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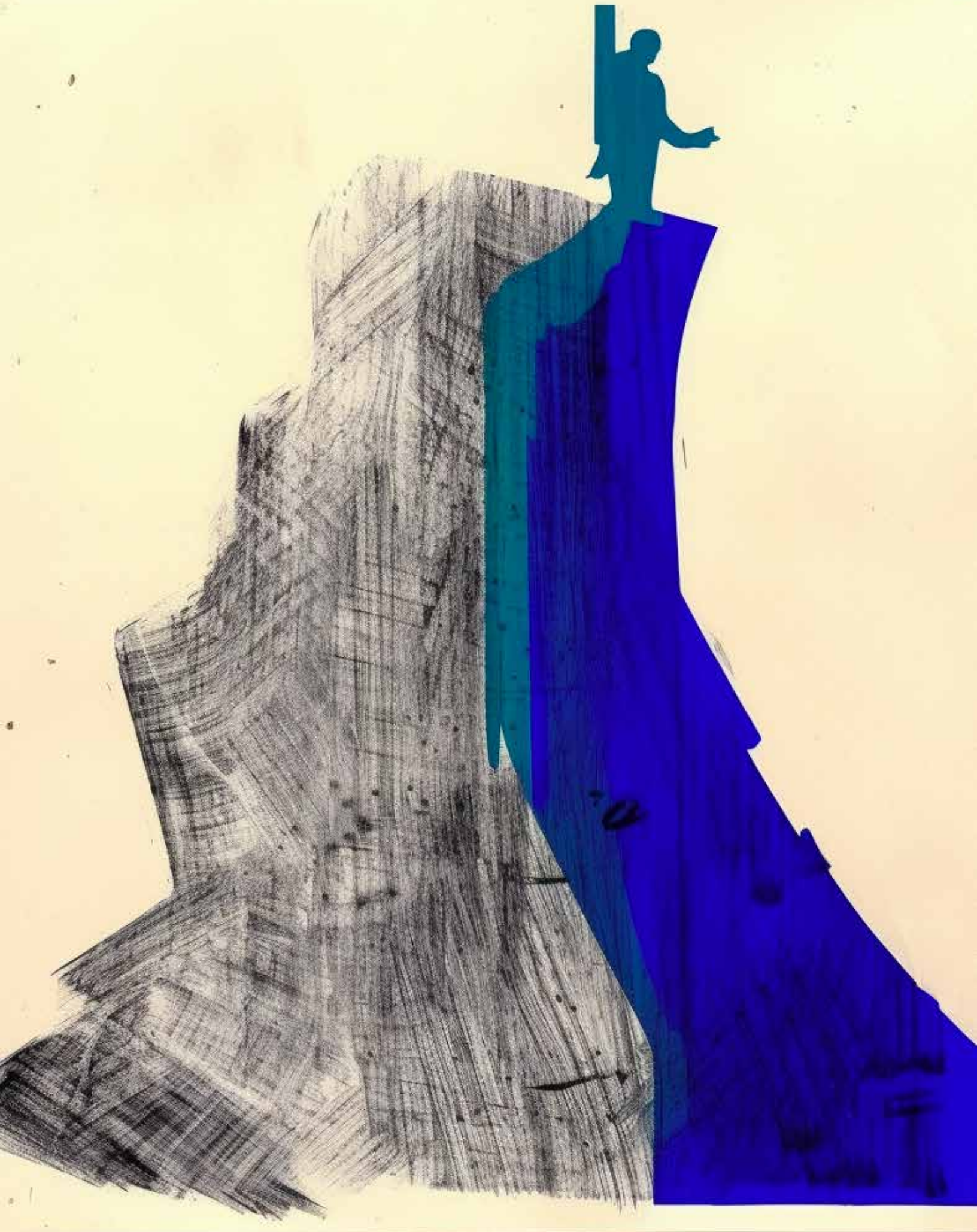
Editor's Letter

Before our minds completely turn to summer, travel, international conferences, and floating in a pool (or maybe that's just me), let's take a look all the back to November. This issue is the fruition of a dream. we have long wanted the DBT Bulletin to serve as a forum for the amazing work done at and by ISITDBT. For attendees of the conference, you well know the high caliber of work that gets delivered every year. Like many of us, you have also probably tried to make sense of the slides later, or remember the outcomes cited at the conference. Well fret no further, this issue is all about ISITDBT 2022. We invited the keynotes to write up their talks and workshops for us. They delivered. We have two articles on diversity issues, one focusing on participatory research, one on anti racism in our clinical work. We have an article on involving family members in DBT adapted for multiple sclerosis patients and their families, as well as one on involving partners in standard DBT. We have works on the importance of phone coaching (and not ruining your life), dialectical dilemmas and strategic interventions, and and preliminary results from an RTC on digital DBT. In addition to the selected proceeds of the conference we are delighted that we have a first person poem (that brought tears to my eyes), an interview with two DBT leaders on the challenges of starting and sustaining programs, and our first President's column from the leadership at ISITDBT. They trace the history of ISITDBT and transparently discuss the challenges and vision for the future. We at the Bulletin are honored to serve as the forum for this discussion. Please enjoy

Lynn McFarr
CBT California



Transparently Describing the Structure and Functioning of ISITDBT

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The purpose of this article to transparently describe the structure and functioning of the International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISITDBT). ISITDBT is a non-profit, volunteer organization originally developed to organize an annual conference to bring together DBT clinicians and researchers from the United States and around the globe. The most recent conference in November 2022 in New York City marked 27 straight years when there has been an annual conference. ISITDBT is independent from other organizations, which many individuals in the DBT world may know, like the DBT Linehan Board of Certification (DBT-LBC), the Behavioral Research and Therapy Clinics (BRTC) at the University of Washington, and the various training organizations that focus on DBT trainings. ISITDBT maintains a website where individuals can find information about the organization and conference at www.isitdbt.net. ISITDBT is an independent organization with legally filed bylaws, the latest iteration of which were approved by the board in 2021.

Currently, there are four main "modes" of ISITDBT: the annual conference, the board, the anti-racism committee, and the listserv. The conference is held every year on the Thursday before the annual conference of the Association of Behavioral and Cognitive Therapies (ABCT). The space for the conference is generously donated by ABCT. At the conference each year one of three major awards is given (i.e., they are rotated so that each award is given once every three years). The three awards are: The Perry Hoffman Service Award, The Cindy Sanderson Educator Award, and The ISITDBT Researcher Award. A call for nominations and description of the relevant award is sent out during the summer before the conference. Additionally, a grant is given to a student researcher and an award is given to the best student research poster. All fees collected from the conference are used to fund the expenses of the conference and to support the functioning of ISITDBT (e.g., legal fees, web support, etc.).

The ISITDBT board is made up of the president, vice-president, treasurer, secretary, conference co-chairs, and members at large. Currently, the board has eight members, although the board may expand when needed to address the increasing demands of the work of ISITDBT. The board has established a process for new board members to join that creates an equitable chance for qualified individuals to apply. A call for applications is sent out when board seats need to be filled. The most recent application asked applicants to provide information including frequency of attending the ISITDBT conference, DBT training, time practicing DBT, relevant DBT research experience, and if they are DBT-LBC certified. The existing board then reviews and ranks the applications and extends invitations to join to the candidate(s) ranked most highly. In special circumstances, the board may directly invite highly qualified candidates to join the board. Board member terms typically last five years.

ISITDBT has also established an anti-racism committee in order to advance the need to enhance anti-racism work in ISITDBT and in the DBT world more broadly. The vision statement of the anti-racism committee is: "The ISITDBT Anti-Racism Committee actively promotes culturally-responsive and anti-oppressive practices in the Dialectical Behavior Therapy (DBT) community. Our approach and goals include utilizing an anti-racist and intersectional lens, making DBT accessible to Black, Indigenous, and People of Color (BIPOC) clinicians and clients, and using DBT to improve DBT". The members of this committee work diligently and in conjunction with the ISITDBT board to advance this vision.

Finally, ISITDBT is the "owner" of the DBT listserv, although the listserv generates no revenue. The listserv is meant to serve as a forum for DBT providers to consult with each other about various questions and topics related to DBT. Portland DBT Institute generously and voluntarily hosts and administers the DBT listserv. DBT providers who are interested in the listserv may join at the following website: https://www.pdbti.org/dbt-l/.

An Entirely Too Brief Description of the First 23 Years of ISITDBT

While the focus of this article is to describe the current functioning of ISITDBT, we would be remiss to not describe a bit about the history of ISITDBT. It is with gratitude that the authors acknowledge the contributions of the many volunteers who steered

ISITDBT to its more recent iteration. The authors of this article joined the board in 2019 (NS and AY) and 2022 (MZ) respectively. Through the years, many individuals have volunteered countless hours to establishing, maintaining, and growing this organization. The first ISITDBT conference was chaired by Dr. Charles Swenson and held in 1996. The organization sprung from the work and guidance of Dr. Marsha Linehan, who developed DBT. With Dr. Linehan's retirement, the organization has worked to adjust to the absence of her leadership and to stay true to the mission of ISITDBT. The original mission of ISITDBT remains embedded in the organization. The bylaws state that the purpose of ISITDBT is: "to advance a scientific approach to the understanding and amelioration of emotion regulation problems across a continuum, from severe and high-risk mental disorders and suicidality to other challenges related to emotion regulation." This is accomplished by, "improving access to DBT through teaching DBT and holding conferences focused on the advancement of DBT."

The Last Four Years: The Present State of ISITDBT

ISITDBT underwent a number of significant changes since 2019, catalyzed by the need to increase anti-racism work in DBT and the COVID-19 pandemic. The bylaws adopted in 2021 state that ISITDBT is "to carry out its purpose while providing an inclusive environment that is anti-racist, feminist, and welcoming to all regardless of their race, gender, religion, sexuality, disability status, country of origin, educational or socioeconomic background or any legally protected status." ISITDBT established an anti-racism committee to help accomplish this mission. This is an active committee, meeting one or two times per month to advance anti-racism work. The committee maintains a website with valuable information including anti-racism resources: https://isitdbt.net/anti-racism/. The committee also facilitates regular meetings and networking for Black, Indigenous, and People of Color (BIPOC) DBT providers. Interested clinicians can find information about joining the BIPOC DBT providers group at the anti-racism website. The anti-racism committee has also provided invaluable contributions to the annual conference by facilitating presentations on anti-racism and ensuring that anti-racism work is embedded throughout ISITDBT. ISITDBT has also established a fund to support BIPOC community members in attending ISITDBT and DBT trainings, and to support research on applying DBT to diverse populations. Donations to this fund can be made at the following website: https://isitdbt.net/contribute/.

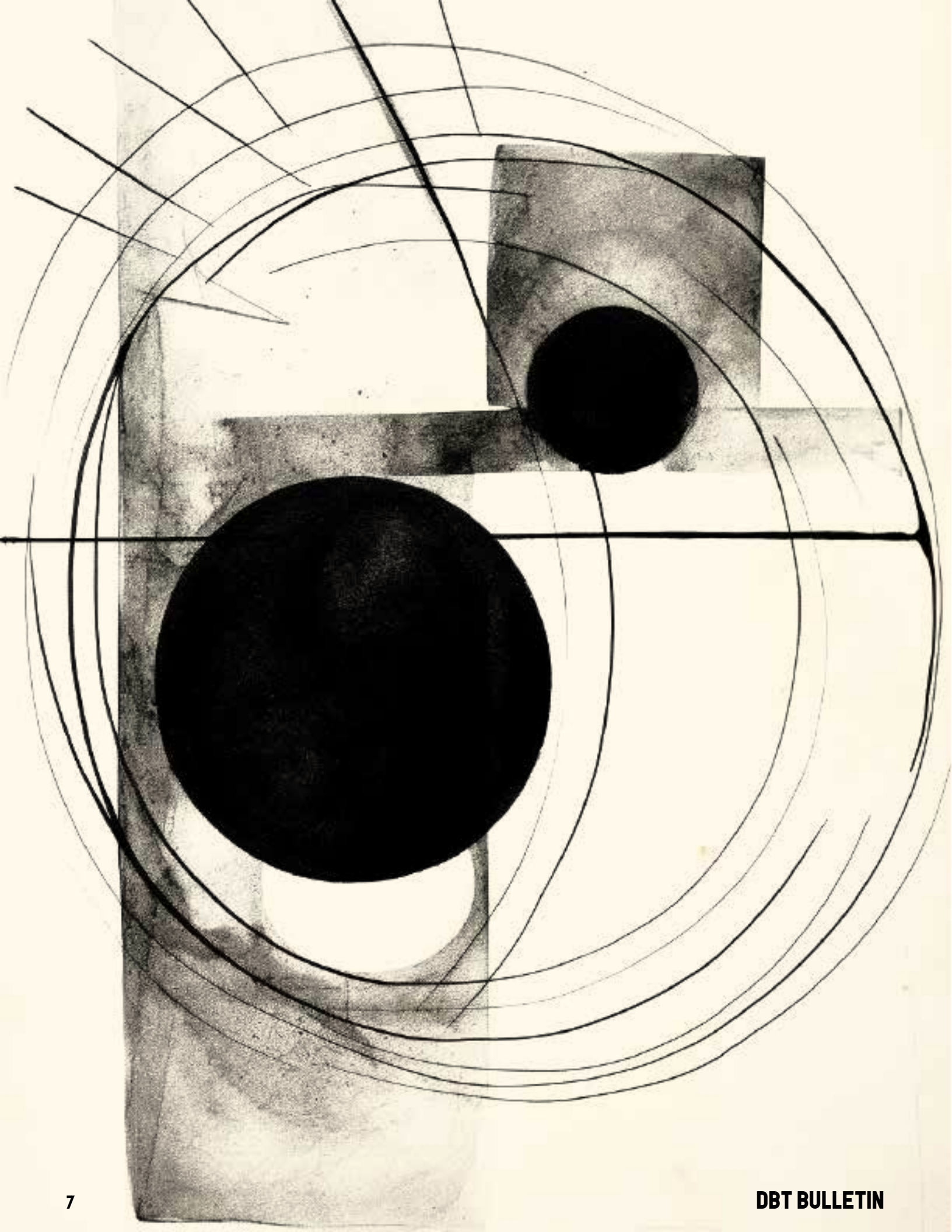
Due to the COVID-19 pandemic, the 2020 ISITDBT conference was presented online for the first time. The board learned a clear lesson from this conference: online availability of the conference greatly increases accessibility. Prior to 2020, the record attendance for ISITDBT was just over 500 people. Each conference with online availability increased attendance to nearly double the previous record with the current record being over 1000 participants, including individuals from over 20 countries. It became clear that, when possible, having online availability of the conference advances the mission of improved inclusivity through accessibility. Nonetheless, this change significantly increased demands to navigate learning how to provide an online conference and then in 2022, a hybrid conference.

Due to the important work needing to be done by ISITDBT, the board has undergone some significant changes in recent years. In order to address the increasing demands and complexity of the work, in 2020, the board changed from meeting once per year to meeting monthly. The board has also worked to increase openness and transparency in joining the ISITDBT board. In addition, by working with a lawyer to file the bylaws, the board has also registered as a 501c3 non-profit organization. The goal is that these changes help fortify ISITDBT for the future.

