ahead, troubleshoot, and do DBT

Effective Use of Stimulus Control Strategies on DBT Consultation Teams

Aditi Vijay[1] and Alan E. Fruzzetti[2]
[1]Kean University, [2]McLean Hospital/Harvard University

DIALECTICAL BEHAVIOR THERAPY (DBT) rests on three foundational principles: acceptance (mindfulness, awareness, validation), change (behavioral or learning principles and behavior therapy) and dialectics, including a dialectical philosophy, dialectical assessment, and dialectical strategies and thinking (Linehan, 1993). These same foundational principles apply across all five modes of DBT (individual therapy, skills training groups, telephone and other coaching, social and family interventions, and DBT consultation teams). On consultation teams there is typically a lot of emphasis on acceptance, validation and mindfulness, in addition to dialectics. However, it may be less common to emphasize change principles as much. Based on the experience of both authors in consultations and trainings on DBT consultation teams, therapists express more comfort and consistency in providing cheerleading and validation as opposed to providing suggestions or a push for change (including "naming elephants"). Further, many DBT therapists are skillful in terms of incorporating a dialectical perspective by seeking multiple points of view but often less so at balancing the interactions among team members or differences in opinions. Of course, a dialectical stance also requires synthesizing the dialectical tension between acceptance and change on the team. Core behavioral strategies include: 1) behavioral assessment (chain analysis), 2) skill training/acquisition and strengthening, 3) stimulus control strategies, 4) exposure & response prevention (a special kind of stimulus control strategy), and 5) contingency management. This article focuses on ways to utilize the often-neglected stimulus control strategies to improve consultation team functioning. On teams, as in all modes of DBT, these behavior therapy strategies are essential to replace problematic links on a person's chain with skillful alternatives (new learning, generalization).

Overview of Stimulus Control

Stimulus control can be especially useful in two general situations: **1) problem behaviors are at least partially under the control of ordinary antecedents ("stimulus conditions"), or, 2) skillful alternatives should be (i.e., it would be much more adaptive to be) under control of existing stimuli.** For example, one common situation occurs when a car driver moderates her speed when a police car is present or when road conditions are slippery, and increases her speed when the conditions change (stimulus is removed). In behavior therapy terms, the behavior (speeding up, slowing down) is at least partially under the "control" of the situation (a police car or an icy road). This is adaptive, and the absence of this moderating effect would be problematic. Note for the behavior therapy geeks among us: In different situations the stimulus might be a "conditioned stimulus" (in classical conditioning) or a discriminative stimulus (in operant conditioning). For our purposes, we'll often not worry about the distinction, while acknowledging that it might be important at times. For now, we'll consider both types of stimuli as "antecedents" (and discuss discriminative stimuli in more detail below).

Sometimes, a stimulus communicates that a behavior won't work. **An "S-delta" describes a stimulus (or lack of a stimulus) that signals that a reinforcer is less likely if the person does a particular behavior in a particular circumstance.** For example, it isn't effective to "answer" a phone that isn't ringing. That is, the behavior is unlikely to work or get the person what they want under certain stimulus conditions: answering a phone that is not ringing will not result in a conversation with a friend. When something really should not cue up a behavior, but it does, that is also problematic and useful to consider. Answering any phone that's not ringing is problematic (active behavior in response to what really is an S-delta), and not answering your phone that is ringing is also problematic (the cue should pull for "answer it" but instead elicits "don't answer it"). On a DBT consultation team, setting the agenda is one cue (discriminative stimulus) that, hopefully, elicits interest in engaging and getting help and feedback and adding that to the agenda. If instead a DBT therapist does not identify topics for help and support, and fails to put them on the agenda, there has likely been maladaptive conditioning (operant, classical, or both).

Similarly, the absence of a behavior in certain situations is also important. For example, a judgmental or invalidating statement is unlikely to elicit warmth, kindness or increased connection in a relationship. DBT consultation team members must remain aware of both what is being expressed and what is not, and under what conditions (what is, and what is not, present in the meeting, or the "stimulus conditions" of the consultation team).

