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Editor's Letter

Hello and welcome to DBT Bulletin, Volume 7. It's been a challenging time in the world and in the DBT community. Those of us on the editorial board have struggled with how to respond and much like the article on dialectics by Gold and Finkelstein, our conversations with each other and our loved ones involve more plaid than Venn diagram. One thing we do agree upon is that we unequivocally condemn Hamas and the killing of innocent Jews and Palestinian people. We call for a return of the hostages unharmed and send our care and support to our Jewish friends and colleagues and to all of the people ravaged by this conflict. Since our board is not wholly represented by the communities most affected, we wanted to give a voice to those that are, allowing representatives from the affected communities to share their wishes for the DBT community moving forward. This was not completed by the time of press, so will defer until the next issue. Until then, we wish you comfort and support in your communities.

Onto the Bulletin. This issue offers a call to understand and treat suicidal youth from various minoritized backgrounds. Dr. Sheftall offers a reminder of her powerful research on Black youth, which was presented at last year's ISIT conference, and Dr. Goldstein and colleagues shares their important research on the significant impact of DBT for youth with bipolar disorder. We are also delighted to have Dr. Hendler's commentary to help build our collective awareness of implicit judgment in some of our language around substance abuse in the context of DBT. As we all know, language is powerful, and his suggestions can help us all be more thoughtful with clients and loved ones alike.

Seeking to stretch us in other ways, Dr. White's article suggests ways to use process-based interventions for conceptualizing and understanding Stage 2 work. We can see ourselves referring to the figure he created over and over. And for all of you who have waited patiently while your client finished their diary card, rejoice! Sakhan and colleagues present data to suggest that it's worth the investment! Finally, we are sure we're not the only ones who have had clients who are part of the BDSM community and wondered if and where to place certain behaviors on the treatment hierarchy. Boyd-Rogers has done a great job breaking it down for us. Thank you to all of the authors, our amazing art director, Jesse Finkelstein, our dedicated board, and our fabulous editorial team! We hope you enjoy the issue and have a great ISIT!

Lynn McFarr and Ashley Maliken

The Changing Landscape of Youth Suicide and Suicidal Behavior: An Examination of Racial Differences

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In the United States, youth suicide and suicidal behavior has increased over the past decade and in 2020, suicide was the third leading cause of death for youth ages 10-19 years, accounting for 2,797 lives lost (Centers for Disease Control and Prevention, 2020a). When examining youth suicide over the past ten years, specifically between 2010-2020, boys were approximately three times more likely to die by suicide than girls. However, from 2000 to 2020, the rate of suicide in girls increased 114% which accounts for an increase that is four times larger than the increase seen in boys (Centers for Disease Control and Prevention, 2020b). Finally, when we examine self-harm behaviors seen in US emergency departments (ED) nationally, the rate of self-harm presentations for youth, 10-19 years, from 2001 to 2020 has increased 181% (Centers for Disease Control and Prevention, 2020c). From this data, it is clear that youth suicide and suicidal behavior is a major public health concern.

Suicide in the youngest group of youth has also increased significantly (Centers for Disease Control and Prevention, 2020b). Research in the field of suicide has primarily focused on adolescents and adults. However, the data for youth 5-12 years provides the evidence needed to seriously consider examining suicidal behaviors in this age group. In 2009, suicide for 5—12-year-old youth was the eighth leading cause of death. As of 2020, suicide was the fifth leading cause of death and accounted for 180 deaths in this age group (Centers for Disease Control and Prevention, 2020a). From 1990 to 2020, the number of suicide deaths seen in 5—12-year-old youth increased 195% and the number of ED presentations for self-harm behavior increased 411% (Centers for Disease Control and Prevention, 2020b, 2020c). One of the biggest concerns with this age group is the lack of availability of suicide prevention programs and interventions to address suicide and suicidal behaviors in youth 5-12 years. This limits our ability to act in effectively preventing suicide in youth this young.

Not only are we seeing changes by age in suicidal behavior, we also see changes by race and ethnicity. From 2000 to 2020, suicides in the age group of 5-19 years old increased by 78% among Black youth (Centers for Disease Control and Prevention, 2020b). When examining sex differences within Black youth, in 2010, suicide was the third leading cause of death for Black boys and the sixth leading cause for Black girls. In 2020, the number of deaths in Black boys increased by 81% with 278 Black boys dying by suicide. For Black girls, suicide became the third leading cause of death with the number of suicide deaths increasing by 179% (n=117). The second largest increase of suicide deaths for youth aged 5-19 years was found in Asian/Pacific Islander youth, with a 62% increase, and the third largest increase was among Indigenous youth, with a 44% increase (Centers for Disease Control and Prevention, 2020b). When examining ethnicity, in 2020, suicide was deemed the third leading cause of death for Hispanic youth 5-19 years, accounting for 555 deaths. This is an 87% increase in suicide deaths since 2010. For Non-Hispanic youth age 5-19 years, in 2020, suicide was the third leading cause of death accounting for 2,259 deaths which was a 39% increase since 2010.

The rates of youth suicidal behavior are changing and the groups who are experiencing these increases are shifting in age (e.g., 5—12-year-old youth). Unfortunately, the research on the reasons why these increases have occurred, the mechanisms related to suicidal behavior in youth of color, and the proper way to assess suicidal behaviors in this population is limited (Molock et al., 2023; Sheftall & Miller, 2021). We must not only educate others of the increases present in different groups of youth, but we must also work together with community leaders and researchers to create and implement culturally, developmentally relevant suicide prevention programming for the groups of youth experiencing these increases. If we work together, the change created will be sustainable and we will have a fighting chance at decreasing the lives loss to this preventable method of death.

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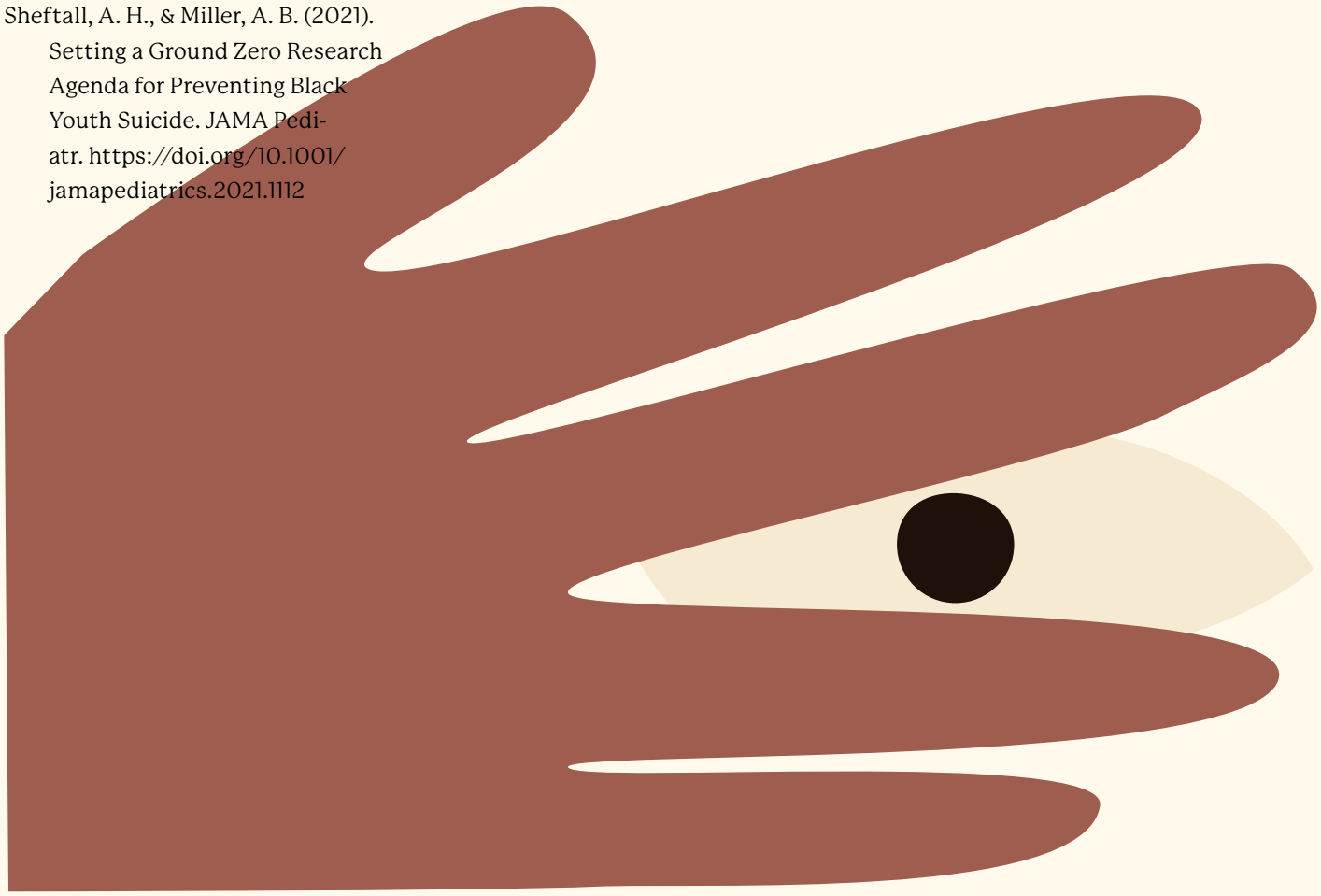

Dialectical Behavior Therapy (DBT) for Adolescents with Bipolar Spectrum Disorder: Results from a Randomized Trial

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YOUTH WITH bipolar spectrum disorder are at substantially elevated risk for suicidal behavior. In fact, of all psychiatric disorders in youth, bipolar disorder is associated with the greatest risk for death by suicide (Brent, 1995), and represents the most costly, primarily driven by emergency department visits and hospitalizations for suicide attempts (Peele et al., 2004; Stensland et al., 2010). Longitudinal data suggest that 20% of youth with bipolar disorder will attempt suicide over 5 years, 40% of whom will attempt multiple times during this period (Goldstein et al., 2012). Despite these statistics, although there are several evidence-based psychosocial treatments for youth with bipolar disorder, none of these interventions expressly targets, nor reports on, suicidal behaviors in this population (Brickman & Fristad, 2022). While Dialectical Behavior Therapy (DBT) has demonstrated efficacy in decreasing suicidal behavior among transdiagnostic adolescents, these samples either exclude youth with bipolar disorder, or youth with bipolar disorder are under-represented (McCauley et al., 2018; Mehlum et al., 2014), rendering conclusions about efficacy for this ultra-high-risk population of youth limited. We therefore conducted a randomized clinical trial to examine the efficacy of outpatient DBT-A, as compared with Standard of Care psychotherapy (SOC; delivered by clinicians trained in other evidence-based approaches for adolescents with bipolar disorder but not trained in DBT) for adolescents with bipolar spectrum disorder. Primary outcomes included mood symptoms and states and suicidal behavior over one year. We hypothesized that youth who received DBT, as compared with those who received SOC, would have fewer suicide attempts and lesser mood symptom severity over one year follow-up. We also hypothesized that those youth with a history of suicide attempt would exhibit greatest benefit with DBT (moderation) and that DBT effects on suicide attempts would be mediated through improvement in emotion dysregulation.

Methods

Greater detail on study methods is available in the original manuscript (Goldstein et al., 2023). In sum, the study was a 2-arm, parallel group randomized clinical trial. Participants (n=100) included adolescents ages 12-18 diagnosed via semi-structured interview with a primary bipolar spectrum disorder via the Kiddie-Schedule for Affective Disorders and Schizophrenia (KSADS; Kaufman et al., 1997). Youth with developmental disability, autism spectrum disorder, and/or other ongoing psychotherapy services were excluded, as were those who were unwilling to engage with a study-affiliated child psychiatrist and those who did not have a parent, guardian or other close contact willing to participate in DBT family skills training (if randomized to the DBT condition). Trained Master's level clinicians blind to treatment assignment assessed participants quarterly over 12 months. Primary outcomes included suicide attempt measured via the Columbia Suicide Severity Rating Scale (CSSRS; Posner et al., 2011) and the Adolescent Longitudinal Follow-Up Evaluation (ALIFE) Self-Injurious Behaviors Scale (Goldstein et al., 2012) as well as depression and mania symptom severity via the KSADS Mania and Depression Rating Scales (MRS, DRS; Axelson et al., 2003; Chambers et al., 1985). The borderline personality disorder module of the Structured Interview for DSM-IV Personality (SIDP; Pfohl et al., 1997) was also administered to assess for co-occurring borderline personality disorder.

All participants received medication management with a study-affiliated child psychiatrist who utilized a flexible medication algorithm (Kowatch et al., 2005). Participants were randomly assigned to receive one year of either: DBT for adolescents with bipolar disorder (Goldstein et al., 2007; Goldstein et al., 2015) or Standard of Care (SOC) psychotherapy delivered in a specialty outpatient clinic for youth with bipolar spectrum disorders. DBT for adolescents with bipolar disorder is based on Miller et al.'s model for suicidal adolescents (Miller et al., 2007), and includes all standard DBT components, with adaptations for youth with bipolar disorder (see Goldstein et al., 2007 for further details). SOC was delivered by clinicians trained in other evidence-based approaches to treating youth with bipolar spectrum disorders (e.g., Family Focused Therapy, Cognitive Behavioral Therapy, Psychoeducation), but not trained in DBT.

A random sample of 15% of DBT individual and skills training sessions rated quarterly throughout the study by independent fidelity coders trained to reliability on the DBT Adherence Coding Scale (Harned et al., 2021) indicate 95.6% of DBT sessions were delivered at or above fidelity to DBT, whereas 94.4% of SOC sessions were rated below fidelity to DBT, supporting DBT adherence and minimal contamination between treatment conditions.