What Does the Future Hold for ISITDBT?

ISITDBT will continue to work to advance the science and adherent practice of DBT. The board and the organization as a whole will continue to dedicate significant effort and resources toward anti-racism in DBT. Accessibility and inclusivity will be prioritized. ISITDBT is an entity that brings together DBT practitioners to advance the mission of reducing suffering through science. The World DBT Association (WDBTA) is an emerging organization with significant overlapping goals. The board anticipates supporting WDBTA in ways that mutually advance both organizations.

As has been true in the last 27 years, the future of ISITDBT depends on the participation of the people who make ISITDBT a wonderful organization. The members of the board have gratitude for all who have and continue to support ISITDBT by attending the conference, presenting at the conference, volunteering for the organization, and conducting the science and practice of DBT. It is a privilege to be a part of ISITDBT and the board is grateful to all of you.



Incorporating Partners into BPD Treatment: Leveraging the Interpersonal Context of BPD

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PEOPLE WITH BORDERLINE PERSONALITY disorder (BPD) report a range of problems in their relationships in general, and especially in their intimate relationships. In particular, nearly 60% of adults with BPD are in a long-term marriage or cohabitating intimate relationship (Zanarini et al., 2015), and intimate relationships in BPD involve high rates of conflict, distress, breakups, and violence (Bouchard et al., 2009, Lazarus & Cheavens 2017; Navarro-Gomez et al., 2017). Accordingly, BPD not only affects those with the disorder, but also their significant others. Indeed, significant others of people with BPD experience higher distress, grief, burden, and depression than those of inpatients with other severe mental illness (Bailey & Grenyer, 2013).

How do Interpersonal Processes Contribute to BPD Maintenance?

In our ISITDBT presentation (November, 2022), we argued that people with BPD are overly attentive to, and perceptive of, threat in their relationships, and have difficulties communicating effectively. We further argued that these problems may be exacerbated by emotion dysregulation processes, and create a critical context that elicits emotion dysregulation. Although a central assumption of DBT is that emotion dysregulation is the key driver of BPD symptoms (Linehan, 1993), evidence for the unique nature of emotion dysregulation in BPD relative to other disorders is mixed at best (e.g., Chapman et al., 2009; Rosenthal et al., 2016). Instead, studies show that people with BPD exhibit dysregulated emotion specifically in response to interpersonal stressors (e.g., rejection), but not intrapersonal ones (Elices et al., 2012; Sauer et al., 2014). In fact, over 73% of first suicide acts in people with BPD follow an interpersonal stressor (Brodsky et al., 2006). Furthermore, individuals who experience remission from BPD are more likely to have non-distressing intimate relationships than those who do not remit (Zanarini et al., 2015), emphasizing the role that intimate relationships can play in recovery.

In response to such research, members of our team developed the Borderline Interpersonal-Affective Systems (BIAS) model (Fitzpatrick et al., 2021), which conceptualizes BPD as both an interpersonal and emotional disorder. The model asserts that individuals with BPD have a heightened sensitivity to interpersonal threats (e.g., scrutiny or rejection), which leads them to experience emotion dysregulation in response to interpersonal cues. We also suggest that individuals with BPD experience difficulties effectively communicating when they perceive interpersonal threats, either expressing inaccurate secondary emotions (Fruzzetti & Fantozzi, 2008), avoiding sharing their emotions, or engaging in unhelpful communication behaviors (e.g., hostility, contempt). Ineffective communication makes it difficult for partners to engage in behaviors that could regulate the individual with BPD's emotions or correct the perception of interpersonal threat and may even elicit unhelpful responses from partners (e.g., individuals with BPD expressing secondary anger, leading to partners becoming defensive and invalidating the person with BPD; Fruzzetti & Fantozzi, 2008). These transactions therefore elicit and exacerbate emotion dysregulation. These emotional and communication problems are theorized to lead to destructive behaviors (e.g., self-injury). Importantly, these kinds of processes do not occur in a vacuum — instead, they interact with the significant others' beliefs, emotions, and communication patterns. We believe that significant others often have their own unhelpful beliefs about emotions and/or individuals with BPD, which contribute to their own dysregulated emotions and communication problems in response to interactions with people with BPD. These dysfunctional emotional and communication patterns between people with BPD and their significant others inadvertently escalate miscommunication and distress for both parties, and ultimately work in tandem to maintain BPD.

If we think about BPD in this way our approach to BPD treatment changes. First, if both emotion and interpersonal dysregulation are driving BPD, it is important to target both processes in tandem to optimize treatment outcomes, rather than centralizing emotion dysregulation. Although Dialectical Behavior Therapy (DBT) offers skills to navigate interpersonal situations (Linehan, 2015), many DBT clinicians do not routinely incorporate significant others to directly target and enhance

relationship functioning. Second, given data suggesting that destructive behavior is particularly likely to serve interpersonal functions in BPD (e.g., Gardner et al., 2016), changing significant others' responses may extinguish rather than reinforce destructive behaviours. Incorporating significant others into treatment therefore offers key opportunities to directly alter contingencies that maintain target behaviors. Third, working to treat not only the individual with BPD but also the relational contexts within which they are embedded has the potential to construct a more supportive environment — one that elicits, reinforces, and maintains skillful behavior, rather than punishing or extinguishing it. Finally, as significant others experience mental health challenges and little access to support, incorporating them into treatment offers the potential to improve their well-being alongside that of individuals with BPD.

Key Treatment Targets when Incorporating Partners into BPD Treatment

Our ISITDBT presentation therefore outlined several key treatment strategies that we have developed to incorporate significant others into BPD treatment. These strategies were developed in the context of a trial that we are conducting to test a couple intervention for BPD (Fitzpatrick et al., 2022), and its primary results are forthcoming. It is therefore important to note that the efficacy of such dyadic interventions for BPD still require empirical scrutiny, and we look forward to continuing to test them. With such caveats, below we outline some key strategies for incorporating partners into BPD treatment.

Interpersonal Distress Tolerance Skills

Like individuals in DBT, couples need dyadic distress tolerance skills to get through high intensity conflict without damaging the relationship or engaging in destructive behavior (Fruzzetti, 2006; Fruzzetti & Fantozzi, 2008). Intense conflict can maintain or even exacerbate intense emotions and can lead to individually damaging behavior (e.g., self-injury), as well as harm to the relationship. Further, histories of intense conflict can make couples more vigilant for, and reactive to, future instances of conflict, perpetuating people with BPD's sensitivity to interpersonal threat. Therefore, couples benefit from learning how to disengage from each other when conflict is intense. To this end, we routinely teach couples a "Time-Out" skill derived and modified from Cognitive/Behavioral Couple Therapies (e.g., Jacobson & Margolin, 1979; Monson & Fredman, 2012) using the acronym STOP:

1. Self — Each member of the couple is asked to monitor their emotions and their intensity. Telling someone else to take a time-out tends to escalate conflict, so we emphasize that, when someone calls a time-out, it is for themselves, it is not called on their partner.
2. Time-out — When a time-out is needed, we ask the person to clearly signal it to their partner using previously agreed-upon verbal and non-verbal cues, at which point communication stops. Clients are then asked to pre-emptively agree on the length of the time-out and when/where they will return to communication.
3. Outlet — Once separated, a client can use DBT-informed crisis survival skills (Linehan, 2015), and reflect on how to better communicate key issues from the conflict.
4. Process — It is important that communication resumes after the time-out so as not to facilitate avoidance, with renewed focus on the issues that were clarified during the outlet.

Interpersonal Emotion Regulation Skills

If enhancing emotion regulation is central to improving the emotion dysregulation that theoretically drives BPD (Linehan, 1993), and emotion dysregulation is often an interpersonal process (Fitzpatrick et al., 2021), then reorienting interpersonal transactions to be regulating rather than dysregulating is a key treatment target. We argue that effective communication of emotions and supportive responses are inherently regulating to emotions. When both members of a dyad effectively communicate emotions to each other and receive validation and understanding in return, people with BPD may experience corrective learning that can alter interpersonal threat sensitivities that may elicit emotion dysregulation in the first place. We therefore teach couples interpersonal emotion regulation skills to help them identify and express emotions to each other, and to respond to these communications in regulating and intimacy-enhancing ways. As one example, we developed the I-FEEL skill to provide couples with steps they can take to communicate effectively when emotions are high and collaborate on deciding a skillful response to an emotion and its urges. Using the I-FEEL skill, when a member of a couple notices that they are experiencing intense and negative emotions, they are asked to:

1. Identify their emotions;
2. Feel them in the body (to block emotional avoidance); and
3. Express the emotions to their partner.

Partners are then asked to respond in a regulating way by:

4. Expressing validation and
5. Looking at the options together, by openly discussing whether acting on emotional urges will be effective or not, and deciding on a plan for responding to the emotion.

Enhancing dyadic emotion regulation also requires identifying and targeting ways that individual members of a couple avoid their own and each other's emotions, and how interaction patterns can operate to facilitate emotional avoidance. Emotional avoidance, while temporarily offering relief from distressing emotions, may obstruct people with BPD's capacity to build distress tolerance and learn adaptive emotion regulation skills. It also prevents opportunities for building emotional intimacy between members of a couple. Low emotional intimacy can further exacerbate emotion dysregulation because it does not allow for perceived interpersonal threat (e.g., "I can't trust my partner", "My partner is going to reject me") to be corrected, decreases couples' potential resiliency against conflicts that may be dysregulating to someone with BPD, and potentially reflects aspects of an invalidating environment that punishes emotional expressions.

Interpersonal Contigency Management

Finally, we have found that partners often inadvertently reinforce destructive and ineffective behaviors in a myriad of ways. For example, partners may increase care or concern in response to self-injury or ineffective communication of suicidal ideation, thus reinforcing self-injury or suicidal behavior as a pathway to increased care and support. Similarly, partners may take over responsibility for implementing a safety plan, diminishing the opportunity for the individual with BPD to learn and strengthen skills needed to promote their own safety, and reinforcing potential passivity in people with BPD during life-threatening crises when activity is needed. We encourage therapists to watch closely for contingencies that, in the short-term, facilitate avoidance or escape from emotions, thereby preventing people with BPD from learning to use skills autonomously and reinforcing the use of destructive behaviors in the long-term. Clinicians and couples can collaborate to alter these contingencies, including asking partners to reinforce skillful rather than unskillful behavior and openly discussing ways that partners can observe their own limits in crisis situations.

Conclusions

One of the core assumptions of DBT is that clients need to learn skills in every relevant context (Linehan, 1993). The data is clear that one of the most critical contexts for people with BPD is interpersonal, and we have an important opportunity to bring that context into treatment by incorporating significant others. BPD wedges itself between people with the disorder and their significant others, and in doing so impacts more than the person with the diagnosis. Dyadic BPD treatments offer us the opportunity to unite people with BPD and their significant others against the problematic behaviors that torment them both and leverage their intimacy to promote individual and shared lives worth living.

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Multiple Sclerosis and Support Partners: DBT as a Transdiagnostic Intervention for Reducing Depression and Anxiety Symptoms

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DIALECTICAL BEHAVIOR THERAPY (DBT) is as an effective treatment for individuals at increased risk for suicide who also present with other difficult-to-treat comorbidities (DeCou et al., 2019). DBT is also effective for heterogenous mental health disorders (Delaquis et al., 2022; Harned & Botanov, 2016; Miga et al., 2018). Although traditional intervention trials typically require homogenous disorders and populations, the growing literature on transdiagnostic application of DBT, particularly skills training, allows for group treatment with a wider and more diverse range of participants. Trials demonstrating DBT's efficacy for depression and anxiety (Harned & Botanov, 2016), use with neurologic populations (Backhaus et al., 2019; Drossel et al., 2011), efficacy for partners and family members of individuals with mental health disorders (Wilks et al., 2017), and as a treatment with caregivers and support partners (Backhaus et al., 2019; Drossel et al., 2011) indicate that DBT may be an ideal fit for individuals with multiple sclerosis (MS) and their support partners. To explore feasibility and further develop the evidence-base for DBT as a transdiagnostic treatment with neurologic populations, we conducted a pilot randomized controlled trial (RCT) of DBT skills training for individuals with MS and their support partners presenting with elevated symptoms of depression and/or anxiety (Hughes et al., 2022).

Methods and Results

Full details about methods are available in the original article (Hughes et al., 2022). In brief, the study was a single-masked, two arm, parallel group pilot 12-week RCT. Due to the onset of the COVID-19 pandemic, treatments were provided via remote delivery through HIPAA-compliant Zoom with participants and treatment providers typically attending sessions from home. Depression and anxiety symptomatology was measured via the Hospital Anxiety and Depression Scale (HADS, Zigmond & Snaith, 1983; Watson et al., 2014). For inclusion, individuals with MS were required to score ≥ 11 on either the Anxiety (HADS-A) or Depression (HADS-D) subscale of the HADS and partners were required to a score ≥ 8 on either subscale. Secondary outcomes examining emotion dysregulation were measured via the 16-item Difficulties in Emotion Regulation Scale (Bjureberg et al., 2016; Gratz and Roemer, 2004) and well-being was measured via the RAND 36-item Short-Form Survey (Hays et al., 1993). To increase internal validity, DBT skills training was compared to an active control group, facilitated peer support (FPS).

The control condition, FPS, was co-led by two licensed clinical psychologists with formal postdoctoral training in MS rehabilitation, and an advanced doctoral student who completed prior supervised training in group intervention. The protocol followed key themes from publicly available education resources from the National MS Society (2016; 2019). Sessions began with introductions and brief check-ins, followed by weekly facilitated discussion, and ending with members' feedback and interactions. The FPS group did not focus on skills training or psychotherapeutic treatment. The experimental condition, DBT skills group, was co-led by a licensed clinical psychologist with formal postdoctoral training in DBT, and an advanced doctoral student who completed the DBT Foundational course (Behavioral Tech, LLC). Aside from individual therapy, all other modes of DBT were included; out-of-session coaching was available and group leaders met weekly as a DBT consultation team. Due to the pilot design for this RCT and a need to reduce the length of treatment compared the typical DBT protocol, the DBT skills schedule was adjusted to 12 weeks and included three modules (mindfulness, interpersonal effectiveness, and emotion regulation, see Table 1). Forty individuals (20 patient-support partner pairs) were recruited for the trial, with 10 pairs randomized to each condition.

At post-treatment, participants randomized to DBT skills exhibited lower total HADS, HADS-A, and HADS-D scores compared to participants randomized to FPS, with moderate effect sizes (Cohen's ds) ranging from 0.50 to 0.60 and statistically significant beta coefficients for group differences on the total HADS and HADS-A (ps = .04), but not HADS-D (p = .10). At 3-month follow-up, effect sizes were generally small (ds < .04) with non-significant beta coefficients (ps > .05). Secondary outcomes examining emotion dysregulation and well-being favored the DBT group, with

moderate effects sizes of 0.50, but did not reach statistical significance (ps = .07).

