Vol.8
Is.1
2024

# DBT BULLETIN



**DBT BULLETIN**
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# Editor's Letter

Dear Readers,

Welcome to the 8th volume of the DBT Bulletin, arriving just in time for a perfect summer read! Each volume brings new discoveries, fresh perspectives, and substantial insights from our dedicated contributors. This issue is particularly rich in content that challenges our understanding and expands the boundaries of DBT, making it more inclusive, effective, and responsive to a wide range of client needs.

In this edition, we are privileged to present a spectrum of articles that delve into innovative approaches, such as DBT tailored for autistic clients. From practical strategies for navigating the challenges of parenting young adults struggling to meet the demands of adulthood to nuanced explorations of treatment credibility and outcomes, each article reflects the rigorous inquiry and compassionate care that define DBT practice. We explore topics like multi-problem eating disorders, as well as the critical role of postvention strategies to foster support and healing after a suicide death—a topic that accentuates the compassion and sensitivity central to our field. This volume even introduces a first for the DBT Bulletin: an exploration of creativity through art and poetry! A poignant reminder of DBT's profound impact outside of clinical settings. These contributions highlight the adaptability of DBT and underscore its potential to transform lives across diverse populations.

We extend our deepest gratitude to all our contributors for their continued dedication and expertise. Your commitment to advancing DBT theory and practice continues to enrich our community and inspire future generations of practitioners. Grab a cool drink, find a sunny spot, and immerse yourself in these pages—a perfect companion for your summer as we strive to explore new frontiers in DBT! We hope that the diverse and innovative content of this 8th volume of the DBT Bulletin will inspire and inform you in your practice.

Warm regards,
Sydney Lopez & Brittany Drake

# Increasing Effectiveness of DBT for Autistic clients

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In recent years, there has been increasing recognition of the importance of tailoring DBT to improve its effectiveness for marginalized populations, including LGBTQIA+ (Skerven, 2023) and BIPOC (Kamal, 2023) clients. Autistic people, who often struggle with emotion recognition and regulation (Mazefsky, 2015), suicidality (Segers & Rawana, 2014; Hedley & Uljarevic, 2018), and self-harm (Blanchard et al., 2021), are routinely marginalized as well. Invalidated by a social environment that pathologizes Autistic traits, they eventually invalidate themselves and often suffer from pervasive shame. This shame drives camouflaging, which consists of trying to hide Autistic traits ("masking"), adding strategies to compensate for perceived deficits ("compensation"), and trying to blend in to perceived norms ("assimilation"; Hull et al., 2019). Camouflaging reflects and exacerbates self-invalidation and shame, and adds to emotion dysregulation and elevated suicide risk (Cassidy et al., 2020). Guided by its biosocial theory and assumptions about clients and therapy, and with the full package of protocols, strategies, and skills, DBT is well-positioned to help Autistic individuals regulate their emotions and pursue their goals. Some recent research has shown benefits of DBT skills training for Autistic people (Bemmouna et al., 2022; Phillips et al., 2024; Ritschel et al., 2022). Other research is exploring how to modify DBT to increase accessibility and effectiveness for Autistic clients, and to avoid unintentional harm (Keenan et al., 2023; McVey, 2023; McVey & Locke, 2022). Based on a workshop presented at ISITDBT 2023 by three Autistic clinicians and a non-Autistic DBT trainer, this article will suggest ways of tailoring DBT to help Autistic clients work towards their life worth living goals.

### Neurodivergence, Neurodiversity, Neurohumility, and Ableism

Traditionally, the medical model views autism as a collection of deficits (DSM-5) to be "fixed" or "cured" so that an Autistic client can function in a more typical manner. This is based on a faulty assumption that a higher prominence of Autistic features inherently causes a lower quality of life. In contrast, the Neurodiversity Model (Singer, 1998) frames the Autistic neurotype as part of the natural diversity of human minds. Another critical concept, Neurohumility (Kraus, 2023), an extension of cultural humility consistent with DBT's assumptions about treatment as well as the fallibility agreement, is a stance and a self-reflective process wherein one maintains curiosity, respect, and humility toward the lived experience of other body-minds. It positions the client rather than the therapist as the expert in their own experience. Neurohumility is practiced through partnering with the client, validating their experience, and staying centered on the client's goals and values, rather than "fixing" what the medical model would consider "deficits."

Ableism, a term and concept consistent with the medical model, is full of societal "shoulds." An ableist perspective views neurotypical functioning as superior, and anything less or different as a deficit. It fuels emotional and interpersonal myths about Autistic clients, and is perpetuated through societal structures that reinforce ableism rather than maximizing inclusion. Ableism can be explicit and/or intentional, or more often implicit and unintentional. Just as DBT therapists must work to be actively anti-racist (Kamal, 2023), they need to be actively "anti-ableist" to create safer spaces for Autistic clients.

Being anti-ableist and neurodiversity affirming means making DBT more inclusive and accommodating to the needs of Autistic individuals. The "double empathy problem" describes the impact of different communication styles between Autistic and non-Autistic ("allistic") people (Milton, 2012). Research found that a group of Autistic individuals communicated with each other as accurately as a group of non-Autistic people who were talking among themselves. A mixed group of Autistic and non-Autistic people, however, experienced difficulties due to their communication differences (Crompton, Ropar, et al., 2020). Keeping this in mind, a practice rooted in Neurohumility is imperative.

### Autistic Traits and Trauma History to Keep in Mind When Tailoring DBT

Many Autistic people who do not fit the "non-speaking little white boys who like trains" stereotype have been overlooked by clinicians. This includes those who are female, non-binary, BIPOC, high IQ, and highly verbal. Such individuals are often misdiagnosed or not diagnosed at all. Diagnostic rules have contributed

to this. Before 2013, clinicians were not allowed to diagnose both Autism and ADHD, thereby excluding the frequently occurring overlap of the two (the "AuDHD" neurotype).

Additionally, due to a history of chronic, traumatic invalidation and resulting shame, many Autistic people try to hide or compensate for their Autistic differences. As DBT therapists well know based on "dialectical dilemmas," chronically attempting to project an image misaligned with one's true self is not sustainable, increasing shame and emotional dysregulation (Linehan, 1983). Autistic females and those with higher IQ and verbal ability may be able to camouflage more than Autistic males and those with lower IQ and verbal ability, contributing to "missed diagnosis" in these populations. DBT clinicians need to be aware of Autistic camouflaging and its high costs for both the client, such as increased shame, self-invalidation, emotion dysregulation, and suicide risk, and for the therapy, by making it harder for the therapist to recognize Autistic clients or be aware of their struggles.

Autistic traits are innate but may be more obvious under stress. Hiding Autistic characteristics via camouflaging strategies (Hull, et al., 2019) may be followed by melting down later. Rigid societal norms may invalidate Autistic clients and make it difficult for them to live their authentic lives.

Recently, multiple clinicians have proposed neurodiversity-affirming criteria for autism (Henderson et al., 2023; Lowry, 2023) that align with the social model of disability. From this perspective, autism is characterized by differences, not deficits, in social communication and behaviors. Autistic people's social reciprocity may look different. They may love "parallel play" rather than unstructured group interaction, may communicate very directly rather than hinting, and may be non-speaking, minimally speaking, or situationally non-speaking. They may need more time to process information, be very detailed, ask a lot of questions, and process information from the bottom-up. Nonverbal differences may include differences in tone, being less comfortable with (even if forced) eye contact, and having less obvious facial expressions. Autistic people may encounter difficulties in relationships with non-Autistic people, often being rejected more than peers and developing high levels of rejection sensitivity as a result. They may not recognize social hierarchies or interact differently with people depending on status. Additionally, and critically for the therapeutic relationship in DBT, many Autistic people have a history of being traumatically invalidated because others don't understand their communication, or worse, because others know the Autistic people are missing subtle signals and intentionally take advantage of them. Due to this relational trauma, many Autistic people become hypervigilant for signs that other people are deceiving or trying to manipulate them.

Autistic people may engage in "stimming or stims," moving or saying the same sounds or phrases over and over again, for many reasons including to soothe themselves or express joy. They may engage in echolalia and scripting conversations to feel more comfortable. They tend to thrive on routine and predictability, which helps them make sense of a world not designed for their divergent minds. They may have differences in executive functioning such as initiating tasks or needing more time to get out of hyperfocus to shift attention to something else. They may need more time to prepare for change. They may have intense, special interests (SPINs) that are integral to their identities, that they can connect to everything, and through which they bond with others (which the DSM-5 recognizes but pejoratively refers to as "restricted, fixated…abnormal… excessively circumscribed… perseverative"). They may be more or less sensitive to sensory stimuli than other people, not only in the well-known five sensory systems, but also in the interoceptive (sensing signals within the body such as the need to eat, drink, or go to the bathroom), vestibular (position of the body), and proprioceptive (feedback from joints and muscles) systems. Interoceptive awareness differences can contribute to alexithymia.

**Tailoring DBT for Autistic Clients**

To most effectively help Autistic clients, we need to be neurodiversity-affirming and anti-ableist. Conversion therapy was damaging to LGBTQIA+ clients in the past, and trying to convert Autistic clients to appear non-Autistic is just as damaging. We propose that DBT not be seen as a treatment for autism; it's a treatment system to be tailored so that Autistic clients can pursue their life worth living goals. We need to tailor based on differences in communication, non-verbal behaviors, sensory experiences, stimming, special interests, need for structure, and executive functioning. Of course, not all Autistic people are the same so treatment has to be tailored further to each individual.

We need to accommodate differences in communication. Such accommodations include being direct, not relying on neurotypical nonverbal communication, allowing longer processing time before responding, welcoming questions, and offering other communication options in addition to spoken or "mouth" words. Communicating honestly and directly not only results in more accurate transmission of information, but crucially begins to repair the mistrust

that has been sown by past relational trauma. See Figure 1 for an example of a visual for teaching "Turning the Mind," which demonstrates a more concrete visual representation of a concept. We also recommend video clips such as the ones produced by DBT-RU (youtube.com/dbtru), among others.

Additionally, we need to accommodate sensory needs by assessing sensory differences at the beginning of therapy and inviting clients to adjust the therapy environment to meet their needs. For example, clients may benefit from the options to adjust the volume and turn off their cameras during remote sessions, wear earplugs that filter sound, wear glasses that filter light, have offices free of added aromas, and so forth. In skills training, we recommend adding an extra "S" to the PLEASE skills for "balancing Sensory input."

The need to stim, serving many important functions for Autistic clients, should be validated. This can be done by discussing the benefits that the client obtains by stimming, encouraging stimming as needed, and having stim tools/toys in the office. If a stim is harmful, such as cutting or headbanging, validating the short-term function and exploring non-harmful alternatives (e.g., other intense sensory input such as holding an ice cube, eating something spicy, deep tissue massage, or hanging upside down) can be helpful. Stimming can also be supported through teaching of skills including mindfulness, self-soothing, and PLEASE(S).

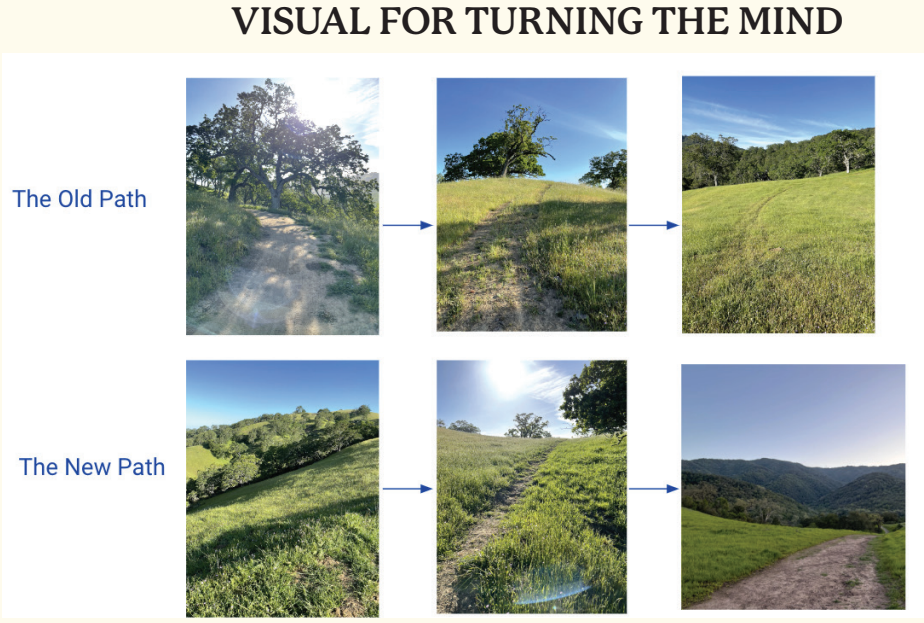
Incorporating special interests (SPINs) into DBT therapy can help in several ways. Autistic people can naturally connect with others through their SPINs, so asking about and showing interest in an Autistic client's SPINs can help with rapport-building, which many non-Autistic therapists may otherwise find challenging with Autistic clients. Connecting skills teaching to SPINs can also help build interest in topics that are otherwise of less interest to the client. This is a great place to make use of AI! For example, you could ask an AI tool to explain mindfulness in the context of Minecraft or another SPIN. Therefore, even if you know nothing about the client's SPIN, you can use it to help them learn DBT skills! Engaging in SPINs is also helpful for grounding following trauma work, as focusing on SPINs is both easy and enjoyable for Autistic folks. Though a full discussion of the reasons is beyond the scope of this article, we do not recommend that the therapist surreptitiously withhold discussion of STIMs to use as a reinforcer, as this is tantamount to telling the client they can only access part of their identity if they behave as the therapist wants. Such a strategy may be experienced as invalidating, manipulative, and a sign that the client can no longer trust the therapist, and thus is likely to be therapy interfering or destroying on the part of the therapist.

We can also support Autistic clients by honoring their need for clear, consistent structure with transparent rationale. It is important to be collaborative, invite all questions, and problem-solve together, as Autistic clients do not tend to see or follow hierarchies, and may find it difficult to understand and comply with arbitrary rules. Autistic clients often appreciate a clear, consistent agenda, in multiple formats. Finally, Autistic clients may need more notice and help adjusting to changes in routine.

Given that many Autistic clients have executive functioning differences, consider executive functioning supports. These may include modifying diary cards to be less overwhelming or in more accessible formats, providing information such as agenda and homework in writing, filing materials in an accessible place for clients in case they lose the originals, providing multiple reminders, helping break down large tasks into do-able chunks, and recording and providing transcripts of teaching. These executive functioning supports will help both Autistic clients and others thrive in DBT therapy.