Results

The sample included 100 youth (DBT n=47, SOC n=53); 85% were female sex assigned at birth. The majority identified ats White (74%) followed by Black (17%), more than one race (6%), another race (2%) and Asian (1%). Seven percent self-identified as Hispanic ethnicity. Per inclusion criteria, all had a primary diagnosis of bipolar disorder; 62% had a lifetime history of suicide attempt, and less than 10 total participants met criteria for borderline personality disorder at study intake (exact figure withheld to prevent identifiability).

We utilized repeated measures linear and generalized linear mixed models fitting random intercepts to account for within-subject clustering over repeated measures and random slopes where Wald tests indicated significant variation in fixed effect slopes by participant. Models included treatment, time, baseline level of the outcome being modeled, and second and third order interactions. Additional information on the study sample and analytic approach can be found in Goldstein et al. (Goldstein et al., 2023).

Outcome data indicate that mood symptoms similarly improved in both treatment groups over a 1 year period (standardized DRS slope =−0.17, 95% confidence interval (CI)=−0.31 to -0.03; standardized MRS slope=−0.24, 95% CI=−0.34 to −0.14). In line with hypotheses, risk for any suicide attempt as well as total number of suicide attempts over one year was significantly lower among youth who received DBT as compared to those who received SOC (ALIFE incidence rate ratio (IRR)=0.32, 95% CI=0.11—0.96; CSSRS IRR=0.13, 95% CI=0.02—0.78). This finding was further moderated by lifetime history of suicide attempt, whereby DBT was particularly effective among those youth (62% of the total sample) with a lifetime history of suicide attempt (IRR=0.23, 95% CI=0.13—-0.44).

Discussion

This study represents the first to examine efficacy of DBT for adolescents diagnosed with bipolar spectrum disorder in a randomized clinical trial. Findings indicate improvement in mood symptoms (depression and hypo/mania) among youth who received DBT on par with SOC, which included other evidence-based approaches to treating youth with bipolar disorder. Critically, DBT was associated with decreased risk for, and lesser number of, suicide attempts over one-year follow-up. Youth with a lifetime history of suicide attempt were particularly likely to demonstrate decreased risk for suicidal behavior during follow-up.

We recognize limitations of the study, primary of which includes limited diversity in this treatment-seeking sample (primarily includes individuals who identify as female sex assigned at birth, non-Hispanic, White and middle class). It will be critical for our future work to address disparities in this population. Furthermore, the SOC psychosocial comparator condition was not manualized and SOC sessions content was based on SOC clinician report. Although adherence data from independent coders indicate that a random selection of SOC sessions in the study were clearly below DBT competence (i.e., not adherent DBT), the quality of the SOC content delivered is not known.

Despite clear evidence supporting the validity, reliability and continuity of bipolar disorder diagnoses among youth (Goldstein et al., 2017), controversy in the field remains regarding the developmental presentation and diagnostic criteria (Malhi et al., 2023). Indeed, differential diagnosis of early-onset bipolar disorder can be challenging, and distinguishing symptoms of bipolar disorder from those of borderline personality disorder is particularly difficult given symptom overlap (Bayes et al., 2019; Zimmerman & Morgan, 2013). It is noteworthy that participants in this study were carefully assessed for both bipolar spectrum disorder and borderline personality disorder via semi-structured interview, and DSM-IV criteria were applied. In keeping with other studies utilizing similar rigorous methods, few (<10) also met criteria for a co-occurring borderline personality disorder diagnosis (Yen et al., 2015).

We hypothesized a priori that youth who received DBT would exhibit lesser mood symptom severity over follow-up than those who received SOC. However, over the one-year study period, depression and hypo/mania similarly improved in both treatment groups. These findings are perhaps not surprising given prior studies demonstrating similar impact on depressive symptoms among individuals receiving DBT and comparator psychosocial interventions (Panos et al., 2014). Furthermore, the SOC comparator condition in this trial was delivered by experienced clinicians with training in other evidence-based interventions for this population that have demonstrated impact on mood outcomes. As such, these findings offer support for DBT as an effective intervention for stabilizing mood among adolescents with bipolar spectrum disorder. Given the relatively low base rate of bipolar spectrum disorder as compared with other psychiatric disorders in youth associated with elevated risk for suicide (e.g., major

depression), and the recognition that few clinicians and programs serving high-risk youth offer specialized intervention for youth with bipolar spectrum disorders, these data provide preliminary support for common shared treatment approaches and potentially underlying mechanisms if replicated.

Importantly, youth who received DBT demonstrated decreased risk for, and lesser total number of, suicide attempts over one year, rendering this the first study to demonstrate an impact on suicidal behavior for this high-risk population. Forthcoming data from this trial will further examine longer-term outcomes, psychological and neural mechanisms of treatment response, and cost effectiveness.

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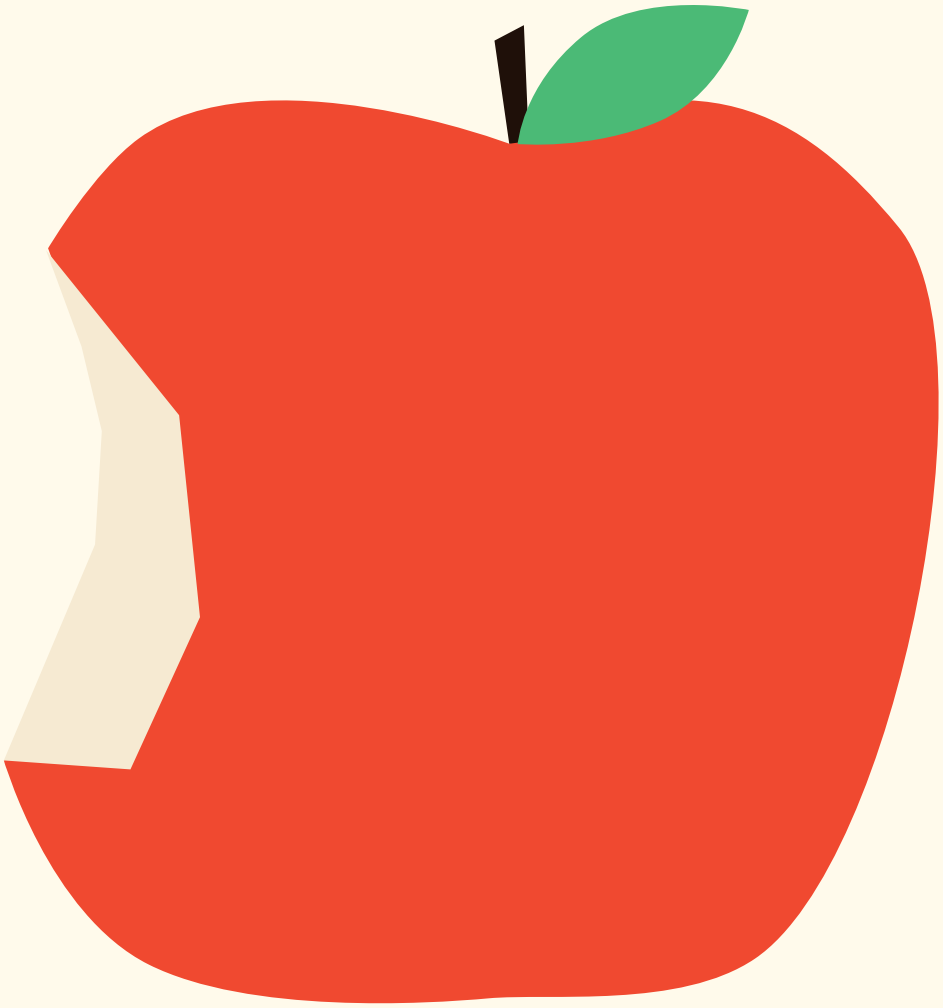

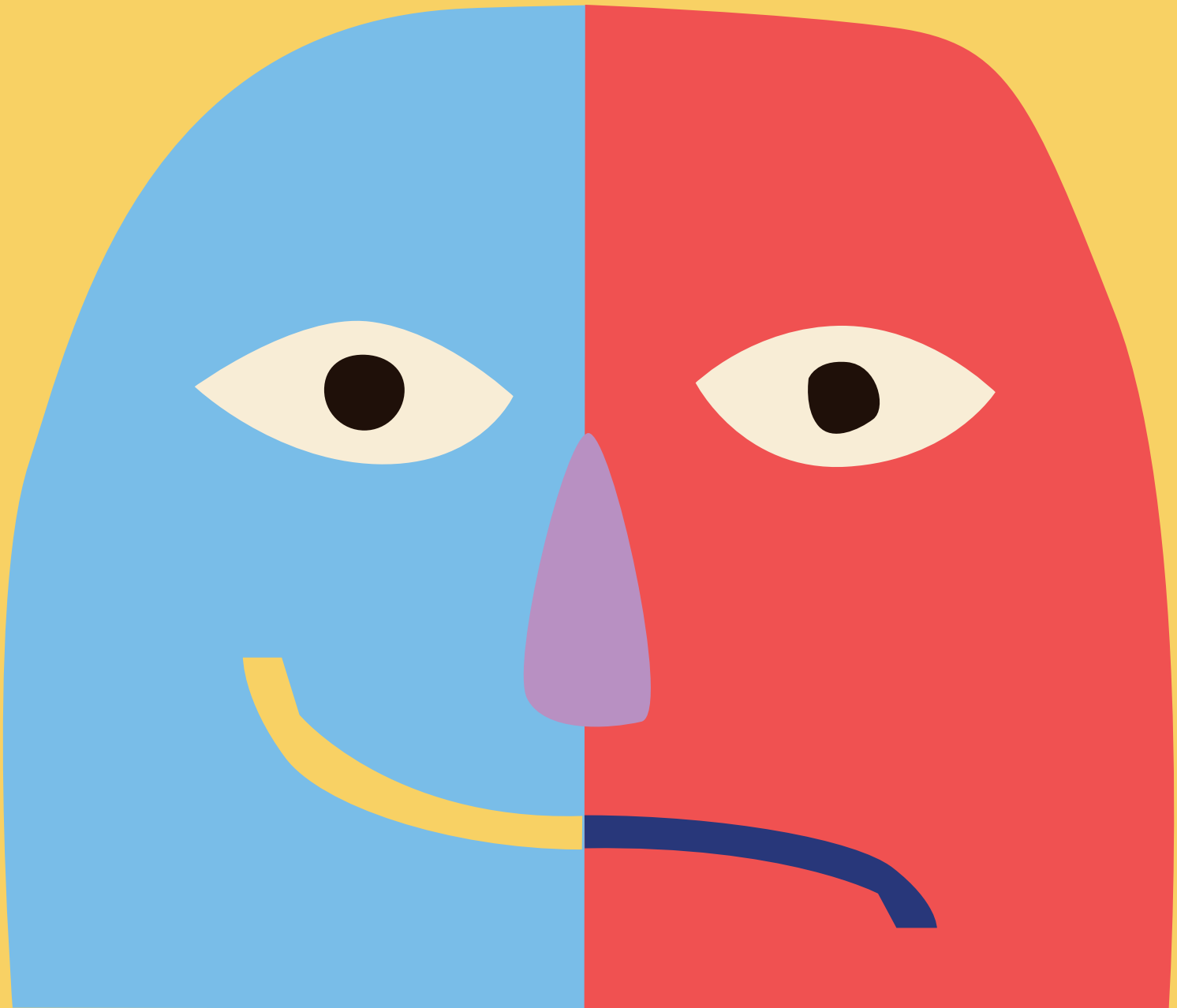

Exploring the Relationship between Diary Card Completion and Symptom Reduction in Outpatient DBT

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BORDERLINE PERSONALITY DISORDER (BPD) is a complex mental health condition characterized by pervasive instability in interpersonal relationships, self-image, emotions, and impulsivity. Individuals living with BPD frequently struggle with intense mood swings, a profound fear of abandonment, a persistent sense of emptiness, and a tendency towards self-destructive behaviors, including self-harm and suicidal ideation. BPD is also frequently comorbid with other psychiatric disorders, including depression (Choate et al., 2021; Edwards et al., 2021; Probst et al., 2018; Roberts et al., 2021; Steil et al., 2018), anxiety disorders (Choate et al., 2021; Edwards et al., 2021; Probst et al., 2018; Roberts et al., 2021; Steil et al., 2018), and post-traumatic stress disorder (PTSD; Edwards et al., 2021; Jowett et al., 2020; Roberts et al., 202; Steil et al., 2018), compounding the challenges faced by those affected.

Dialectical behavior therapy (DBT) has emerged as the gold-standard treatment for BPD (Linehan, 1993). DBT integrates elements of cognitive-behavioral therapy (CBT) with mindfulness and acceptance strategies to help clients build emotion regulation skills, improve interpersonal effectiveness, and enhance their overall well-being (Linehan, 1993). Research has demonstrated that DBT has the potential to lessen symptoms of BPD and comorbid disorders (Edwards et al., 2021; Steil et al., 2018; Roberts et al., 2021).

Central to the DBT framework is the use of outside-of-session skills practice through homework completion and phone coaching. These elements of the treatment have been demonstrated to be integral to mitigating both BPD and PTSD symptoms, including decreasing the frequency of self-injurious behavior and lowering dissociative symptoms (Steil et al., 2018). DBT uses homework like diary cards to track clients' skills application throughout treatment. Diary cards are also designed to facilitate self-monitoring and the use of skills, presence of emotions, and frequency of target behaviors. Diary card completion is a cornerstone of DBT homework, serving as a tool for both therapists and clients to set their weekly session agenda, as well as assess treatment progress to make informed adjustments to the treatment plan if/as indicated. In fact, targeting diary card completion is often second only to suicidal behavior in DBT.