Feasibility and satisfaction data show that most (86%) individuals screened were eligible for the trial and study retention was acceptable (70%), with no differences in attrition between groups. Treatment completion (defined as attending ≥ 9 out of 12 sessions) did not differ between groups and was acceptable (60%). Compared to FPS, individuals in DBT skills training reported significantly greater perceived benefits interpersonally, with a large effect size ($t = 2.08$, $p = .02$, $d = 0.79$). There were no differences in overall perceived benefits or satisfaction across groups, with both groups reporting moderate overall benefit (Ms > 63 out of 100) and high overall satisfaction (Ms > 8 out of 10).

Table 1. List of Skills Covered within Pocket Skills.

Session	Module	Skills
1	Mindfulness	Goals, guidelines, Wise Mind, What Skills
2	Mindfulness	What Skills and How Skills
3	Interpersonal Effectiveness	Goals of IE, Factors
4	Interpersonal Effectiveness	DEAR MAN
5	Interpersonal Effectiveness	GIVE, Validation
6	Interpersonal Effectiveness	FAST, Evaluating Options, Dialectics
7	Mindfulness	Goals, guidelines. Wise Mind, What Skills
8	Mindfulness	What Skills and How Skills
9	Emotion Regulation	Goals, Emotions, Myths, Describing
10	Emotion Regulation	Check the Facts, Opposite Action
11	Emotion Regulation	Problem Solving, A (of ABC)
12	Emotion Regulation	B, C, PLEASE, MF of Current Emotions

Lessons Learned

This RCT was originally planned to be an in-person study; but due to the COVID-19 pandemic, the trial was adapted to remote delivery. Several important adaptations were necessary for successful transition to remote delivery with a novel population for DBT. Importantly, we realized that many of the common mindfulness practices employed in DBT did not easily translate to a remote practice. Additionally, some of the common exercises required adaptation to disability. For instance, mindful walking was expanded to include other types of mindful movement to accommodate for diverse physical disability. Other common practices were modified to align with remote delivery. For example, the practice of "throwing sounds" was amended to include the thrower stating the name of the intended recipient. Of note, this adaptation could also be applied for an in-person group involving individuals with low vision.

To provide participants DBT handouts and worksheets, binders were prepared and mailed to participants' homes. Participants would meet with a co-leader about 30 minutes prior to the first meeting. This time was used as a DBT commitment meeting, to troubleshoot technology, and to become acquainted with the Zoom interface, which was novel for most users at the time. Since homework could not be collected during each session, prior to each participant's homework review, the group leader requested a verbal reply to whether the homework was completed. When meetings began, participants were asked to keep their microphones muted and to only unmute when they wanted to speak. Similarly, they could use the raised hand feature before they wanted to speak. Our experience indicates that 4 pairs was the maximum group size to effectively complete the content for each session. Sessions typically lasted 90 minutes aside from when new participants joined or when participants graduated.

Given this study was designed as a pilot, limited to 2 years and 40 participants, length of treatment and selection of skills modules were shortened from the typical DBT practice. Although results supported important and significant treatment gains, it is possible that gains were attenuated by the shortened 12-week protocol. A longer treatment that includes all skills training modules, especially distress tolerance and acceptance, may have more long-lasting therapeutic effects. A larger sample size would also support more comprehensive investigation of secondary outcomes (emotion regulation and well-being), as well as mediating and moderating factors and increase statistical power. Future DBT trials will emphasize extending duration and content, while also balancing feasibility of participation.

Conclusion

We believe DBT is an ideal intervention to apply with heterogenous populations across varied mental health problems, including mental health symptoms that accompany chronic medical conditions. Therefore, we conducted a pilot RCT of DBT skills training, compared to an active control group, to reduce depression and anxiety symptomatology for individuals with MS and their support partners. Our results indicate statistically significant and moderate treatment gains (i.e., total HADS and the anxiety subscale) compared to the control group at post-treatment. More research is needed to determine, and potentially extend, the longevity of treatment gains. Additionally, due to the COVID-19 pandemic, we were able to demonstrate that the treatment gains could be achieved through a remotely delivered DBT intervention.

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Lessons Learned During an Initial Feasibility Trial of Digital Dialectical Behavior Therapy Skills Training in Outpatients with Substance Use Concerns

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Abstract

INTERNET-DELIVERED and digital formats of dialectical behavior therapy skills training (DBT-ST) remain an untapped method of service delivery to increase access to the intervention. In the current study, we investigated the feasibility and acceptability of a DBT-ST webapp called Pocket Skills, which was previously evaluated in a research context, in a new tertiary care setting. Here, we describe and then provide some early results of a 16-week randomized wait-list-controlled trial of Pocket Skills in outpatients seeking treatment for alcohol or substance use. We also discuss how these results informed a revised protocol with modifications to improve engagement and adherence.

Introduction

Emotion dysregulation underlies many different mental disorders (e.g., depression, anxiety, substance use disorders, borderline personality disorder) as well as clinically relevant behaviors such as impulsive behavior, binge-eating, and non-suicidal self-injury (Gratz et al., 2020; Linehan, 2014). Dialectical behavior therapy (DBT) is a psychological intervention that targets people's abilities to regulate emotions and has been used to treat challenging clinical presentations such as suicidal behavior, non-suicidal self-injury, and borderline personality disorder (for review, see Wilks et al., 2021). Briefer formats of DBT that focus on skills training (DBT-ST) have been effective in reducing mental health concerns such as depression, anxiety, suicidal ideation, and alcohol dependence in as little as 6 to 8 weeks (Warner & Murphy, 2022). However, few studies have leveraged internet-based or digital delivery options for DBT-ST, leaving a largely untapped format for service delivery in need of evaluation.

The aim of the current pilot study was to examine the feasibility and acceptability of a digital DBT-ST webapp called Pocket Skills in a sample of adults seeking treatment in a tertiary care setting. A 16-week randomized wait-list-controlled design was initiated, with participants randomized to receive immediate access to the intervention or delayed access after 8 weeks. All participants were followed for 16 weeks total. The research team partnered with clinical services that provide treatment to individuals with a primary concern related to alcohol or substance use and could potentially benefit from an internet-delivered DBT-ST option within their program delivery. We chose these services because treatment-seekers often exhibit concurrent disorder presentations (i.e., co-occurring mental health and alcohol or substance use disorders) and this clinical group tends to report elevated difficulties in regulating their emotions (e.g., Fox et al., 2007; Gratz et al., 2008; Tull et al., 2015; Weiss et al., 2013). Our initial pilot study launched in December 2021. We paused recruitment in April 2022 due to concerns about engagement and adherence to study procedures within our initially enrolled 16 pilot participants. We present these initial findings and discuss changes made to launch a revised study in July 2022, which has led to improved engagement and adherence.

Method

Participants were adults waiting for psychosocial care at the Centre for Addiction and Mental Health in Toronto, Canada. The two services we partnered with provide psychosocial programming for adults with alcohol or substance use concerns, with one service specifically supporting LGBTQ+ individuals. Inclusion criteria were: currently on waitlist for programming (with a primary concern of alcohol or substance use disorder), age 18-65, fluency in English, and access to a computer or smartphone with internet connection. Exclusion criteria were: practical factors affecting participation (e.g., moves or vacations during the study period), acute psychiatric or medical condition precluding participation (e.g., acute suicidality or psychosis), or participation in another treatment/intervention study. All prospective participants were initially informed about the study and prescreened for eligibility over the phone.

During the fulsome eligibility and baseline assessment, participants provided informed consent, completed baseline questionnaires and interviews, and were randomized to their condition. Randomization was conducted in fixed blocks of 4, 6, or 8, and

Table 1. List of Skills Covered within Pocket Skills.

Skill Area	DBT Lessons and Exercises	Brief Skills Description
Mindfulness	Intro & Goals; Wise Mind; Observing; Describing; Participating; Non-judgement; One-mindfully; Effectively	To introduce the foundational skills to develop non-judgmental awareness of the present and practice mindfulness with skillful effectiveness.
Emotion Regulation	Identifying and understanding emotions; Check the Facts; Opposite Action; Problem Solving; Building Mastery; Coping Ahead; Accumulating positives	To teach the functions of emotions, how to describe them, and skills to reduce the frequency and quantity of unwanted emotions. To teach skills to build future resilience against intense emotion.
Distress Tolerance	TIP; Distract; Self-Soothe; Pros and Cons	Weather crises and intense negative emotions. Skills to manage experiential changes and produce cognitive change.
Interpersonal Effectiveness	DEAR MAN, GIVE, FAST, Evaluate Intensity of Request/Saying No	Learning skills to navigate interpersonal situations and needs more effectively.
Addiction	Dialectical abstinence; Pros and Cons (addiction context); Clear Mind; Community Reinforcement, Burning Bridges	To help learners find a middle path between oppressive sobriety and unrestrained freedom of substance use. Develop a clear mind. Strategies to identify relationships and activities that aim to stop or reduce problematic substance use.

allocation concealment was ensured with the use of opaque envelopes with randomization condition opened with participants after the completion of the baseline assessment. Ten individuals received immediate access to Pocket Skills, while six received delayed access after 8 weeks. Following the baseline assessment, participants completed follow-up assessments every 4 weeks. Participants were provided with an honorarium in the amount of $20 for time spent on the assessments.

The intervention used in this study, Pocket Skills, has been described previously (Schroeder et al., 2018; Wilks et al., 2018). Briefly, it is an online intervention including videos with Marsha Linehan describing and teaching skills across each of the four skills training areas of DBT as well as addiction more specifically. A conversational chatbot further helps users learn and practice each of the skills (see Table 1 for a list). The version of Pocket Skills used in the current study includes a novel Interpersonal Effectiveness module, as well as revised content and additional videos (see Figure 1 for several screenshots).

Participants completed the following measures at baseline: Diagnostic Assessment and Research Tool, a semi-structured clinical interview (McCabe et al., 2007); Patient Health Questionnaire - 9 (Kroenke et al., 2001); Generalized Anxiety Disorder Scale - 7 (Spitzer et al., 2006); and Severity of Dependence Scale (Gossop et al., 1995). Measures of treatment feasibility and acceptability included the Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000); Treatment Acceptability Questionnaire (TAQ; Hunsley, 1992); and mHealth App Usability Questionnaire (MAUQ; Zhou et al., 2019). For the feasibility and acceptability measures, we converted the raw scores into percents for easier interpretation, with higher percentages indicative of more favorable ratings and a maximum score of 100%. We also extracted engagement metrics, including number of days logged-in, number of unique days used, duration of time spent on the app, and the number of actions (e.g., clicks, responses, and pages viewed) within 10-minute intervals. We finally collected qualitative feedback about Pocket Skills with open-ended questions about what participants liked and disliked and how they might improve it. The full design can be found on our ClinicalTrials.gov registration page (NCT#05094440).

Results

Recruitment and Adherence

Of 34 interested patients, 25 were eligible, and 16 were randomized and enrolled (Mage = 40.19, SD = 11.97). The sample identified as diverse (sex: 50% male, 50% female; gender: 25% woman, 43.8% man, 12.5% transgender, 18.8% non-binary) and complex, with a range of current depressive, bipolar, anxiety, and alcohol and/or substance disorder diagnoses (37.5% Major Depressive Disorder; 37.5% Persistent Depressive Disorder; 12.5% Bipolar Disorder I; 31.3% Panic Disorder; 18.8% Agoraphobia; 50% Generalized Anxiety Disorder; 31.5% Social Anxiety Disorder; 31.5% Post-Traumatic Stress Disorder; 37.5% Alcohol Use Disorder; 50% Substance Use Disorder).

One participant withdrew from the study at week 4. Eleven (8 immediate; 3

Table 2. Means and Standard Deviations for Depression, Anxiety, and Substance Dependence by Group and Timepoint

		Baseline		Week 4		Week 8	
		M	*SD*	*M*	*SD*	*M*	*SD*
Depression (PHQ-9)	Immediate	12.45	6.95	14.17	7.55	12.00	5.39
	Delayed	11.00	5.67	13.00	9.41	11.20	6.80
Anxiety (GAD-7)	Immediate	8.73	6.10	11.20	8.20	8.14	4.95
	Delayed	13.8	4.55	13.60	4.83	12.60	6.88
Substance Dependence (SDS)	Immediate	1.75	.76	2.05	.60	1.46	.72
	Delayed	.72	.67	.88	.50	1.16	.43

Note: PHQ-9 = Patient Health Questionnaire-9, Depression Subscale; GAD-7 = Generalized Anxiety Disorder Scale-7; SDS = Severity of Dependence Scale; Baseline, n = 16 total (n = 10 immediate; n = 6 delayed); Week 4, n = 11 total; Week 8, n = 12 total. Table 2. Means and Standard Deviations for Depression, Anxiety, and Substance Dependence by Group and Timepoint

delayed) out of 16 participants connected to the webapp: two in the immediate group had difficulty connecting due to technical issues; three people in the delayed group did not respond to study communications and never connected. The percentage of study questionnaires returned fluctuated: Week 4 (68.8%), Week 8 (75%), Week 12 (66.7%), and Week 16 (31.3%).

Feasibility, Acceptability, and Engagement

Perceptions of the intervention at baseline were positive (n = 15; 68.9%); participants thought it would be useful and would feel somewhat confident in recommending it to another person. Participants also estimated about a 50% improvement in symptoms (52.7%). Based on seven participant ratings of the intervention, the acceptability was as "good" (80.6%). Moreover, the same seven participants indicated positive ratings for ease of use (82.0%), interface/satisfaction (72.3%), and usefulness (75.9%) on the MAUQ. Of the 11 users who did connect to the intervention, participants logged in an average of 7.6 unique days and reported a 21-span of activity on average (earliest date of access to latest date of access). Participants spent about 90 minutes total on average on the webapp, which corresponds to roughly 900 actions on average (e.g., clicks, text inputs, responses). Participants evidenced approximately 8 different tasks on average within 10-minute intervals (this includes videos which were approximately 3-8 minutes long).

Clinical Outcomes

Overall, participants (n = 16) across both groups reported moderate levels of depression (M = 12.00, SD = 6.40), anxiety (M = 10.31, SD = 6.02), and substance dependence severity (M = 1.35, SD = .86) at baseline. Similar levels were reported at the end of the acute phase of the treatment and follow-up at Week 8. Formal analyses were not undertaken due to a lack of necessary statistical power; however, means for the first three time points are displayed in Table 2 per group and timepoint.

Qualitative Findings

In summarizing responses to an open-ended qualitative feedback form, positive feedback centered on the availability of the intervention at any time or place and the high-quality content itself. Participants also commented on how helpful it was to have tasks to do each week and different tools to try and reported feeling more connected to the hospital because of the resource. Negative feedback was related to ideas for improving content (e.g., including more life skills or exercises); the lack of rewards or encouragement to practice; lack of ability for the app to remember previous choices; lack of ability to send reminders/push notifications; and lack of connection with others.