Consultation Team Example 1

Emma's consultation team members agreed to record their client sessions and share a clip of a session on a rotating basis during consultation team meetings to improve the effectiveness of consultation. Several months after agreeing to this, other members of her team have shown videos on multiple occasions, while Emma has not yet done so. The first time Emma was on the schedule she said that she was unable to record and the second time she told the team that she had another urgent matter for consultation, so they focused on that instead. When Emma missed her third scheduled time, she again asked the team to focus on a different urgent matter, the team decided to do a chain on Emma's behavior (not bringing a video for consultation).

Assessment of Cues

In this instance, the behavior (redirecting the team to an urgent matter...and not showing video) is under control of some variable(s): the antecedent(s) and/or consequence(s), or both (what we often call "controlling variables"). The first hypothesis might be that it functions to avoid showing session video, and maybe thus to reduce anxiety. But if we assume this and try only to block the avoidance, showing video could become more aversive for Emma in some situations, and just being in the consultation team meeting could be associated with that negative emotion (generalized). We can ask: "What is making this so difficult?" Maybe there are some maladaptive stimuli operating here and reconditioning them might help to block the avoidance without creating more aversive conditioning. Although it is most common to think that blocking avoidance or escape solves the problem, that may not always be entirely true. For example, the way we block could be aversive (demanding, embarrassing, judgmental, invalidating, etc.), and may not include enough understanding, or help, for the person to change (and have that change, or improvement, reinforced). Consequently, it is important to block and invite a new response so that exposure works (e.g., showing video) without unintended consequence (further aversive conditioning). Fortunately, most DBT therapists have a lot of skills to block in non-aversive ways once they are alert to the possibility of inadvertently falling into aversive conditioning.

Similarly, a chain can be approached in a variety of ways both by the person whose behavior is being analyzed and those conducting the analysis. The approach used to do a chain analysis can change the experience of it for both. For the other team members, genuine and clear curiosity (e.g., "It seems like it's not obvious how to do ___ differently. Let's do a chain and figure it out together") is likely to have a very different effect than a more frustrated or abrupt response (e.g., "let's do a chain"). The former likely leads to less negative emotion for Emma, increased learning and willingness and a deeper understanding. Over time, the simple, "let's do a chain" can be reconditioned not to be aversive, of course. For Emma, others' judgments and anger or frustration can condition the experience so that elements of the team become aversive stimuli (team consultation meeting overall, certain team members or situations, and so on). To be effective, everyone can start by activating their own wise mind. Notice that mindfulness (paying attention to something on purpose, in a particular way, with curiosity and not with judgments) is a stimulus control strategy. Mindfulness and even a bell (if used regularly in a pleasant way) can function as specific stimuli, inviting and reminding DBT therapists to remain in the present moment and approach each other with curiosity, kindness, and without judgments.

From a stimulus control perspective, understanding more specifically what is aversive about showing a video of her session can lead to reconditioning the situation/stimulus. In this way, stimulus control strategies make skill generalization possible, or at least easier to do. For example, the thought of being observed might elicit shame (or fear of criticism). To recondition the situation, team members can help Emma slow down and notice in the present moment that team members are curious instead of judgmental and want to be helpful (neither aversive nor treating her as fragile). Then, receiving effective feedback can reinforce showing video efficiently and the cues for negative emotion on the team become less aversive.

A discriminative stimulus signals that a reinforcer is more likely if the person does a particular behavior in that situation (in operant conditioning this might show up as SD). In other words, a discriminative stimulus sorts out or discriminates among the world of various stimuli and lets us know under which circumstances a given behavior likely will work. In this example, if Emma makes an effort to be descriptive and accurately expresses her reaction to showing a video it makes it easier for the team to validate and reinforce this behavior; avoidance behaviors are unlikely to elicit a similar response. This is also a place where team members can be helpful by eliciting (inviting) and then reinforcing certain behaviors (accurate expression, being descriptive) and not reinforcing ineffective behaviors (avoidance, general anxiety without a description). This process overall is a set of stimulus control procedures because it results in more effective cues eliciting effective behaviors (and thus facilitates skill learning and generalization).