Chain analysis can be made more visual and active by, for example, writing links in the chain on post-its that clients can move around. Mindfulness exercises can be modified to be more literal and realistic. In distress tolerance, TIPP skills

**Figure 1**



can be given more emphasis to help with a hypersensitive nervous system, and the 8 sensory systems can be taught in the context of self-soothe. In emotion regulation, therapists need to be very careful not to invalidate the client's experiences during teaching of "check the facts," as Neurohumility informs us that our clients experience the world differently. Given the tendency of Autistic clients to ask many questions and need to understand details, therapists need to be prepared to thoroughly explain all parts of charts in the emotion regulation module. Teaching interpersonal effectiveness for Autistic clients without encouraging excessive masking is especially tricky. First, DEAR MAN can be presented as a scripting process, which is a very Autistic friendly communication strategy. FAST can be taught as a balancing skill, which some Autistic clients may naturally be very good at, and which chronic invalidation may have made difficult. Finally, "mindful masking" can be taught as a form of middle path, in which clients are encouraged to see interpersonal effectiveness skills use as an optional choice, and decide mindfully whether or not to use them (and to what degree) in a given situation depending on their energy levels.

**Summary**

In the neurodiversity model, autism is a neurotype, not a disorder. For many, being Autistic is also an identity. Chronic invalidation of Autistic individuals drives shame and masking, which can further increase emotion dysregulation, suicidality, and self-harm. Tailoring DBT to the needs of Autistic clients can help them reduce these risks and help them to work towards their life worth living goals.

**"Quick Glance" Glossary**

*Ableism*: Prejudice and/or discrimination against people with disabilities (Dunn, 2019)

*Allistic*: Someone who is not Autistic (Cambridge Dictionary, 2024)

*Anti-ableis*t: Actively opposing Ableism and promoting access for all people (Dunn, 2019)

*Assimilation*: Trying to fit into perceived norms (Hull et al., 2019)

*Autistic*: A person with an Autistic neurotype (Taboas et al., 2022)

*Camouflaging*: Attempting to fit in to the norms of a social group (Hull et al., 2019)

*Compensation*: Adding strategies or skills that are valued by a social group (Hull et al., 2019)

*Eight Sensory Systems*: Both the 5 "classic" sensory systems that detect stimuli originating outside our bodies (Tactile, Auditory, Visual, Gustatory, Olfactory) and the 3 "hidden" sensory systems that are focused inside our bodies (Vestibular, Proprioception, Interoception; Neff, 2023)

*Masking*: Hiding certain characteristics that are expected to elicit maltreatment from others (Hull et al., 2019)

*Neurodivergent*: A brain that operates differently from a typically functioning brain (Singer, 1998)

*Neurodiversity*: All the diversity of human brain functioning, including neurodevelopmental, cognitive, and psychiatric differences (Singer, 1998)

*Neurohumility*: A process of humility, curiosity, and respect toward the lived experience of other body-minds, which positions the client rather than the therapist as the expert in their own experience (Kraus, 2023)

*Neurotype*: A particular description of brain functioning, such as Autistic, ADHD, Allistic, or Neurotypical (Crompton, Sharp, et al., 2020)

*Neurotypical*: A brain that functions in the ways that most brains are expected to operate (Cambridge Dictionary, 2024)

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# Absence of Alternatives: Building Motivation and Commitment with Clients Mandated to DBT

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Authors' note: For the sake of brevity, detailed explanations of various DBT strategies and clinical examples were removed from this piece. Please see ISITDBT 2023 recording for greater emphasis on practical application to working with incarcerated and eating disordered youth populations (Yadlosky & Boeh, 2024).

### The Importance of Voluntary Commitment and Effectiveness of DBT

Linehan made it very clear in her original 1993 manual that voluntary client commitment is a cornerstone of DBT:

> "Formal therapy cannot begin until the patient and therapist have arrived at an agreement to work together, the patient commits to the patient agreements, and the therapist commits to the therapist agreements. ***This point cannot be overemphasized*** (p. 444, emphasis added)."

Often, however, clinicians in various settings find themselves working with clients where obtaining client's voluntary commitment prior to beginning DBT isn't possible or likely. Some clients may have their rights and autonomy limited by legal mandate (e.g., clients experiencing incarceration) or the severity of their symptoms (e.g., clients with eating disorders).

In situations like these, Linehan urges clinicians to "consider carefully whether [DBT] can actually help the patient as much or better than available alternative treatments" (1993, p. 445). Fortunately, since 1993, DBT has been adapted and applied with various populations and in various settings, so we can explore the literature. We propose the following three questions to address Linehan's consideration:

1. Is there a theoretical rationale for using DBT with this population?
2. Are the required modifications to DBT feasible?
3. Is DBT an effective treatment with this population?

For both clients with eating disorders and those who are incarcerated, there is a solid theoretical rationale for the use of DBT, practical feasibility, and demonstrated preliminary effectiveness regarding treating behaviors relevant to each clinical population such as eating disorder behaviors or dangerous criminal behaviors (Bhatnagar et al., 2018; Ivanoff & Marotta, 2018; McCann et al., 2007). This suggests that DBT is likely to be able to help these clients, which leaves us with the challenge of building motivation and commitment in mandated settings.

### Common Challenges to Motivation and Commitment to DBT

While there are many challenges to building motivation and commitment to DBT with mandated clients, three common challenges are highlighted below. Additionally, societal structures of and intersectional experiences of racism, ableism, classism, heterosexism, sexism, etc. are very real and incredibly significant challenges to accessing, committing to, and engaging in DBT. These challenges require exploration, understanding, and conceptualization alongside those selected below.

For example, if working with a Black adolescent cisgender heterosexual male client from a low socio-economic background in a secure detention setting, one cannot accurately assess and understand barriers to treatment motivation without acknowledging and discussing a large number of intersectional factors (e.g., impact of systemic racism, interactions between race and socio-economic status in their community, gender and sexual-identity-related norms and beliefs client has grown up with, dynamics of a marginalized individual having their rights taken away and power exerted over them by a system, etc.). Including these realities in how we conceptualize all clients is an essential first step to navigating the challenges discussed below.

Additionally, the clinical challenges presented below interact with other concepts central to DBT case conceptualization (e.g., secondary targets) that are beyond the scope of this article.

#### Challenge 1: "F*#% You!" or [...]

This challenge captures clients who are completely unable or unwilling to engage in conversations about treatment. Some of them escalate into shouting or throwing things. It's big, loud, and sometimes genuinely scary. Alternatively, sometimes clients go in the opposite direction – saying or doing absolutely nothing. No matter what the therapist says or does, you could hear a pin drop; the client actually falls asleep; or the therapist is met with a constant stream of shoulder shrugs or "I don't know." Either way, the therapist and client are completely unable to even begin the conversation about motivation

and commitment.

**Challenge 2: "I don't have a problem" or "It's not MY problem"**

In this challenge, the client consistently asserts that they're not experiencing distress. Nothing is wrong; everything is fine. Alternatively, the client may assert that the distress exists solely in the environment – it's not their problem – it's their parents', parole officer's, school's, therapist's problem. And subsequently, it's not the client's responsibility to do anything about it. End of conversation. See Figure 1 for examples.

> **Figure 1:**
> Eating disorder client: "I was restricting for years before my mom found out; it's only a problem now because she needs to control my life."
> Incarcerated client: "It's not my fault they didn't lock their car door."

**Challenge 3: "This won't work at home"**

This challenge is mostly about generalization of DBT to home environments. Clients highlight existing environmental barriers including oppressive systems that block or punish effective application of skillful behavior. Peers and community members may bully or threaten violence in response to behavior change. Caregivers or teachers may actively punish the "more skillful" responses that DBT teaches. Clients, and sometimes caregivers and other stakeholders, are unwilling to engage because DBT won't help in client's real-world context. See Figure 2 for examples.

> **Figure 2:**
> Eating disorder client: "Are you kidding me? My friends, my family – even my doctor – says I look great having lost the weight. I'd never hear the end of it for going back to eating Oreos."
>
> Incarcerated client: "Forget DEARMAN – or whatever it is – everyone has a gun. DBT sounds great in here, but you don't get what it's like outside of detention."

These challenges can leave therapists feeling stuck. The next section highlights key considerations for creatively integrating DBT concepts and strategies together to address these challenges.

## Considerations in the Face of Challenges

*DBT Pretreatment is DBT*

It can be easy to view DBT Pretreatment as a steppingstone to the "main event" of full Stage 1 DBT. When working with low commitment and mandated clients, it is OK if you never leave pretreatment or repeatedly return when needed. With clients who didn't choose to be in treatment, targeting motivation and commitment to changing life threatening behaviors for their entire length of treatment may actually be the most clinically relevant and therapeutic target. Despite never collaborating on change strategies to target certain behaviors, spending sufficient time targeting motivation and commitment may lay the foundation for future change in the client's life.

When spending extended time in DBT pretreatment, it is vital to integrate all DBT strategies just as you would in later treatment stages. DBT pretreatment is, after all, DBT. While Linehan is clear on this point, it is our experience in these treatment settings that programs and systems can quickly lose sight of this when faced with clients who are slow to commit to stage 1 DBT, especially if strict treatment time limits exist.

*Life Worth Living Conversations*

Arguably the most important tools for increasing and maintaining motivation and commitment are a client's life worth living (LWL) goals. LWL goals are the big-picture values-driven things that a client wants that make tolerating their current level of pain and suffering worth it. They are the bedrock on which motivation and commitment stand. See Figure 3 for a consideration about LWL in alternative settings. Clients are often asked to change behaviors that provide control, acceptance from peers, and intense relief from pain, and that have been practiced to the point of mastery. To move towards change, they have to truly believe that it will be worth it in their own personal lives.

> **Figure 3:**
> In our experiences, at times "life worth living" can miss the mark or be invalidating with clients who are not struggling with suicidality and may be very content with their ineffective behaviors (e.g., eating disorder, criminal behaviors). Thus, we propose an optional, alternative term: life worth fighting for, and life worth fighting for goals. "Life worth living" will be used throughout this article to prevent confusion, as it is the terminology most clinicians are familiar with.

So often, clients in mandated eating disorder treatment or detention settings are told they should change their behaviors because the behaviors are "unhealthy," "wrong," "harmful," or "criminal." LWL goals put the client more in the driver's seat of therapy, and this can increase motivation to participate. These concepts can be particularly helpful for navigating challenges #2 ("Not a problem"/"Not my problem") and #3, ("This won't work") described above, since instead of the therapist, the client is the one defining the problem and setting the goals of treatment.

Goal setting is a skill that needs to be taught and shaped. Some clients may not see themselves living into adulthood, while others may be in day-to-day survival mode and haven't had the luxury of thinking to the future. Start with smaller, shorter-term goals that a client can connect with (e.g., increased video game time, saving or earning money to buy new shoes). Helpful topics to explore include values, important relationships, interests and hobbies, and childhood dreams. These things can help generate LWL conversations when the direct route isn't working. This may be particularly helpful when navigating challenge #2 ("Not a problem"/"Not my problem").

*Dialectics to Consider*

Staying dialectical is another important tool for increasing motivation of both client and therapist. When working with mandated clients, stay mindful of the dialectic of LWL goals and life-threatening or destroying behaviors. As therapists, we can become understandably polarized to the LWL end (e.g., staying alive, achieving a career). This can lead us to reject the validity in the life-threatening or destroying end (e.g., restricting to avoid bullying, committing violent crimes due to a lack of resources).

When this happens, we can become judgmental of our client's behaviors and lack of motivation (e.g., "They're being ridiculous!"). We can become invalidating and polarized, which can block understanding the kernels of truth in the client's stance. This often leads to missing critical information regarding the function of life-threatening behaviors and damaging the therapeutic relationship. While incredibly difficult, it is essential to practice non-attachment to LWL goals to prevent polarization. Navigating this dialectic is discussed in depth by Swenson (2016). Your team will be essential for finding a synthesis and practicing radical acceptance of where your client is in treatment.

*Bringing it all together: the importance of synthesizing all of DBT*

None of the above considerations will be of much help if used in a vacuum. Frequently practice and use the commitment strategies in chapter 9 of the DBT manual (Linehan, 1993). Maintain movement, speed, and flow. Nothing will cause a teen mandated to treatment to check out faster than an adult who has one default setting. Use irreverence and dialectical strategies often, and mix up your style, energy, and affect to avoid getting stuck in a rut. Be unexpected and keep your client off balance. This is particularly crucial for navigating challenge #1 ("F* you").

Lean heavily on validation. Mandated treatment and the environments it takes place in are often incredibly change oriented and, thus, invalidating. A strong therapeutic relationship will be essential to increasing motivation, and genuinely validating your client's perspective and experiences will go a long way in strengthening willingness to engage in treatment. This can be particularly useful in facing challenge #3 ("This won't work").

Roll with resistance, then shape it. Therapist emotions often run high with these clients — from hopelessness to rage — and it can be easy to miss opportunities to reinforce approximations of desired behaviors. Stay open to agreeing on intermediary goals in treatment, even if they feel miles away from what you're "supposed" to be targeting. Zoom in to keep an eye out for microscopic, behaviorally specific targets and track them explicitly (e.g., time spent with eyes open) to catch and reinforce change. This can be particularly helpful with challenge #1 ("F* you"). Then, spread that reinforcement around! Highlight how microscopic movements connect to long term goals for families, staff, and other stakeholders. Even if they are not able to see meaningful change right now, you are!

**Key Take Aways Building Motivation and Commitment with Mandated Clients**

Linehan is very clear about the importance of obtaining voluntary commitment before moving forward with Stage 1 DBT. Before proceeding, make sure that DBT is the treatment that is most theoretically, practically, and empirically likely to benefit your client in their setting. From there, target motivation and commitment in pretreatment. Remember that DBT pretreatment is DBT. All DBT strategies apply and are likely needed to be effective.

Doing DBT with mandated clients often requires extra patience, humility, and creativity. Be mindful of polarization with your client. Be unexpected and willing to mix things up. Consider ways to really understand your client's perspective and encourage them to help you really "get it," so you can radically validate their position before pushing for change.

Lastly, realistically adjust your outcome measures for success. Use your team frequently and often to help you identify and celebrate wins. This work can be as challenging as it is rewarding, so lean on your team when soft signs of frustration, hopelessness, and burnout arise.