Discussion

This pilot study provides some support for the feasibility, acceptability, and usability of Pocket Skills as a standalone intervention. We also found a wide range of engagement with the webapp, coupled with positive and constructive feedback. Though we saw few changes in clinical outcomes at Week 8, this small pilot study was not powered to detect significant effects between arms. We expect to report significant changes in clinical outcomes and statistical differences between the two arms at 4 weeks in our revised 12-week protocol with a full sample of 70 participants. Piloting digital interventions in novel clinical contexts is essential, as both efficacy and implementation trials require

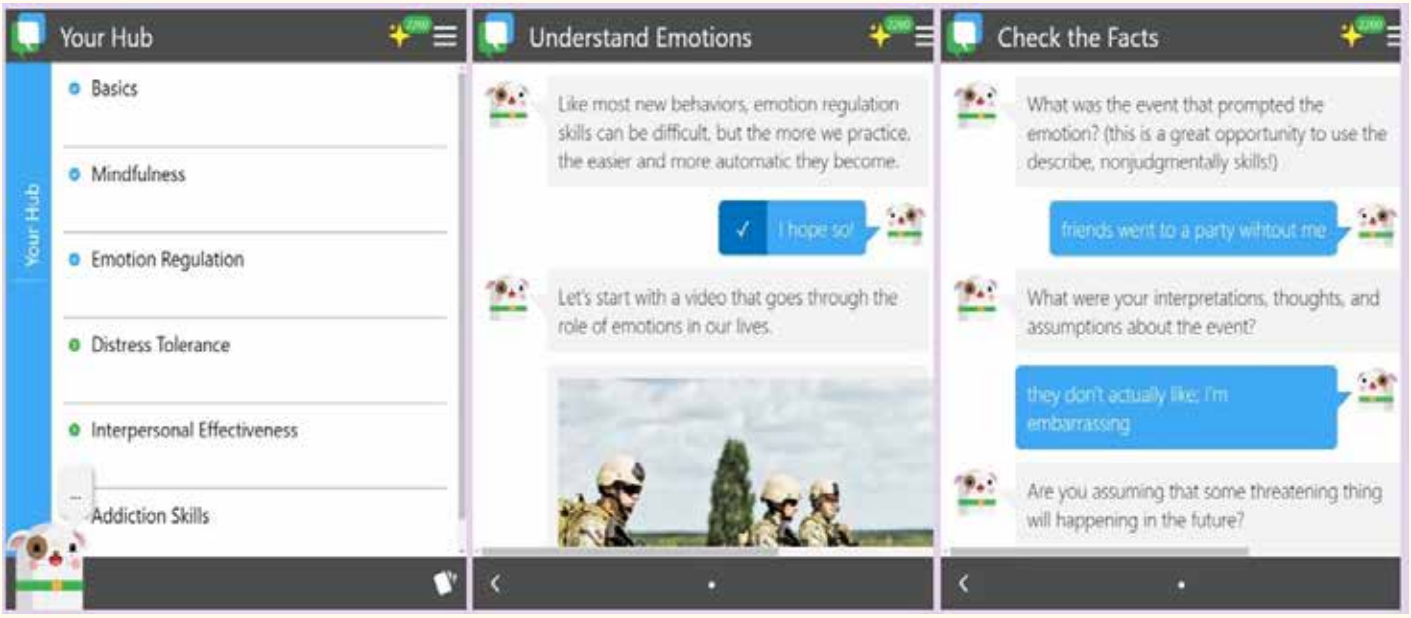

Figure 1. Screenshots of the Pocket Skills web-app, with the main menu ("Your Hub") and sections of the Understand Emotions and Check the Facts sections (both part of the Emotion Regulation module). Didactic videos were uploaded to a private Vimeo channel and were embedded into most sections of the webapp. Also presented in the screenshots are examples of open (type in a response) and closed (click on a generated response) chat generative functions.

appropriate engagement strategies. As a result of this formative experience, the research team incorporated numerous changes including weekly check-ins (e.g., calls, texts), reduced study length of 12 weeks (with delayed access being 4 weeks rather than 8, in line with previous studies; Miner et al., 2016; Mohr et al., 2019), and removing weekly exercise suggestions. We further modified eligibility criteria, including the addition of past year alcohol/substance use disorder, past month substance use, and at least contemplation levels of motivation to make a change about substance use problems (Biener & Abrams, 1991). We also increased the compensation value, linked compensation to completion of the assessments, and modified troubleshooting procedures for technical issues to make the sign-in process more seamless. Since implementing the revised protocol in August 2022, with increased automation of reminders, compensation, and testing of first-time login procedures, we have seen improvements in engagement (e.g., fewer technical issues and more logins) and adherence to follow-up questionnaires (82% of all requests thus far).

These initial findings are a valuable illustration of the challenges in moving DBT-ST to an online format within a tertiary care setting. Digital formats of DBT-ST are still rare and require evaluation; however, understanding how to consistently implement these interventions in an outpatient tertiary care setting is critical to rigorously evaluate them and ultimately, improve access to DBT. We envision Pocket Skills being a valuable stand-alone intervention or adjunct for those receiving DBT. For example, the webapp could improve engagement with in-person or virtually-delivered DBT material (e.g., handouts and worksheets), promoting the development and retention of DBT skills. It may also promote encouragement and retention in waitlist scenarios, providing orientation and motivation for successive treatment. Further investigation will provide a more reliable assay of feasibility, acceptability, useability of Pocket Skills, as well as provide initial estimates of efficacy in this clinical context.

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Questioning Objectivity in Science: The Case for Participatory Research

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In the past few years, there has been increasing awareness of the extent to which racism is embedded within psychological science (Smith, 2021). There have been several calls by the American Psychological Association (APA) and the National Institute of Mental Health (NIMH) to explicitly recognize how systemic racism affects the research processes that we use to create, test, and report on the experiences of people of color (Buchanan & Wiklund, 2020; Galan et al., 2021, Buchana, Perez, Prinstein & Thurston, 2020). Moreover, within the field of clinical psychology, there has been a focus on trying to highlight and change systemic practices that discriminate against people of color, both in training and in treatment. This paper extends the ISIT DBT 2022 research lightening round presentations to highlight the importance of using a different methodological approach to address this problem.

How do we get accurate information that will best help us understand the experiences of people of color so that we can use that information to make changes in the system? This is the question we as a field have been attempting to answer. Particularly, the concept of "accuracy" is essential, as it brings up the notion of "objectivity". There is an assumption within the field that scientific research, especially quantitative research, is inherently objective. However, when we investigate further, especially after reviewing the individuals who are credited with developing these methods and what these methods were originally designed for, it raises the question of whether they are truly objective (Zuberi, & Bonilla-Silva, 2008). The NIMH is the largest funder of research on mental disorders in the world. In 2014, only 33% of principal investigators were female and 21% self-identified as belonging to an under-represented racial or ethnic group (Insel, 2015). Tracking of the distribution of funds over the years has been done by the National Institute of Health (NIH) and used as a proxy for NIMH's funding demographic (Insel, 2015). A review of NIH funding showed that after adjusting for covariates such as experience, education, training, previous NIH grants and employer characteristics, Black Americans were 10.4% and Asians were 4.2% less likely to receive an R01 award compared to White Americans. The study also found that Black and Asian Americans are less likely to be awarded an R01 on their first or second attempt and must resubmit more often to receive funding compared to their White counterparts.

These figures are concerning because they raise several issues with the belief that research is objective. Projects that get funded tend to be able to grow and improve their methodologies and practices. If a person creates a new self-report measure, and that project gets funded, they can test it multiple times, ensure its reliability, publish their findings, and disseminate it widely. However, this creates a disparity in improving other research methodologies that are not important to a majority group: in this case White Male Americans. In the field of psychological science, this has resulted in a focus on quantitative, biological, mechanistic studies that require large sample sizes. While these approaches help understand a variety of problems, it is also discriminatory in for whom this type of research is designed, implemented, and interpreted.

Most of these approaches are top-down, where researchers impose a research question onto the participant. This has resulted in catastrophic events for some racial minorities (Buchanan, & Wiklund, 2020; Buchanan, Perez, Prinstein, & Thurston, 2020). Beyond the more well-known Syphilis study at Tuskegee, as early as the 1990s, a research study was conducted using monetary incentives which had African American boys withdraw from all medication, stay overnight without parental supervision, withheld water and enforced different diets and medications that effected aggressive behavior (Scharff et al., 2010). This approach can lead the investigator to imposing their construct onto a population and does not leave room for other information that could be more important. The history of the development of these methods, particularly inferential statistics, some of which were created based on the belief of eugenics that discriminated based on race, has also created mistrust amongst underserved communities (Galan et al., 2021; Zuberi, & Bonilla-Silva, 2008). There is also a lack of measures developed to understand the experiences of people of color and measures that exist are undeveloped and not validated for this population. Finally, using a quantitative approach to power such a study would require large sample sizes. With such few people of

color participating in research and using mental health services, this would be difficult to achieve (Zuberi, & Bonilla-Silva, 2008).

On the other hand, participatory research was designed to address many of these issues. Participatory research employs a more collaborative approach where the person with the lived experience is a stakeholder in the research study. Rather than having a top-down approach, participatory research encourages input and participation by those with direct experience to the phenomena being studied, after which these inputs are valued and embraced (Desai, Bellamy, Guy, Costa, O'Connell & Davidson, 2019). By having the participants be part of the research design process, investigators can learn how to frame their study, know what questions to ask, and have more effective ways to recruit and design methods that would be most appropriate to potential participants. This would allow them to expand the scope of their research to get to the issues that are most important to that population, which in turn will be more helpful when designing programming and interventions.

Participatory research also provides an opportunity to understand the experiences of the participant and potentially build relationships between communities that have historically been discriminated against. By providing opportunities for the community to participate in the research study on equal footing with the researchers sends the message that their voice and perspective is valued (Desai et al., 2019). This allows for healing and encourages participation from populations that have not been included in more traditional methods.

This methodology was utilized to understand the experiences of trainees of color in a DBT program. The primary goal of DBT clinical training programs is to provide trainees with the opportunity to develop strong clinical skills, to ensure adequate treatment of patients and to promote professional growth especially in developing their own professional identity. Supervision, consult team and didactics are integral and core parts of this process in DBT training programs. However, some consult teams, programs and supervisors may not have an integrated and contextual approach to managing issues regarding diversity. This is problematic for trainees of color who are often navigating multiple identities in professional spaces and are at risk for burnout and unintended harm from the program and individuals in a supervisory role. Understanding their experience is therefore important to help improve the training for DBT programs and encourage more diversity within the specialty.

There were three parts to this project. The first part was a focus group with the trainees of color, where we discussed what kinds of questions they would like to be asked about their experience, specific themes or theories they feel are relevant to explore, and any other narratives that they would like to discuss in the individual interviews. Participants were recruited through a listserv that had been created for all previous trainees in the program. The recruitment notice specified that this was only for trainees of color and participants had to complete a questionnaire before consenting. The criteria were left broad to any trainee of color rather than a specific race or type of trainee due to the smaller number of trainees of color in the program. The second part was the individual interviews where the same trainees were asked the questions that were formulated from the first focus group. The third part was a focus group that reviewed the findings of the narratives and elicited feedback on changes that the program can implement. The narratives were coded by creating a one-to-two-page document of each participant's narrative using their interview. The coders then met for the "white board" session where they reviewed all the narratives and elicited the themes from each one to create one cohesive narrative that represents all participants' experiences. While the results are still being coded, this provides a case example of how to conduct participatory research using a phenomenological approach. As the participants were included in each step of the process, their input helped to ensure that the spaces where interviews were conducted felt safe, that the interviews were designed to best elicit the information that was needed for change, and that the final findings were accurately reflective of their experience.

This case example contributes to the growing number of participatory research studies, which illuminate the need for the field to move towards developing and utilizing different research methods to address the systemic racism and bias in scientific research. If we truly want to break barriers and make changes for people of color, we must be able to accurately understand and investigate the problem. Who better to help us do that than the people experiencing it themselves, using their own words and within a framework of their own making?

Acknowledgements

We would like to acknowledge Seth Axelrod, who passed on January 25, 2022, for his contributions and mentorship of the project. Seth was passionate about DBT and supervision and without his significant input and openness to change, this project would not have existed, and we continue this work in honor of him.

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Dancing with DBT Dialectical Dilemmas: Case Example of the Acceptance and Change Protocol (ACP)

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DBT IS A PRINCIPLE-BASED therapy with protocols, unlike other manualized therapies that are defined by their protocols. This means that DBT therapists must adapt their use of specific strategies according to the case formulation, which includes the unique needs, capabilities, and challenges of each client. The application of DBT, and whether a therapist's actions are classified as adherent, depend on the function of the behavior. For instance, the same therapist response could be regarded as either adherent or non-adherent, depending on the antecedents, behaviors, and consequences of the intervention. In DBT, functional assessment of both the therapist's and client's behaviors is an ongoing and iterative process. Therapists use case formulation to guide their choice of interventions in each client interaction. They then evaluate the function and effectiveness of each intervention, updating their case formulation accordingly. Thus, DBT therapists rely on their case formulation to predict how a given intervention is expected to function for each client in their given context.

DBT formulation is rooted in the fundamental worldview of the treatment model: dialectics. In her formulation of behavioral characteristics observed among individuals with borderline personality disorder (BPD), Linehan (1987, 1993) describes three behavioral patterns, the 'dialectical dilemmas', as transactions between the client and their environment. Functional assessment of the dialectical dilemmas and their links with therapist-client transactions promotes therapists' empathic and non-pejorative case formulations, rooted in understanding the challenges and needs common among clients with BPD.

While case formulation is an essential ingredient for therapists' adherent delivery of DBT strategies, the treatment manuals (Linehan, 1993; 2015) offer little guidance for how a client's particular dialectical dilemma(s) informs both the overall intervention and the therapist's responses in-session. Moreover, dialectical dilemmas reflect one of the more complex and under-described areas of DBT. This leaves clinicians challenged in their efforts to understand and differentiate between these patterns, and even more challenged in turning the related descriptive labels into active treatment plans. To address this gap in our field, the late Seth Axelrod, Ph.D. and colleagues developed the Acceptance and Change Protocol (ACP). The ACP presents a formulation-driven framework that helps therapists identify a given dialectical dilemma and associated secondary target to determine the timing and focus of change, acceptance, and dialectical strategies. Specifically, the ACP guides therapists to clarify client behavior patterns, develop treatment goals that address secondary targets, and inform strategic interventions (or, "what to do when").

In a clinical workshop at the 2022 ISITDBT meeting (Gold, Decker, & Axelrod, 2022), we presented a tribute to Dr. Axelrod and his career-long body of work developing the Acceptance and Change Protocol. Axelrod lovingly referred to this work as "dancing with the dialectical dilemmas," based on Linehan's (1993) metaphors about dancing to describe dialectics in the therapy relationship. The full Acceptance and Change Protocol detailing the steps of formulation and strategic intervention for all three dialectical dilemmas is beyond the scope of this article, and will be reported elsewhere (Axelrod, Gold, & Decker, in prep). The goal of this article is to provide an introduction to the ACP illustrating its promise to enhance effective, adherent delivery of DBT. To this end, we present a case example of in-session polarized behavior patterns (i.e., active passivity) underlying life-threatening, treatment-interfering and quality-of-life-interfering behaviors (i.e., primary target behaviors to decrease). We offer a brief summary and infographics to summarize the ACP (Figures 1-2), followed by an annotated transcript of a case example roleplay accompanied with video recordings.