Consultation Team Example 2

Dr. Patel is a new member on the DBT Consultation Team. She recently finished a clinical postdoctoral fellowship with a focus on DBT. Dr. Patel has had two meetings with her supervisor, Dr. Kennedy, in which Dr. Kennedy seemed to express doubts about Dr. Patel's competence and ability to carry her new case load. Dr. Patel now looks forward to the days when Dr. Kennedy misses the team meeting because she feels freer to ask questions or ask for help without "confirming Dr. Kennedy's negative appraisal" of her. In this example, Dr. Patel needs to ask for help and support from the team but does not do so when Dr. Kennedy, whom she perceives as judgmental, is present. The supervisor is now an S-delta for asking for help, which is problematic. That is, in the presence of her supervisor she does not engage in accurate expression nor seek needed support and/or adherence feedback. Note that identifying this situation as an S-Delta doesn't tell us *how* the stimulus

Table 1. Different stimulus conditions

Discriminative stimulus	Signals that in this particular situation one behavior (or a class of behaviors) is likely to work. That is, a particular behavior will be reinforced. It might "work" often, or intermittently, but often enough to reinforce the behavior and maintain the stimulus properties of the situation.
S-Delta	Signals that in this particular situation a particular behavior (or a class of behaviors) will very likely not work. "Not work" might mean extinction, punishment, or pairing with something aversive.
Unconditioned stimulus	This situation or stimulus naturally elicits a certain response (or a class of responses). We call these responses "unconditioned responses." You don't have to learn them or condition these responses.
Conditioned stimulus	After pairing often enough with an unconditioned stimulus, a conditioned stimulus will elicit the same response as the unconditioned stimulus. We call these responses "conditioned responses" because these responses do not naturally occur in the presence of the conditioned stimulus...only after repeated pairings.

became conditioned (e.g., punishment, extinction, classically conditioned, or lack of skill). Assuming that this is due to punishment is limiting because that would suggest only one solution: the supervisor has to change, unilaterally. One of the advantages of thinking about this as a stimulus control situation is that it facilitates dialectical or transactional thinking (Fruzzetti, 2022), and then all parties can focus on their own change to improve the outcome.

Dr. Patel's reluctance to ask for help potentially reinforces concerns the supervisor has about her competence and can create a problematic transaction. She "learns" that the best way to cope is by staying quiet and passive even though it will likely lead to job dissatisfaction and burnout, and further negative evaluations from her supervisor. Dr. Kennedy may, in fact, not be judgmental about Dr. Patel at all; however, the transaction is ineffective, so one or both must do something different to improve it. Just like our clients, we cannot expect supervisors/colleagues to be mind- readers. If she does not overcome the present barriers to engage in a difficult conversation, she likely will continue not to ask for help and support. It is clear that this is not a 'good' or effective situation for anyone – Dr. Patel, Dr. Kennedy or the consultation team – and it will affect overall team functioning negatively if it remains unaddressed.

Reconditioning the Stimuli and Cues and Presenting New Effective Cues

In this situation skills *are* the solutions, and it appears that Dr. Patel is having difficulty accessing those skills in this situation. We can safely assume that as a DBT therapist Dr. Patel has the necessary skills in her repertoire to ask for help. However, the conditioned cues from the social environment (potentially invalidating supervisor/fear and shame) are overwhelming her ability to access these skills. Employing stimulus control strategies first, before focusing on skills, could be helpful to change the relationship and make more effective skills use possible (e.g., opposite action).

Dr. Patel has several options: 1) recondition the stimulus (change how she experiences or reacts to her supervisor), 2) change (or introduce) other cues that help to elicit her skills; 3) recondition the current cues, or 4) utilize mindfulness as stimulus control. Reconditioning the stimulus could include, for example, engaging in a pleasant interaction with her supervisor in which Dr. Patel accurately expresses something about herself/her experience (maybe unrelated to DBT or her job) and the supervisor responds in a validating or otherwise collegial manner (or she asks Dr. Kennedy about something around which they have common interests). In this type of interaction, it would be important for Dr. Patel to be a bit more active and open than she usually is, so she is able to experience a different response from her supervisor. This approach also serves to change the intensity (level of validation) and frequency of the cue (differential responses from the supervisor). The supervisor's responses had become the antecedent for Dr. Patel's

behavior of disengaging and shutting down. Reconditioning or changing the cue could also change the transactional pattern that has developed.