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# Conceptualizing Autism–Affirming, Full–Scale DBT (DBT–AA)

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Dialectical Behavioral Therapy (DBT) has been recognized for its potential to aid autistic people in managing emotional dysregulation (Bemmouna et al., 2021; Hartmann et al., 2012; Huntjens et al., 2020). However, autistic self-advocacy has highlighted concerns about iatrogenesis driven by neurotypical biases in interventions designed and adapted for autistic individuals (see Dawson, 2004; Lilienfeld, 2007; Mercer, 2017). Neurological differences between autistic (Legault et al., 2019; Milton, 2014; Jaarsma & Welin, 2012) and allistic (i.e., non-autistic) people require different strategies in regulating behavior (Ibrahim et al., 2019; McDonnell & Milton, 2014; Perrykkad & Hohwy, 2020), cognition (Wadhera & Kakkar, 2020), sensory experience (Schoen et al., 2009), social interaction (Olivito et al., 2017), and emotion (Cai et al., 2018; Mazefsky, 2015; Morie et al., 2019; Samson et al., 2014; Santomauro et al., 2017; Weiss et al., 2018). Psychiatric/medical co-occurrence with autism (Bejerot & Wetterberg, 2008; Brondino et al., 2019; Linsao & Morgan, 2019) and physiological differences between allistic and autistic individuals (Herbert, 2010; Reynolds et al., 2012) necessitate treatment conceptualization and delivery differences (Walker, 2021). This paper aims to demonstrate the power of DBT to be autism-affirming by using our team's approach to DBT with autistic people as a case study.

We ground our approach in awareness of biases and a commitment to validating and respecting autistic experiences. Aligned with DBT's philosophy of valuing therapists and clients as equals (Linehan, 1993), we affirm allistic and autistic brain styles as equally valid and important (Walker, 2021). This ethos drives our efforts to deepen our understanding of autism, autistic culture, and autistic lived experiences. We actively seek consultation from autism-affirming (AA) therapists and neurodivergent thinkers and collaborate with autistics when altering allistic treatment elements. Furthermore, we engage with literature authored by autistic scholars and thinkers and pursue professional development opportunities led by autistic professionals. This holistic approach ensures our practices are informed, respectful, and genuinely supportive of the autistic community, which is consistent with recommendations from the autistic community to prevent iatrogenesis (Botha & Frost, 2020; Branford et al., 2019a,b; Brede et al., 2022; Donaldson et al., 2017; Farahar, 2022; Fiore, 2017; Gillespie-Lynch et al., 2017; Lipinski et al., 2022; Milton, 2014; Milton & Bradshaw, 2018; Ne'eman, 2021; Nicolaidis et al., 2015; Norbury & Sparks, 2013; Pantazakos, 2019; Walker, 2021).

Since 2020, we have striven to provide high-fidelity, full-scale DBT while honoring autistic people's needs (Bradshaw et al., 2021). Neurological differences between autistic (Legault et al., 2019; Milton, 2014; Jaarsma & Welin, 2012) and allistic (i.e., non-autistic) people require different strategies in regulating behavior (Ibrahim et al., 2019; McDonnell & Milton, 2014; Perrykkad & Hohwy, 2020), cognition (Wadhera & Kakkar, 2020), sensory experience (Schoen et al., 2009), social interaction (Olivito et al., 2017), and emotion (Cai et al., 2018; Mazefsky, 2015; Morie et al., 2019; Samson et al., 2014; Santomauro et al., 2017; Weiss et al., 2018). Psychiatric/medical co-occurrence (Bejerot & Wetterberg, 2008; Brondino et al., 2019; Linsao & Morgan, 2019) and physiological differences (Herbert, 2010; Reynolds et al., 2012) necessitates treatment conceptualization/delivery differences (Walker, 2021).

### Biosocial Model of DBT-AA

Scholarship documents the emotional vulnerability experienced by autistic people (Mazefsky, 2015; Rieffe et al., 2006; Samson et al., 2014). Autistics often live in environments that are ill-suited for their neurology (Pantazakos, 2019), as many allistics lack understanding of autism, rendering environments inflexible regarding neurotype differences. Subsequently, allistic social landscapes demand significant internal resources to navigate (Rosqvist et al., 2015). Differences in autistic and allistic sensory processing, self-regulation, socialization, and communication render neurotypical environments chronically invalidating to autistics (Rosqvist et al., 2015) and perpetuate pathological views of autism that negatively impact well-being (Lam et al., 2021). Navigating neurotypical spaces potentiates sensory distress, "masking" (Hull et al., 2017) of autistic traits, engagement in unwanted social

interactions, and being shamed for distressing sensory experiences that are benign to allistics (Kern et al., 2007).

### Autistic Burnout

Social landscapes that are sensory overloading, promote masking, and are intolerant of autistic regulation can leave autistics depleted (Higgins et al., 2021). Consistent with biosocial theory, invalidating environments can trigger autistic burnout (Raymaker et al., 2020), which is conceptualized as an energy supply-demand problem. When energy needs exceed supply, nonessential functioning is reduced for survival. Accordingly, this "burnout" causes global impairment (Boren, 2017). Autistic burnout is linked with suicidality (Higgins et al., 2021; Raymaker et al., 2020), partially explaining autistics' high suicide risk (Cassidy et al., 2014; Kirby et al., 2019; NICE, 2018). Additionally, autistic burnout has been associated with mental and physical exhaustion, and a temporary reduction of verbal and speaking abilities, social skills, coping, cognitive function, and sensory tolerance (Boren, 2017; Higgins et al., 2021; Linsao & Morgan, 2019; Raymaker et al., 2020). This culminates in poorer health outcomes, reduced independence, and a lack of empathy from allistics (Raymaker et al., 2020).

### DBT-AA Therapy

In our practice, we have made many thoughtful adaptations to traditional, allistic-informed therapy and DBT. We engage clients by embracing autistic traits through sensory engagement (Kapp et al., 2019), fidgeting, and stimming (Perrykkad & Hohwy, 2020), as well as activity-based interactions that cognitively enliven and regulate clients to support therapeutic goals. This often occurs through utilizing clients' special interests (Monteiro, 2021) and "info-dumping" (Milton, 2016; Winter-Messiers et al., 2007), which allows the client to "dump" ephemeral information with personal salience to ease the transition into the therapeutic space and create space for the cognitive load of therapy. This provides a safe, affirming transition to therapy, where no masking is required, and allows for a smooth transition to DBT's hallmark session-structuring events, such as attention to the hierarchy of targets and diary card review (Linehan, 1993). Additionally, neurodiversity-interfering behavior (NIB) was added to the hierarchy of targets.

NIB often causes and exacerbates life-interfering behavior and is ranked above therapy-interfering behavior (TIB) because enacting brain-style specific regulation behaviors (e.g., stimming, sensory engagement) is a right of personhood. We acted to reduce/eliminate allistic biases that lead therapists to misidentify behavior as TIB and under-recognize therapists' NIB. Scholars have recognized the double empathy problem (Williams et al., 2021), whereby those with different brain styles misread one another, a detrimental prospect in allistic therapist-autistic client collaborations. Evidence of NIB (e.g., sensory distress, demand avoidance, autistic meltdown/shutdown, autistic burnout) triggers a chain analysis - an integral part of DBT-AA. Clients describe chain analyses as validating, and significant others who can appropriately participate describe them as helpful. We have witnessed a significant other's realization of the autistic person's NIB-related suffering, demonstration of empathy and validation, and construction of a plan for environmental change during chaining.

All diary cards (for adults, teens, and parents) were created to be AA and reflect skills learned in DBT-AA. In addition to feelings, skill use, and other classic diary card features, our modified diary cards track NIB (Lee & Shatto, 2020; Lee et al., 2022; Shatto & Troyer, 2020; Shatto et al., 2021, 2022), autistic regulation skill use, and energy level. Many diary card changes were made in response to autistic adults' feedback (e.g., increased use of images over words; energy-level-based diary cards to prevent overload during autistic burnout). Monitoring our clients' progress through the hierarchy of targets, diary cards, and progress measures has demonstrated our clients' improvement in suicidal symptoms, depression, and emotional regulation.

### DBT-AA Skills Groups

AA accommodations were incorporated in skills groups (adult/multifamily). We have developed over 70 skills to support autistic people, which are featured on our diary cards (Shatto et al., 2022). Figures 1 and 2 show the daily diary card we developed for our autistic adult clients as an example. We populated spaces thoughtfully regarding sensory processing (e.g., environment's sensory inputs, sensory-based mindfulness, sensory coping) and offered alternative social communication methods. Rule-abiding fraternization was encouraged, reflecting the value/importance of autistic friendships (Crompton et al., 2020; Rosqvist et al., 2015). We conceptualized group as in-vivo practice of interpersonal effectiveness (Dolan et al., 2016; Miller et al., 2007), a platform to reinforce autistic social skills (Bolis et al., 2021), and a forum for validating social experiences.

### Coaching in DBT-AA

Clients and families receive coaching for skill generalization (Linehan, 1993) that respects autistic communication preferences. We use client-preferred communication methods with informed consent (e.g., phone, email, and messaging; Chapman, 2019; Rizvi & Roman, 2019). Communication options are essential, as distress can temporarily reduce communication abilities. GIFs are

used as low-input methods to provide caring messages that respect the cumulative load clients may experience when distressed. We find that our clients prefer messaging most of the time. When providing phone coaching, AA modifications are made, such as giving clients adequate time to verbalize if speech or other communication skills have been temporarily lost. Clients may require several minutes to verbalize, during which the therapist reinforces the client's coaching use, reassures the client of the therapist's presence with them, coaches distress tolerance, offers alternative communication options, and engages in body-doubling to help the person enact behaviors that facilitate regulation and coaching. This illustrates the importance of understanding autistic needs and experiences that might otherwise be viewed as TIB (e.g., longer phone call). We suggest that failure to provide autistic people longer times to verbalize, especially during distress, is NIB. Providing this accommodation is an AA response to cognitive differences and realigns coaching from time-limited to solution-focused. Because coaching calls can require more provider time and emotional labor, we frequently "tag" teammates to provide coaching, create coaching plans involving multiple teammates, and support the provider through real-time reinforcement (e.g., messaging, "Awesome coaching! Great job helping CODENAME use their skills!"). Beyond structuring the home environment and eliciting natural supports, our clients frequently benefit from advocacy (Artman & Daniels, 2010). A continuation of environmental structuring for our team includes frequently providing psychological assessment, attending school meetings, and writing advocacy letters.

### DBT-AA Consultation Team

As DBT consultation team (DBT-CT) is "therapy for the therapist," we routinely engage in team cohesion and communication behaviors, which are identified as salient to trust and DBT fidelity (Ditty et al., 2015; Linehan, 1993; Sayrs & Linehan, 2019). In addition to adhering to DBT's assumptions about clients and therapy, mutually submitting to team agreements, and following a meeting format (Sayrs & Linehan, 2019), we maintain a unique team culture through continuing education regarding autism, discussion of novel concerns, development of AA skills, and discussions to balance adaptation and DBT fidelity. We developed team-specific agreements such as the neurodiversity- and autism-affirming agreements.

### Summary

Historically, therapy for autistics has been neurotypical constructs where "problems" are defined by deviations from allistic thinking, feeling, behaving, and relating. Pathological views of autism have negatively affected autistic wellness by encouraging masking (Hull et al., 2017) and autistic burnout (Higgins et al., 2021; Raymaker et al., 2020) that promote suicidality (Cassidy et al., 2014; Kirby et al., 2019). Chronic environmental invalidation and subsequent emotional dysregulation experienced by autistic people are consistent with the biosocial model; therefore, DBT targets of skill-building and environmental structuring allow for AA treatment modifications, which is essential to avoid iatrogenesis. We worked to integrate AA stances throughout DBT. Autistic social engagement methods were implemented, communication and sensory modifications were made, skills were created for autistic experiences, diary cards were modified, and differences in coaching needs were honored. We made effort to center autistic voices, adhere to AA team agreements, and be mindful of neurotypical biases/assumptions. We found that clients have had positive, clinically significant responses to DBT-AA.

**Figure 1. Front side of daily diary card for adults in autism-affirming DBT.**

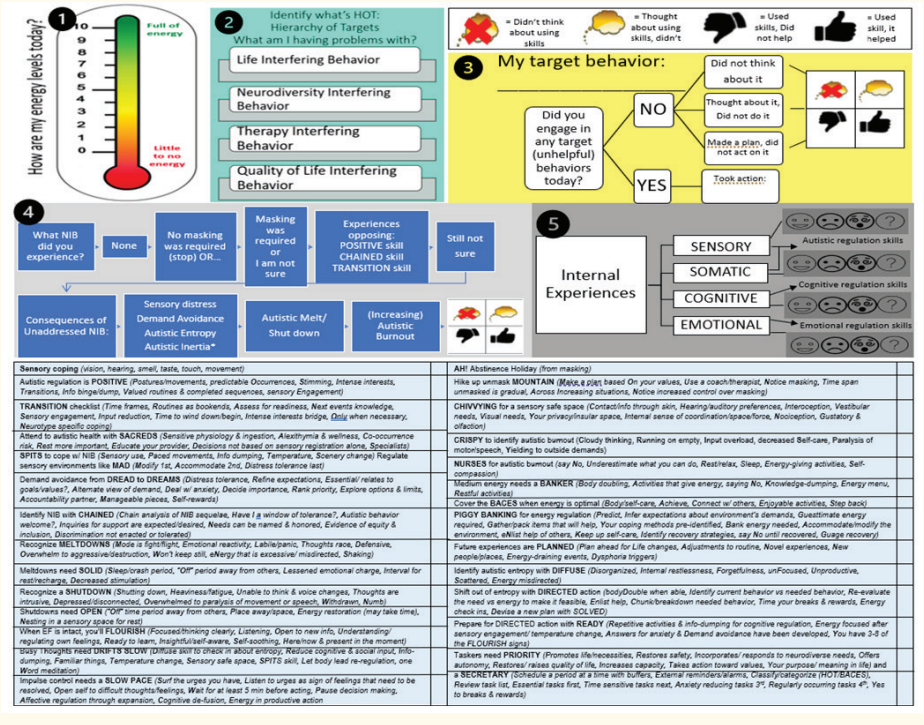
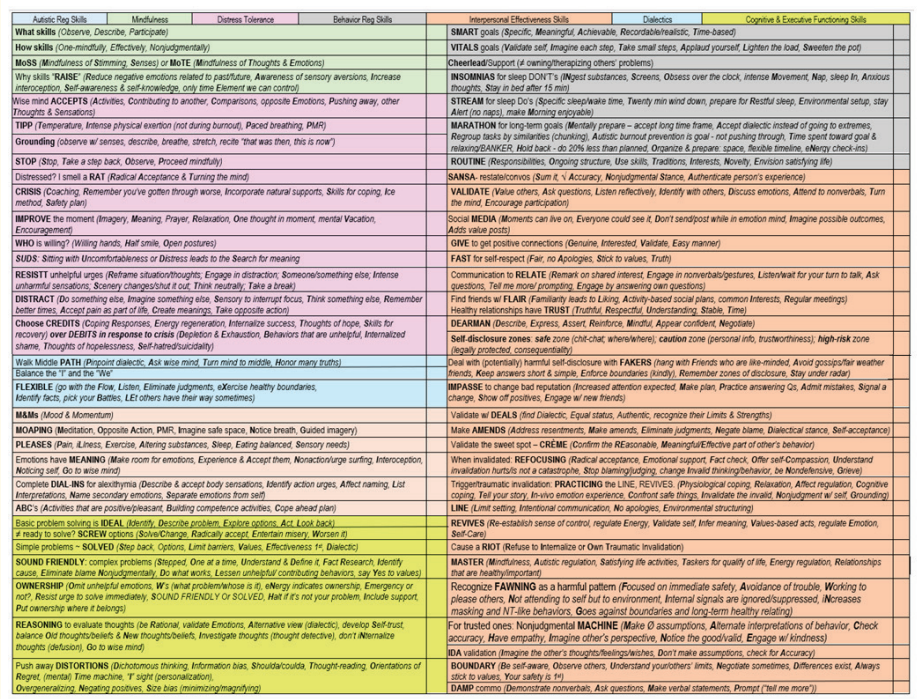