While all components of the ACP are referenced in the DBT treatment manuals and conceptualization work (Linehan 1987, 1993, 2015; Koerner and Linehan, 1997; Koerner, 2012), Dr. Axelrod's novel contribution was his synthesis of Linehan's original work on formulation and intervention (See Figure 1). Dr. Axelrod's synthesis is just like any good dialectic: the sum is greater than the whole of its parts.

As shown in Figure 1, DBT formulation is rooted in the borderline behavioral patterns described in the dialectical dilemmas and defined by their opposite poles of over- and under-regulation of

emotion: i.e., apparent competence versus active passivity, self-invalidation versus emotional vulnerability, and inhibited grieving versus unrelenting crisis (Linehan, 1993, Figure 3.1, p. 67). Figure 2 presents an infographic as a tool to guide formulation, summarizing the context, heart of the problem, secondary targets or behaviors to increase and decrease in treatment, and examples of invalidation and emotional vulnerability associated with each of the three dilemmas. From the top of the infographic, the social element of the transactional, biosocial model is represented in the ovals showing types of invalidation that the client internalizes (e.g., underestimating task difficulty and oversimplifying ease of problem solving becomes "it's not so hard, just ___!"). Secondary treatment targets for the over-regulated pole of each dilemma (e.g., increase accurate communication of emotion and competencies) and the pole's name (e.g., apparent competence) are described next. The context that tends to elicit this particular pattern (e.g., performance and problem solving) is represented in rectangles next to the heart of the problem: the dilemma as the client may experience it, an essential understanding required for an empathic formulation. The bottom of the figure shows parallel information for the under-regulated pole of the dilemma (e.g., secondary treatment target: increase active problem solving; pole name: active passivity). Finally, the client's experience of the emotional vulnerability element of the biosocial model underlying the under-regulated pole is represented in the bottom row (e.g., "I can't handle this by myself!").

In addition to developing a phenomenologically empathic formulation for each client and their experience of the dialectical dilemmas, DBT intervention requires therapists to respond effectively to clients by balancing acceptance and change strategies in a manner that is both flexible and centered, at once nurturing and demanding. As shown in Figure 1, Linehan describes therapist stances, defined as the requisite characteristics, skills, attitudes, and interpersonal positions that the therapist takes in relation to the client, as the synthesis of three dialectical dimensions: the central stance of change versus acceptance, along with the two related dimensions of benevolent demanding versus nurturing and of unwavering centeredness versus compassionate flexibility (Linehan, 1993, Figure 4.1, p. 109). Thus, both cases of client dialectical dilemmas and therapist stances are depicted as sets of three dimensions, or dialectics, defined by opposite poles. Both cases of client and therapist behavior patterns share an overarching goal of DBT: to promote synthesis of opposite poles.

Axelrod carefully considered this goal in the context of dialectics in the therapy relationship, which Linehan compared to ballroom dancing. Axelrod was inspired by this metaphor, as Linehan described: "the idea is to move the patient slightly off balance but with a hand firmly guiding her…the therapist has to move in quickly with a counterforce to stop the patient from moving off the dance floor. 'Dancing' with the patient often requires the therapist to move quickly from strategy to strategy, alternating acceptance with change, control with letting go, confrontation with support…." (Linehan, 1993, p. 203). Accordingly, Axelrod developed the "two-step dance" as a way to help therapists balance the dialectical dilemmas in their interactions with clients by connecting each pole of the dialectical dilemmas to a countering and a corresponding pole of the therapist stances. The ACP characterizes therapist responses within each stance as either countering or corresponding to the original need and expression of the client behavior expressed at the pole of each dialectical dilemma. For example, Axelrod linked the polarized behavior pattern of active passivity to the therapist stance of benevolent demanding and nurturing as countering and corresponding responses, respectively. The inverse is true for its opposite pole on the dialectical dilemma, apparent competence, which he linked to nurturing and benevolent demanding as countering and corresponding therapist responses, respectively.

Case example of the Acceptance and Change Protocol: Active Passivity

The following is an annotated transcript of the two roleplay examples we presented at ISITDBT 2022 to illustrate the transactional nature of the dialectical dilemmas (Gold, Decker, & Axelrod, 2022). The first roleplay illustrates an ineffective (but well-intentioned and understandable!) therapist response to a client's active passivity behaviors, which can be viewed https://drive.google.com/drive/folders/1vU-9ha_PhEn_M6HA7UQSaJlMR6eCCWrLa?usp=share_link. The second roleplay of an effective therapist response using the ACP can be viewed https://drive.google.com/drive/folders/1vU9ha_PhEn_M6HA7UQSaJlMR6eCCWrLa?usp=share_link.

Roleplay example 1 – Ineffective therapist response to active passivity: corresponding with nurturing. First, we show a therapist's well-meaning yet ineffective responses that unintentionally reinforce a client's polarized behavior pattern of active passivity. Relationships are transactional: clients and therapists influence each other's responses. One person's behavior functions as the antecedent for the other person's behavior, which in turn functions as a consequence for the other's behavior. In a context that cues a strong emotion, a client may emit a polarized, ineffective behavior (corresponding to a pole of one of the dialectical dilemmas). This behavior functions as an antecedent for the therapist, cuing the therapist's

own emotional response. The therapist may then respond to the client in a corresponding way that reinforces the client's behavior while modulating the therapist's emotional response. Over time, the therapist may shape up more of this client's polarized, ineffective behavior, and the client may inadvertently reinforce the therapist for doing so. This transactional pattern unfortunately maintains and exacerbates dialectical dilemmas, leading to the client and therapist feeling stuck in the therapy and the therapy relationship.

In a client-therapist transaction about setting treatment goals, active passivity appears, cued by the context of a demand situation. Here we show therapist behaviors representing a **corresponding** response (i.e., therapist stance of nurturing) that is well-meaning, but nonetheless ineffective given that it reinforces the client's polarized behavior (i.e., under-regulated pole of client's dialectical dilemma of apparent competence versus activity passivity). External (and public/observable) client (C) and therapist (T) behaviors are presented first as left justified text, followed by indented text describing the internal (and private/not observable) client and therapist behaviors, which are accompanied by ACP annotations:

T: "Alright, let's do this last section of the treatment plan. Here's where we're gonna talk about reducing quality-of-life-interfering behaviors. Now tell me, what kind of changes do you wanna see in this area in the time we're working together? What behaviors might we want to problem-solve for you to get the life you want?"

*T asking about goal-setting elicits context of **performance & problem-solving**; T's behavior cues C's internal behaviors on chain, including emotion of fear, thought "oh shit, I can't do anything", then secondary emotion of shame with urge to hide and avoid.*

***Behavioral functions**: Client=antecedent*

C exhibits withdrawal behaviors shrugs, looks away, fidgets in seat, states, "I don't know" and continues to shrug and avoid eye contact, looking downward, hiding face

T: "It's kinda hard to think of goals, isn't it? I'm remembering you had talked about changing your eating behavior, quitting smoking. Do those feel like they may still be important?"

C: "Yeah, like I could ever do them. I mean, I don't know. I guess. I think whatever you usually do. Whatever you think. I don't know." Continues withdrawal behaviors, looks away, hides face.

*C's **active passivity** behaviors cue T's worry thoughts that they have pushed client too much, anxiety, and urge to "rescue" or "bail out" C, offering help in response to the client's inactivity.*

***Behavioral functions**: Client=behavior, Therapist=antecedent*

T: "You said they were important to you before. Why don't I write those down for you here? I'll just jot them down real quick, and um, we can revisit it if we want. I can see you're tired. This has been a long session for us. I'm wondering if we can shift, spend the rest of our session kinda talking about more near-term things. Is that okay?"

C appears to exhale with a sigh of relief, stating, "yeah"

T changes topic away from goal setting (i.e., context of performance and problem-solving) and asks, "So, what are you going to do this weekend?

*T's **corresponding response** of **nurturing** in response to C's **active passivity**:*
T's corresponding stance of nurturing means taking helping, caring actions for the client (e.g., "doing it for them"), rather than having the client take active steps or progress.

T engages in nurturing by dropping any task demands from C, offering to write down solutions generated by T, without C's input or active participation, and suggests they shift topics. C's relief and minor shame reduction function as reinforcers of C's polarized behavior.

***Behavioral functions**: Client=consequence (+antecedent for future client behavior, reflecting oscillations between opposite poles of dialectical dilemmas), Therapist=behavior*

C's body appears to relax, C states, "I think I'll just go to the library Saturday".

T: "now that's an outing, right? Sometimes that's tough for you. Tell me a little more. Do you think we maybe need a cope ahead for that?

C: "It's just the library. It's not a big deal. Anyone could go to the library. I should be able to do it, it's fine."

T: "Of course you can do this. Alright"

T's anxiety and sense of worry after observing C's body relax and increased engagement, coupled with T's own sense of warmth after nurturing reinforce T's corresponding response of nurturing. However, T exhibits inaccurate communication, oversimplifying task demands and, subsequently, increased sense of hopelessness.

Given C's learning history and over repeated interactions, T's corresponding responses to C's polarized behaviors function to maintain C's dialectical dilemmas. Within and across sessions, C oscillates between extreme poles of active passivity & apparent competence.

Over time, the client's behavior of active passivity (withdrawal, lack of collaboration, becoming passive instead of voicing an opinion or goal, not voicing emotions) is likely to become strengthened through negative reinforcement, as the therapist withdrew the aversive request for goal setting leading to the immediate (and short-term) relief of aversive emotions for both the therapist and client. Unfortunately, this leaves the client in a position where the polarized, ineffective behavior gets stronger, and a goal behavior (accurately communicating that they are scared to set goals, or ashamed of past failures) is not enacted and therefore cannot be reinforced.

Roleplay example 2 — Effective therapist response to active passivity: countering with benevolent demanding before corresponding with nurturing. The second roleplay example illustrates how the ACP guides DBT therapists to change client-therapist transactions in ways that balance, rather than reinforce, polarized behavior patterns. The ACP does this by synthesizing the formulation of the client's dialectical dilemmas with the DBT therapist's stances. Specifically, the ACP "two-step" guides therapists to first block the client's expression of polarized behavior (e.g., active passivity) by providing a countering response (e.g., benevolent demanding) to drag out new behavior from the opposite pole of the dialectical dilemma. This first "countering" step is then followed by a second step of meeting the initial need of the client's polarized behavior through a corresponding response (e.g., nurturing), and continuing to move to synthesis with movement, speed, and flow.

The second roleplay example demonstrates the ACP "two-step" of responding to active passivity by first countering with benevolent demanding, then corresponding with nurturing. In this instance, the therapist effectively identifies the client's in-session behavior as active passivity, the under-regulated pole of the dialectical dilemma. The therapist blocks the client's polarized expression of this pole along with the therapist's own urge to offer a corresponding response of nurturing, which she predicts would positively reinforce the client's ineffective active passivity based on her formulation of the client's dialectical dilemmas. Instead, the therapist uses just enough verbal validation of the client's legitimate need to keep the conversation going, while countering active passivity with the stance of benevolent demanding. This is the first step of the "two-step dance." Once the client responds to the therapist's countering response of benevolent demanding by emitting a new behavior from the opposing dialectical position, the therapist then moves to the second step of the dialectical dilemmas "two-step": corresponding to the client's need of their initial behavior via a nurturing response, which they offer through a level three validation. In this example, the therapist's level three validation functions as a nurturing response given that the therapist does the hard work of describing current experiences for the client, who cannot quite do it themselves in this moment.

The following annotated transcript begins after the same initial antecedent from the previous roleplay, with the therapist's task demands of goal setting in the context of performance and problem-solving. The client's behavior prompted by this antecedent included fear, self-judgments and the secondary emotion of shame with the urge to hide and avoid, leading to withdrawal behaviors reflecting active passivity.

C exhibits withdrawal behaviors shrugs, looks away, fidgets in seat, states, "I don't know. Whatever you think" and continues to shrug and avoid eye contact, looking downward, hiding face

*C's **active passivity** behaviors cue T's worry thoughts that they have pushed client too much, anxiety, and urge to "rescue" or "bail out" C, offering help in response to the client's inactivity. T uses the ACP to promote awareness of own urge to nurture, and has thoughts about the ACP "two-step dance."*

***Behavioral functions:** Therapist=antecedent*

T: "Oh, I can see this is hard to talk about. And, I'm having the thought, boy, if we don't talk about where you want to go, we're not gonna be able to get you there. Could you do me a favor? I see you're hunched over. Could you sit up for me? Straighten those shoulders back?"

C: Looks at T and asks, "Why does it matter?"

T: "It actually matters a lot. In doing this you're acting opposite to the emotional urge you're feeling right now. Humor me a little. Roll those shoulders back. That's it. Head up. Sit up. Look at me."

*T applies the ACP to **block** own urges for nurturing as a corresponding response to active passivity. Instead, therapist uses just enough verbal validation to keep the conversation going, using a both/and dialectical statement. Then, T **counters C's active passivity with benevolent demanding**. The client's internal behaviors include increased*

curiosity, and the therapist proceeds to drag out new behavior. The therapist stance of benevolent demanding follows from Linehan's suggested therapy response to active passivity: "Breaking through the active passivity and generating coparticipation is a continuing task…Active work can occur if the therapist stresses the inherent difficulty of change and at the same time requires active progress" (Linehan, 1987, p. 269). In this case, the therapist's demand is benevolent – she starts with a tiny step, offering ample scaffolding and coaching.

***Behavioral functions**: Therapist=behavior, Client=antecedent*

C sits up a bit and looks directly at therapist, no longer hiding face or exhibiting withdrawal behaviors.

T: "Fantastic, thank you. I know that was hard. You just did a skill. That was opposite action for what I think was probably shame. And then you decided to take charge of it. You held up your head and now I see you. Okay, fabulous."

T was able to successfully drag out new behavior, and C responded to T's effective countering response by acting opposite to shame, sitting up and showing herself, rather than continuing to hide and avoid. C's increased coparticipation and T's sense of mastery positively reinforced T's countering response to active passivity via benevolent demanding before nurturing.

***Behavioral functions**: Therapist=-consequence (+antecedent for future therapist behavior, reflecting "dancing" or balancing opposite poles of the therapist stances with movement, speed, and flow), Client=behavior*

T (level 3 validation: mind-reading): "Now I'm thinking it was shame that showed up – I might be wrong. Am I maybe in the ballpark here?"

Upon C emitting new, less polarized behavior in response to T's countering stance of benevolent demanding, T provides a corresponding response of nurturing to meet C's initial need. In this case, to balance C's pole of apparent competence, T enacts a nurturing stance by communicating interest and availability, providing level three or "mind-reading" validation of the client's experience of facing challenges. In this case, T's effective response involves naming shame for the client, rather asking client to do it herself (i.e., nurturing), before then asking client to rate the intensity of shame (further balancing nurturing with more benevolent demanding, and so forth). T's stance as an ongoing synthesis of nurturing and benevolent demanding blocks T's reinforcement of C's polarized behaviors. Instead, the "two-step dance" of countering, then corresponding helps C to synthesize apparent competence and active passivity through transactions with T.