Edwards et al., 2021 found that skills homework completion and phone coaching in outpatient DBT were associated with reductions in several important target behaviors, including suicidal behaviors and substance use. Skills homework completion was associated with significantly reduced urges of suicidal behaviors and substance use. This study indicated that completing skills homework was marginally associated with reduced alcohol use. Frequency of phone coaching use was also significantly associated with reduced self-harm urges. The relationships between these treatment components and broader symptom reduction for DBT patients are not yet well understood, so new research is needed to dive deeper into the relationship between specific DBT interventions and symptom reduction, particularly in comorbid BPD and PTSD participants.

Given previous research which indicates that incomplete homework can be an early warning sign of poor treatment outcomes (Probst et al., 2018), it seems important that each instance of missing homework in DBT is assessed and strategies (e.g., problem solving, commitment) are applied to increase completion (Edwards et al., 2021). Through thorough analysis, clinicians can determine the cause for not completing homework (e.g., lack of engagement, difficulties with comprehension of homework, assuming that homework is not important to one's personal and treatment goals, difficulties with applying skills outside of the therapy context) and intervene accordingly. Further research on DBT outcomes in treatment should focus on the completion of skills homework and utilization of skills coaching, which our study assesses. The present study also examines whether diary card homework completion and duration of treatment predict positive treatment outcomes in full-model DBT, as indicated by reductions in PTSD, depression, anxiety, and BPD symptoms.

Methods

A naturalistic within-subjects design was used to examine the relationship between diary card completion in DBT and symptom reduction across a range

of mental health measures. Our primary hypothesis was that greater diary card completion would be associated with more rapid reductions in symptoms over the course of treatment.

Participants (N = 299, Mage = 27.9, SD = 11.3; 65% Cisgender Women, 31% Cisgender Men, 4% Nonbinary or Transgender) were patients completing comprehensive DBT treatment at an outpatient clinic in Southern California. Table 1 displays constructs and corresponding measures examined in analyses, including depression, anxiety, borderline symptoms, emotion dysregulation, post-traumatic stress symptoms, and mindfulness. Measures were administered at intake and every 2 months throughout treatment. Diary cards were administered daily. Mixed linear effects models were used to examine the association between diary card completion and outcome change over time. Time in months from baseline, the proportion of diary cards completed (ranging from 0 to 1), and their interaction term were included in the final model for each outcome.

Table 1. Constructs and Corresponding Measures Examined in Analyses

Constructs	Measure
Depression	Patient Health Questionnaire (PHQ-9)
Anxiety	Generalized Anxiety Disorder Assessment (GAD-7)
Borderline Symptoms	Borderline Symptom List (BSL-23)
Emotion Dysregulation	Difficulties in Emotion Regulation Scale (DERS-18)
Post-Traumatic Stress	PTSD Checklist (PCL-5)
Mindfulness	Five Facet Mindfulness Questionnaire (FFMQ-15)

Results

As depicted in Figure 1, there was a significant interaction between months in treatment and diary card completion rate for borderline symptoms (b = -1.13, se = 0.42, p < .01), as well as depression (b = -0.46, se = 0.14, p < .001), and anxiety (b = -0.32, se = 0.12, p < .01) symptoms, such that a higher proportion of diary cards completed by a patient was associated with fewer symptoms endorsed for each month of treatment.

The interaction effects on emotion dysregulation (b = -0.49, se = 0.26, p = .062), post-traumatic stress symptoms (b = -0.72, se = 0.40, p = .080), and mindfulness (b = 0.30, se = 0.20, p = .129) were statistically nonsignificant; however, they exhibited a similar directional trend as the other effects.

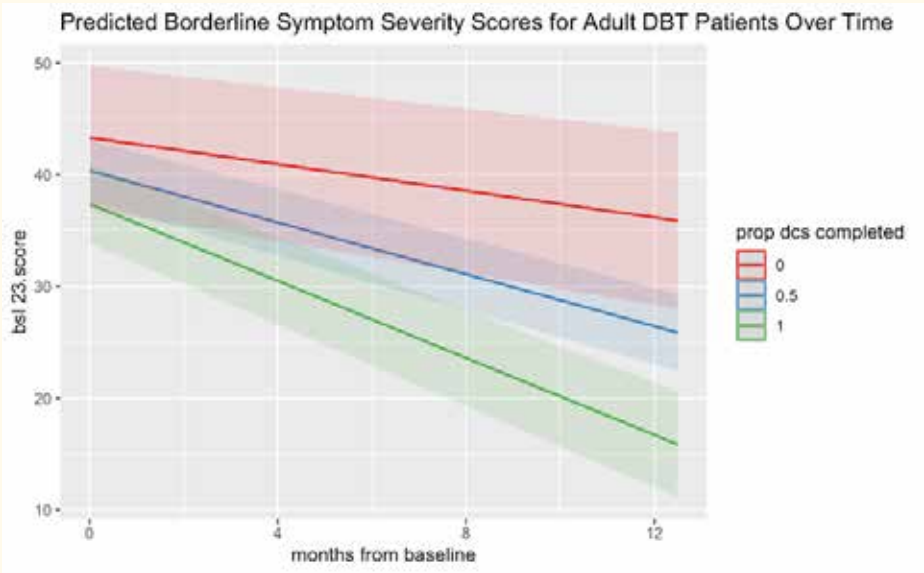
Additionally, significant main effects for months in treatment were found for emotion dysregulation (b = -0.58, se = 2.15, p < .001) and mindfulness (b = 0.35, se = 1.35, p < .05), such that patients, on average, experienced improvements on average each month of treatment, over and above the effect of diary card completion.

Discussion

The primary hypothesis was partially supported in that a greater proportion of diary card completion was associated with more rapid improvement in symptoms of depression, anxiety, and BPD, highlighting the utility of diary cards for addressing and managing these symptoms within the context of DBT treatment. However, results did not reveal a similar relationship between diary card completion and symptom reduction for emotion dysregulation, post-traumatic stress, and mindfulness, suggesting that diary card completion may not have the same level of impact on these dimensions of mental health.

Additionally, results supported our other hypothesis that more time spent in treatment would be associated with more significant improvement in patient symptom scores. The demonstration of symptom improvements persisting 12 months into treatment underscores the importance of adhering to, at minimum, the standard six-month DBT model. Results also offer compelling evidence of the progress clients can achieve when they continue DBT (an additional 6 months of treatment) to solidify and fine-tune their newly acquired skills.

Figure 1



Several factors may account for the divergence in observed effects of diary card completion across specific constructs measured in this study. Variance in patient engagement may be one explanation for this pattern of results. For example, more severe PTSD symptoms could present as an obstacle to attending sessions, limiting the benefit of completing diary card homework. It is also possible that PTSD symptoms, mindfulness, and emotion dysregulation are less responsive to self-monitoring. Further research is needed to understand the effects of diary card completion and duration of treatment on PTSD, trait mindfulness, and emotion dysregulation.

This study had several limitations. First, the majority of the participants were white, women, well-educated, and able to pay for services out-of-pocket, limiting the generalizability of results. Second, the lack of a control group and random assignment prevents causal inference. As discussed above, given that the models did not include data related to the therapist, it remains unclear whether variability in adherence to diary card review procedures of the therapists influence the impact of diary card completion on the measures examined. For example, emphasis on diary card content within sessions differs between providers. While an overarching principle of DBT is to acknowledge and address diary card responses continually, therapists also tend to have different approaches to targeting diary card compliance and varying levels of commitment to diary card reviewing protocols. Treatment may have also differed between new and more experienced clinicians and the strategies used amongst them. Lastly, although patients were included as a random intercept in the model, therapists were not included in the model and may spend more or less time addressing specific aspects of the diary card related to emotion regulation, mindfulness, and PTSD which could be another limitation.

Despite these limitations, there are also a number of strengths worth highlighting from this study. First, this study provides valuable insight into one of the critical components of DBT – the diary card – and its relationship with symptom improvement. Second, our use of multiple scales as a longitudinal tracking method proved to be a robust statistical approach, effectively emphasizing the wealth of data obtained from participants' consistent measurement collection throughout treatment. Although DBT has been established as an evidence-based treatment for decades with a central means of monitoring progress using diary card responses, little research assessing and affirming its continued effectiveness exists, particularly within populations experiencing comorbid BPD and PTSD populations. Finally, the use of measures from an existing outpatient sample underscores the real-world application of our findings.

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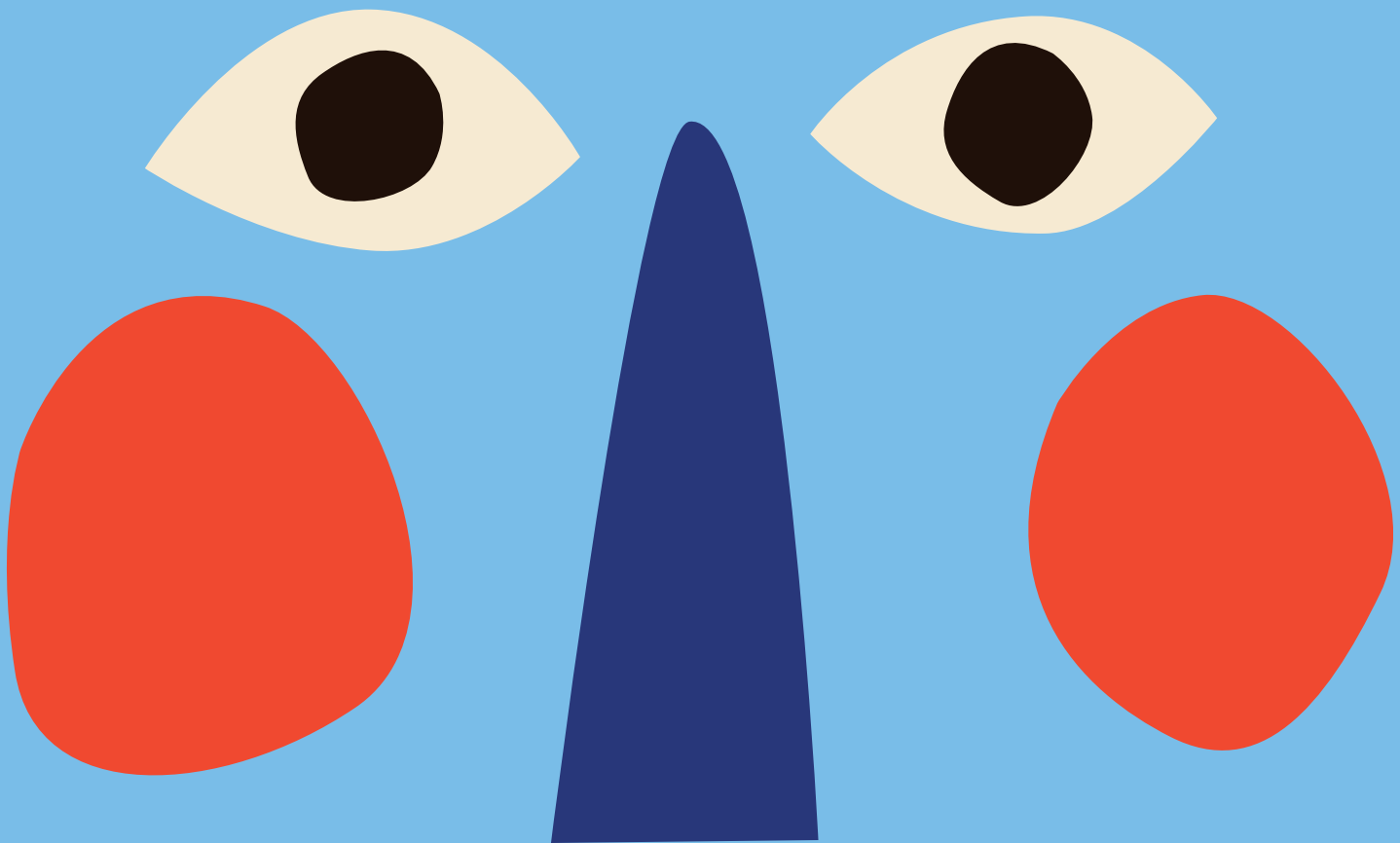

BDSM 101 for DBT Providers

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University of Iowa

BONDAGE/DISCIPLINE, dominance/submission, sadism/masochism (BDSM) is described as a sexual preference for consensually giving or taking control during a sexual encounter. Though some may see BDSM as a "niche" sexual interest, 76% of a large sample of therapists reported working with at least one client with a history of engaging in BDSM. Further, only about half of those providers perceived themselves to be competent in this area (Kelsey et al., 2012) and BDSM-practicing individuals report being frequently misunderstood by their clinical health providers in therapy contexts (Dunkley & Brotto, 2018). The prevalence of BDSM community membership has not been examined specifically among clients with a diagnosis of borderline personality disorder (BPD), who are clients frequently triaged to DBT programs, nor among clients receiving DBT. However, when comparing both populations, there are superficially similar behaviors that may be present (e.g., non-suicidal self-injury) but that serve critically distinct functions (e.g., emotional regulation vs. sexual arousal) of which DBT clinicians in particular should be aware. Indeed, in one study, the now outdated "sexual masochism disorder" from the DSM-IV was much more likely to be diagnosed in a sample of women also diagnosed with BPD compared to women with other personality disorders (though formal BDSM membership was not assessed in this work) (Frias et al., 2017). Thus, having a greater degree of knowledge about the function of these behaviors, in addition to the form, will allow DBT clinicians to more adequately assess the functional difference of these behaviors and take that into account during the case conceptualization process. It is important for clinical scientists, and particularly DBT clinicians, to have a greater understanding of the profile of BDSM practitioners for purposes of both clinical practice and research with sexual subculture populations.