Dr. Patel also could consider reconditioning the cue such that when she feels invalidated by Dr. Kennedy, she works towards finding a different way to respond. For example, if she can accumulate a few positive interactions, she might then be able to remind herself that Dr. Kennedy is not only invalidating, that they have some connection (relationship mindfulness). If she decides to use this kind of mindfulness as a stimulus control strategy, Dr. Patel can change how she pays attention in supervision thus changing the interaction in the moment as well as the ongoing transaction. Dr. Patel can employ these strategies without ever telling her supervisor about it and it may reduce the intensity of her negative emotions enough to engage skillfully describe how she experiences supervision more accurately.

Dialectics of Stimulus Control

Although this example is written from Dr. Patel's perspective, she is not responsible for all of the changes on her own. The team is there to help change some of the stimulus properties of Dr. Kennedy and the team and provide support to both. Over time, Dr. Patel's supervisor became an aversive stimulus for her AND she may have had a similar impact on the supervisor. If Dr. Patel is able to (slightly) shift her stimulus properties she might elicit a different response from the supervisor, which will then alter the transaction: this would be good for both, and also a dialectical solution. For example, this might involve putting herself on the agenda in a team meeting when Dr. Kennedy is present or asking for help in individual supervision from Dr. Kennedy. Ideally, however, Dr. Kennedy would respond with curiosity and compassion to these requests.

Based on the current state of the transaction it seems that any efforts Dr. Patel has made have not been effective. Therefore, they may need the help of the team to help the supervisor consider some changes. And Drs. Patel and Kennedy are not the only participants in the ongoing ineffective transactions and addressing these challenges is not solely Dr. Patel's responsibility. Team members are also participants who (we hope) notice the shifts in Dr. Patel's behavior on days when her supervisor is present or absent and respond with curiosity and determination. There may be a similar (ineffective) transaction between team members and the supervisee-supervisor pair: no team member has yet put this transaction on the agenda (either they have not noticed or avoided). Every consultation team member has the option and obligation to put it on the agenda in an inviting manner once they become aware of it. Putting it on the agenda in a welcoming way then becomes the antecedent stimulus for a conversation characterized by curiosity, descriptiveness, accurate expression and validating responses. If one team member puts it on the agenda (e.g., "I've noticed that Dr. Patel frequently does not ask for help. I want to be sure she is getting the support that she needs.") it allows the team to begin to understand the behavior and its impact on her clinical care, job satisfaction and burnout. It will also have an impact on the nature of the transaction between 1) Dr. Patel and Dr. Kennedy.; 2) Dr. Patel and the team; 3) Dr. Kennedy and the team; and 4) Dr. Patel/Dr. Kennedy and the full consultation team.

In conclusion, the role of stimulus control strategies is often overlooked on DBT consultation teams. We have provided a couple of common situations in which thinking about the role of stimulus control likely will lead to more efficient implementation, or generalization, of skills and can help make the consultation team a warm, helpful, and welcoming place for DBT therapists to get and give support, and to provide and receive expert help to deliver effective DBT.

Further Reading

Fruzzetti, A. E. (2022). Dialectical thinking. *Cognitive and Behavioral Practice*, 29, 567-570. DOI: 10.1016/j.cbpra.2022.02.011

Sayrs, J., & Linehan, M. M. (2019). A community of therapists: A manual for DBT consultation teams. In A. E. Fruzzetti (Series Editor) Guilford DBT Practice Series. New York: Guilford Press.

SIDEBAR: How do I apply this on my team?
Stimulus control is a set of behavioral principles. It can be used in a variety of ways which are dependent upon the situation. Instead of a prescriptive approach, here are some items to consider as you think about stimulus control and your own experience on your consultation team:

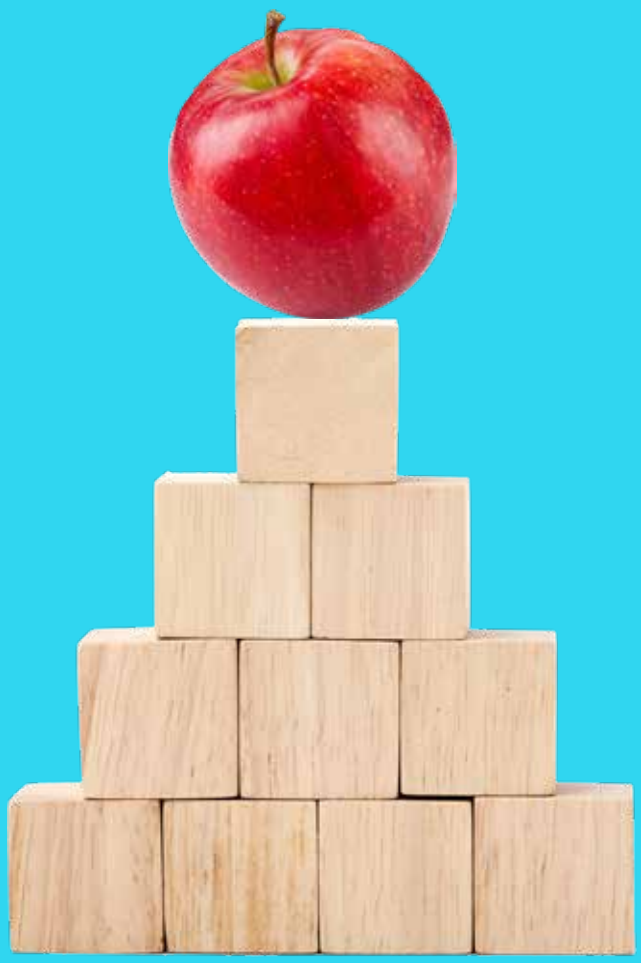
- What do you wish were happening on your team or what changes would you like to see? These might include more/less validation, more/less assessment before problem-solving, more/less change strategies, suggestions to improve adherence. What do you think are the factors (controlling variables) that influence what is happening or not happening?
  - ► This would be an appropriate agenda item for consultation team. A team chain analysis would allow for a look at the multiple factors that influence something happening or not happening on your team.

- Consider the degree to which you know your colleagues' experience on your DBT consultation team. Does this affect your ability to support their clinical work and provide consultation. It is important to note that we are not suggesting that team members must be best friends, of course. However, genuinely liking one another likely makes for a more pleasant team experience and **understanding another person's experience on your DBT team and a bit about their life** can lead to more effective and meaningful consultation.
  - ► Consider ways to incorporate relationship mindfulness exercises to help understand one another's experiences. These types of exercises are designed to help you get a glimpse into one another's experiences to gain a deeper understanding of the other person. Examples include noticing your curiosity about one another, having a conversation for a brief period of time about things that do not have to do with DBT or work, practicing accurate expression and/or sharing something about your life with each other.

- Select targets for your consultation team to work on together. Think about ways in which you think your team could function more effectively together to meet each member's needs to increase adherence and job satisfaction.
  - ► Are you working on improving adherence or obtaining certification or improving job satisfaction? How might you all work on these things together? What would a behaviorally specific goal be that allows you to problem solve effectively to get closer to that goal?

Help! I Need Somebody: The Role of Attachment in Contingency Management

Megan Plakos Szabo and Patricia Huerta
The Compass Behavioral Health Research and Training Institute



HAS THIS EVER HAPPENED TO YOU? You're working with a family to decrease an adolescent's life-threatening behaviors. You've assessed the function of the behavior and controlling variables. You've highlighted the problematic transactions to the caregivers, and the caregivers understand how they reinforce the behaviors they want to decrease. The caregivers agree to enact a comprehensive, collaboratively developed contingency plan, and you've helped the caregivers identify and practice any missing skills. You've addressed anticipated barriers to follow through, and you've used commitment strategies to increase their willingness. It's "go time!"

A week passes, and you're excited to hear about the caregivers' implementation of the contingency plan. They arrive to the session and sheepishly report that they didn't execute the plan. Your missing links analysis confirms that the caregivers were aware of the plan and the associated steps. So, what happened? When you inquire about barriers, the caregivers respond, "I didn't want to upset her," "she threatened not to talk to me," or "I hate being the bad guy." Caregivers often share concerns that implementing the plan would damage the relationship with their adolescent, which resulted in them avoiding executing the plan, even if doing so impacted their adolescent's safety.