C nods yes, with slight smile

T: "Yeah, okay, and shame makes a lot of sense, we're talking about goals, especially in a treatment context with a therapist. Zero to 10, 10 is max, I'm wondering how high did that shame get for you?"

C: "I don't even know if you're gonna believe me"

T: "I think shame when you're setting goals sometimes really shows up for lots of folks. Wanna give me a try?"

C "A 9."

T: "Thanks for trusting me. Shame showed up real big here. Shame tells us something, right? Do you know what message shame is trying to give you right now?"

C (accurate communication): "I'm just really scared to make goals because I honestly don't know if I'm going to be able to – no, I'm actually terrified, fucking terrified, that I'm not going to be able to do all the things you're going to ask me to do. And because I can't do it, I'm not gonna get the help I need."

T: "I'd be terrified too if that's what was rolling around in my head. Wow. That's big. Thank you for telling me. Here's what I think. One the one hand, feeling shame, feeling fear right here makes total sense, and on the other hand, you just did something extraordinary. You told me what was going on, you trusted me with it."

C: "Yeah, I usually just hold that in."

T: "Yeah, today was a little different. You were practicing some huge willingness here. I think this is going to be a really important part of our work together. You and me, talking together, helping you try some new things. Speaking of trying new things, I'd like to get back us back to that idea of your goals. Can I turn our attention back there?"

C nods yes.

Through T's use of movement, speed, and flow continuously balancing nurturing with benevolent demanding, the client increasingly shows new, effective behaviors of accurate communication of emotion. T collaboratively and openly links this formulation-driven intervention to

C's treatment plan.

In addition to the "two-step dance" illustrated in this case example, the strategic interventions elucidated in the ACP involve helping the client develop mindful awareness of their dialectical dilemmas and move towards synthesis. This involves additional DBT strategies informed by the formulation, such as insight strategies, dialectical strategies, exposure, and behavioral rehearsal (Axelrod, Gold, & Decker, in prep). As summarized in Figure 1, the ACP synthesizes DBT formulation and intervention to understand dialectics in the therapy relationship and, as Axelrod loved to expand on Linehan's metaphors, teach therapists to effectively dance with the dialectical dilemmas.

Resources

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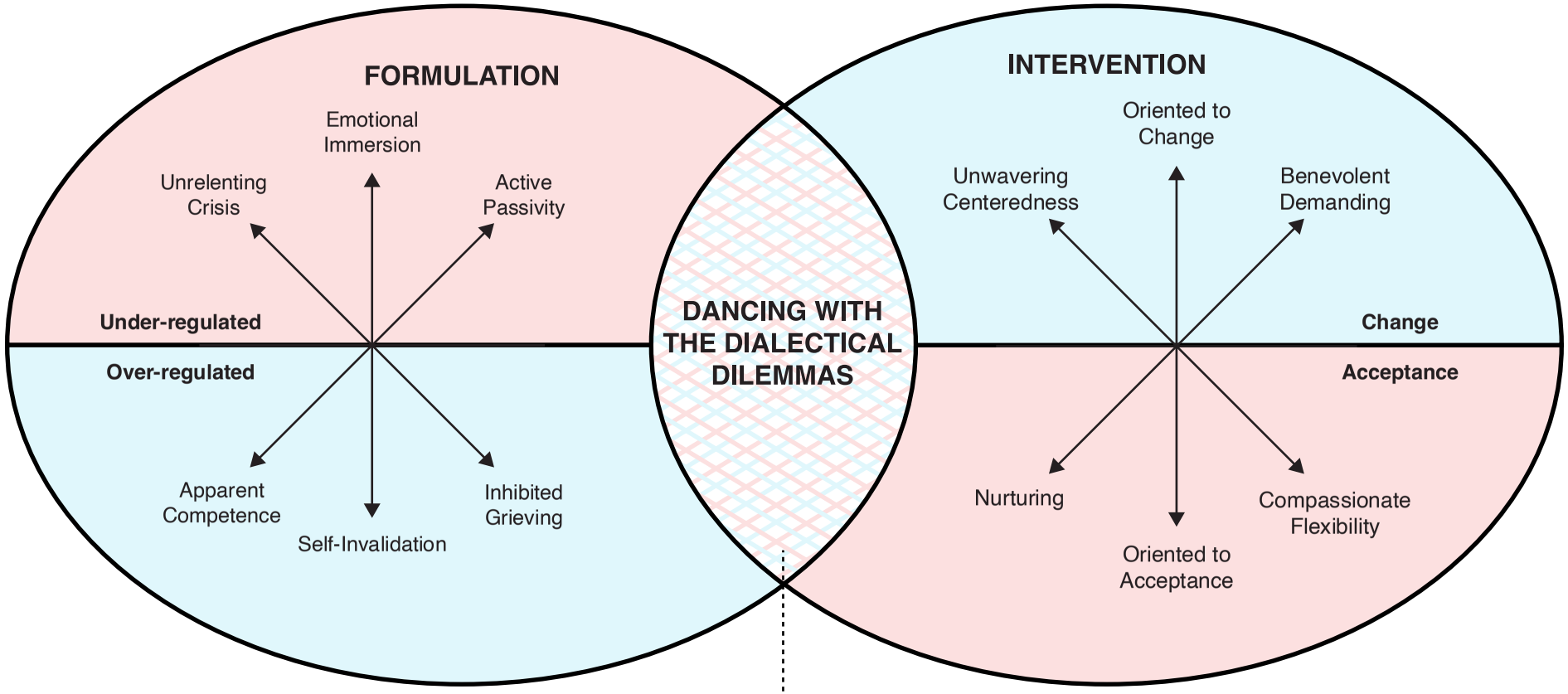
ACCEPTANCE AND CHANGE PROTOCOL (ACP)



FORMULATION:

- Identify dialectical dilemma(s) and associated secondary targets
- Develop empathic, non-pejorative formulation of needs and challenges based on Biosocial Theory

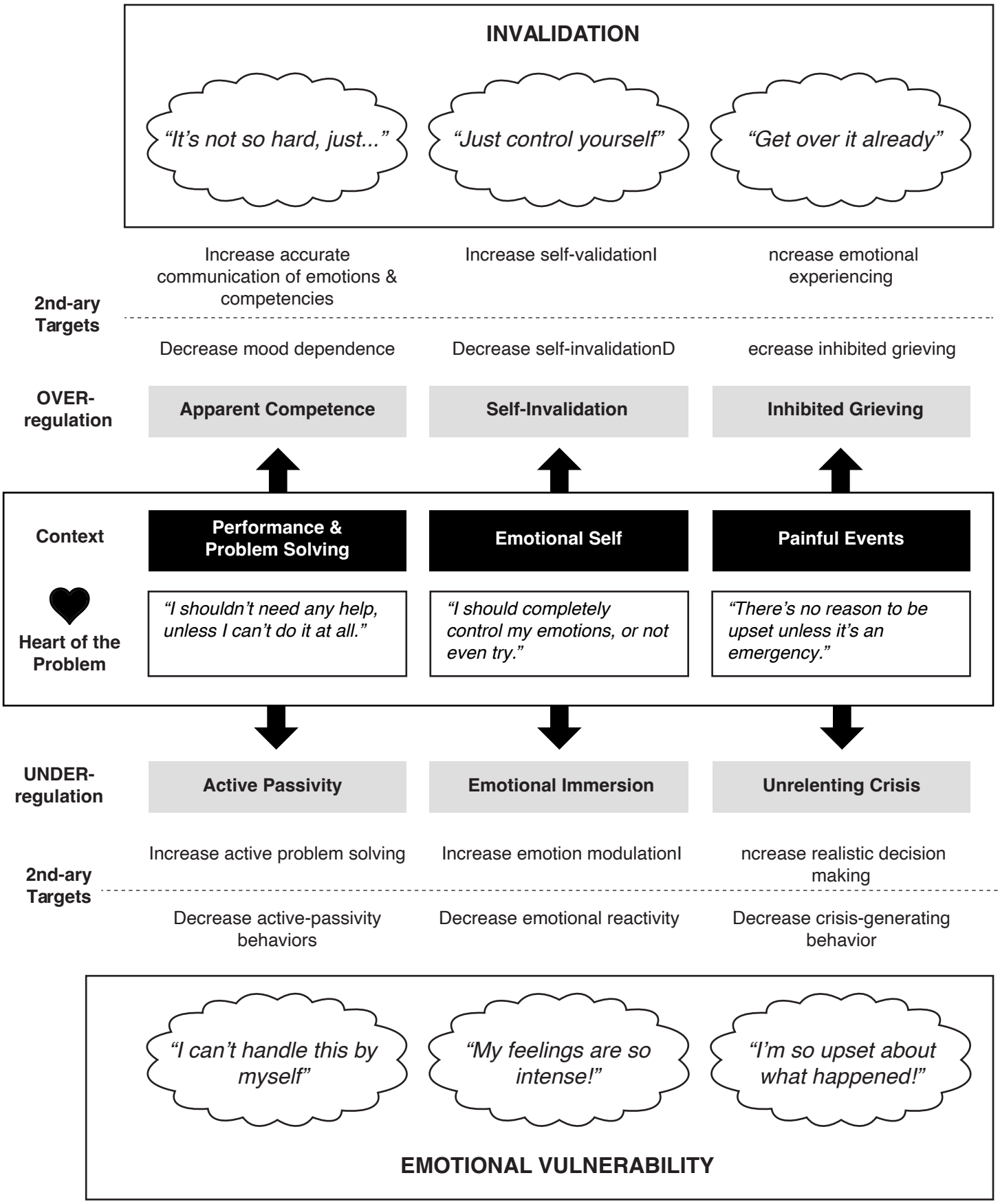
STRATEGIC INTERVENTION:

- Synthesize dialectical dilemma poles with therapist stances: *Counter, then Correspond*
  - Counter *under*-regulation with change before corresponding with acceptance
  - Counter *over*-regulation with acceptance before corresponding with change

Help client develop mindful awareness of dilemmas & synthesis, using insight & dialectical strategies, behavioral rehearsal, exposure

Gold, Decker, & Axelrod (2023). Dancing with DBT dialectical dilemmas: Case example of the Acceptance and Change Protocol (ACP). DBT Bulletin, *7*(1). Adapted from Linehan (1993). Cognitive behavioral treatment of borderline personality disorder. Guilford Press. Graphic design by Jesse Finkelstein, Psy.D.

ACCEPTANCE AND CHANGE PROTOCOL (ACP)



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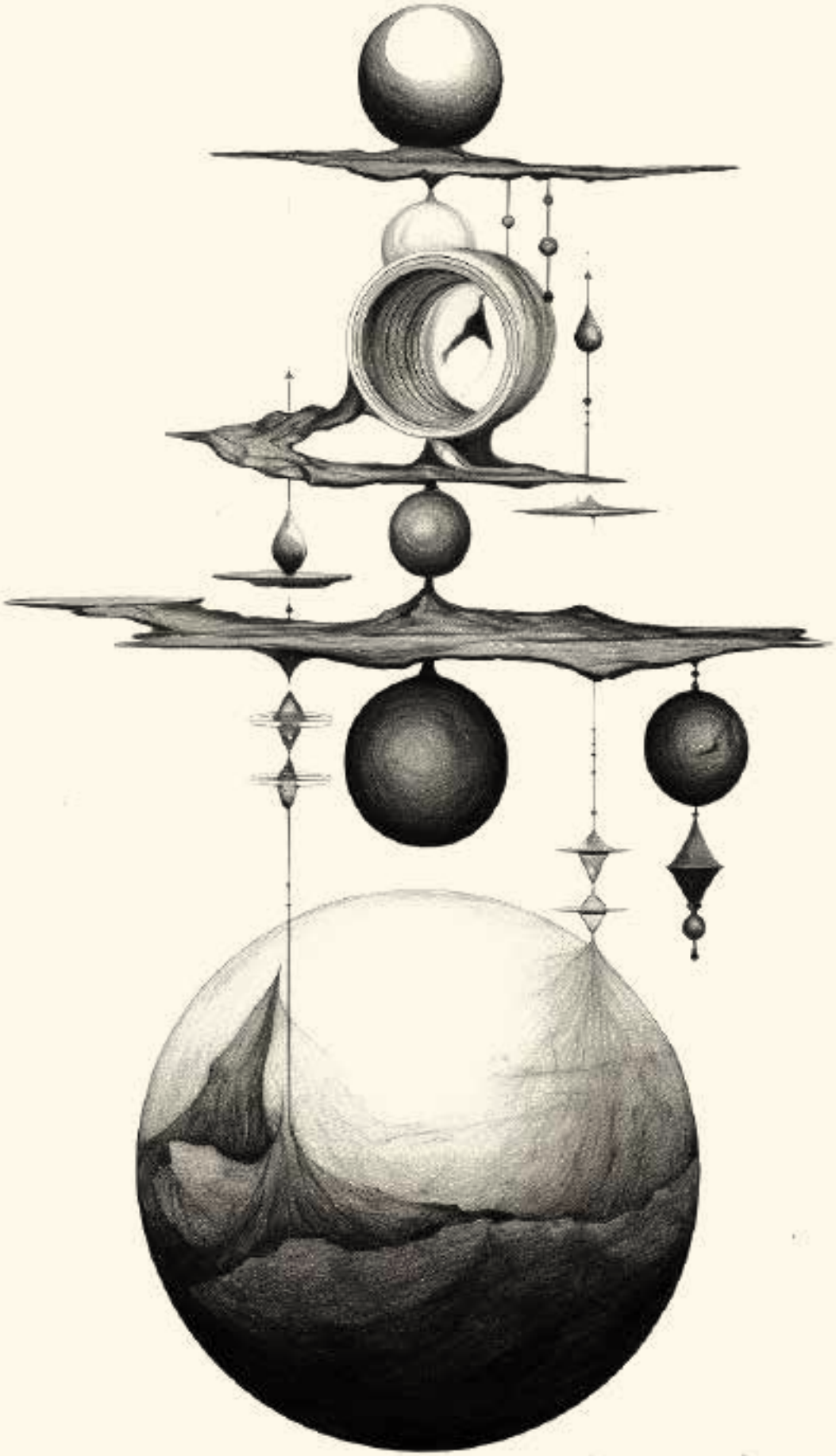

Making DBT Work: Interviews with Dr. Michele Berk[1] and Dr. Alan E. Fruzzetti[2]

Jesse Finkelstein[3] and Jessica Weatherford[3]
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THE INTERVIEWS presented in this series, entitled Making DBT Work, aim to capture the experiences of leaders in the DBT community who have created successful practices in various clinical settings. As clinicians, we are not necessarily formally trained in management, business development, leadership, and/or operations. Despite this lack of instruction, many in the DBT community have developed extensive knowledge and expertise in developing DBT clinics. Through documenting the helpful and unhelpful practices that leaders in our field have encountered, the goal of this series is to share the accumulated knowledge of some of the most impactful clinicians practicing DBT today.