Mental Health Profile

BDSM-related behaviors were pathologized in the Diagnostic Statistical Manual (DSM) until the publication of the DSM-5 in 2013. However, mental health research comparing cisgender BDSM practitioners to cisgender community samples have not found many differences in psychological functioning. Both male and female BDSM practitioners ranked higher on subjective well-being, conscientiousness, openness to new experience, and extraversion while scoring lower on measures of rejection sensitivity, and neuroticism, when compared to a non-BDSM identifying control group (Wismeijer & van Assen, 2013). Relative to non-BDSM samples, male BDSM practitioners show less psychological distress and female BDSM practitioners show no significant difference (Richters et al., 2008). Thus, BDSM behaviors are not necessarily linked to negative mental health functioning, a history of sexual trauma, or distress, as historically depicted in the DSM. Indeed, a recent study found that BDSM practitioners actually showed greater emotion regulation compared to a general community adult sample (Dahl et al., 2023).

Some research has found that BDSM practitioners are more likely than the general community to endorse non-zero levels of suicidal ideation (Brown et al., 2017). However, particularly in the absence of any expected mental health correlations with this finding, it may be the case that members of this population are more likely than general community samples to endorse certain items on measures of suicidality and non-suicidal self-injury because of their practices in BDSM (e.g., intentionally burning or cutting). These behaviors, while superficially similar or identical to self-harming behaviors displayed in other clinical populations, typically serve opposing underlying functions. While those with, for instance, BPD, may use non-suicidal self-injury as a form of emotion regulation or grounding, BDSM practitioners may engage in similar behaviors for purposes such as sexual arousal enhancement, trust building, spirituality, or intense recreational leisure (e.g., Baker, 2018; Sloan, 2015; Sprott & Williams, 2019; Williams et al., 2016). In addition, these studies reporting higher rates of non-zero levels of suicidal ideation in BDSM practitioners failed to control for their subjects' other intersectionally marginalized identities that are associated with minority stress (e.g., sexual and gender minority individuals). This is particularly problematic because BDSM practitioners have a higher likelihood of also identifying as lesbian, gay, bisexual, transgender, queer, intersex, or asexual (LGBTQIA+) compared to general community samples (Richters et al., 2008).

BDSM and LGBTQIA+

Members of the LGBTQIA+ community are more likely than their heterosexual counterparts to endorse engagement in BDSM (Richters et al., 2008). From a Minority Stress perspective, (Meyer 2003), BDSM practice could operate as another source of minority stress, given the enactment of stigma toward those who engage in BDSM behaviors (Stockwell et al., 2010; Weiss, 2006). However, active membership in a BDSM community may also provide a source of social

support and community resilience (Boyd-Rogers & Maddox, 2022). From a research perspective, assessing potential BDSM identity and subsequent risk and resilience factors could provide a more nuanced view of the intersectional experience of some members of this population (e.g., Boyd-Rogers & Maddox, 2022; Richters et al., 2008).

Recommendations

BDSM practitioners may endorse more items on certain suicidal ideation inventories and non-suicidal self-injury forms than a general community sample because of their engagement in BDSM (e.g., intentional cutting, burning). Thus, mental health practitioners, and particularly those in DBT treatment settings, need to assess not only the form of these behaviors but also their function when BPD-associated items are endorsed (e.g., for emotional grounding vs. for sexual stimulation or connection with partner). It may also be the case that there will sometimes be alternating functions or an overlap across functions related to both BDSM practice and emotion regulation. For instance, BDSM practitioners may engage in "pain play" with a trusted partner at the end of a stressful week, as a way to "de-stress" (similar to engaging in recreational activities) but not for acute emotion regulation purposes (Sprott & Williams, 2019). In addition, it is critical to evaluate what safety protocols may or may not be in place when these practices are related to one's engagement in BDSM.

Further, qualitative research with BDSM practitioners has led to two primary recommendations for cultivating an affirming clinical environment for BDSM practitioners. First, BDSM practitioners endorsed the importance of clinicians not focusing excessively on BDSM when concerns were unrelated to BDSM engagement (Dunkley & Brotto, 2018; New et al., 2021). Second, therapists working with a BDSM practitioner should do their own research on BDSM so that they are positioned to understand the nuances of the community and appreciate the stigma associated with holding this identity (Dunkley & Brotto, 2018; New et al., 2021) in order to understand that the centrality of a BDSM identity and sensitivity to stigma are not necessarily consistent across BDSM practitioners. Further, clinical scientists are more likely to encounter BDSM practitioners when working with other sexual and gender minority populations, given the high degree of intersexuality across these two populations (Richters et al., 2008). Clinicians will need to assess both the potential minority stress and resilience related functions of the client's BDSM experience when assessing how this operates within an individual's own life.

Finally, formal practitioners of BDSM participate in communities with several psychological and physical safety nets in place. However, for those who engage in BDSM outside of these formal spaces, these safety mechanisms are not necessarily in place and the use (or lack thereof) of these safety mechanisms should be assessed both in clinical practice and in future research. Because of the thematic overlap between consensual BDSM engagement and nonconsensual sexually aggressive behavior, it also is critical for clinical scientists to draw a distinction between these two phenomena, both when inquiring about client experiences in clinical care (Dunkley & Brotto, 2018) as well as when assessing consensual BDSM in research settings.

In conclusion, BDSM is not only a likely part of many clients' experiences but also a potential source of resilience and community support, particularly for those that hold other marginalized sexual and gender minority identities (Boyd-Rogers et al., 2022).

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Bringing Process Based Structures into DBT

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TAKE A MINUTE to do a thought experiment- you've been working with a patient in your DBT program who has moved from Stage I treatment (e.g. behavioral dyscontrol) to Stage II (e.g. emotion experiencing). Your collaboration (and skills training) has resulted in successful control over high-risk behavior (even in the presence of a stressful cue) and they are committed to (and have some success in implementing) skills use even when "not in the mood". At the same time, they continue to come to session and report difficulty getting the emotion regulation skills to work. This breakdown in being able to regulate is blocking their progress towards their goal of being a standup comic, and they have begun to worry that not only will this never be an achievable goal for them, but that it will be another failed career in a long history of work struggles.

They present the following issue to you- Whenever they are heckled during a comedy set they are reminded of difficult past experiences and begin to feel intense shame and sadness. This has resulted in your client starting to avoid situations where they could get heckled to the extent that they have begun to avoid doing performances, going to see other comedians, or be around any situation where heckling could occur. On this particular day, they come into your tastefully decorated office, sit down, and tell you "I'm really ready to work on this- I don't think I can have the kind of life I want if I can't control these emotions. I've looked through the skills book, and I'm confused about where to go next. I have tried the emotion regulation handouts, but I can't get them to work. What should I do? Does DBT help with things like this? Should I try something else?"

Do you say...

A. "I can refer you to a non-DBT therapist to work on these things, or maybe a life coach"

B. "I have two words for you- STOP IT"

C. "I don't know- I really hope someone writes a book about how to apply DBT to that, I'd like to restart my comedy career as well"

D. "I think we can apply the frameworks in DBT to the problem at hand and doing this might help us solve other things as well."

For the sake of argument, let's go with Option D. Now here is the issue- how do we actually apply the emotion regulation framework used in DBT? After conducting thorough behavioral chain analyses to understand what prompts dysregulation as well as what sustains dysregulation, is the mechanism behind the dysregulation clear? In other words, do you know where the breakdown in emotion regulation is occurring, and which part of the emotion regulation process to target with your intervention? Can you explain in understandable terms what the specific emotion regulation mechanism is which needs to occur for the patient to be able to move towards their life worth living? I am eternally grateful to one of my American Board of Professional Psychology (ABPP) exam interviewers who repeatedly challenged me to clarify the exact mechanism of emotion regulation for a case presentation during my board exam. This line of questioning (and my subsequent failing of my first attempt at the ABPP oral exam!) identified a clear gap in the way I approached DBT- I understood the components of the therapeutic session, how to run a skills training group, the basics of moving between acceptance and change, and at the same time found myself unable to clearly describe how the components of DBT relate to the core change processes involved in emotion regulation. I, like many other therapists, was most likely over relying on Distress Tolerance skills and not applying emotion regulation skills within an organized framework. I was likely falling into the trap which Dunkley described in the Oxford Handbook of DBT (2018, p284)- "...therapists often over-rely on coaching distress tolerance skills... It is possible that while the Distress Tolerance chapter is appropriately named, both therapists and clients wishfully misread the title as either Distress Elimination or Distress Reduction". In an example of how the principles of learning affect us all, I was likely engaging in some magical thinking- I recall in my ABPP oral exam telling the examiners I would coach the client in the case example to use paced breathing and then opposite action, and when they asked me to clarify why those specific skills, and how that would cause change to occur in the case example, I remember thinking "uh, you just kind of mix them together and the person feels better"? While this is an effective strategy for mixing automotive epoxy, is not a recipe for passing your board exam or for effectively coaching clients on why and when to use specific change based interventions. I realized there was a missing piece in my clinical work, training, and supervision- I

needed a better understanding of not only the construction of an emotion, but also a better understanding of the mechanisms by which we humans regulate our emotions.

As part of my study plan for retaking the ABPP oral exam, I went back and read core texts on behaviorism and cognitive therapy. Reading original source material from authors such as Skinner, Beck, and Ellis, emotion regulation theory from Gross and Persons, and process based centering from Hayes was incredibly helpful in filling in gaps in my theoretical training (and was hugely enjoyable- a general reading list is at the end of this paper).This reading led to me to a place where I felt much more comfortable in being able to connect DBT strategies to core processes of change and drastically increased my fluency with the treatment in individual sessions, group skill training, consultation team, and in leading trainings.

One of the texts which now lives on the frequent reference shelf in my office is James Gross's Handbook of Emotion Regulation (Gross, 2014- note: a new edition comes out in December 2023!). The Gross model (Gross, 2014; p5) suggests our experience of an emotion is a modal model consisting of four sequential components: Situation -> Attention -> Appraisal -> Response. Linehan then expanded the "Response" step to include the biological change and expression/action change found in her Model of Describing Emotions (Linehan, 2014; Emotion Regulation Handout 5). Using the example of your patient who wants to become a stand-up comedian, you can see the components of the emotion:

Situation: "I am in a place where the potential for heckling exists- open mic night at a comedy club"

Attention: "When someone in the audience starts to call something out, I stop what I am doing and listen to their heckle"

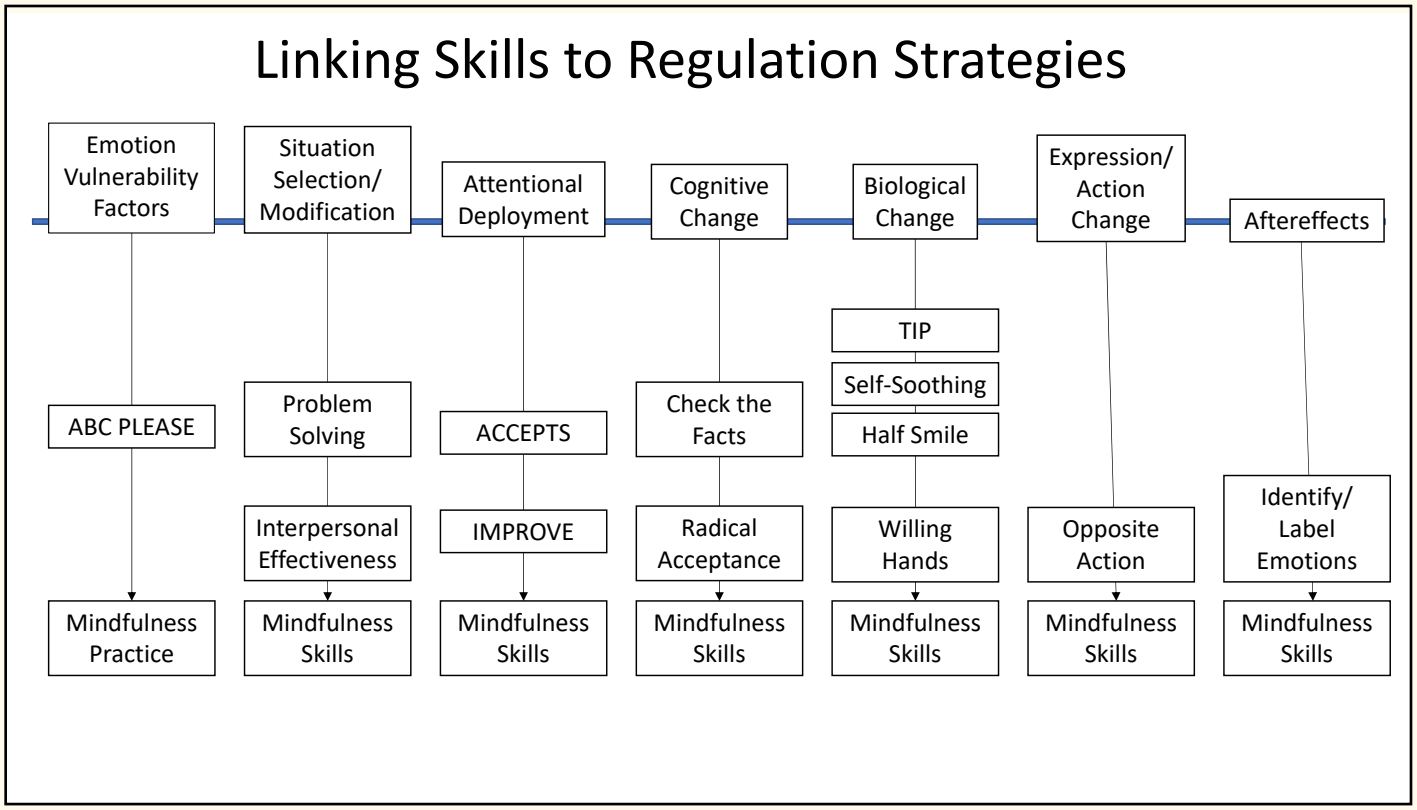
Appraisal: "Everyone will listen to the heckler and believe I am a terrible stand up comic since I don't have a good comeback"