**Figure 2. Back side of daily diary card for adults in autism-affirming DBT.**



| Autistic Reg Skills | Mindfulness | Distress Tolerance | Behavior Reg Skills | Interpersonal Effectiveness Skills | Dialectics | Cognitive & Executive Functioning Skills |
|---|---|---|---|---|---|---|

**What skills** (*Observe, Describe, Participate*)

**SMART** goals (*Specific, Meaningful, Achievable, Recordable/realistic, Time-based*)

**How skills** (*One-mindfully, Effectively, Nonjudgmentally*)

**VITALS** goals (*Validate self, Imagine each step, Take small steps, Applaud yourself, Lighten the load, Sweeten the pot*)

**MoSS** (*Mindfulness of Stimming, Senses*) or **MoTE** (*Mindfulness of Thoughts & Emotions*)

**Cheerlead**/Support (*≠ owning/therapizing others' problems*)

Why skills "**RAISE**" (*Reduce negative emotions related to past/future, Awareness of sensory aversions, Increase interoception, Self-awareness & self-knowledge, only time Element we can control*)

**INSOMNIAS** for sleep DONT's (*INgest substances, Screens, Obsess over the clock, intense Movement, Nap, sleep In, Anxious thoughts, Stay in bed after 15 min*)

Wise mind **ACCEPTS** (*Activities, Contributing to another, Comparisons, opposite Emotions, Pushing away, other Thoughts & Sensations*)

**STREAM** for sleep Do's (*Specific sleep/wake time, Twenty min wind down, prepare for Restful sleep, Environmental setup, stay Alert (no naps), make Morning enjoyable*)

**TIPP** (*Temperature, Intense physical exertion (not during burnout), Paced breathing, PMR*)

**MARATHON** for long-term goals (*Mentally prepare – accept long time frame, Accept dialectic instead of going to extremes, Regroup tasks by similarities (chunking), Autistic burnout prevention is goal - not pushing through, Time spent toward goal & relaxing/BANKER, Hold back - do 20% less than planned, Organize & prepare: space, flexible timeline, eNergy check-ins*)

**Grounding** (*observe w/ senses, describe, breathe, stretch, recite "that was then, this is now"*)

**STOP** (*Stop, Take a step back, Observe, Proceed mindfully*)

**ROUTINE** (*Responsibilities, Ongoing structure, Use skills, Traditions, Interests, Novelty, Envision satisfying life*)

Distressed? I smell a **RAT** (*Radical Acceptance & Turning the mind*)

**SANSA**- restate/convos (*Sum it, ↖ Accuracy, Nonjudgmental Stance, Authenticate person's experience*)

**CRISIS** (*Coaching, Remember you've gotten through worse, Incorporate natural supports, Skills for coping, Ice method, Safety plan*)

**VALIDATE** (*Value others, Ask questions, Listen reflectively, Identify with others, Discuss emotions, Attend to nonverbals, Turn the mind, Encourage participation*)

**IMPROVE** the moment (*Imagery, Meaning, Prayer, Relaxation, One thought in moment, mental Vacation, Encouragement*)

Social **MEDIA** (*Moments can live on, Everyone could see it, Don't send/post while in emotion mind, Imagine possible outcomes, Adds value posts*)

**WHO** is willing? (*Willing hands, Half smile, Open postures*)

**GIVE** to get positive connections (*Genuine, Interested, Validate, Easy manner*)

***SUDS**: Sitting with Uncomfortableness or Distress leads to the Search for meaning*

**FAST** for self-respect (*Fair, no Apologies, Stick to values, Truth*)

**RESISTT** unhelpful urges (*Reframe situation/thoughts; Engage in distraction, Someone/something else; Intense unharmful sensations, Scenery changes/shut it out, Think neutrally, Take a break*)

Communication to **RELATE** (*Remark on shared interest, Engage in nonverbals/gestures, Listen/wait for your turn to talk, Ask questions, Tell me more/ prompting, Engage by answering own questions*)

**DISTRACT** (*Do something else, Imagine something else, Sensory to interrupt focus, Think something else, Remember better times, Accept pain as part of life, Create meanings, Take opposite action*)

Find friends w/ **FLAIR** (*Familiarity leads to Liking, Activity-based social plans, common Interests, Regular meetings*)
Healthy relationships have **TRUST** (*Truthful, Respectful, Understanding, Stable, Time*)

**Choose CREDITS** (*Coping Responses, Energy regeneration, Internalize success, Thoughts of hope, Skills for recovery*) **over DEBITS in response to crisis** (*Depletion & Exhaustion, Behaviors that are unhelpful, Internalized shame, Thoughts of hopelessness, Self-hatred/suicidality*)

**DEARMAN** (*Describe, Express, Assert, Reinforce, Mindful, Appear confident, Negotiate*)

**Self-disclosure zones**: ***safe*** *zone (chit-chat, where/where);* ***caution*** *zone (personal info, trustworthiness);* ***high-risk*** *zone (legally protected, consequentiality)*

Walk Middle **PATH** (*Pinpoint dialectic, Ask wise mind, Turn mind to middle, Honor many truths*)

Deal with (potentially) harmful self-disclosure with **FAKERS** (*hang with Friends who are like-minded, Avoid gossips/fair weather friends, Keep answers short & simple, Enforce boundaries (kindly), Remember zones of disclosure, Stay under radar*)

Balance the "I" and the "We"

**FLEXIBLE** (*go with the Flow, Listen, Eliminate judgments, eXercise healthy boundaries, Identify facts, pick your Battles, LEt others have their way sometimes*)

**IMPASSE** to change bad reputation (*Increased attention expected, Make plan, Practice answering Qs, Admit mistakes, Signal a change, Show off positives, Engage w/ new friends*)

**M&Ms** (*Mood & Momentum*)

Validate w/ **DEALS** (*find Dialectic, Equal status, Authentic, recognize their Limits & Strengths*)

**MOAPING** (Meditation, Opposite Action, PMR, Imagine safe space, Notice breath, Guided imagery)

Make **AMENDS** (*Address resentments, Make amends, Eliminate judgments, Negate blame, Dialectical stance, Self-acceptance*)

**PLEASES** (*Pain, illness, Exercise, Altering substances, Sleep, Eating balanced, Sensory needs*)

Validate the sweet spot – **CRÈME** (*Confirm the REasonable, Meaningful/Effective part of other's behavior*)

Emotions have **MEANING** (*Make room for emotions, Experience & Accept them, Nonaction/urge surfing, Interoception, Noticing self, Go to wise mind*)

When invalidated: **REFOCUSING** (*Radical acceptance, Emotional support, Fact check, Offer self-Compassion, Understand invalidation hurts/is not a catastrophe, Stop blaming/judging, change Invalid thinking/behavior, be Nondefensive, Grieve*)

Complete **DIAL.INS** for alexithymia (*Describe & accept body sensations, Identify action urges, Affect naming, List interpretations, Name secondary emotions, Separate emotions from self*)

Trigger/traumatic invalidation: **PRACTICING** the LINE, REVIVES (*Physiological coping, Relaxation, Affect regulation, Cognitive coping, Tell your story, In-vivo emotion experience, Confront safe things, Invalidate the invalid, Nonjudgment w/ self, Grounding*)

**ABC's** (*Activities that are positive/pleasant, Building competence activities, Cope ahead plan*)

**LINE** (*Limit setting, Intentional communication, No apologies, Environmental structuring*)

Basic problem solving is **IDEAL** (*Identify, Describe problem, Explore options, Act, Look back*)

**REVIVES** (*Re-establish sense of control, regulate Energy, Validate self, Infer meaning, Values-based acts, regulate Emotion, Self-Care*)

≠ ready to solve? **SCREW** options (*Solve/Change, Radically accept, Entertain misery, Worsen it*)

Cause a **RIOT** (Refuse to Internalize or **O**wn **T**raumatic Invalidation)

Simple problems ~ **SOLVED** (*Step back, Options, Limit barriers, Values, Effectiveness 1st, Dialectic*)

**SOUND FRIENDLY**: complex problems (*Stopped, One at a time, Understand & Define it, Fact Research, Identify cause, Eliminate blame Nonjudgmentally, Do what works, Lessen unhelpful contributing behaviors, say Yes to values*)

**MASTER** (*Mindfulness, Autistic regulation, Satisfying life activities, Taskers for quality of life, Energy regulation, Relationships that are healthy/important*)

**OWNERSHIP** (*Omit unhelpful emotions, W's (what problem/whose is it), eNergy indicates ownership, Emergency or not?, Resist urge to solve immediately, SOUND FRIENDLY Or SOLVED, Halt if it's not your problem, Include support, Put ownership where it belongs*)

Recognize **FAWNING** as a harmful pattern (*Focused on immediate safety, Avoidance of trouble, Working to please others, Not attending to self but to environment, Internal signals are ignored/suppressed, INcreases masking and NT-like behaviors, Goes against boundaries and long-term healthy relating*)

**REASONING** to evaluate thoughts (*be Rational, validate Emotions, Alternative view (dialectic), develop Self-trust, balance Old thoughts/beliefs & New thoughts/beliefs, Investigate thoughts (thought detective), don't Internalize thoughts (defusion), Go to wise mind*)

For trusted ones: Nonjudgmental **MACHINE** (*Make Ø assumptions, Alternate interpretations of behavior, Check accuracy, Have empathy, Imagine other's perspective, Notice the good/valid, Engage w/ kindness*)

**IDA** validation (*Imagine the other's thoughts/feelings/wishes, Don't make assumptions, check for Accuracy*)

Push away **DISTORTIONS** (*Dichotomous thinking, Information bias, Shoulda/coulda, Thought-reading, Orientations of Regret, (mental) Time machine, "I" sight (personalization), Overgeneralizing, Negating positives, Size bias (minimizing/magnifying)*

**BOUNDARY** (*Be self-aware, Observe others, Understand your/others' limits, Negotiate sometimes, Differences exist, Always stick to values, Your safety is 1st*)

**DAMP** commo (*Demonstrate nonverbals, Ask questions, Make verbal statements, Prompt ("tell me more")*)

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# Balancing Process and Outcomes in Postvention

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The term "balancing" references an ongoing, fluid, dynamic act. Structures and objects that are balanced tend to not stay balanced during changes in the environment, changes in history, or during the myriad of unexpected events we experience as humans. Describing postvention as being a balance between the process and outcome of the activity is accurate given this definition. For the majority of clinics, clinicians, staff, and affected individuals, moving back to balance with regards to postvention requires continually asking the wise mind question of "what is being left out?" and being open to change occurring. In the 2023 talk at ISITDBT which this article is based on, we invited the ongoing discussion of how to best support each other in thinking through postvention, creating effective protocols, and working as a community.

One of the salient features of the 2023 ISITDBT talk was the extent to which knowledge from individuals with lived experience when structuring, improving, and expanding postvention is essential. In our clinic (Portland DBT Institute), clinicians have remarked on the isolation which can occur after a client's death, especially in the absence of a comprehensive postvention protocol:

> *"It was a truly painful moment to find out via voicemail from a family member, that my client had died, isolated and alone...I was told to "Not talk to anyone about this." I felt incredibly isolated ... I wish I had the opportunity to let my team members know about the impact of my client's suicide on me, such as how I had doubts about being a DBT therapist, urges to leave the practice and to stop doing this work; however, I didn't say anything to them, and I suffered in silence."*

> *"After I heard that my client died by suicide, I was experiencing frequent and intense symptoms which cued me to manage these responsibly based on what I know about trauma. I was experiencing intrusive thoughts, nightmares, and a somatic experience which was the acute sensation that I was going down on a roller coaster for days and weeks after hearing the news of my client's death."*

These experiences speak to the need to have transparent, inclusive planning which minimizes the perception of shaming with giving easy access to structures for support. Clinicians found the connection to peers with lived experience, community support, and community assistance in accessing wise mind to be helpful in moving through the experience:

> *"Like an underwater cave spelunker guide, it is essential that we stay connected to a wise mind path like a lantern guiding our clients out of a dark and dank rocky crevasse. The postvention support group helped me make meaning out of my client's death by getting closer to those DBT clinicians who have experienced a similar loss, and they are all my dear and special friends now."*

> *"What started initially as an attempt to help others feel less alone in the experience of client death by suicide has become a necessary intervention for treating inhibited grief. We love that our time together is centered around "therapy for the therapists." Our time starts with a mindfulness practice, observations about the practice, and the rest of the time, we check in with each other [using validation skills]... to be a "community of therapists treating a community of clients." .... I believe we've each grown in our commitment to work with clients who are suffering tremendously because we grieve together, thereby reducing inhibited grief, which allows us to process and survive what we feared the most."*

Lastly, and perhaps most significantly, the voices of individuals with lived experience point towards the need to focus postvention holistically, using a dialectical approach, rather than moving towards rigid risk management or towards overly fragilizing staff:

> *" [Additionally], because I conduct DBT-PE I decided to use Dr. Melanie Harned's prolonged exposure form to prepare for the chart review...In addition to this providing emotional processing rather than avoiding, one of the most valuable parts of this preparation process was naming what I was afraid would happen before looking at my client's chart, and then writing down any new learning that occurred after reading my client's chart. This helped me stay connected to compassion for myself and compassion for my client, as well as compassion for my colleagues who have experienced a similar loss."*

> *"...Two experiences facilitated my healing. The first was that after several years, I was ready to finally do the chart review..... This was part of my exposure therapy and the fear I had about confronting the chart dissipated. The other experience that helped tremendously was the presentation my coworkers and I prepared in 2018 for ISITDBT on suicide postvention. The opportunity to share about the experience of losing a client to suicide sans the support of my consultation team in 2012 helped me to confront the inhibited grief and through the presentation, we were able to offer meaningful experiences to participants who attended. It was a powerful way to make meaning of my client's death. That is the backdrop for the consultation group we named, "Clinician/staff affected by client suicide." We started this group after a coworker and I spoke about how different our experiences were with our clients' deaths."*

The feedback from clinicians with lived experience is consistent with literature regarding worries of clinicians working with suicidal patients in general (e.g. Jobes, D. A., Rudd, M. D., Overholser, J. C., & Joiner, T. E., Jr., 2008; Jobes, 2010). At the same time, while literature is available regarding suicide rates and postvention protocols for psychiatry (e.g. Erlich et al, 2017; Henry, Ramages, & Cheung, 2020), as well as increased risk of suicide in general for individuals with Borderline Personality Disorder (Yen et al, 2021), there is limited information regarding postvention work for clinicians in general and DBT clinicians specifically (Renz, Miller, & Graling, 2022). Additionally, formal training in graduate programs around suicide remains low with little focus on postvention (Dexter-Mazza & Freeman, 2003; Veilleux & Bilsky, 2016).