In the first interview of the series, we explore the challenges and triumphs of developing a DBT clinic in a research-hospital setting through conversations with two exceptional clinicians and researchers, Dr. Michele Berk and Dr. Alan Fruzzetti.

Dr. Michele Berk is a licensed clinical psychologist and Assistant Professor of Psychiatry and Behavioral Sciences at Stanford University School of Medicine, Department of Child and Adolescent Psychiatry. Her career, which includes research, teaching, and clinical service, focuses on the area of psychotherapeutic approaches for treating suicidal behavior in adolescents and adults.

Dr. Alan Fruzzetti is the Director of DBT Adherence and Director of Training in Family Services for the 3East DBT Programs at McLean Hospital & Harvard Medical School. Dr. Fruzzetti is the Past President of the National Education Alliance for Borderline Personality Disorder, on the Board of Directors of the DBT-Linehan Board of Certification and the World DBT Association, and is co-founder of the Center for DBT and Families.

Both Dr. Berk and Dr. Fruzzetti have made significant contributions to DBT and its dissemination. Despite their distinct professional backgrounds, Dr. Berk and Dr. Fruzzetti share a common understanding of DBT, not just as a treatment approach but as a way of life. They discuss how DBT informs their management and leadership styles, as well as their approach to supervision, working within bureaucratic settings, and use of technology.

Furthermore, both clinicians address the challenges of introducing DBT to cultures that do not share its principles. Lastly, they highlight the importance of passion and enthusiasm in DBT team members and trainees. By reflecting on their individual experiences, we hope this interview provides valuable insights into the necessary elements for developing and maintaining a successful DBT clinic.

Interview with Dr. Michele Berk

Q: How has DBT informed your approach to management?

MB: Using the DBT assumption that people are "doing the best they can." This really helps with solving problems in a collaborative way, or not getting frustrated with people, when things aren't going smoothly. In general, DBT is a team-based approach. It helps to feel like I can really count on the people on my team, and we can all work together to support each other with whatever challenges are coming up, whether it's with patients or administrative type challenges.

Q: What have you found to be the toughest challenges in implementing DBT in a hospital outpatient (inpatient) setting?

MB: DBT, the way Marsha designed it, can be hard to implement in the real world, apart from research, because some of the essential components don't fit easily into the traditional structure of billing and insurance, like the telephone coaching.

One challenge that I have encountered with private insurance is that it only pays for face-to-face psychotherapy. So all of the phone coaching and case management can end up being done for free. It makes people's work load a lot harder, because you're doing work that you aren't getting paid for or productivity credit for. Because of this, it can also be hard to find clinicians willing to be on the DBT team.

Q: What is one aspect of your DBT team's delivery that you find exceptional? How might it be replicated elsewhere?

MB: I'm really a stickler for staying exactly the way we did it in the research study. We only do adherent, comprehensive DBT. We feel strongly about doing evidence-based treatment only and giving families the opportunity to get the version that was tested in research. That's the strength of our program. I'm very passionate about DBT, I've been doing it a long time. I really believe in the model, and the people on my team, by association, really believe in it, too.

For me, I either do comprehensive DBT or nothing at all, I don't want to do something else because it's not evidence based. It gets really confusing when families come in, they say, "Oh, my kid got DBT. And it didn't work." Well, no, they didn't actually get DBT, they got a group or something with no individual therapy to actually tell them how to implement anything. So families get demoralized and think that DBT doesn't work when they haven't really gotten it. What keeps the team going, and what other teams could replicate is to be really passionate about being adherent. And fighting for that and sticking with it.

Q: What sort of qualities and experiences do you look for in a trainee or DBT clinician during the hiring process?

MB: Of postdocs, I would say, number one is a genuine enthusiasm and interest for working with this patient population. I feel like I could train people to do the treatment, but I can't train people to really want to work with these patients. I think that's the number one, that people genuinely feel passionate about this. They're willing to put in the time to do the phone coaching and to deal with the stress that comes with high-risk patients.

I really want people who are genuinely enthusiastic about this, because this is not something that you can do if you're half-hearted about it, you got to be all in to do this kind of work. And I as a supervisor, I'm all in. I'm on call 24/7, for the trainees all the time. It's nice with Zoom, it's actually easy for me to join sessions and we will make decisions about hospitalization together. I will help you deal with difficult parents. I'm going all in for you and want you to go all in for the team. But I think there are people who want to do that and find that exciting versus have a sense of dread. The people I want are the ones who are like, "oh, that sounds great."

Q: What is the biggest resource challenge you face every year?

MB: I think having more staff, because we can only take 10 to 12 patients in the program at a time before everyone is full. The postdocs can only handle four to five individual DBT cases at one time. I'd like to make the team bigger because we always have a waiting list. I'd love to have more admin support, because I feel like I do a lot of things on my own. I find more actual staffing in every way to be the resource that is missing.

Q: What technology have you found to be critical in running your DBT practice?

MB: I'm not very high tech, so I'd say my cell phone for coaching. When I think about Zoom I was terrified at first when we switched to it with the pandemic but it's been fantastic because the teens really like it instead of having to go to the clinic after school when they're tired. It's also much easier to involve the parents, because often a parent is at work, and they wouldn't have been able to come into the clinic, now they can join the zoom, so we get much better family participation that way. It's actually been nice as a new form of technology. Using Zoom and telehealth has actually been pretty beneficial.

Q: What about any blue-sky technology you think about for the future?

MB: Again, I am not very up to date on the latest technology, but anything that would help guide parents to restrict lethal means at home would be helpful. It would also be really interesting to think about how to incorporate ecological momentary assessment technology for clinical purposes, like getting real-time notifications when a patient is headed toward a suicidal crisis and sending real-time reminders to use DBT skills and/or coaching.

Q: What do you wish you had known before you'd taken on your leadership role? What would be helpful for others to know before taking on theirs?

MB: One thing that has been interesting with my current leadership role is the difference in clinicians' willingness to join the DBT team in an academic setting, where people already have their specialties and only treat certain patient populations, versus working in a community mental health clinic, where clinicians are expected to see any patient who walks in the door and wants to join the DBT team because they are going to be seeing suicidal patients no matter what. So, it has been harder to expand my team than I anticipated.

Interivew with Dr. Alan Fruzzetti

Q: How has DBT informed your approach to management?

AF: I think DBT has had a profound effect on how I think about almost anything to do with mental health services, not just the delivery of DBT. If we think about DBT, as Marsha conceptualized it, DBT is integrative. It's integrating acceptance and change. In the things that we do, we are more skillful or less skillful. From a management perspective, and I would extend this to structural management, like hiring people, training people, supervising people, changing people's jobs descriptions, DBT infuses all of that. We ask ourselves: "What are people's strengths? How can we put those strengths to work?" And any strength exposes a weakness, because when we're good at something, it means that we're less good at something else - a skills deficit. And on a team, we don't all have to have the same strengths. We

don't all have to be skillful at everything. At the same time, we all have to have at least a little skill in everything. We have to understand each other, we have to support each other. And sometimes we literally have to fill in for each other.

Q: Based on what you are describing, I'm wondering if you notice that formal performance review conversations rarely feature surprises.

AF: I tell anybody with whom I have a supervisory and/or teaching role that ideally there is constant attention to what you need. "Am I giving you what you need? What do I think you need? What do you think you need? Do I think I'm providing it? And are you receiving it in a way that's helping you learn?" And I say that if we get to your evaluation, and there's anything surprising, I have failed.

How can we work on a target if we don't agree on the target? If you don't even know what my target is? DBT is great at many things, one of them is orienting, "let's be clear what we're working on." That's why we have a primary target. We have overarching goals in life worth living goals, we have primary targets that are getting in the way of life worth living. And then we have chains to tell us what we're working on to change the primary targets, and skills as solutions (with practice and commitment). I mean, that's a learning enterprise. It's a collaborative learning enterprise.

Q: What have you found to be the two toughest challenges in implementing DBT in a hospital outpatient (inpatient) setting?

AF: The two biggest challenges are administrative. There are a lot of things about DBT that are counter cultural within much of mental health care systems. Things like consultation to the patient, really precise behavioral thinking, finding the kernel of truth, validating the valid even when there's lots of invalid, risk reduction vs. automatically stepping people up to higher levels of care, things like that. And, importantly, Not kicking people out of treatment for having the problems that bring them into treatment. Those kinds of things are often countercultural. And the more pieces that are countercultural, the harder administrative systems have with those changes.

I ran an outpatient clinic for 25 years, it's hard to get people to take calls from clients after hours. Taking your own calls from clients is doable if you've got four of them. But, whether it's managed care, public settings in mental health or private clinics, if you've got many clients in many stages, who can handle that many phone calls? I love to get the calls because sometimes they're really effective, assuming they're not too frequent. But what are the incentives and lack of disincentives? Figuring that out requires you not to have rules, but instead it requires talking and listening and trying to figure it all out collaboratively. It's not one size fits all, which is hard. Systems, and often administrators, seem to like rules.

Q: What is one aspect of your DBT team's delivery that you find exceptional? How it might be replicated elsewhere?

AF: This is tricky, because it changes all the time. And sometimes the thing that's clicking right now, that's great, might not be clicking in three months. I think when a residential program is clicking, when it's exceptional, everybody has bought into DBT as the model and there is strong administrative support. DBT programs, especially residential, have a lot of people that are interacting with the patient on any given day. The primary therapist's role is like the orchestra director. We're all supporting each other. We're aware of what the targets are, we each bring our own contribution to those targets and to each other. It's always been my goal to have anybody who connects with the patient, or the patient's family, to be trained in DBT to some extent and use the piece of DBT that's relevant to that connection.

Over the years we actually have trained every single person that would likely have any contact with the patient or the patient's family, including a lot of the ancillary staff, like the kitchen staff. In training those positions, it was really just about how not to take things personally. Mostly the training is how to understand emotion dysregulation and that it doesn't mean certain behaviors are okay, it's the best the client can do at that moment.

Q: What sort of qualities and experiences do you look for in a trainee or DBT clinician during the hiring process?

AF: I think that the single biggest thing is that beyond being oriented to the model, they really like it. Sincerely, if you're really going to be part of a DBT program, as a professional who's delivering treatment, you'd have to like it. I was a psychology professor for a long time in a psychology department and the single biggest thing that I wanted to know or see to select graduate students, doctoral students, was that they love this. Because our work can't just be a means to an end, it's too hard. Does the model make sense to them and are they willing to throw themselves into it?

Q: How do you interview for that quality?

AF: If you're hiring a staff member, presumably they've got some DBT experience. Right? We might take a postdoc, or hire a staff member such as a skill coach, who doesn't have much DBT experience, they're clearly in a training role. That's

different. I've asked people about their previous experience, what they liked, and what they didn't and what was frustrating, and what was satisfying. And what pieces of that they want to keep doing as they imagine their life going forward. And which, if they could change it, what parts would they do differently? Because you could do DBT with lots of different populations and have very different experiences, right? It's partly DBT, but partly DBT with the population that you're going to treat in your setting, it's got to fit there.

Q: What is the biggest resource challenge you face every year?

AF: The biggest resource challenge is the larger mental health system or lack of it. For people to truly have the freedom to choose, there has to be a choice. We can highlight to folks, dialectically, the freedom to choose given the absence of alternatives. And, what if there's literally no other option? What if the client has no resources to access other options? Freedom of choice in the absence of alternatives means different things to folks with different levels of access to resources. Privilege brings choices, and lack of privilege often limits choices. So reaching people in underserved communities is the biggest challenge to us as a system.

Our mental health system does a really lousy job making people from underserved communities feel welcome, developing programs that fit for them and that are accessible to them financially and in other ways. And there are exceptions, there are wonderful people who are doing great work, but as a whole system it's a huge challenge.

Q: What technology have you found to be critical in running your DBT practice?

AF: Video platforms are incredible. I wish we had never had COVID, believe me. And, having video platforms is amazing. It allows us to do stuff that we otherwise just couldn't do. It's particularly about access. I realize there are lots of people who don't still don't have a computer or a smartphone, and on the other hand there are a lot more people who do can now access care. And that's amazing. And it's not just DBT.

Family Connections is now 90-something percent delivered on Zoom, whereas three years ago, it was 100% delivered in a room with everyone in-person. The expansion of being able to connect with people in rural areas, urban areas that are underserved, it's amazing.

Q: What do you wish you had known before you'd taken on your leadership role? Or what would be helpful for others to know before taking on theirs?

AF: I helped start a residential program in Nevada, with a guy who's now deceased, very sadly, from cancer. He was the medical director for this hospital, and he got exposed to DBT someplace along the way. And he started trying to build a team but had no clue that I was two miles away. And so we had lunch and started doing this together. And because he was the medical director, and so high up in the bureaucracy, wow, I had no idea what a gift that was, that was amazing.

And it developed into a really, really good program. So, the moral of this story is that the bureaucracy can completely get in the way. Or it can be structured to allow DBT to thrive. But it won't do the latter on its own.

For example, in an outpatient program the first time somebody breaks the wall or disrupts something.... Whoever runs the clinic, whoever's in charge of the building probably will want to kick that person out of treatment. They want them to be banished from the building. Of course they do. Right, I get that. And, we don't kick people out of treatment for having the problems that bring them into treatment. We've got to at least give them one more chance. we've got to at least have the chance to do a chain; at least to a solution analysis, do a repair, no pun intended.

The advice is to partner up with people who care about the program and help them really understand the principles and practices of DBT overall. And help them understand the parts that are countercultural, that having a budget for spackle and paint is a good idea for example Or maybe providing bus passes or providing childcare are part of the budget so clients can come to treatment. These are non-normative things in many settings that can make a big difference.

Going Where Angels Fear to Tread: Antiracism in Clinical Practice

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"I sit on a man's back, choking him and making him carry me, and yet assure myself and others that I am very sorry for him and wish to ease his lot by all possible means - except by getting off his back."
- Leo Tolstoy

WE ARE A COMMUNITY that profoundly values mindfulness, and in the wake of the protests following the murder of George Floyd and ongoing murders of Black people at the hands of law enforcement, we have had to reckon with our own lack of awareness as DBT practitioners of how racism is weighing heavily on the backs of our BIPOC (Black, Indigenous and People of Color) colleagues, patients, and teams. In the aftermath of the Black Lives Matter movement that awakened our country and the world, many of us have had to look at ourselves, our teams, and our clinical practices with a new commitment to do better, understand racism more deeply, and work to be more effective allies in the fight for racial justice. These seismic moments of collective mindfulness are important in holding up a mirror to each of us, sans makeup and generous filters.

For many of us, it has meant grappling with a far less attractive reflection of ourselves and our communities. It has shed light on the work that we have yet to do, the mistakes we have made, the all too familiar guilt and shame of past behaviors and ever present anxiety of looking into the future with that deep lump in our throats, thinking we do not quite know what to do when issues of racism show up in our clinical work. What we do know now is that it's problematic and against our values to not shift and change to do better — or to put it more simply in the words of our Gen Z patients, "It's giving me the ick [to know this info and not exactly know how to do better]."In order to reduce that 'ick,' we must go where angels fear to tread: Into not just conversations about antiracism, but also the commitment to behaviorally do better, hear difficult feedback and respond non-defensively and effectively.