Clinical Observations

We were eager to understand this avoidance pattern. Based on observations by our family therapists, we arrived at a hypothesis: lack of follow through with contingency plans stems from caregivers' (a) difficulties with emotion regulation and (b) preoccupation with or withdrawal from the caregiver-adolescent relationship. Caregivers who had difficulty regulating unwanted emotions or utilizing emotion regulation skills, along with caregivers who expressed anxiety or resignation about the relationship with their adolescent, seemed to exhibit greater willfulness implementing the plan.

Most caregivers with an adolescent in our program complete at least one round of Multi-Family DBT Skills Training Group (MFG), and many also participate in 1:1 "skills coaching" sessions to behaviorally rehearse missing DBT skills. Caregivers also have access to phone coaching with either their MFG leaders or family therapist. Even with opportunities to learn, practice, and generalize emotion regulation skills, some caregivers experience a "skills breakdown" when the perceived threat of damaging the relationship with their adolescent feels greater than the benefits of contingency management.

Correspondingly, our clinical team posits that caregivers' attachment styles, or their adaptive responses to perceived relationship threats, directly impact their willingness to employ contingency plans. Caregivers who display behaviors associated with secure attachment appear to be more willing to risk a relationship rupture from applying a contingency than caregivers who exhibit behaviors associated with insecure attachment. An insecure attachment style is void of the secure base from which a caregiver can take risks in the relationship like applying contingencies or aversive consequences. Furthermore, if a caregiver has witnessed their adolescent's suicidal behavior or its consequences, the fear inherent in an insecure attachment style may be heightened, thereby creating additional barriers to follow through.

Supporting Research

Stemming from our clinical observations, we turned to the literature on attachment, emotion regulation, and parenting practices to further inform our science-practitioner model. As proposed in attachment theory, all humans possess an inherent need for connection with primary caregivers, or attachment figures, and an innate behavioral system to obtain support to meet our needs (Bowlby, 1982). In response to their early caregivers' levels of accessibility, responsiveness, and consistency, individuals develop an attachment schema, or internal working model, and this attachment schema often carries into adulthood (Bowlby, 1982; Hazan & Shaver, 1987). When caregivers are perceived as accessible, responsive, and consistent, children are more likely to develop schemas and behaviors associated with secure attachment (positive view of self and others), and when caregivers are abusive, neglectful, or inconsistent, children tend to develop schemas and behaviors associated with anxious (negative view of self and positive view of others) and avoidant (positive view of self and negative view of others) attachment styles (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987).

At their core, attachment styles comprise of affective, cognitive, and behavioral strategies that can change, impede, or conceal the development, presence, and communication of emotions, and correspondingly, these attachment strategies aim to regulate emotions and influence individuals' affect, cognitive appraisals, and action urges (Gross, 2007; 2014; Brandão et al., 2019). Frequently, the strategies associated with an individual's attachment style activate in response to a perceived relational threat. For example, when a caregiver experiences conflict with their adolescent, they may perceive a relational threat and use hyperactivating attachment or attachment de-activating strategies to regulate their emotions based on the schemas that inform their attachment style (Brandão et al., 2019). Hyperactivating attachment strategies, typically used by individuals with an anxious attachment, encompass focusing on threat-related thoughts and

emotions and heightened experiencing and expression of unwanted emotions, while attachment de-activating strategies, often used by individuals with an avoidant attachment, include ignoring threat-related thoughts and emotions, denying and suppressing unwanted emotions, and inhibiting emotional expression (Brandão et al., 2019). As a result, a caregiver's attachment style may influence their selection of emotion regulation strategies, which may prevent or result in further conflict or withdrawal within the relationship.

Future Research

While considerable literature exists on caregiver-child attachment processes, less is known about the processes and impact of supportive relationships on caregivers' attachment styles, emotion regulation strategies, and parenting practices (Green et al., 2007). Existing research suggests that individuals who have supportive relationships, characterized by social support and interpersonal investment, tend to experience closer caregiver-child relationships and exhibit more effective parenting skills (Green et al., 2007). As a result, we hypothesize that the presence and quality of caregivers' supportive relationships may influence their expression of their attachment styles, as demonstrated by their emotion regulation strategies, and in turn shape their application of effective contingencies with high-risk adolescents. More specifically, if we support caregivers in accessing and enhancing supportive relationships, they may perceive caregiver-adolescent conflict as less threatening to their relational health and may be able to more mindfully choose emotion regulation strategies that support fulfilling contingency plans.