Proposed protocols for postvention within the context of DBT call for balancing the needs of the family survivors, the needs of the clinician survivor, and the needs of the clinic or agency (Gutin, 2019; Renz, Miller, & Graling, 2022). These protocols typically break up into three components:


In a manner similar to the construct of Wise Mind (e.g. Linehan, 2014, p50), these components can be visualized as a Venn diagram, or as a synthesis between tasks. Putting high levels of focus on one component may serve a function and runs the risk of not seeing the complete picture. For example- just as staying in Reasonable Mind may help to distract from uncomfortable emotions, staying focused on Risk Management/ Communication Strategies would leave out support for clinicians and proactive postvention. Finding a synthesis between the three components (similar to a synthesis between Emotion Mind and Reasonable Mind) is where effective balance begins and solutions are created.

### Wise Mind Risk Management and Communication Strategies

The period after a completed suicide is rife with intense emotions, pressure, urges to act, and cognitive disorganization, to name a few of the very human experiences. These experiences infuse all individuals affected, whether they be clinicians, support staff, families, administrative staff, billers, supervisors, or any other connected individual. Risk management and communication leverages structures put into place before a suicide occurs which allow for accessing wise mind during times where emotions and urges may pull individuals into decisions outside of their own wise mind. General structures in this area include:

- <u>Systematic structure for notification of staff and affected parties:</u> Create a written, easily accessible, streamlined plan for steps to take when the clinic is notified about the death of a patient. For example, does your practice have a clear, written protocol for exactly what to do if a death notification is called in to your front desk staff by a community member? Would that staff know what to do (and know where to find a plan)?
- <u>Creation of Wise Mind plan with team for emotional support:</u> Create a policy for connecting affected staff to their team leads/managers to create an initial personalized plan for support and set up proactive follow up meetings (e.g. scheduled meetings) rather than relying on affected staff to reach out. This plan should include outreach and

support for the clients' family (if appropriate) as well.

- Contacting liability insurance carriers: As part of the wise mind support plan, set up a time for the staff to contact their liability insurance and notify them of the event.
- Documentation: Ensure clinical records are updated with any contact from the family or outside sources, change the client status in medical and billing systems to ensure family members are not getting calls regarding billing and administrative issues in the immediate aftermath.
- Setting up future meetings to review patient clinical chart: Doing a review of the treatment timeline and clinical chart can be extremely helpful not only for improving quality of care and learning from the case, but also for affected clinicians to have a way to process and find closure. Higher level targets (supporting the clinician and the family) will preclude this from happening in the immediate days after the death, and scheduling a time to have this meeting before excessive time has elapsed is important in maintaining balance during this process.

**Proactive Postvention**

When joining a DBT team, there is a general process for orienting the clinician and obtaining commitment to the team (Sayrs & Linehan, 2019). One additional element which has been suggested by theorists in the area (and in talking to these theorists, has been slow to be implemented) is the creation of a "proactive postvention plan" (e.g. Barman & Kablinger, 2021; Nazem, Pao, & Wortzel, 2020; Spruch-Feiner et al., 2022). This plan, done when joining a team, asks the staff (in conjunction with their team, if needed) to write down and keep a worksheet with items such as:

| Postvention Item | Example(s) |
|---|---|
| Insurance Carrier policy and phone number | • Policy 2701, Stevenson and Associates, 1.800.349.1021 |
| Contact information for supervisors and peers | • Supervisor: Binx Bolling (503.607.1223)<br>• Work team buddy: Gates Falls (503.919.1531) |
| Wise Minded Coping Statements | • "There may be times I experience loss at work, and I can get through it"<br>• "Feeling despair and sadness after a loss is normal and means I care about the work I do"<br>• "I can be a professional and still ask for help when things are difficult" |
| Checklist for needed items in the first week post suicide | • Met with my supervisor and created a written wise mind game plan (including meeting with family if indicated)<br>• Made a plan and/or a diary card to ensure self-care and decrease vulnerabilities<br>• Called my insurance carrier to inform them of the event<br>• Scheduled times to meet with friends and/or clinical peers for support and social time<br>• Scheduled sessions with personal therapist or other support systems as needed |
| Wise mind cope ahead plan for reducing vulnerabilities at this time | • Monitor and practice PLEASE skills to reduce vulnerabilities<br>• Limit access to lethal means if necessary<br>• Do activities related to personal values<br>• Add/increase monitor daily mindfulness practice<br>• Avoid avoiding and increase connections with family/friends/peers |

This plan, consistent with the Cope Ahead skill (or the Turning the Mind skill), radically accepts inherent vulnerabilities in being a clinician and working with high-risk patients and provides a path to return to wise mind after an event such as client suicide. For example, after the event of a suicide, clinicians may be likely to move to rational mind (e.g. "I shouldn't be upset about it, I'll just ignore it and keep working") or emotional mind (e.g. "I can't possible ever do this job again and the whole word is collapsing). Having a plan which decreases vulnerabilities and creates wise mind connections to others helps to move individuals to a place of "being upset is normal - I can reach out for help and take time if I need it, and even if there are times I feel the world is falling apart, I know there is a structure to catch me."

**Support for Clinicians and Families**

In addition to wise mind-based systems described above, ongoing support to affected staff and families is essential. This support exists both in the short-term (e.g. processes listed above, reaching out to the client's family and saying close if appropriate) and in the long-term. Longer-term support structures include:

- Creation of ongoing clinician support groups: These groups create a space where clinicians with lived experience can support individuals who have more recently gone through a suicide loss, allowing for modeling of recovery, emotional support, and concrete support where needed.
- Proactive focus of meetings: Rather than waiting for affected parties to reach out, team leads and managers set up structured meetings to check-in. Is this part of the clinician support group or the general team consultation meetings?
- Family support: Clinicians work with their team leads and consultation teams to offer ongoing support to the family (where appropriate) to assist with the loss and to stay close.

As previously noted, many of the presented concepts and structures in this article originated in preparation for and discussions at our postvention talk at ISITDBT 2023. These conversations have continued to resonate in our clinic and with interactions with the larger community, and in many ways, represent continued attempts to find balance and improve the work we do. Our hope is this article continues that process and opens space for future work around implementing postvention protocols, publishing research on both the process and outcomes of postvention, and integration of lived experience. We look forward to continued conversations and collaborations in this area with our larger treatment teams throughout the world.

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# Dialectical Behavior Therapy for Parents of Struggling to Launch Young Adults: finding Synthesis with SPACE.

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**Introduction**

Referrals of parents asking for help with young adult children who are unsuccessful in transitioning into the societal requirements of adulthood have grown exponentially in recent years (McConville, 2021) and our clinic is no exception. At intake, parents report that their young adult children are under/unemployed, not actively pursuing education/training options, struggle with emotion dysregulation and behavioral activation, spend much time playing video games or using THC, and are solely reliant on parents' financial and emotional support. Although the parents often describe these young-adult children as having a long history of pervasive and complex treatment needs, at the time of intake these young adults are generally not in therapy or have been in supportive therapy for an extended period with little improvement. Frustrated parents describe vacillating between feeling unable to effectively encourage change in their young-adult child and demanding rapid change in ineffectively sized doses. To complicate the picture further, the parents themselves report struggling with emotion regulation deficits, making implementing interventions difficult and at times explosive.

While Dialectical Behavior Therapy (DBT), with its established impact on multi-diagnostic presentations and skills training for emotion regulation, seemed a natural fit for instructing parents on interventions to help themselves and their adult children, we became aware that these loving/caring parents had often inadvertently reinforced problem behavior and had moved into hopelessness and problem accommodation. Helping parents behaviorally redefine how to offer support and confidence while establishing appropriately sized contingencies felt key for a successful intervention.

**Intention**

The SPACE (Supportive Parenting for Anxious Childhood Emotions) protocol, developed as a parent only intervention for treating childhood anxiety (Lebowitz, 2019), has an adaptation for parents of failure to launch young adults (Lebowitz, 2016). While the SPACE protocol includes psychoeducation and skill instruction for parents, the treatment had contraindications that often excluded DBT clients. These included adult children with a multi-diagnostic presentation, suicidal ideation and self-injurious behaviors, forensic involvement, and ongoing substance abuse. As DBT targeted these same symptoms by design, it seemed a natural next step to combine these two modalities. Our team combined DBT principles, protocols, and skills training with the tenants and structure of SPACE to develop a 16-week intervention that teaches parents how to provide support, set limits and to help their adult children take steps toward change. The specific inclusion of DBT skill instruction allowed parents to manage limits around both acute and chronic high-risk behaviors, as well as establish nonjudgmental expectations of functioning around the tasks of adult living.

**Rationale**

Tenants of SPACE treatment aligned with DBT's emphasis on a nonjudgmental stance from the start. Young adults have real problems that are not caused by their parents, and most have a history of additional vulnerabilities as well as extensive forms of interventions. Despite this, these young adults continued to suffer without measurable differences in functioning or improved outlooks. An environmental intervention made sense. Still, the original SPACE protocol named exclusion criteria for adult children, including severe psychopathology, substance abuse problems, suicidality, self-harming behavior, and forensic involvement. As DBT therapists, we felt comfortable combining SPACE with DBT's evidence-based protocols to address these additional complexities.

There were other natural areas of overlap with DBT and SPACE. They included acceptance and change principles, a prevailing nonjudgmental stance, the concept of consultation to the client, and instruction on behavioral principles of shaping and contingency management. Instruction on dialectics was a key component throughout the treatment, leaving room for both acceptance and change in skillful parenting. With these concepts in mind, our team set about to build a model of intervention for parents of multi-diagnostic adult clients.

**Treatment**

An overarching goal of the intervention centered on the concept of accommodation, defined as parental

responses to an adult child's distress that attempted to influence the behaviors and lifestyle of the adult child. These efforts are rarely effective, and lead to exacerbated parents, frustrated young adults, and unrelenting and unresolved tension. A foundational four-week orientation introduced parents to the concept of accommodation in parenting young adult children. All programming was modeled on the concept and practice of dialectics. The first two weeks emphasized awareness and acceptance in teaching the what's and how's of parental accommodation, with an active practice of validation without specific agreement. Week three focused on change principles by teaching parents how to establish and enforce appropriately sized behavioral expectations. Finally, parents walk through sharing a plan for change that emphasized validation, confidence, and a shared responsibility for enacting change at home.

An additional twelve weeks of DBT skill instruction honed in on teaching parents skills to both tolerate and change emotions, thoughts, and urges to accommodate. Two weeks of mindfulness instruction on states of mind is applied to parental accommodation. Another two weeks of distress tolerance skills emphasized crisis survival and Radical Acceptance practice for parents. A month-long cycle of emotion regulation skills addressed the function of emotions while gauging how and when to effectively change the experience of emotions. Problem-solving skills were applied to help reduce parental accommodation. Two weeks of interpersonal effectiveness lent specific structure to sorting priorities in communication with adult children, while a final two weeks of reviewing behavioral principles allowed parents real life practice with shaping, reinforcement, and contingency management.

Lastly, the group itself offered a community of like-minded people who often found themselves feeling alone in their struggles, much like "tulips in rose gardens." Judgement from immediate and extended family as well as friends led to parental isolation and hopelessness. The sense of community found among group members was often cited as one of the primary benefits from attending the course. A favorite DBT tenant is often cited in sessions: "All people at any given point in time are doing the best they can, and all people can do better, try harder, and be more motivated to change." Our Team thanks the parents who have allowed us to participate in their journey as they walk both sides of the dialectic.

Our program has continued to teach this parenting course and offers a specific track for the Orthodox Jewish community. We welcome feedback from members of the DBT community on implications for future programming and research. Please do not hesitate to reach out to akalasunas@cebtohio.com.

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# Throwing the Baby Out with the Bathwater: Shortcuts Don't Work in DBT Research, Implementation Science Matters!

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The youth mental health crisis, exacerbated by the pandemic, has been well documented and highlighted last year by US Surgeon General Vivek Murthy, MD (2023). Rates of anxiety, depression, self-harm and suicide among young people have never been higher. Access to quality outpatient mental health care is challenging at best; hence, schools have become the mental health "front line." As a result, the need for empirically-based strategies and skills to help empower adolescents intervene in their own lives has become a necessary reality to stem the current mental health crisis. A school-based universal approach in teaching social emotional learning (SEL) that is empirically-based, would seem like an ideal solution, yet it is this very strategy that is being thrown out with the bathwater, in a time when it is likely needed the most. This article will review and critique both the Atlantic article "These teens got therapy; and then they got worse" (Khazan, November 6th, 2023) which draws their point of view from the Harvey et al. (2023) study's inaccurate and over-reaching conclusions. Further, the authors of this article will highlight how implementation science matters, and how taking shortcuts in the areas of dosage and fidelity can impact the effectiveness of a program, thus drawing inaccurate conclusions that could have adverse effects on young people receiving mental health prevention and treatment.