To start, we need to first define antiracism. In the words of Ibram Kendi:

"I define an antiracist as someone who is expressing an antiracist idea or supporting an antiracist policy with their actions, and I define an antiracist idea as any idea that says the racial groups are equal. To be antiracist is to think nothing is behaviorally wrong or right -- inferior or superior -- with any of the racial groups. Whenever the antiracist sees individuals behaving positively or negatively, the antiracist sees exactly that: individuals behaving positively or negatively, not representatives of whole races. To be antiracist is to deracialize behavior, to remove the tattooed stereotype from every racialized body. Behavior is something humans do, not races do" (Kendi, 2019).

This definition is of particular significance to us as behavioral therapists engaged in the work of shaping behavior daily. Often, in discussions, words such as 'racist' and 'racism' elicit high emotional reactivity/defensiveness and urge driven responses of "I'm not racist." Kendi's definition allows us to understand that racist and racism are not characterological flaws, but rather behaviors (and policies) in need of change. This means that in one moment, I can act as an anti-racist provider and be supportive to BIPOC patients/colleagues, and in another moment, my behavior may be racist and I am upholding a racist system and structure. Antiracism clinical practices center the impact, not the intent of one's racist behaviors (Kendi, 2019).I highlight this at the outset because it is important as behavioral therapists to understand that racism and antiracism, simply stated, is a set of behaviors that we have the power to identify, shape, change, and extinguish.

Before we can intervene or respond effectively to racist incidents in our clinical practice, we must first assess and accurately identify the racist behavior. While there are many racist behaviors that can be identified, this article will focus on the most frequently occurring and common form of racism: Microaggressions (Smith et al., 2022). Microaggressions are "everyday slights, indignities, put-downs and insults that members of marginalized groups experience in their day-to-day interactions" with individuals who are often unaware that they have engaged in an offensive or demeaning action (Sue et al., 2020). While many of us as DBT practitioners understand microaggressions theoretically, we are often unable to identify when these behaviors show up in our sessions, groups, teams, and practices. To help us bridge the gap between theory and practice, below is a list of microaggressions with clinical examples:

Once we are able to accurately identify and assess the problem behavior or microaggression, we need to be able to intervene effectively. Our response(s) will depend on a myriad of factors, including the context of the

Table 1. Type of Microaggression, Subtypes, Clinical Examples

Types of Microaggressions	Subtype	Example
Microassaults: Intentionally discriminatory behavior	**None**	**Clinician on DBT team states "What's up with Black mothers?"**
Microinsults: Unintentionally discriminatory behavior	Ascription of intelligence	White patients disproportionately inquiring into credentials of BIPOC therapist and not once asking White coleader in group about her credentials.
	2nd class citizen	BIPOC pts (in all white groups with white facilitator) note their identities/race/experiences were not asked about.
	Pathologizing cultural values	White pt states during DBT group break: "OMG Chinatown is so dirty and WTF is up with animals hanging on windows?"
	Assumption of criminality	Black DBT provider walks into group to colead group for first time and upon entering, White pt states, "You should smile more."
	Cultural mimicry	White DBT provider with Black team member on a majority White team changes interpersonal style, language, and mannerisms only when conversing with Black colleague, mimicking Black cultural references.
	Ascription of talent	White pt states to Brown DBT clinician: "You're so articulate, no really. Your vocabulary is so expansive, I'm surprised."
Microinvalidations – Invalidating statements about person/group	Alien in own land	White pt states during group: "These people are always yelling at each other. They don't speak [English] so maybe they're yelling at me but these people have more bass in their cars than a goddamn club. I don't live in a nice neighborhood [referencing the Bronx] so you can imagine how living with people like this can be."
	Color blindness	In clinical assessments, race, ethnic identity frequently overlooked, not directly asked about/assessed so, as clinicians, we are often doing color blind assessments + case conceptualizations.
	Myth of meritocracy	During individual therapy, white clinician cheerleads Black patient: "You got this, keep going. You can work hard and get same job as other people." Ignoring reality of evidence in literature where Black people are not hired with same credentials as whites.
	Denial of individual racism	When white pt given feedback of how they were racist towards BIPOC DBT leader, white pt responds with, "I went to immigration protests over the weekend."
	Cultural appropriation	Patients have given feedback that DBT appropriates concepts around mindfulness without explicitly acknowledging the cultures it borrows said concepts from.

microaggression (e.g., during individual session or group), the composition of participants involved (all white or BIPOC folks present), and if the microaggression occurred at our clinical site(s) or elsewhere.

If BIPOC patients are in an individual session and navigating how to manage or respond to microaggressions, a helpful way to guide them to a wise mind decision is to employ Nadal's (2014) resource and ask them the following questions:

- If I respond, could my physical safety be in danger?
- If I respond, will the person become defensive and will this lead to an argument?
- If I respond, how will this affect my relationship with this person (e.g., co-worker, family member, etc.)
- If I don't respond, will I regret not saying something?
- If I don't respond, does that convey that I accept the behavior or statement?

These questions are intended to help patients determine their priorities: Self-preservation (i.e. do not respond to conserve energy, using their own DT & ER skills) OR self-respect and values (i.e. needing to use IE skills). Simply stated, is the patient more interested in taking care of themselves right now OR educating the other person and letting them know they did something wrong? Depending on the patient's priorities, using the pros/cons skill may be helpful in identifying long- and short-term impacts of responding/not responding.

When microaggressions occur in DBT skills groups, it is important we recognize and treat them as group destroying behaviors. While DBT skills groups adhere to a specific structure that oftentimes leans on the side of ignoring and redirecting treatment interfering behaviors in order to focus on teaching skills, if we are taking an antiracist stance and building a culture of antiracism in our groups, it is imperative that DBT group leaders directly and clearly address the racist behavior in the room as group destroying. This serves several functions:

1. It models to all patients, BIPOC and White, that we are not 'neutral' when racial injustice presents at our practice. We are anti-racist and therefore take a stance of identifying egregious behaviors clearly so BIPOC patients do not have to do more work following an incident.

   When doing antiracist clinical work, it is important to identify the context (public context = group or place with other individuals present, private context = individual session or place with only patient and therapist present) in which racist behavior occurs and intervene within that context. In other words, when racist behavior occurs in DBT group, the antiracist response must also occur within the group. Many providers may be inclined to address this behavior only in an individual session with the patient who engaged in the racist behavior or individually support patient on the receiving end of the racist behavior. While this is often helpful and can be done in conjunction, it is necessary to address the racism in group so all members present are learning how to be more effective antiracists through modeling and psychoeducation.
2. It demonstrates that we are introducing environmental consequences when patients engage in racism. Given that our society frequently does not dole out natural consequences for racist behavior (in fact, frequently reinforces racist behaviors), it is important we as DBT group leaders change contingencies in order to shape patients to behave in antiracist ways.
3. It facilitates necessary emotional experiencing by patients engaging in racist behaviors to feel justified guilt and shame for going against personal and/or group norms and values. In the words of Brene Brown (2020) "being held accountable for racism and feeling shame is not the same thing as being shamed…. We need to understand the difference between being held accountable for racism and experiencing shame as a result of that accountability."

When deciding how specifically to respond to microaggressions in group contexts, the following resource details strategies we may employ:

RESPONDING TO MICROAGGRESSIONS AND BIAS

RESTATE OR PARAPHRASE. "I think I heard you saying_____ (paraphrase their comments). Is that correct?"

ASK FOR CLARIFICATION OR MORE INFORMATION. "Could you say more about what you mean by that?" "How have you come to think that?"

ACKNOWLEDGE THE FEELINGS BEHIND THE STATEMENT. Express empathy and compassion. "It sounds like you're really frustrated/nervous/angry……." "I can understand that you're upset when you feel disrespected."

SEPARATE INTENT FROM IMPACT. "I know you didn't realize this, but when you _____ (comment/behavior), it was hurtful/offensive because_____. Instead you could_____ (different language or behavior.)"

SHARE YOUR OWN PROCESS. "I noticed that you _____ (comment/behavior). I used to do/say that too, but then I learned_____."

EXPRESS YOUR FEELINGS. "When you _____ (comment/behavior), I felt _____ (feeling) and I would like you to_____."

CHALLENGE THE STEREOTYPE. Give information, share your own experience and/or offer alternative perspectives. "Actually, in my experience_____." "I think that's a stereotype. I've learned that_____." "Another way to look at it is _____."

APPEAL TO VALUES AND PRINCIPLES. "I know you really care about _____. Acting in this way really undermines those intentions."

PROMOTE EMPATHY. Ask how they would feel if someone said something like that about their group, or their friend/partner/child. "I know you don't like the stereotypes about _____ (their group), how do you think he feels when he hears those things about his group?" "How would you feel if someone said that about/did that to your sister or girlfriend?"

TELL THEM THEY'RE TOO SMART OR TOO GOOD TO SAY THINGS LIKE THAT. "Come on. You're too smart to say something so ignorant/offensive."

PRETEND YOU DON'T UNDERSTAND. As people try to explain their comments, they often realize how silly they sound. "I don't get it……." "Why is that funny?

USE HUMOR. Exaggerate comment, use gentle sarcasm. "She plays like a girl?" You mean she plays like Serena Williams?" Or Mia Hamm?

POINT OUT WHAT THEY HAVE IN COMMON WITH THE OTHER PERSON. "I'm tired of hearing your Muslim jokes. Do you know he's also studying _____ and likes to _____? You may want to talk with him about that. You actually have a lot in common."

W.I.I.F.T. (What's in it for them). Explain why diversity or that individual/group can be helpful/valuable. "I know you're not comfortable with _____ but they can help us reach out to/better serve other groups on campus/in the community." "In the real world, we are going to have to work with all sorts of people, so might as well learn how to do it here."

Adapted from: Goodman, D. (2011). *Promoting Diversity and Social Justice: Educating People from Privileged Groups.* New York: Routledge

Climb Poem

by Ben Ray

The
task
which lays
before you,
Looming.
Daunting.
Scary.

The
journey of
a thousand miles,
begins with,
a single,
step.

That's
what they say.

But
where is
that
first step?

All
I see
are cliffs;
Not a step
in sight.

So
what now,
oh
wisdom
of the ages?

How
does one
take a step

on a cliff?

A
Looming.
Daunting.
Scary.
Cliff.

You
find the
handholds.

And,
you climb.

Slowly,
but,
maybe not
steadily.

And
then,
the slope
decreases.

And
the climbing
gets easier.

And
then,
the ground
evens.

And
you can walk.

Only,

because,
you climbed.

How Phone Coaching in DBT–A Will Change (Not Ruin) Your Life

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PHONE COACHING (defined as the availability of the primary therapist to be reached by their Stage 1 clients 24 hours a day, 7 days a week) is one of the four core modes of comprehensive, adherent DBT (in addition to individual therapy, skills group, and consultation team; Linehan, 1993). Linehan (1993) described the function of phone coaching in DBT as multifaceted – to improve skills generalization, to help clients learn to effectively ask for help, and to emphasize the importance of the therapeutic relationship by offering an avenue for repair between sessions. Despite the clear rationale, in our experience phone coaching is the mode of DBT that is most aversive to therapists, commonly cited as the reason therapists are unwilling to do comprehensive DBT (or to do DBT at all). This holds true for DBT with adolescents (DBT-A) as well as DBT with adults, with the former involving the complicating variable of parent phone coaching. Our presentation at the 2022 ISIT DBT conference on the topic of phone coaching in DBT-A attempted to debunk some common myths about phone coaching, review benefits of phone coaching for clients and providers, and provide real-world utilization data in an effort to increase provider willingness, potentially by decreasing their related anxieties.

In order to more clearly define what phone coaching is, it is important to understand what phone coaching is not. It is not therapy over the phone; calls are short, aiming for 5-10 minutes in length. It is not client venting; clients calling for coaching are expected to be willing to receive coaching. It is not instant; clients are oriented that providers will respond in 1 – 2 hours, and clients are expected to use skills in the interim. And it is not guaranteed; the 24-hour rule prohibits contact after engagement in target behavior to limit potential reinforcement of that behavior with provider attention. Additionally, providers are human, full of fallibility and real-world limits. By orienting our clients thoroughly to what works best for us – calls vs text messages, preferred structuring of messages, how to communicate after hours, what happens when we go on vacation – we can empower them to use coaching in a way that is therapy enhancing instead of therapy interfering.

The topography of phone coaching is complex, so orienting (and reorienting!) clients to the how of phone coaching is a crucial component of sustainability. Novice therapists can struggle to identify or set limits or tolerate client distress in response to those limits. Strategies to support clarity in communication with clients include orienting clients verbally at the outset of treatment, reorienting when checking in about coaching calls, and providing a handout orienting clients to phone coaching that can be referenced before calling. It is also important for providers to assess client's ability to use phone coaching effectively. As skills deficits are identified, providers use shaping principles to support the client towards more effective utilization. Remember – we don't kick clients out of treatment for engaging in the behaviors that brought them to DBT, and many of our clients have pre-existing interpersonal challenges that may show up in phone coaching. Instead, we assess skills deficits and target these in treatment.

Though the how may be complicated, the why we do phone coaching is clear. It helps clients get better, faster (e.g., Oliveira & Rizvi, 2018; Chalker et al., 2015; Edwards et al., 2021). The data show that clients who have access to phone coaching have been found to have lower drop-out rates, higher treatment satisfaction, and reduced engagement in target behaviors. It enhances skills generalization, provides clients with support to reduce emotion-minded behaviors in the real-world, and can enhance the therapeutic relationship through increased opportunities for validation and reinforcement. Phone coaching can also make individual sessions more rewarding – when target behaviors are avoided between sessions, we can spend session time focused on our client's life worth living goals.

While seeing our clients improve is often all the reinforcement we need, phone coaching also offers additional benefits for providers. We have that much more information about our clients' lives, which can allow us to refine our case conceptualization and treatment plans. We also have the opportunity to support our clients in choosing skillful behavior over a target behavior. This cannot be overstated: we have the opportunity to intervene before self-harm or suicidal behavior occur. Phone coaching can, and has, saved lives.

Despite the data on effectiveness and the opportunity to prevent high risk behavior, providers may still hesitate, worrying about the impact it will have on their personal lives. Let's look at some numbers. In the DBT-A program at the University of California, San Francisco, data collected over a two year period for ~7 providers showed that the most

common number of coaching calls per week was zero. The average number of coaching calls per week was 1.7 (~20 min) with clients and 1.2 (~17 min) with parents. Though only from one program, these numbers suggest that phone coaching need not be life interfering for the provider.

Phone coaching can be very intimidating. The work we do is hard and the idea of "bringing it home" can seem aversive or overwhelming. Yet the data are clear and support Linehan's early beliefs on the importance of phone coaching. In addition, the experiences of many DBT providers support its sustainability. Through clear orientation, assessment and shaping of clients, and the support of a consultation team in observing limits, we truly believe that phone coaching will enhance your satisfaction with and effectiveness at being a DBT therapist.

Resources

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