Our program hopes to collect additional observations on these proposed associations and invites feedback from the DBT community. If you are interested in future collaboration, please contact our research team at megan@compassbehavioralhealth.com or patricia@compassbehavioralhealth.com.

References

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61(2), 226-244.

Bowlby, J. (1982). Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry*, 52(4), 664–678.

Brandão, T., Matias, M., Ferreira, T., Vieira, J., Schulz, M. S., & Matos, P. M. (2020). Attachment, emotion regulation, and well-being in couples: Intrapersonal and interpersonal associations. *Journal of Personality*, 88(4), 748-761.

Green, B. L., Furrer, C., & McAllister, C. (2007). How do relationships support parenting? Effects of attachment style and social support on parenting behavior in an at-risk population. *American Journal of Community Psychology*, 40(1), 96-108.

Gross, J. J. (Ed.). (2007). Handbook of emotion regulation (1st ed.). The Guilford Press.

Gross, J. J. (Ed.). (2014). Handbook of emotion regulation (2nd ed.). The Guilford Press.

Shaver, P., & Hazan, C. (1987). Being lonely, falling in love. *Journal of Social Behavior and Personality*, 2(2), 105-124.

The All-in-One DBT Skills Handout

Shira Davis, Sarag Green, and Chaya Lieba Kobernick
The CBT/DBT Center

What Is It
The DBT Skills Master Handout is a one-page document that lists the DBT skills with concise explanations of the skill and/or what the acronym stands for. The skills are organized by module.

Why We Made It
In truth, it can be challenging for clients new to DBT to remember the skills when they need them. Although the skills are all listed and explained in depth in the DBT workbook, clients can sometimes feel lost or easily overwhelmed when needing to live skillfully. We therefore created a user-friendly and accessible handout with all the skills and a brief explanation to address this need.

How To Use It
The purpose of this handout is to make DBT skills as accessible and understandable as possible, so that clients can increase their skill use outside of session. Therefore, the handout is organized in a way to facilitate ease of use. The handout is a one-page document, making it feasible for clients to put it in their room, in their wallet, or as the wallpaper on their phone. It is intended to be utilized by anyone trying to live skillfully.

All in all, the DBT Skills Master Handout was created to be a straightforward guide for clients to remember and implement the skills that they learned in DBT. We hope this is a step in the right direction for more people to generalize their use of skills.

A Client's Story
One of our DBT clients struggled with learning skills, frequently stating "I'm just stupid" when her primary therapist and group co-leaders would encourage skills use. Through chain analyses, the client and her primary therapist discovered that the thought "I'm stupid" appeared when trying to learn something new. The client's vulnerabilities included a history of multiple sexual traumas and childhood neglect, which made it difficult for her to be successful in school, leading to the belief "I am stupid". This thought came up whenever the client tried to use phone coaching and couldn't remember a skill or struggled to complete home practice, preventing her from taking the next steps to become skillful. Although she wanted to use the DBT skills she was learning, her lack of memory led to frustration. In response, our team created the DBT Skills Master Handout to help her, and other struggling clients. This client was thrilled to receive the DBT Skills Master Handout, hung it up on her wall, and proudly refers to it during phone coaching calls, which has enhanced her confidence in knowledge, acquisition, and generalization of skills.

CBT Center
Real Results in Mental Health

DBT SKILLS MASTER HANDOUT

TheCBTDBTCenter.com

Mindfulness

Three States of Mind

Notice if you're in reasonable or emotion mind. Try to spend most of your time in Wise Mind - balanced, intuitive, respecting both reason and emotion.

What

Observe: Notice internally (thoughts, emotions, sensations) and externally (5 senses) without words
Describe: Label what you observed
Participate: Throw yourself into the moment

How

Non-Judgmentally: Stick to the observable facts
One-Mindfully: One thing at a time
Effectively: Focus on what works over what's right/fair

Distress Tolerance

Crisis Management:

STOP

S: Stop
T: Take a step back
O: Observe
P: Proceed mindfully

Pros and Cons

Make a chart (4 boxes) of the pros and cons of both engaging and not engaging in urges/behavior.
Label each pro and con as Short Term or Long Term.
Check which side has the most Long Terms.