### Background

The need for youth mental health prevention and intervention programs is without dispute (CDC, 2023). The youth suicide and self-harm rates have continued to climb over the past decade, with the trend pointing to higher rates among adolescents. The effectiveness of therapeutic treatments, especially Dialectical Behavior Therapy (DBT) for adolescents, have been shown to be superior to all other therapeutic treatments for suicidal multi-problem adolescents to date and has been adopted worldwide (Miller, Rathus & Linehan, 2007; Mehlum et al., 2014; McCauley et al., 2018). Psychologists have extended DBT from clinical settings to school settings delivered at both a) a comprehensive DBT level for those youth already showing signs and symptoms of distress as well as at b) a universal classroom level considered more of a prevention intervention (Dexter-Mazza et al, 2020; Miller, et al., 2023). SEL programs designed at the universal level to teach DBT skills and strategies have been offered as a means to broaden the reach of DBT skills and strategies (Mazza, Dexter-Mazza, Miller, Rathus & Murphy, 2016) and have shown to be effective in prior studies (Hastings et al., 2022; Martinez et al., 2022).

Conducting research examining the effectiveness of both clinical interventions and universal programs is an important and necessary endeavor to show treatment effectiveness or the lack thereof and in what populations. In addition, replication studies are essential to ensure that established published programs work as they are written and described. Both types of research studies are equally important, though what is termed a replication or extension of an original program must be close to identical if conclusions are to be drawn about the original program. A case in point is the Australian study by Harvey and colleagues (2023) titled: "Investigating the efficacy of a Dialectical Behavior Therapy-based universal intervention on adolescent social and emotional well-being outcomes", which we argue is not close to identical to the original program. A detailed critique of this research and the subsequent follow-up article in the Atlantic are discussed below.

### Implementation Science

Before getting into the details of the critique, it is important to highlight the field of implementation science, defined as the "scientific study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers" (Implementation Science at UW, 2023). In layperson's terms: implementation science is a set of variables that provides the "how to" map for implementing programs and curriculum. Some of these variables are central to the critique below, particularly dosage (the amount of the intervention or selected curriculum that is delivered or implemented) and fidelity (the degree to which the selected curriculum or intervention is delivered as prescribed and/or as intended). The dosage is central to understanding how interventions produce their desired

effects, are resourced, and how they are scaled has important implications (Rowbotham, Conte, & Hawe, 2019). Fidelity holds its importance as a variable that affects the utility and credibility of the research examining the program, since it describes the degree of faithfulness to the treatment or prevention model as written by the developers and implemented in initial trials (Carroll et al., 2007).

**Summary of the Harvey et al. study**

The Harvey et al. study (2023) examined a large-scale comparison study examining the impact of a SEL curriculum delivered over eight weeks called "WISE Teens" compared to "class as usual" among 1,047 8th and 9th graders in Australia. Students in "class as usual" received psychoeducation on body changes, nutrition, cyber safety and drug education and risk management. Results after 8 weeks showed that students receiving the WISE Teens curriculum (8th graders) showed slightly higher levels of depression and anxiety compared to their 9th grade peers, though these differences disappeared after six months. In addition, relationships between students and their parents were slightly worse in the WISE Teens group compared to 9th grade peers after eight weeks and remained significantly worse at follow-up.

**Implementation critique: Dosage challenges**

The WISE Teens was developed as a brief, modified version of the DBT Skills in Schools: Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A) curriculum (Mazza et al., 2016) designed to teach DBT skills and strategies in school-based settings. There are several notable dosage challenges in the WISE Teens curriculum compared to the DBT STEPS-A curriculum.

First, the DBT STEPS-A curriculum is 30 weeks, the WISE Teens program is eight weeks, so approximately 27% of the full DBT STEPS-A curriculum. The length of time is important to allow students opportunities to practice the skills and strategies learned in the lesson. Other studies using DBT STEPS-A in schools worldwide where positive outcomes were achieved all had dosages over 15 weeks (Flynn et al., 2018; Gasol et al., 2022; Harned, 2023; Hastings et al., 2022; Martinez et al., 2022).

This brings us to the second challenge: the student diary card assigned to track skill use was given only once per week in the WISE Teens program, and completed in class for the whole previous week. The DBT STEPS-A curriculum calls for completing this accountability form daily to capture real-time use and practice of skills. Relying on past memories of events and emotions over the past week is not as reliable nor accurate as daily reporting of life situations.

Third, the eight WISE Teens lessons often included two, and sometimes three different skills or strategies, in contrast to the DBT STEPS-A curriculum which prescribes one skill per lesson to facilitate understanding, engagement and an opportunity to practice the skill over the next week. Thus, from a dosage and method of implementation standpoint: the WISE Teens curriculum had too few lessons over too few weeks, too many skills packed into lessons preventing the requisite skills practice, and only about half as many skills taught overall compared to DBT STEPS-A. WISE Teens taught skills from 16 lessons packed into 8 classes of the same length while DBT STEPS-A teaches 30 lessons over a 30-week period. Additionally, WISE Teens did not include 10 of the skills taught in DBT STEPS-A and did not repeat any of the mindfulness skills, which are taught three times over the course of the curriculum, given they are foundational to all the other skills. Of note, even students who completed the WISE Teens program shared that they didn't have sufficient time to learn the skills: *"I believe we didn't have enough time with this program. Because we had so much to learn in such little time, we didn't go in depth with this, and I didn't learn as much as I could've. I think the topics are important."*

> *"We covered a lot of topics but more detail about each and how to implement them in daily life would've been good."*

Bottom line: It appears that dosage matters and may have been a significant factor that impacted their results. To the authors' credit, they identified these limitations in the discussion of their research, yet failed to address them in their highlights and overall conclusion.

**Implementation Critique: Fidelity Challenges**

The implementation fidelity is about delivering the program as it was intended or designed. In closer examination of this variable, the Harvey et al. study (2023) has several fidelity issues as well.

First and foremost, the DBT STEPS-A curriculum was designed and written for school-based educators (i.e., teachers, school psychologists, school counselors, school social workers, etc.) as the primary instructors. This was not the case for the WISE Teens program that was delivered by masters and doctoral level postgraduate trainee clinical psychologists who were not part of the school-based setting. Given adolescents tend to be less forthcoming with adults in general, educators from within the school have established visibility and relationship with students, whereas outside clinicians likely do not. This may have impacted the low frequency of participation and homework follow through that the authors reported. A recent meta-analysis found teachers to be more effective deliverers of Tier 1 prevention programs in schools when

accounting for existing classroom skills and sustainability (Franklin et al., 2017).

Second, the short- and long-term outcomes of the DBT STEPS-A curriculum are primarily prevention-focused and educational in nature, evaluating skill acquisition and skill practice, respectively. Thus, the focus of DBT STEPS-A is upstream mental wellness promotion, targeting emotion regulation broadly and decision making. The WISE Teens curriculum study's primary outcomes were focused on specific psychopathology, namely anxiety and depression, which in a prevention study is unlikely to find significant changes in those domains after only 8 weeks.

Third, the DBT STEPS-A manual recommends training from experts in the areas of education and DBT skill implementation that includes participant demos of teaching the actual lessons to ensure fidelity. The instructors for the WISE Teens program were selected from a pool of clinical psychology trainees. The length and focus of the training and the amount of school-based experience, especially in teaching classes, was not provided regarding the instructors. Teaching classes at the universal level in school-based settings versus running clinical DBT Skills groups are not synonymous, and raises another concern about the WISE Teens program with regard to how the curriculum was implemented. In addition, it is unclear how the authors measured intervention fidelity so it is unclear if the lessons were taught in the manner in which they were intended.

Finally, there is no explanation how the authors selected the skills for the WISE Teens program, other than consulting with someone who is trained in DBT treatment, not DBT STEPS-A. There are ten skills in the DBT STEPS-A curriculum that were not included in the WISE Teens program, which may meaningfully impact the ability of students to link the skills and practice them at home, something the authors reported. Many of the DBT skills build upon one another and importantly, take time to acquire, strengthen and generalize.

Bottom line: Fidelity matters. The WISE Teens program has numerous differences in the content, delivery, and outcomes compared to the DBT STEPS-A curriculum. These fidelity challenges make it difficult to compare the WISE Teens program results with DBT STEPS-A and the supporting literature. Thus, conclusions of the results are limited to the WISE Teens program only, and should not be generalized to other universal DBT-based curricula.

**Journalism and its Responsibility**

Journalists also play a central role in getting important scientific information out to the public. Peer-reviewed journals are often the high bar standard for research to be published. In doing so, journals rely on peers within the same field to evaluate the scientific rigor of the research. It is not a perfect system, and design challenges can go unnoticed. In this case, the study authors in their journal article acknowledged the limitations, yet emphasized over-reaching conclusions that went beyond their findings in their abstract and summary/conclusions of their study. The Atlantic article titled: These teens got therapy; and then they got worse" (November 6th) appear to be based on a superficial rather than an in-depth reading of this journal article, only perpetuating the faulty conclusions drawn. The Atlantic article was quite enthusiastic in promoting the narrative of how these "DBT skills do not work", rather than investigating WHY they did not result in positive outcomes here, especially given the numerous peer-reviewed published research studies showing that they do, both as a universal prevention curriculum delivered with adequate dose and fidelity (e.g., Mazza et al., 2016), and as a free-standing skills curriculum in clinical settings (e.g., Rathus & Miller, 2015). Because magazines, such as the Atlantic, have a large audience, promoting research findings on face-value without checking all the facts perpetuates risk of harm to its readers. In this case, potential harm includes school professionals, mental health clinicians, parents, and teens, in turning away from evidenced-based programs in both school and clinical settings that are effective during a time when emotional regulation skills and youth mental health strategies are needed the most.

**Conclusion**

The need to conduct replication studies of universal emotion regulation skills is an important endeavor. The Harvey et al. study had a large sample of participants and was a multi-school study that incorporated a comparison group. These are all worthy design features. Results were not as expected and the authors, in their brief, shortened version of DBT skills called WISE Teens, concluded that the enthusiasm for universal dissemination of DBT skills curricula is not supported by the current research evidence. Unfortunately, the authors seemed to have missed the most salient point: that a brief, shortened version of DBT Skills in Schools compressed into several weeks, such as WISE Teens, is not effective and may even make things worse. Yet the author's conclusion casts doubt on ALL universal DBT skills-based programs delivered in schools, going well beyond their data in the study.

For purposes of clarification, we provide a parallel example. An established math curriculum for teaching multiplication to 3rd graders has been developed where 30 hours of practice on the multiplication flashcards is recommended for single-digit multiplication mastery. A new calculus

teacher, who has been assigned to teach math in 3rd grade, tells the students they only need to practice 8 hours on the flashcards, and when the students' multiplication skills do not improve or get worse, the teacher blames the math curriculum.

The important message is this: when it comes to teaching emotion regulation skills and having youth practice them, shortcuts don't work and implementation matters. Let's not throw the baby out with the bathwater because one study implemented a brief, highly compressed DBT skills curriculum, and generalized their results to other universal DBT skills curricula. It simply means that the WISE Teens curriculum, as implemented, was not effective. With the current global mental health crisis affecting youth, we need more evidence-based resources, not fewer: KEEP THE BABY! AND change the bathwater.

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# What happens next? The principles and practicalities of treating Stage II clients with multi-problem eating disorders

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**Introduction**

We now understand that psychiatric disorders and eating disorders are commonly comorbid, regardless of the initial diagnosis (Momen et al., 2022). Up to 54% of patients with borderline personality disorder (BPD) will experience an ED (Zanarini et al., 2004). Furthermore, up to 10% of individuals with Anorexia Nervosa (AN; Arcelus et al., 2011; American Psychiatric Association, 2013), 3.9% of those with Bulimia Nervosa (BN), and 5.2% of those with the DSM-IV diagnosis of Eating Disorder Not Otherwise Specified (EDNOS; Crow et al., 2009) will die from complications of these disorders. In the United States of America, 10,200 deaths per year are directly attributed to EDs (Deloitte Access Economics, 2020). Contributing to this premature mortality rate is a substantially increased risk of suicide. Suicide attempts are considered common among those with EDs, and studies report an increased risk (10 times greater) of suicide compared to the general population (Duriez et al., 2023; Goodwin et al., 2014; Cliffe et al., 2020). This combination of psychiatric comorbidity and lethality, alongside the established evidence for DBT as an effective treatment for these issues in general, has made DBT a preferred choice for the treatment of multi-problem eating disorders (MED).

**What is MED-DBT?**

MED-DBT was developed for individuals with an eating disorder in the context of other co-occurring conditions and for whom problems with emotion regulation (both over and under control) are a central area of difficulty (e.g., Federici & Wisniewski, 2013). The "M" refers to multi-problem or multi-diagnostic presentations and was included to differentiate MED-DBT from other DBT-ED adaptations (see Chart 1). The Stanford Model developed by Debra Safer and colleagues, also known as DBT-BN (bulimia) and DBT-BED (binge eating disorder), are skills-only adaptations of DBT. These treatments are effective for youth and adults with a primary eating disorder (i.e., no major co-occurring illnesses requiring attention) with "Stage III" presentations. These single-modality treatments are offered individually or in a group setting and are not comprehensive or designed to manage suicide/self-injury or therapy-interfering behaviors.

RO-DBT has been proposed as an alternative treatment for individuals with anorexia nervosa; however, research support is lacking (e.g., Reilly et al., 2020). Conceptually, RO-DBT may be suited for those in "Stage III" given that the treatment is not designed to manage medical instability, food/fluid intake difficulties, or weight stabilization (e.g., "Stage I" clients), which we find our clients need help to navigate.

MED-DBT is the only DBT adaptation that was designed for "Stage I" eating disorder treatment. Comprehensive, collaborative, and multimodal, MED-DBT integrates foundational eating disorder research and treatment strategies with standard DBT principles and interventions. MED includes an adapted biosocial theory, which addresses ED-specific neuro-metabolic underpinnings and unique body/eating/food-based invalidating environments (see Wisniewski et al., 2021 for more information).

The treatment uses the target hierarchy and diary cards adapted to track food and fluid intake to manage life-threatening ED behaviors in the context of suicide and self-injury. MED-DBT was initially developed as an outpatient treatment. "Stage I" treatment for MED-DBT has been explored in the literature (Ben Porath et al., 2020; Ben Porath, Wisniewski, & Warren, 2009; Federici & Wisniewski, 2013;).