Response: "My face flushes and my heart beats quickly, I look at the ground and become silent"

At each of these components, you can overlay emotion regulation mechanisms- Situation Selection, Situation Modification, Attentional Deployment, Cognitive Change, Response Modulation (Gross, 2014, p7). For example, your client could use Attentional Deployment when they first hear a heckler to move their auditory attention away from the voice, or use Cognitive Change to reconceptualize the heckling (i.e. "This is a great chance to use the comeback I practiced!"). To take this a step further with regards to your DBT sessions, you can overlay the DBT skills and the core treatment principles onto these emotion regulation mechanisms. This figure, adapted from a table DBT chapter from the Handbook of Emotion Regulation (Neacsiu, Bohus, & Linehan, 2014), overlays DBT skills with the authors expansion of Gross's original emotion regulation framework:

So what's so great about this figure? It's the map for starting to think in terms of core processes and mechanisms of change as clinicians, as opposed to segregating certain behaviors and emotion experiences to be treated within DBT and certain behaviors and experiences to be treated outside of DBT. It allows us to help our clients build their own roadmaps to understand (and when desired, change) their emotional experiencing and regulation process. It highlights areas of emotion regulation process where specific skills may be effective and points us away from overuse of Distress Tolerance skills. Although Distress Tolerance skills may come into play when deciding to use distraction to change your focus or avoid a situation (e.g. Situation Selection/Modification and Attentional Deployment), Emotion Regulation skills are used when you are deciding to think about the situation in a way which alters your emotion response (rather than avoid it). In keeping with Linehan's original theory around use of mindfulness skills to increase attentional focus and experience reality as it is, there is also room built in for mindfulness throughout the regulation process.

The model proposed in the Handbook of Emotion Regulation for DBT has initial support from a pilot randomized trial (Neasciu, Eberle, Kramer, Wiesmann, & Linehan, 2014) showing decreases in emotion dysregulation in a transdiagnostic sample, and fits well with Process Based CBT in general. Process Based CBT (e.g. Hayes & Stefan, 2018) challenges clinicians to understand the core processes involved in emotion regulation and move towards process-based perspectives rather than rigid diagnostic based perspectives. The good news here is the needed work on this in DBT has been done for us in many ways. A mentor and colleague of mine (Linda Dimeff) quotes the Wizard of Oz when training on Stage II treatment stating "you already have everything you need". Although I may prefer to quote Gandalf the Grey (My favorite example of wise minded movement-speed-and-flow is: "Do not take me for some conjurer of cheap tricks! I am not trying to rob you! I'm trying to help you"), this point is totally correct- DBT was created from core processes and puts these processes into a system which therapists are able to skillfully apply. DBT is an excellent example of the "kind environments with heuristic frameworks" suggestion Kelly Koerner makes (Koerner, 2018, p52) when discussing how to increase implementation in the "real world". Rather



than needing to have a book written for every issue we can come across, one implementation of the idea of "a community of therapists treating a community of clients" is using the work done by authors in the area of process-based work and emotion regulation regarding thinking through how to tie emotion regulation principles to session structure and skills training structure.

Think back to the original thought experiment. Using the Gross model of emotion regulation with the Linehan expansion in Figure 1, do you feel in collaboration with your client you would be able to outline which aspect of emotion regulation is breaking down (e.g. Situation Selection, Situation Modification, Attentional Deployment, Cognitive Change, Response Modulation), and know the specific process to coach the client on (e.g. which change strategy and/or skill) in order to move towards their life worth living goals? Additionally, does it line up in your mind in a way you can explain it quickly and succinctly to the client? I have found being able to frame these issues in treatment in concise and practical ways has made a huge difference in my own confidence as a clinician, as well as increasing the likelihood of treatment homework completion due to principles of change making more sense to my clients. For example, depending on the information presented during chain analyses of my client in the thought experiment, I might say something like:

"OK, I hear you saying that what prompts these emotions is not really avoidable- it goes along with your life worth living. So it sounds like we need to focus on where to put your attention when this emotion is prompted (e.g. Attentional Deployment), changing your thoughts about the emotion and the prompt (e.g. Cognitive Change), and also making sure we have skills on board to tolerate and regulate the inevitable emotion response (i.e. Response Modulation). I think this is wicked awesome- I have some ideas which I think will really help out- we can let go of trying to not have the emotion, and instead we can work on exposure to the emotion and skills to help with once the emotion fires."

From here, I would likely go into a creating a plan for specific behaviors involved with emotion exposure (as well as skills to use at each step), relying on the steps laid out for missing links analysis by Rizvi (2019, Chapters 6 and 7) to identify change processes to apply if the individual I am working with does not engage in the homework task. Additionally, this is a place where I mentally (and/or with the client) run through the Four Options for Solving Any Problem (Linehan, 2014, p10), which is a great example of how process-based work is baked into the treatment. Walking through how to behaviorally engage in each option can be helpful in ensuring the most effective aspect of emotion regulation is being targeted and that we are using the wise mind question of "what is being left out?" to double check our treatment strategies. You can see how the Four Options map onto the process model- for example, Solving the Problem maps to Situation Selection (e.g. no longer having a situation which prompts the emotion) while Feeling Better About the

Problem and/or Tolerating the Problem map to Cognitive Change and/or Expression/Action Change after the emotion has already fired.

For example, recall the patient in the original thought experiment. If we run through the four options, we might find that solving the problem (e.g. never being heckled) might be impossible if your life worth living goals is to do 4-5 sets per week of stand-up comedy. In emotion regulation terms, Situation Selection and Situation Modification may not be available. Dropping to Option 2, we might see that thinking about the problem differently (e.g. Attentional Deployment, Cognitive Change) would be helpful in terms of this long term goal, as would finding ways to control responses after being cued (e.g. Response Modulation). We'd likely also find that using Acceptance skills (Option #3) would be helpful in both Cognitive Modification and Response Modulation (additionally, note the ability to use mindfulness skills to reduce suffering across the emotion regulation spectrum), and last but not least, find ways to identify suffering (Option #4). As a side note, I have learned a ton from my colleague Natalie Stroupe around coaching folks to make a decision to suffer well (e.g. effectively suffer)- observing when suffering is occurring (or going to occur) and then create a system for how long to suffer and when to reevaluate if suffering is truly where they want to be. Walking through and mapping these four solutions onto not only skillful means but also onto the core structures of emotion regulation has greatly helped my fluency with being able to explain to individuals I work with why I am suggesting the intervention and why it links to their long-term goals.

My personal perspective on bringing process based models to DBT is that building connections between daily work and the core processes of change is a consistent, incremental process where I try to place what I am hearing in session within the emotion regulation theory from Gross (and expansion by Linehan), and obtain consult from others (whether by reading or talking) to think through the process of change linked to the specific emotion regulation task. Having resources and colleagues to bounce these ideas off is essential and shows another place process-based work shows up in DBT- the use of the consultation team to increase therapist effectiveness. My hope as folks read the thought experiment above they notice the thoughts "I think I know where to go with this" as well as "I have no idea where to go with this" and we work together in helping each other in find resources, consultation, and places to brainstorm with colleagues, peers, clients, and mentors to ensure we are connecting our case conceptualizations and clinical work to the core theoretical processes inherent to our work as scientist practitioners.

My personal process-based therapy bookshelf I keep within arm's reach:

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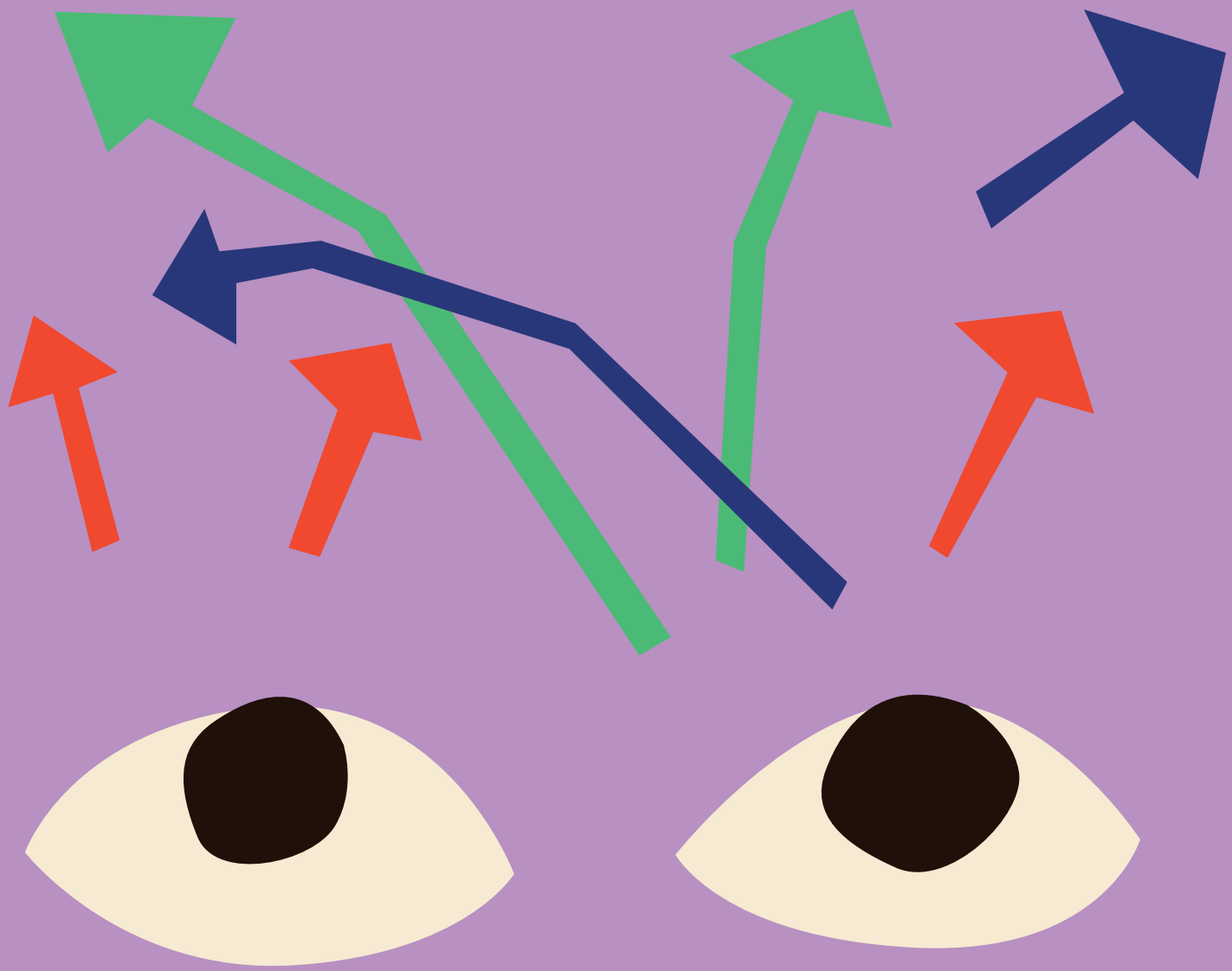

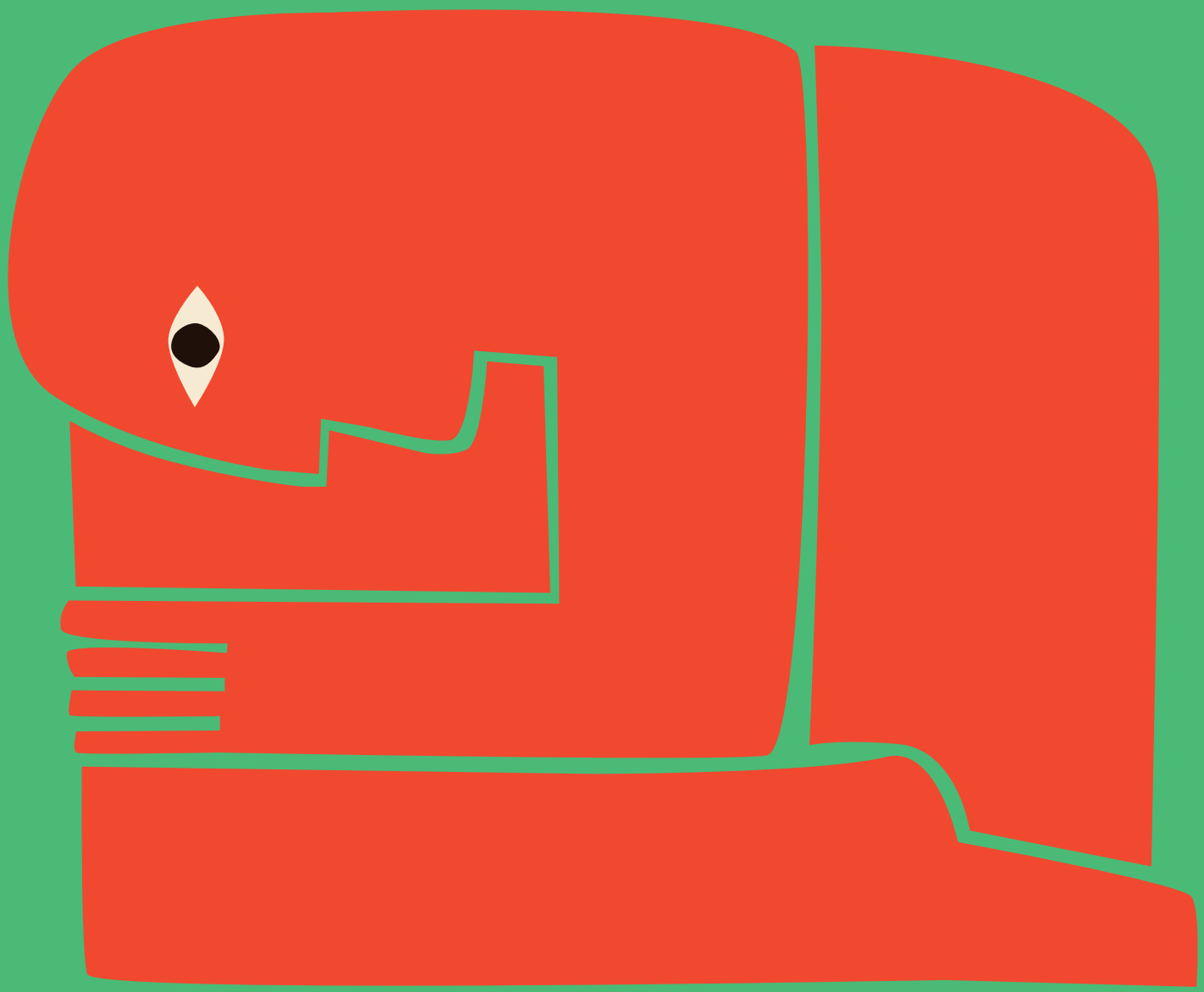

Therapeutic Language in Dialectical Behavior Therapy for Substance Use Disorders

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IN THE INTRODUCTORY chapter of Dr. Marsha Linehan's foundational text Cognitive-Behavioral Treatment of Borderline Personality Disorder (BPD), she calls for a revision in how patients with BPD are understood and their behavior described.