TIP

Reduce super-high, body-based emotions:
T: Temperature
I: Intense Exercise
P: Paced Breathing
P: Progressive Muscle Relaxation

Self-Soothe

Use the 5 senses (plus movement) to get through a crisis

Distract with wise mind A.C.C.E.P.T.S.

A: Activities
C: Contributing
C: Comparing
E: with other Emotions
P: Pushing away
T: with other Thoughts
S: Sensations

I.M.P.R.O.V.E. the Moment

I: Imagery
M: Make Meaning
P: Prayer
R: Relaxation
O: One thing in the moment
V: Vacation
E: Encouragement

Radical Acceptance

Acknowledge treality and accept it when there is nothing left for you to do to change it.
Practice willing hands and half-smile.

Emotion Regulation

Check the Facts.

Observe and describe the facts of the situation. Does the emotion fit the facts or is it based on interpretations?
If it's ineffective, try opposite action.
If in crisis, go to crisis management skills.
If it can be solved, use problem solving.
If the emotion needs to be felt, give it mindful attention.

Problem Solving.

Identify what the problem and goal are and brainstorm different solutions. Try one and see if it works.

Mindfulness of Emotions

-Experience emotions like waves: observe them coming and going without holding on or pushing them away.

Opposite Action

When emotions are not serving us or not effective, act opposite to whatever the urge says to do

Reduce Emotional Vulnerability:

A.B.C.

A: Accumulate Positives. Mindfully participate in pleasant activities and take value-based action.
B: Build Mastery. Do something every day that gives you a sense of accomplishment.
C: Cope Ahead. Prepare the skills before the challenge Imagine coping well every day.

PLEASE

PL = Treat Physical Illness
E = Balance Eating
A = Avoid mood-altering substances
S = Balance Sleep
E = Get Exercise

Interpersonal Effectiveness

D.E.A.R. M.A.N.

Skills to Either Request or Refuse
D; Describe facts of the situation
E: Express feelings
A: Assert/ask for what you want
R: Reinforce - why is it worth it for them to do it?
M: be Mindful of your assert, be a broken record
A: Appear confident
N: Negotiate and be willing to compromise

G.I.V.E.

Build and Maintain Relationships
G: Gentle
I: act Interested
V: Validate
E: use an Easy manner

F.A.S.T.

Maintain Self-Respect:
F: be Fair to yourself and to the other person
A: no over-Apologizing for behavior or requests
S: Stick to your values and opinions
T: be Truthful - no excuses or exaggerations

Student Award

Yoel Everett, MA

PhD Candidate, at the University of Oregon (UO).

**Visit Dbtbulletin.org for full details.*

Recognized by Maureen Zalewski

Student Award

Sarah McHugh, PhD

University of North Carolina at Chapel Hill, postdoctoral fellow at Brown University/Bradley Hospital

**Visit Dbtbulletin.org for full details.*

Recognized by Andrea Gold

Student Award

Christine Bird, MA

PhD Candidate, at UCLA

**Visit Dbtbulletin.org for full details.*

Recognized by Hollie Granato

STUDENT AWARD NOMINATIONS

Recognize your outstanding trainee by submitting a brief description of what strikes you about their contributions, dedication to DBT and its foundations, and promise. Award recipients receive paid registration to ISITDBT

CALL FOR SUBMISSIONS

The DBT Bulletin is published as a service to the DBT community. Two issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of recent advances, research findings, innovative applications of Dialectical Behavior Therapy, and diversity and professional issues related to DBT.

- *Brief articles, less than 1500 words, are preferred.*
- *Research articles should be accompanied by a 75 to 100 word abstract with citations in APA format.*
- *Creative submissions, involving multimedia, are welcomed.*
- *Letters to the Editor, sometimes termed "Devil's Advocate," may respond to articles previously published in the DBT Bulletin or to voice a professional opinion. Letters should be limited to 500 words.*

Electronic submissions should be directed to the editors, at dbtbulletin@gmail.com. Please include the phrase Bulletin submission and the authors last name in the subject line of your email. Include the corresponding author's email address on the cover page of the manuscript attachment.