**MED-DBT Stage II: Introduction**

The use of DBT for MED clients who have completed "Stage I" work (i.e., a reduction of life-threatening behaviors, increased behavioral control, and skills acquisition) has not been systematically

explored in the literature. Clinicians may encounter several clinical issues, such as deciding when to consider starting "Stage II" work or when to return to "Stage I" work. They must also be aware of the clinical goals of "Stage II" and of evidence-based treatment of common targets, which may include Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), perfectionism, body image concerns, emerging emotion experiencing, navigation of social pressures, and continued management of ED behaviors with a lens toward dialectical abstinence and relapse prevention. Further, this work may often occur in a private practice or solo practitioner setting, which may exacerbate the experience of clinical challenges due to limitations in training, resources, and opportunities for clinical consultation. This publication serves to review principles for "Stage II" treatment of this highly complex population.

### MED-DBT "Stage II": Why, When, and How

Just as MED-DBT "Stage I" target hierarchy and goal setting follow the general principles of standard DBT "Stage I", MED-DBT "Stage II" focuses on increasing dialectical behavior patterns and non-traumatizing emotional experiencing (Linehan, 1993). MED-DBT "Stage II" targets may include intrusive eating disorder symptoms (not meeting criteria for "Stage I" or "Stage III"), avoidance behaviors, negative body image, negotiating life in a (partially) recovered body in the context of a weight-biased world, and emotion and interpersonal dysregulation which is no longer mediated using eating disorder behaviors. Associated problems also exist which increase the difficulty of achieving life worth living goals, such as trauma/PTSD, OCD, neurodivergence, and ongoing medical complexities.

During MED-DBT "Stage II" work, clinicians and clients must maintain a laser focus on the possibility of bi-directional behavioral movement between "Stage I" and "II". Eating disorder relapse rates are 30-50% when followed for up to 10 years (Sala et al., 2023). By its nature, "Stage II" generates emotional vulnerability. As such, clients may experience Stage shifts as ED behaviors re-emerge in the face of treatment fatigue, trauma- or body image-focused work, and everyday life stressors. If a Stage shift has occurred, it is incumbent upon the clinician to pause "Stage II" work until the ED target 1 and/or 2 behaviors are re-achieved.

Identification and functional analysis are imperative to establish agreed-upon targets and goals and hypothesize treatment solutions. Target behaviors and goals are identified according to the hypothesized function of the behavior (Table 1). Problem-solving in "Stage II" MED-DBT utilizes the same set of change procedures as "Stage I": Skills Application, Exposure, Cognitive Restructuring, and Contingency Management. Exposure procedures can encapsulate both formal (e.g., Exposure Response Prevention for OCD (ExRP) or DBT-Prolonged Exposure (DBT-PE) or Cognitive Processing Therapy (CPT)) and informal strategies.

When other treatment protocols are woven into MED-DBT (e.g., DBT-PE or ExRP), the session structure is adapted accordingly to facilitate concurrent clinical work. As the client and clinician are laser-focused on undergoing "Stage II" work without resumption of "Stage I" target behaviors, the client must draw on all they have learned in "Stage I" and apply it to the "Stage II" targets. For example, when employing formal exposure protocols, the client agrees to eat following an exposure practice no matter what. This ensures that food restriction is not functioning as a safety behavior and thereby risking successful outcomes. The client maintains full cognitive functioning and biological capability for emotion regulation through the duration of the exposure treatment protocol. When DBT-PE is considered, we propose using guidelines adapted from Harned (2022; Table 2).

Clinicians contemplating providing "Stage II" MED-DBT have many responsibilities and considerations. It is considered essential that any clinician providing "Stage II" MED-DBT be trained in "Stage I" MED-DBT work, as the clinician must be able to monitor for behavioral movement between stages and to pivot clinical care accordingly. Additional considerations in determining the features of "Stage II" work include therapist resources and training to provide adjunctive treatments and the timing of these treatments according to case conceptualization and active targets. Furthermore, it is essential that during "Stage II" treatment, there is agreement around continued oversight of physical health parameters and weight. However, the frequency and intensity may differ from "Stage I." This ensures sustained physical improvement and medical safety and provides an early warning system for any behavioral recurrence. Re-emergence of old or emergence of new ED behaviors, and the function of these, may not be immediately obvious to the client or therapist, especially when considering the ego-syntonic nature of EDs. Furthermore, weight loss for any reason is a significant risk factor for ED relapse and should be prioritized and problem solved if it occurs.

### Summary

In summary, there is little guidance on when and how to move into "Stage II" work in MED-DBT treatment. We have highlighted the importance of considering moving to Stage II targets only after completing "Stage I" work. In other words, after a period of medical stability, when one is able

to feed oneself reliably, and there is an absence of other life-threatening behaviors. While doing "Stage II" work, it is important to keep "Stage I" MED-DBT targets in mind throughout. Clients with MED presentations require specialized treatment, and clinicians require training in both ED theories and interventions in addition to DBT. More research is necessary to further refine guidelines for best practices in moving between "Stage I" and "Stage II" in treating complex eating disorder presentations.

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**Chart 1. Adaptations of DBT for eating disorders**

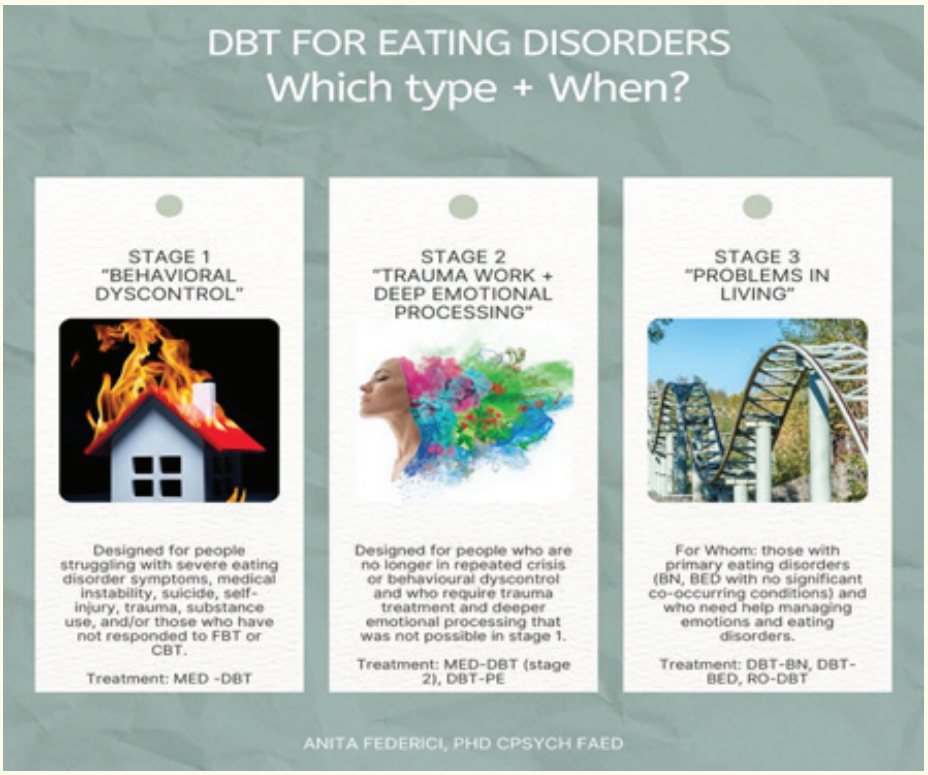


**Table 1. Examples of Stage II target development**

| Identified Stage II Target Behavior | Hypothesized Function | Target Behavior Goal |
|---|---|---|
| Forgetting to eat during day in context of return to normative daily life (school/work) | Reducing demands on daily life | Continued work toward normalized eating & weight stabilization in new context |
| Avoidance of mirrors | Decrease shame/guilt/disgust | Improve Body Image and body experiencing |
| Increase in reliance on counting and cleaning ritual behavior | Anxiety management | Treatment of co-occurring psychological Problems (e.g. PTSD, OCD) |

Table 2. DBT-PE Readiness and ED Considerations

| DBT-PE Readiness Criteria | ED Considerations/Behavioral Indicators |
|---|---|
| Not at imminent risk of suicide | Not at imminent risk of suicide |
| No recent life-threatening behavior (2 months) & Ability to control life-threatening behavior in presence of cues for those behaviors | No self-harm, medically stable (AEB weight, vitals, labwork) or no recent life-threatening behavior including medical instability caused by the ED |
| No serious therapy-interfering behavior | Weight restored sufficiently to cognitively and physically engage in PTSD treatment (e.g., able to remember, able to attend treatment, do homework, participate in sessions). |
| PTSD is client's highest priority quality of life target | Maintained improvements in ED behaviors; Eating adequate to maintain weight and medical stability (may not be fully restored yet). Wants to work on PTSD now. PTSD symptoms maintaining factor of ED |
| Ability and willingness to experience intense emotions without escaping | Able to experience intense emotions without turning to ED behavior to cope; able to feel AND eat effectively without compensatory behaviors |

Note. Adapted from Harned, 2022

# The Effects of Client–Perceived DBT Skills Group Treatment Credibility on Treatment Outcomes

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In the field of Dialectical Behavior Therapy (DBT; Linehan, 1993), there has been increasing interest in the investigation of the efficacy of DBT Skills Training (DBT-ST) as a stand-alone treatment. Randomized controlled trials found DBT-ST to be largely superior in improving clinical symptomatology compared to alternative group therapies (e.g., Soler et al., 2009; Neacsiu et al., 2014). Moreover, Neacsiu et al. (2010) found DBT skills use mediated differential changes between conditions in emotion dysregulation and psychopathology, highlighting the importance of DBT-ST and skills use. However, little research exists on variables that may impact DBT-ST and how this may influence overall outcomes in DBT. Specifically, the effects of client perceptions of DBT and its modalities (i.e. skills training) is largely understudied.

Within the limited existing literature, the following client perceptions have been measured: outcome expectations, client satisfaction, helpfulness, treatment credibility and therapeutic alliance (Olsson et al., 2021). The relationships between these variables and outcomes are inconsistent, possibly due to variability in measurement and no consensus on appropriate measurement tools (Constantino et al., 2018; Constantino et al., 2019; Olsson et al., 2021).

Previous research suggests client perceptions of treatment impacts treatment outcomes. Meta-analyses have found small positive associations between treatment outcome expectations (Constantino et al. 2018), and treatment credibility (Constantino et al., 2019), on psychotherapy outcomes. Outcome expectations mediated the credibility-outcome relationships, suggesting that treatment credibility may enhance outcome expectations, in turn promoting improvement (Constantino et al., 2019). The individual studies utilized within the meta-analyses compiled various psychotherapies, most of which were CBT, making it difficult to discuss the client perceptions-outcome relationship of specific therapies. Nevertheless, together these findings illustrate the interrelationship of these variables and potential diverse pathways to clinical improvement in psychotherapy.

Barnicott et al. (2016), in a longitudinal study examining skills use and common treatment processes (treatment credibility, therapeutic alliance, and self-efficacy) in DBT, found that treatment credibility was positively associated with DBT skills use as well as the other treatment processes, and negatively associated with self-harm. Although treatment credibility was not significantly associated with some of the outcomes (e.g., likelihood of dropout, concurrent self-harm frequency) when controlling for the other treatment processes, this study demonstrated that credibility is a factor that may relate to more established treatment process variables and should be examined further.

Given the scarce literature on client perceptions of DBT skills group, the current study endeavored to explore whether treatment credibility of DBT skills group impacts treatment outcomes. Devilly at el. (2000) define patient-perceived treatment credibility as personal beliefs regarding a treatment's logicalness, suitability, and efficaciousness. Our study gathered ratings from clients on their perceptions of DBT skills group acceptability, helpfulness, and the extent to which the group met their needs; for the purpose of this study we will refer to these ratings as DBT-ST credibility. Although analyses were exploratory and there were no formal hypotheses, we expected positive client ratings to have positive effects on clinical outcomes.

## Methods

### Participants

In this naturalistic within-subject design, the sample (N = 208) were adult and adolescent clients completing 6- or 12-month comprehensive DBT treatment in a private outpatient clinic in Southern California. Participants were 27.76 years-old on average (SD = 10.96, Range = 13-64).

Fifty percent identified as cisgender women and 50.5% White (see Table 1 for more detailed demographics).

### Materials

Outcome measures included assessment of BPD symptoms (Borderline Symptoms List – Short Version; BSL-23; Bohus, 2009), anxiety (Generalized Anxiety Disorder Assessment; GAD-7; Spitzer et al., 2006), and depression (Patient Health Questionnaire-9; PHQ-9; Kroenke et al. 2001), as well as degree to which clients' symptoms impacted their functioning across domains (Work and Social Adjustment Scale; WSAS; Marks, 1986). To assess DBT-ST credibility, clients were asked if skills training is helpful, acceptable, and

meets their needs at the end of each skills module. Clients rated the items on a Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). The sum of the ratings was used, with higher scores representing higher credibility. The three-item measure of DBT-ST credibility had a very high internal reliability (Cronbach's alpha = .92).

**Procedure**

Baseline measures were collected using a survey website at intake. Follow-up measures and treatment credibility ratings were collected subsequently every two months throughout treatment. All groups were provided via telehealth. Of note, 19 clients received at least part of their skills training individually when barriers prevented them from participating in group (e.g., scheduling conflicts with group times offered, difficulty paying attention to group over video, cognitive functioning deficits, etc.).

**Analyses**

Hierarchical Linear Models (HLM) were used to test associations between clients' skills training credibility ratings and outcome changes over the first 6 months of treatment. Models tested interactions between time in treatment and credibility ratings. Due to the naturalistic setting, sample size was limited, and measure completion was inconsistent, limiting our ability to run time-lagged analyses. As such, all analyses are testing for association and are not testing direction of effect. Treatment trajectory (i.e., whether the client was in DBT for 6 or 12 months, or dropped out), age, and format of skills training (individual vs group) were tested as covariates. Age and skills format were not significant on any models and were not included in the final models. Baseline scores were included in each model to account for clients' severity at the start of treatment. Data analyses were performed using SPSS.

## Results

Participants engaged in DBT for an average of 8.8 months (SD = 5.6, Range = 1.9 - 34.9), with 58.7% completing 6 months, 10.1% in 12 months, and 31.3% dropping out. Participants rated treatment credibility an average of 17 points (out of a maximum score of 21; SD = 3.63).