One of the main goals of my theoretical endeavors has been to develop a theory of BPD that is both scientifically sound and nonjudgmental and nonpejorative in tone. The idea here is that such a theory should lead to effective treatment techniques as well as to a compassionate attitude. Such an attitude is needed, especially with this population: our tools to help them are limited; their misery is intense and vocal; and the success or failure of our attempts to help can have extreme outcomes (Linehan 2018; p.18).

Dr. Linehan highlights examples of terms commonly applied to patients with BPD like "manipulative" that may mistakenly assume malintent behind behaviors and perpetuate negative attitudes towards a highly stigmatized group. Misunderstandings about and antipathy towards patients with BPD on the part of clinicians, the public, and patients themselves can compound the intrinsic challenges of the disorder itself. Indeed, a recent systematic review of studies examining the impact of structural stigma on individuals with BPD found that stigma often interferes in the healthcare of individuals with BPD (Klein et al. 2022). These findings underscore Dr. Linehan's rationale for addressing factors that contribute to stigma in Dialectical Behavior Therapy (DBT), a first-line treatment for BPD.

Developing a clinical language that reflects scientific rigor and engenders compassion similarly benefits individuals with substance use disorders (SUDs). Like BPD, SUDs carry potent stigma. The World Health Organization, examining the relative stigma associated with different conditions across multiple countries, found that drug use disorders carry even more stigma than HIV, homelessness, and criminalization (Room et al. 2001). A commonly held assumption about people with SUD is that their substance use is a form of willful misbehavior. As in BPD, this can make punishment rather than caring a default response to behavior arising from illness and can engender shame in people with SUD. This in turn helps explain why fewer than 10% of people with SUD receive specialized treatment (Substance Abuse and Mental Health Services Administration 2021). Policies like the War on Drugs derived from this way of thinking about SUD have an array of devastating consequences for individuals with SUD and perpetuate stigma against this population (Godlee & Hurley 2016).

Patients with both BPD and SUD face the intersection of these stigmas, and so the use of scientifically grounded, nonpejorative language in their treatment is doubly important. And this is not a small group; approximately 50% of patients with BPD have met criteria for an SUD in the past 12 months (Grant et al. 2008). Importantly, comorbidity reduces likelihood of remission of BPD (Zanarini et al. 2004) and increases risk for suicide attempts (Bosch et al. 2001) compared to either condition alone. Dialectical Behavior Therapy for Substance Abusers (DBT-S), an adaptation of standard DBT tailored to individuals with both BPD and SUD, has shown promise for decreasing substance use and increasing emotion and behavior regulation for patients with both conditions (Axelrod et al, 2011). DBT-S circumvents some pejorative assumptions about SUD by utilizing a behavioral approach to understanding the function of substance use among individuals with BPD. However, DBT-S as currently formulated contains some language that reinforces stigma associated with SUD. This commentary is meant to invite reflection on therapeutic language in DBT-S and suggest updated terminology.

DBT-S teaches several skills for addressing addiction dialectically, including the skill of "Clear Mind," summarized in the foundational paper introducing DBT-S as follows:

Patients with SUD typically begin DBT in a mental and behavioral state that we call "addict mind." Their thoughts, beliefs, actions, and emotions are under the control of drugs. As they achieve increasingly lengthy abstinence, they typically develop an outlook that we call "clean mind." In this state, they are off drugs but seemingly feel immune from future problems—a lack of vigilance that can set the stage for lapses. The alternation between addict mind and clean mind constitutes a dialectic that leads to the emergence, during the process of dialectical abstinence seeking, of a third state called "clear mind." Now, the individual enjoys abstinence while remaining fully aware of the nearness and tendencies of that addict mind; he or she is vigilant and takes measures to avoid or cope with the circumstances

that can—in a moment—restore addict mind Dimeff & Linehan 2008).

The noun "addict" has become disfavored as a clinical term because it conflates a problem someone has (i.e. addiction) with who they are (Recovery Research Institute 2022). This mirrors a general trend in medicine to pass up the efficiency of referring to a patient as, for example, "the cancer in room eight," to avoid increasing the salience of the disease to such a degree that one loses sight of the person. This move towards person-first language in mental health calls for referring to someone as a "person with schizophrenia" or a "person with BPD" rather than "a schizophrenic" or "a borderline," to emphasize that people have problems rather than are problems. Being mindful of language in this way supports the DBT clinician's goal of helping a person transcend the limitations of illness to develop a "life worth living."[1]

Additionally, the word "clean" is problematic as a term for abstinence because it implies that using substances makes someone *un*clean (Kelly et al. 2015). The DBT corpus illustrates how that perpetuates disgust for people who use substances. Emotion Regulation Handout 6 lists under Prompting Events for Feeling Disgust "Having a person or an animal that is dirty, slimy, or *unclean* come close to you" (emphasis added). The consequences of disgust, the DBT handbook advises, may include "pushing or kicking away," "treating with disdain or disrespect," and "physically attacking causes of your disgust" (Linehan 2015). To avoid perpetuating stigma in this way, we can use terms that are more scientific and less loaded with pejorative connotations, without sacrificing normative judgments about what constitutes health and the value of health.

How can this be done in practice? In the DBT-S group I co-facilitate in a dual diagnosis residential treatment setting, our approach could fairly be characterized as dialectical. Rather than discarding the proverbial baby with the bathwater, we do teach the "clear mind" skill; however, we recognize and draw patients' attention to its use of language and invite considerations of alternatives. In so doing, we validate the usefulness of the concepts these terms express but problematize the terms themselves. For example, in lieu of "addict mind," we encourage patients to consider the phrase "addicted mind" or "addiction mind." In lieu of "clean mind," we suggest "complacent mind" — alternatives could include "'cured' mind" (with scare quotes), "overconfident mind," "invincible mind," or "invulnerable mind." These terms hew closely to the original meanings and maintain clarity. Although these terms bear a few more syllables, what is sacrificed in efficiency is made up for by avoiding reductionism and stigma. Comprehensive guides to less stigmatizing language around substance use disorders can be found in research literature (e.g. Saitz et al. 2021) and accessible online resources (Recovery Research Institute 2022; National Institute on Drug Abuse 2023).

One may point out that terms like "addict" and "clean" are in common parlance and have been adopted uncritically by many patients. Why would clinicians problematize language that many patients find acceptable to describe themselves? Identifying as an "addict" is particularly common among people who attend 12-step meetings; identifying that way in a supportive, affiliative setting may reduce shame, remind of the need for vigilance against return of addictive behavior, and reclaim a word used by others to stigmatize them (Ashford et al. 2019). However, identifying oneself as an "addict" is different than being identified by someone else as an "addict," especially across the power differential that separates clinicians and patients. One empirical study found that although over 70% of people seeking treatment for heroin use disorder used the noun "addict" to describe themselves, less than half wanted to be called this by others; a significantly greater percentage preferred to be called a "person with heroin addiction." (Pivovarova & Stein 2019) One of the largest empirical studies to date of language preferences among people with SUD found "person-first" terms like "person with an addiction" and "person with substance use disorder" to be preferred by a group of people taking methadone for opioid use disorder (Gazzola et al. 2023). When a patient calls themself an "addict," we can respond dialectically: there may be value in using the patient's own language to connect with them, and it can also be helpful to encourage the patient to reframe how they see themselves to address internalized stigma.

Some believe that word choice has little consequence, but research suggests that language impacts how clinicians view patients and evaluate treatment approaches. For example, one study randomized several hundred clinicians to read a case vignette referring to someone as either "having a substance use disorder" or "being a substance abuser." Participants were then asked what interventions they felt would be appropriate for the person in question. Clinicians primed to think of the person as a "substance abuser" favored more punitive interventions (Kelly et al. 2010). Empirical evidence demonstrates how language can serve as a link in the psychological chain that determines whether clinicians respond to patients with punishment or care.

In summary, beyond the intrinsic challenges of BPD and SUD, the many patients with this comorbidity face considerable stigma. DBT invites clinicians to conceptualize patients' behavior in scientific, non-pejorative, and compassionate ways. Modifying language

in the manual would support DBT clinicians in doing so. It is a step in the right direction that what was initially termed "DBT for Substance Abusers" is now being called "DBT for Substance Use Disorders" (Dimeff et al. 2020). By continuing to update our language and concepts of SUD, we can maintain the skillful approaches of DBT-S while avoiding the therapy-interfering behavior of perpetuating stigma.

Acknowledgements

Brittany Wilkinson BS co-developed and co-facilitates the DBT-S group that prompted the idea for this commentary and where we implement the approach described above. Nuanced feedback and invaluable support for the development of this manuscript was provided by members of the Two Brattle Center DBT consultation team, including director Joan Wheelis MD and members Kelly Urban MA LMHC, Ardith Welwood MA LMHC, Kelly Zuromski PhD, Elliott Eggan MD, Celeste Peay MD JD, Raquel Dargenio MA, Miriam Rowan PsyD, Hila Ben-Levi PsyD, and Melissa Broughton PMHNP-BC.

[1]A separate question is whether it is best to use person-first language (e.g. "a patient with borderline personality disorder") or identity-first language (e.g. "a borderline patient"), which is currently debated particularly in reference to autism. Many autistic individuals prefer identity-first language, noting that autism is essential to identity and can be understood as reflecting neurodiversity rather than pathology. Some argue that person-first language can have the unintended consequence of drawing further attention to a condition through unconventional syntax and unintentionally perpetuate stigma – by separating a condition from someone's personhood, implying that close association with the condition is anathema (Taboas et al. 2023). These critiques illustrate the challenge in sculpting an ideal language for psychiatric conditions and underscore the value of humility as terminology evolves in reference to scientific understandings, stakeholder preferences, and social attitudes. However, neither identity-first nor person-first approaches advocate for identifying someone solely by their condition (e.g. "an autist" or "an addict").

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Thinking and Acting Dialectically is Challenging and Freeing: Tools for Teaching Dialectics

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[1]Alpert Medical School of Brown University and [2]Columbia University Irving Medical Center

IT IS CRITICAL for providers and consumers alike to cultivate their understanding and application of dialectics to practice skillful Dialectical Behavior Therapy (DBT). Dialectics represents the worldview of DBT, establishing its framework, principles, strategies and skills. This applies not only to the content or "what" of DBT but also to the process of "why," "how," and "when." In a nutshell, dialectics acknowledges that opposite sides or ideas can be true at the same time. By asking "What is being left out?" from either extreme and by considering multiple sides together, we can think and act dialectically. This involves balancing opposites to identify new ways of viewing a situation. Sometimes this means arriving at a "synthesis" or "middle path" that holds both sides at the same time and offers a new truth. Other times doing this is not possible or effective (at least not at the moment). Dialectics reminds us to allow and embrace confusion, to enter the paradox of "yes and no" or "true and not true" (Linehan 2015; Rathus & Miller, 2015).

While defining dialectics may appear simple and straightforward, teaching and applying dialectics to real-life can be complicated, challenging, and, frankly, overwhelming. This is particularly true in the context of heightened emotional reactivity, exquisite emotional sensitivity, and a history of invalidation, as is often the case in DBT and with DBT clients. The goal of this article is to offer new tools in the instruction and application of dialectics. Specifically, we introduce two new ways of teaching the principles of dialectics. In the Plaid Venn Diagram metaphor, we highlight the principles of synthesis, distinguishing it from compromise. In the Cylinder metaphor, we illustrate how seemingly contradictory perspectives can coexist, calling attention to the qualities of flexibility, curiosity, and connectedness inherent in dialectical thinking.