Fixed effects for the interaction between DBT-ST credibility and time in treatment were significant in the models predicting change in depression ($p = .004$), BPD symptoms ($p = .01$), emotion dysregulation ($p < .001$), and anxiety ($p < .001$). This suggests clients who rated DBT-ST as more credible saw a greater reduction in symptomatology over the course of treatment. Additionally, fixed effects of treatment trajectory were significant for models predicting change in BPD symptoms ($p = .01$), and anxiety ($p = .03$), indicating symptom reductions for clients who graduated after 12 months was slower than clients who dropped out or who graduated in 6 months. Main effects of DBT-ST credibility ratings were not a significant predictor of symptom change for any measure. No main effects nor interactions of group ratings or time in treatment were significant for the WSAS. See Table 2 for more details.

## Discussion

This study aimed to explore whether client-perceived DBT-ST credibility influenced treatment outcomes. When exploring change in symptomatology across treatment, significant interactions were detected for most measures, suggesting higher ratings of credibility were associated with greater improvements each month.

Our findings differ slightly from Barnicott and colleagues (2016) who found no significant independent association of treatment credibility on self-harm in clients receiving DBT. Conversely, direct comparison with the current findings is problematic due to disparity in the context of the samples (i.e., public UK National Health Service vs. private practice) and outcome measures of interest (i.e., self-harm), although self-harm is independently associated with psychopathology constructs utilized within our study (Witt et al., 2019). Previous non-DBT research, however, has found some support for the positive effects of treatment credibility on treatment outcomes in psychotherapy (e.g., Constantino et al., 2019). Our findings provide further support to the idea that treatment credibility positively impacts treatment outcomes.

The association between DBT-ST credibility and differences in symptomatology was statistically significantly higher for six-month graduates compared to 12-month graduates when examining emotion dysregulation and anxiety, even when controlling for baseline severity. One explanation may be that 12-month graduates and those who dropped out were less-responsive to treatment, and as such may have reported less improvement. This is in line with an RCT by McMain and colleagues (2022) who found participants within the 6-month DBT condition exhibited more rapid reductions in general psychopathology compared to 12-months of DBT. It should be noted that the differences between 6- and 12-month graduates observed in our sample were marginal and not likely to be clinically significant, and no differences were observed among treatment trajectories for other measures.

Alternative explanations for the observed effects of DBT-ST credibility on symptomatology are positive psychology constructs: hope and self-efficacy. It may be that individuals reporting higher credibility present with higher levels of hope and self-efficacy about their treatment. Studies

examining the impact of positive psychology on DBT treatment may provide support for this argument. Ritschel et al. (2012), in a naturalistic study (N = 56) of individuals completing DBT, found changes in hope over time predicted final depression and anxiety scores accounting for 7-10% of the variance. Furthermore, Barnicott et al., (2016) found greater self-efficacy at any time point was independently associated with less frequent self-harm in a longitudinal study investigating DBT skills use and common treatment processes. It is beyond the scope of the current study to test this idea with the current sample, nor is it possible to discern direction of effect. As such it is conceivable that clients who were improving consequently rated DBT-ST as more credible. Similarly, clients who were improving may in turn become more hopeful about treatment subsequently rating DBT-ST more highly, and vice versa.

The interaction between months in treatment and DBT-ST credibility was not significant for the WSAS. This may be due to the fact that the WSAS measures functional impairment rather than psychopathology, as with our other measures. Furthermore, the aims of skills group often target variables more commonly aligned with psychopathology (e.g. emotion dysregulation and distress; Aldao et al., 2016) rather than functioning. It is also possible that since this is a sample from a private pay clinic, patients overall functioning may not have been an issue despite symptoms.

**Limitations and future directions**

Firstly, there was no control or comparison group, prohibiting conclusions about whether treatment credibility is specific to DBT or a broader relation between treatment credibility and outcomes. Secondly, our measure of client-perceived DBT-ST credibility is not an externally validated measure and is likely an oversimplification of treatment credibility. The investigations between client perceptions and treatment credibility in DBT is relatively understudied; there is no formal agreement on appropriate measurement tools. Lack of agreement on measurement tools is a broader issue when trying to bridge gaps between controlled research trials and routine clinical practice (Jensen-Doss & Hawley, 2010). Furthermore, individuals who did not report their group ratings were excluded and as such we may have a selection bias. We also did not assess perceived credibility of other DBT treatment components (e.g., individual therapy, phone coaching), so we cannot distinguish the relative contribution of skills training to client's perceptions of DBT overall. Lastly, as this was a private pay clinic, clients in this sample may have different perceptions of the DBT skills group than samples from other settings.

Future studies should examine the relationships between client perceptions (e.g. treatment credibility, and interactions with positive psychology, and skills use) in DBT through controlled clinical trials. They should also explore directionality of the effects, using time-lagged analyses to clarify whether higher treatment credibility precedes better treatment response, or vice versa. Additionally, establishment of appropriate measurement tools that are easily accessible and utilizable for clinicians in practice may promote routine monitoring of treatment credibility. Credibility monitoring may allow DBT teams to identify potential interventions to promote DBT-ST credibility in their service.

In conclusion, the current study aimed to explore potential relationships between client perception of DBT-ST credibility and clinical outcomes in participants completing comprehensive DBT. Results implied small yet significant positive effects of client perceptions of treatment credibility for most measures of important symptomatology. Additionally, the study found some evidence suggesting 6-month graduates exhibit greater associations between DBT-ST credibility and emotion dysregulation and anxiety. These findings provide evidence for the importance of skills training credibility in DBT programs and imply regular monitoring of credibility may be useful.

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## Appendix

**Table 1. Demographics**

| | % | M(SD) | Range |
|---|---|---|---|
| Age | | 27.88 (10.97) | 13 to 64 |
| Gender | | | |
| Cisgender woman | 49.5 | | |
| Cisgender man | 21.6 | | |
| Nonbinary | 2.9 | | |
| Didn't answer | 26 | | |
| Race or Ethnicity | | | |
| Asian | 5.8 | | |
| Black or African American | 1 | | |
| Hispanic or Latine | 3.8 | | |
| West Asian | 1.9 | | |
| Native Hawaiian or Pacific Islander | 1.9 | | |
| White or European American | 50.2 | | |
| More than one | 2.9 | | |
| Didn't answer | 2.2 | | |
| Sexual Orientation | | | |
| Asexual | 1 | | |
| Bisexual | 9.6 | | |
| Heterosexual | 36.5 | | |
| Gay | 7.2 | | |
| Pansexual | 1.9 | | |
| Unsure | 2.4 | | |
| Didn't answer | 40.9 | | |

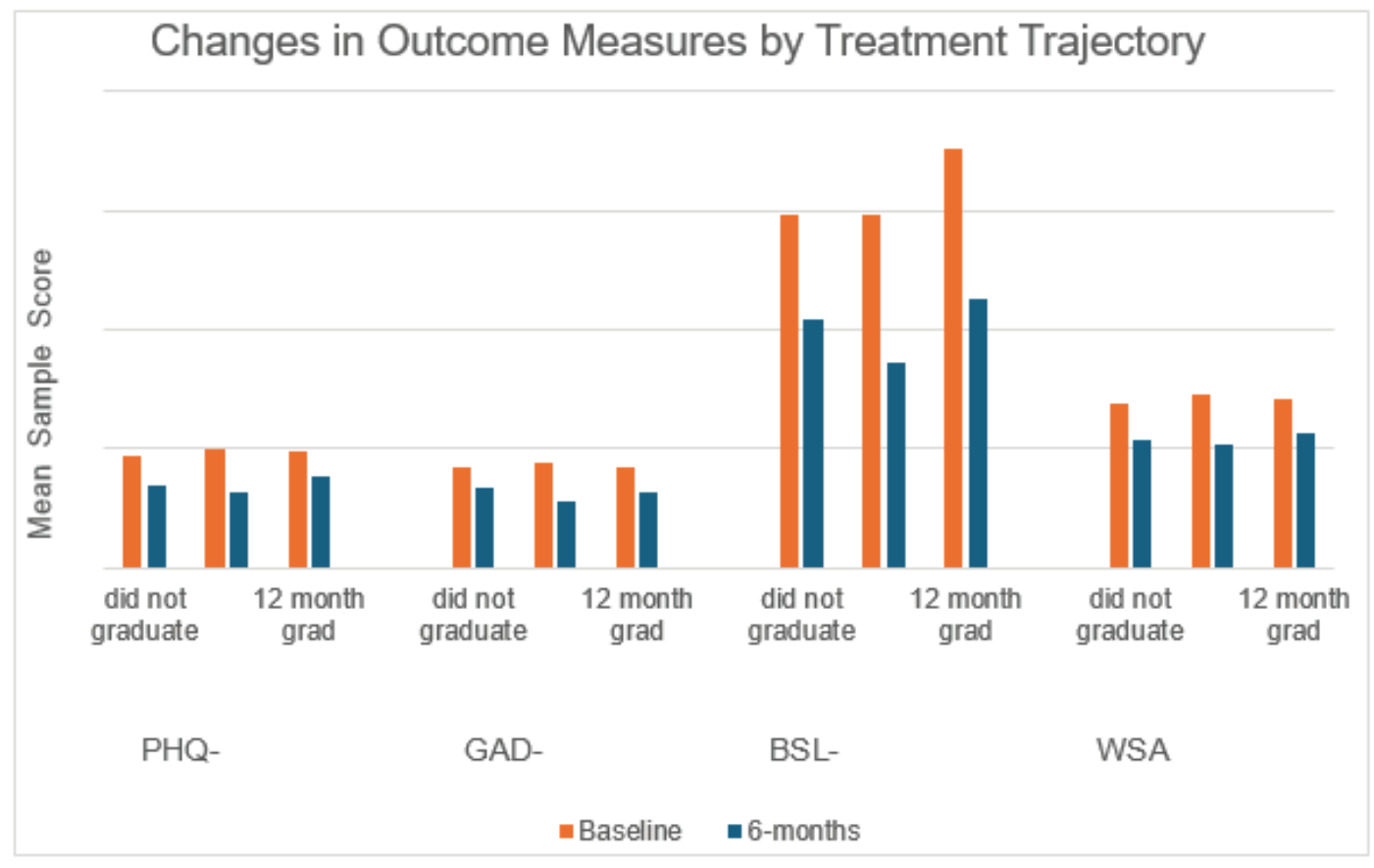
**Table 2. Interaction of Group Ratings and Time in Treatment Predicting Change in Symptom Scores**

| **PHQ-9** | | | | |
|---|---|---|---|---|
| **Fixed Effects** | **Est. (SE)** | **t** | **F (df)** | **p** |
| Intercept | .27 (.07) | 3.89 | 12.22 (1, 475.13) | <.001* |
| Graduation Category | | | 2.99 (2, 236.40) | .05 |
| Baseline Score | .61 (.04) | 16.34 | 221.86 (1, 266.83) | <.001* |
| Group Rating | <.001 (.003) | -.14 | 0.02 (1, 529.84) | .88 |
| Time in Treatment | .009 (.01) | .66 | 0.44 (1, 601.53) | .51 |
| Group Rating * Time | -.002 (<.001) | -2.91 | 8.49 (1, 600.56) | .004* |
| **Random Effects** | **Est. (SE)** | **Wald Z** | **ICC** | **p** |
| Intercept | .008 (.001) | 5.50 | .25 | <.001* |
| **BSL-23** | | | | |
| **Fixed Effects** | **Est. (SE)** | **t** | **F (df)** | **p** |
| Intercept | .30 (.06) | 4.70 | 18.01 (1, 474.41) | <.001* |
| Graduation Category | | | 4.61 (2, 233.02) | .01* |
| Baseline Score | .61 (.03) | 18.90 | 357.12 (1, 218.88) | <.001* |
| Group Rating | -.003 (.003) | -.87 | .75 (1, 522.82) | .39 |
| Time in Treatment | .01 (.01) | .45 | .20 (1, 585.70) | .65 |
| Group Rating * Time | -,002 (.001) | -2.84 | 8.06 (1, 584.46) | .01* |
| **Random Effects** | **Est. (SE)** | **Wald Z** | **ICC** | **p** |
| Intercept | .007 (.001) | 5.46 | .25 | <.001* |
| **GAD-7** | | | | |
| **Fixed Effects** | **Est. (SE)** | **t** | **F (df)** | **p** |
| Intercept | .33 (.08) | 4.29 | 15.05 (1, 496.64) | <.001* |
| Graduation Category | | | 3.44 (2, 237.30) | .03* |
| Baseline Score | .61 (.04) | 16.49 | 272.01 (1, 225.90) | <.001* |

**Table 2. Interaction of Group Ratings and Time in Treatment Predicting Change in Symptom Scores**

| | | | | |
|---|---|---|---|---|
| Group Rating | -.001 (.004) | -.37 | .14 (1, 550.62) | .71 |
| Time in Treatment | .02 (.02) | 1.35 | 1.83 (1, 618.92) | .18 |
| Group Rating * Time | -.003 (<.001) | -3.38 | 11.41 (617.06) | <.001* |
| **Random Effects** | **Est. (SE)** | **Wald Z** | **ICC** | **p** |
| Intercept | .009 (.002) | 5.13 | .22 | <.001* |
| **WSAS** | | | | |
| **Fixed Effects** | **Est. (SE)** | **t** | **F (df)** | **p** |
| Intercept | .25 (.07) | 3.78 | 15.15 (1, 465.24) | <.001* |
| Graduation Category | | | .78 (2, 225.13) | .46 |
| Baseline Score | .66 (.03) | 19.63 | 385.25 (1, 215.12) | <.001* |
| Group Rating | -.003 (.003) | -.96 | .92 (1, 524.83) | .34 |
| Time in Treatment | -.01 (.01) | -.99 | .99 (1, 578,82) | .32 |
| Group Rating * Time | -<.001 (<.001) | -1.05 | 1.11 (1, 577.61) | .29 |
| **Random Effects** | **Est. (SE)** | **Wald Z** | **ICC** | **p** |
| Intercept | .01 (.001) | 4.87 | .22 | <.001* |

**Note.** *p<.05, BSL-23 = Borderline Symptoms List – Short Version, GAD-7 = Generalized Anxiety Disorder Assessment, PHQ-9 = Patient Health Questionnaire-9, WSAS = Work and Social Adjustment Scale.



**Artwork courtesy of a patient from one of Dr. Tzermias' skills groups in Brazil**

# To My Mindfulness Teacher
# by Alexandre Tzermias

While living in the city
Deep down in turmoil
In the midst of
right and wrong
should and can't
left and right;
I often find myself
rebelling again –
sitting on my cushion,
counting breaths.

## 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.

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## ARTWORK PROVIDED BY: JESSE FINKELSTEIN

For this issue I used the AI engine MidJourney to generate a theme of photorealstic images related to clouds and DBT. For more information about the artwork head to to www.talkgood.org