Among the countless ways that dialectics appears in DBT, two prominent examples stand out as receiving the most "airtime" in discussions about dialectics: (1) the opposites of acceptance and change, and (2) the DBT states of mind skill, in which Wise mind is taught as the synthesis of the opposites of Emotion mind and Reasonable mind. This makes sense given that both examples are taught at the outset of DBT—both for clinicians new to DBT and for clients/family members learning DBT skills in a treatment setting. The goal of moving back and forth between the two opposites of acceptance and change is a defining feature of DBT, differentiating it from other treatment models, such as Cognitive Behavioral Therapy (CBT). When introducing DBT, providers also frequently teach states of mind by drawing a Venn diagram of two overlapping circles, each of which depicts one of two polar opposites/extremes. One circle representing thesis is labeled as Reasonable mind; the other circle representing its opposite or antithesis is labeled Emotion mind; and the conjunction, or overlap, of the two circles is labeled Wise mind to illustrate synthesis.

There is a potential limitation in presenting dialectics using this Venn diagram metaphor. If we were to draw the Venn diagram of states of mind with Reasonable Mind as a blue circle and Emotion Mind as red, often trainers and learners will label Wise Mind as purple (see Handout). This makes sense given that when blue and red mix, they create purple. AND, Wise Mind is not purple. Purple reflects a watered down version of red and blue. With purple we lose the essential redness and blueness of each state of mind.

Though often described as such, synthesis does not represent a compromise or blend of opposing sides. Synthesis does not mean combining watered down versions of each polarity. Doing so is ineffective as it tends to invalidate each side – purple is neither red nor blue. A common misconception of dialectics is to insist that being dialectical means you must hold both sides at once and equally. Rather, dialectical thinking emphasizes understanding each perspective's complexities and integrating them into a richer understanding. Insisting on equal balance oversimplifies dialectics, limiting its fluidity and depth. Moreover, there are times when the effective way to think and act dialectically is to spend time observing and understanding one side.

We encourage you to consider this practice: try visualizing Wise Mind or any synthesis as a plaid, rather than a blend of two colors (see Handout). The plaid is a playful way to represent a synthesis of thesis and antithesis. Our plaid contains red and blue, and purple, and also new colors entirely! We encourage you to think and talk about each of the colors/patterns both on their own and together. For example, in DBT individual and family sessions we discuss the Plaid metaphor in the context of

specific examples and ask, "What is the red? What is the blue? What is the kernel of truth for each side (color)? What are those new funky colors? What does the pattern look like up close? If we step back, what else is there to notice?" Sometimes, this inquiry involves embracing confusion and entering the paradox of how the same situation can be viewed as different colors and textures entirely. When viewing a plaid, or synthesis, we observe how the whole is greater than the sum of its parts. Additionally, some plaids may contain more strands of thread from one color than another. In other words, finding a "middle path" or synthesis is not about establishing an equality of truths. Doing so may have the unintentional impact of invalidating each side, which in turn furthers polarization. Instead, seeing a plaid allows each side to validate the other perspectives and strands of truth.

The Plaid Venn diagram metaphor helps to explain how two opposing ideas, when held together, can inform a new truth and a new way of viewing the situation. To further enhance our understanding of dialectical thinking and its emphasis on perspective, we offer an additional teaching tool of the "Cylinder metaphor" (see Handout). This metaphor depicts opposing shadows of a square and a circle from different perspectives of flashlights shining on a three-dimensional cylinder. These shapes illustrate how thesis (square) and antithesis (circle) are both true, depending on which way we look at the same situation; both coexist in synthesis (cylinder).

For the person holding the green flashlight on the right, they see a square and that is true. For the person holding the blue flashlight on the left, they see a circle and that is also true. These shapes in this configuration illustrate a key takeaway from dialectics: there is more than one way to view the same situation, or in this case, cylinder. Without taking a step back and seeing multiple perspectives, two people may argue about circles versus squares and invalidate each other's experience, increasing hurt and emotional dysregulation. When we recognize these simultaneous truths and ask what is missing, we can arrive at a synthesis, or the cylinder.

Of note, the original source image[1] labeled the cylinder as "this is truth." We have modified the current version for our handout to label the cylinder as "this is true." This revision is important to highlight when teaching the cylinder metaphor. Participants may have the urge to argue that the cylinder is "clearly the truth and most representative of reality." However, this point would be undialectical.

Instead, we label all three (thesis, antithesis, and synthesis) as true and none as truth, illustrating how each is true and each is partial. Dialectics reminds us that truth is neither absolute nor relative. Rather, meaning and truth evolve over time, and change is the only constant (Linehan 2015). Thus, finding the synthesis or middle path of two opposites is not a "one and done" process, but more like the instructions on the back of a shampoo bottle: "Rinse and repeat." Upon finding the synthesis between two opposites, that synthesis over time becomes a new thesis, which has its own opposite or new antithesis. And so it goes.

As DBT providers, we practice DBT and its worldview of dialectics as an all-in life philosophy. As such, we know[2] that the practical application of dialectics in understanding our own and others' experiences is liberating across situations, well beyond the DBT therapy hour. Together, the Plaid and Cylinder metaphors both illuminate how thinking and acting dialectically does not mean that one has to give up, dilute, or invalidate their own perspective in order to observe and validate others' perspectives. Given the ample benefits of validation—of both self and others—these tools for understanding and applying dialectics can be freeing. Dialectical thinking frees the mind from rigid viewpoints, enabling a more holistic and adaptable perspective of our reality. As helpful and freeing as it is, the practical application of dialectics is also challenging. That is why we lean on a range of ways to effectively understand and teach dialectics. Sometimes it's a plaid Venn diagram and other times a cylinder. We use our mindfulness "effectiveness" skill to do what works. Our hope is that these tools can be applied by anyone (not just DBT providers!) to approach extremes and get unstuck from polarizations with curiosity to build understanding, acceptance, growth, and a (middle) path forward.

[1]If you are the creator or know the identity of the creator of the original cylinder art, please contact us at andrea_gold@brown.edu so we can give credit.

[2]This knowledge is based on a wise mind state of knowing as both intuitive and learned from experience, which is yet another dialectic!

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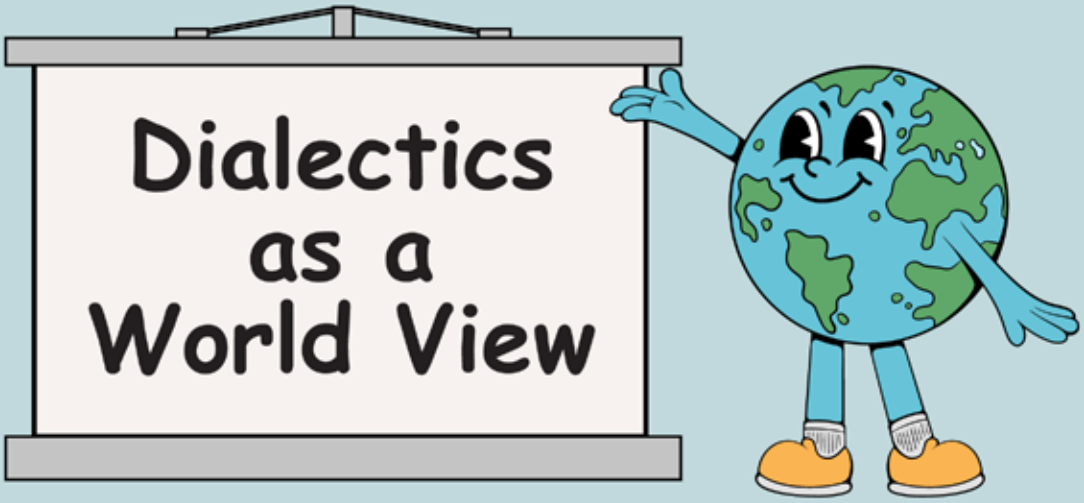
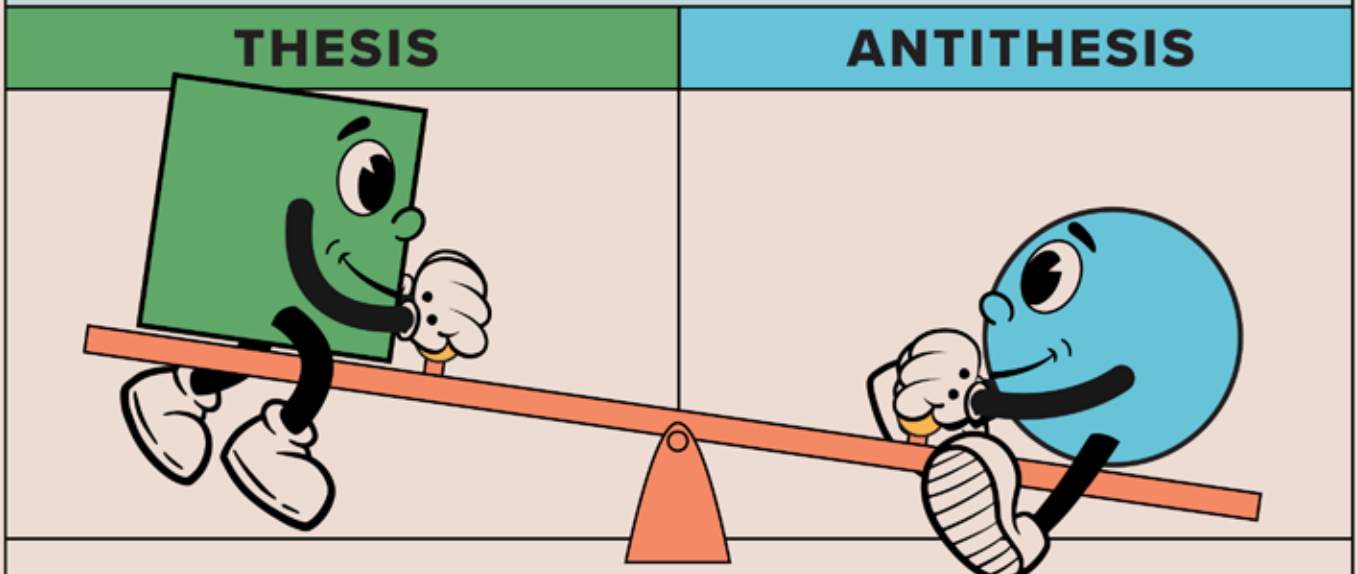
UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)



A **dialectical** philosophy guides **DBT**. It assumes that everything is interrelated, that tension is inevitable, and that change is constant. To adopt a dialectical worldview means to strive to embrace that seemingly opposite ideas can both be true and to accept change as a natural occurrence.



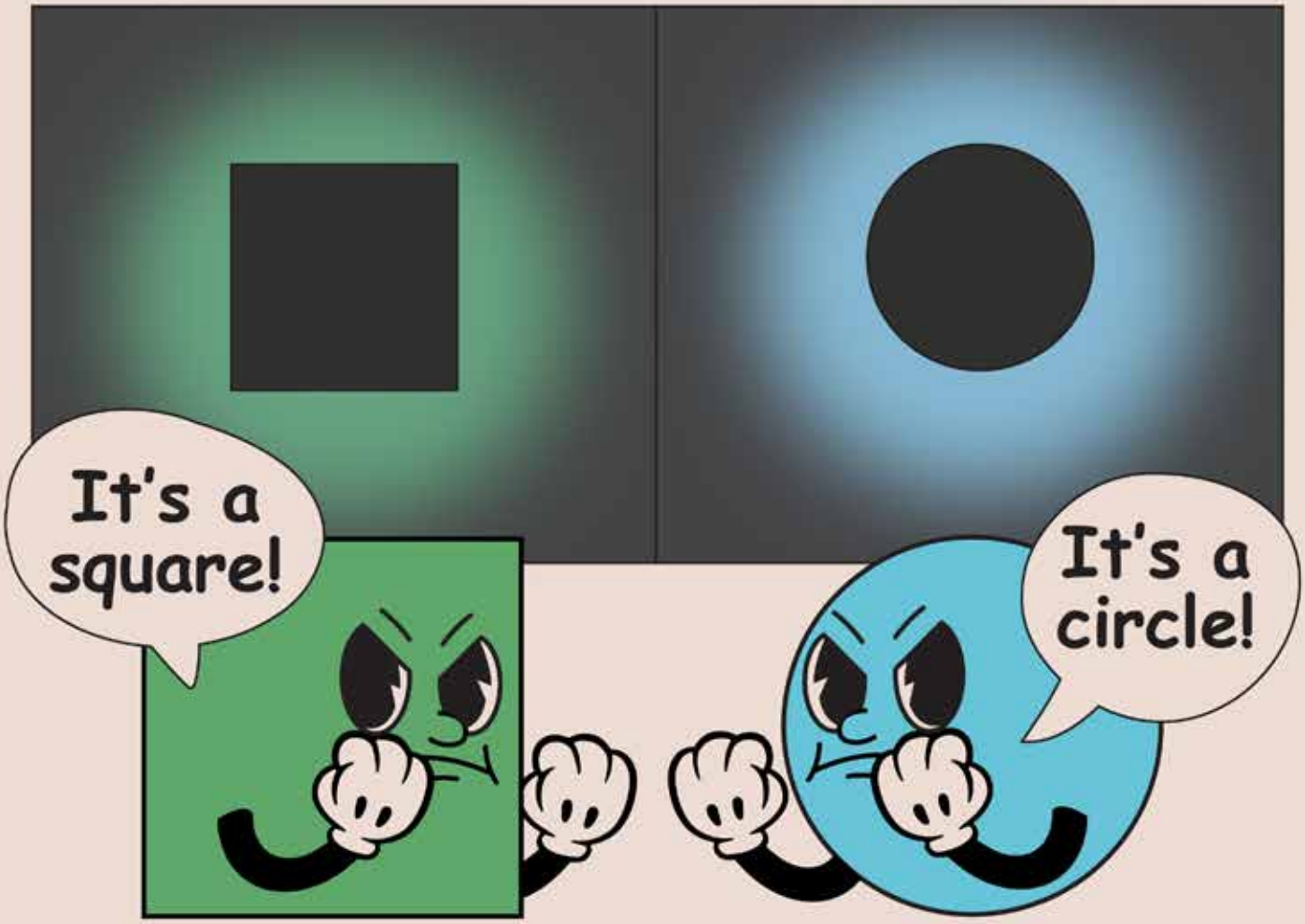
Dialectics is like a teeter-totter: the two seats reflect opposite sides or truths that can exist at the same time. These opposites sides are called **"thesis"** and **"antithesis."**

WITH SUPPORT BY DBT-RU DIRECTOR OF DBT-RU, & DBT BULLETIN DR. SHIREEN RIZVI

*Adapted from Linehan, M., M., (2015). DBT Skills Training Manual (2nd ed). Guilford Press. and Rathus, J. H., & Miller, A. L. (2015). DBT Skills Manual for Adolescents. Guilford Press.

UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)

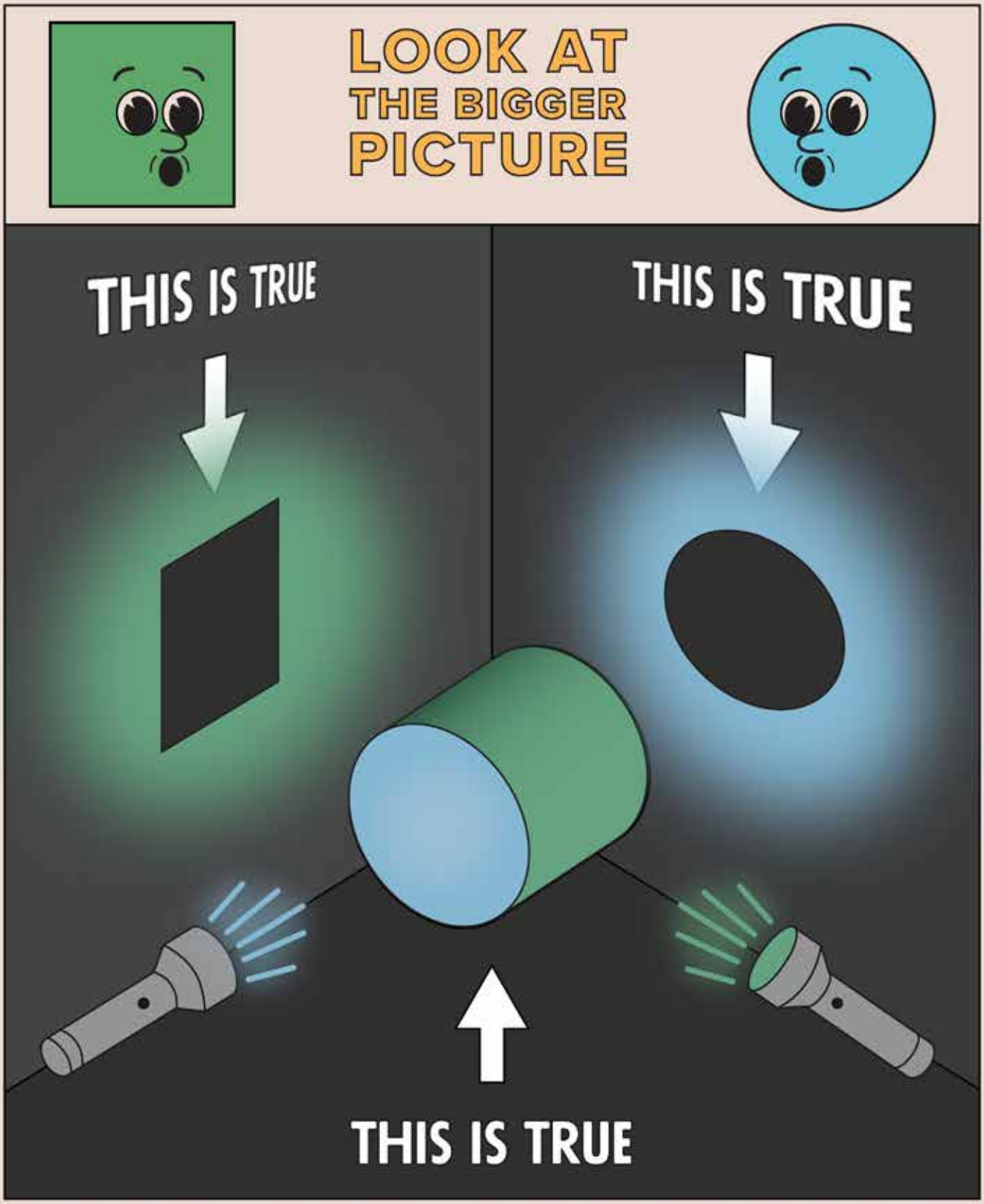
SHINING A LIGHT ON MULTIPLE TRUTHS



THE PROBLEM

When we get stuck in one "truth," we don't see things from different perspectives, which can intensify negative emotions. And when we don't consider other viewpoints, it's hard to find solutions that will help us manage our emotions and communicate effectively with others.

UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)

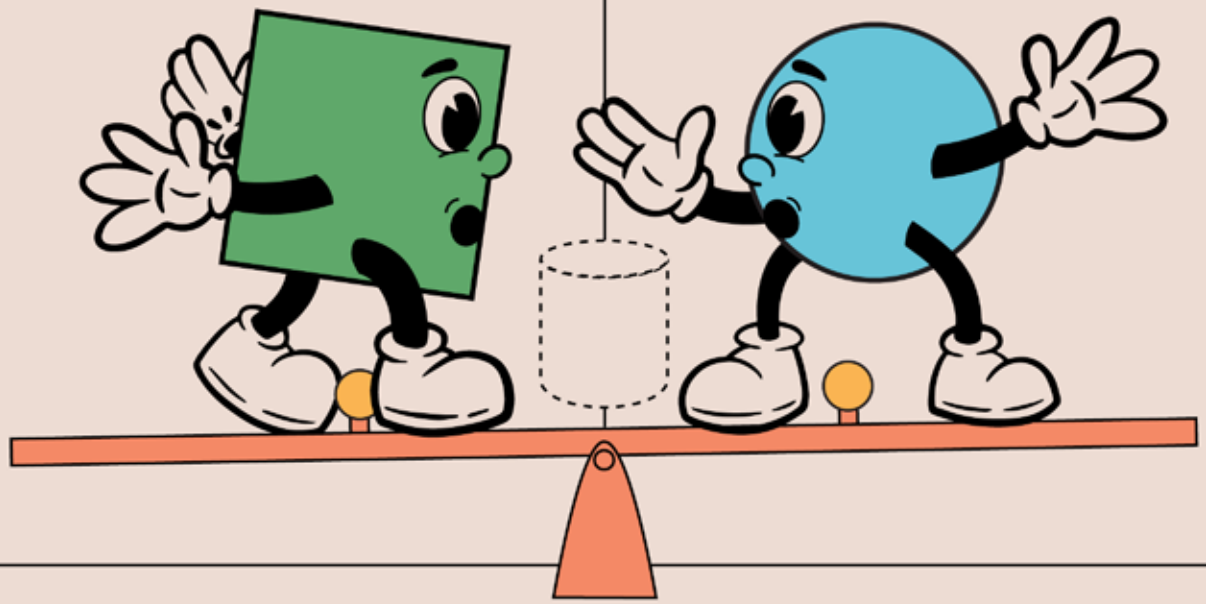


*If you are the creator or know the identity of the creator of the original cylinder art, please email andrea_gold@brown.edu so we can give credit.

UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)

THESIS

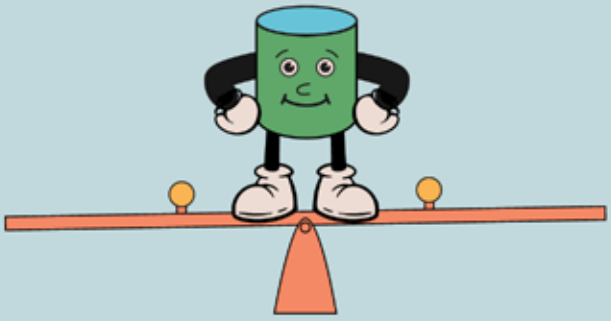
ANTITHESIS



Being **dialectical** means sliding back and forth on the teeter-totter to balance both sides. Then we can move to the middle and achieve a greater level of understanding called a...

SYNTHESIS

A **synthesis** is a new way of seeing a situation by balancing the opposites of **thesis** and **antithesis**.



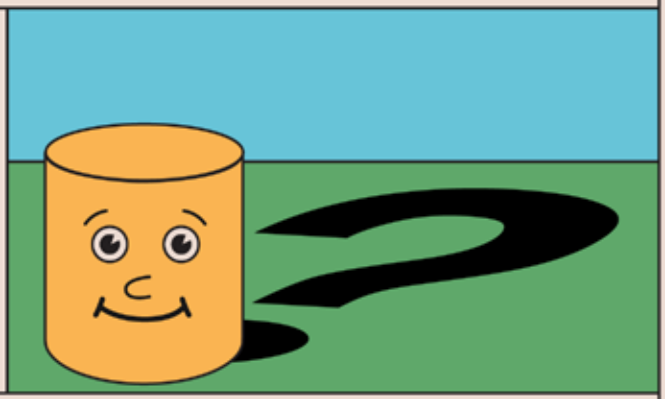
A balancing of opposing ideas to find a "middle path" or new truth.

UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)

DIALECTICS REMINDS US:

THERE ARE MULTIPLE TRUTHS: Just as the cylinder casts both a square and a circle shadow, every situation contains more than one perspective or truth. Multiple truths can exist at the same time.

THERE IS ALWAYS MORE TO SEE: Looking just at the shadows, we miss the full picture. Thinking dialectically means asking, "What am I missing?"



OUR REALITIES ARE CONNECTED: Each shape reveals different aspects of the other, and when combined form a fuller understanding, or a synthesis, which is represented by the cylinder.

UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)

WISE MIND AND SYNTHESIS

A common example of dialectics in **DBT** is the **States of Mind**. DBT identifies three primary **States of Mind**.

THE THREE STATES OF MIND

REASONABLE MIND

Reasonable Mind is when our actions are driven by logic.

EMOTION MIND

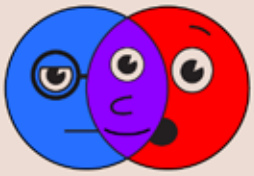
Emotion Mind is when our actions are driven by emotions.

+

WISE MIND

Wise Mind is the **synthesis** of Reasonable Mind and Emotion Mind. It is when we integrate logic and long-term goals with our wants and feelings.

Often the synthesis of **Reasonable Mind** and **Emotion Mind** as **Wise Mind** is represented by a **Venn diagram.**



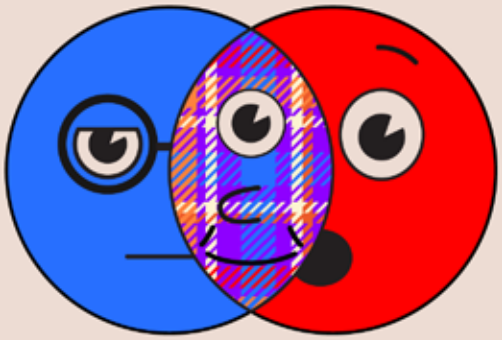
In a typical Venn diagram, when you overlap **blue** with **red**, you get **purple**.

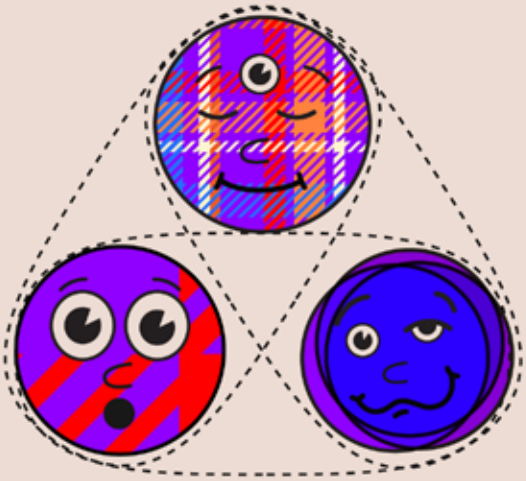
WAIT! THERE'S MORE...!

UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)

DIALECTICS REMINDS US:

SYNTHESIS IS NOT COMPROMISE: Synthesis is not just a blend of **red** and **blue** into **purple**. Rather, synthesis is a **plaid**, integrating the original colors while also introducing new shades and textures.





TO EMBRACE PARADOX AND CONFUSION: From far away plaids can blur into a single color, from up close they can look like a mish mash of interweaving threads. Dialectics challenges us to see situations from various perspectives and embrace complexities, without erasing either side.

SYNTHESIS LEADS TO NEW TRUTHS: Opposing truths can coexist, leading us to a richer understanding. The plaid pattern shows how our combined insights are deeper than the sum of individual perspectives.

STUDENT SPOTLIGHT AWARD

Christopher Georgiadis, MS by Andrea Gold, Phd

STUDENT SPOTLIGHT AWARD Christopher Georgiadis, MS by Andrea Gold, Phd We at DBT Bulletin are so excited to announce this year's student award winner, Christopher Georgiadis. Christopher was selected for his outstanding work as a trainee, dedication to DBT and its foundations, and promise.

CALL FOR SUBMISSIONS

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

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

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

STUDENT AWARD NOMINATIONS

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

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