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DBT BULLETIN

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Editor's Letter

Dear Readers,

It is our pleasure to welcome you to the 8th volume of the DBT Bulletin, as we celebrate the opening of the ISITDBT meeting on November 14, 2024. This issue is an exciting one, and we are eager to share with you the Bulletin's new collaboration with the National Education Alliance for Borderline Personality Disorder (NEABPD). Since our last issue, NEABPD hosted our inaugural virtual "Launch Party", featuring severals authors bringing the Bulletin to life. We are excited to share this new tradition of twice a year NEABPD-hosted Bulletin launch parties. Fear not if you cannot join us live - you can view recordings at your leisure at https://www.youtube.com/@NEABPD. Check out NEABPD's website (neabpd.org) to stay up to date on resources, education, and advocacy for BPD and chronic emotion dysregulation.

In the meantime, we hope you enjoy reading and "self-soothing with vision" the art in this edition of the DBT Bulletin. We (Andrea Gold and Hollie Granato) have teamed up as co-editors to bring you articles that help us consider "learning to love the dandelions". We are all faced with an abundance of dandelions, individually and collectively. Our overarching goal through the Bulletin and specifically this issue is this: that you might feel a bit more connected to our DBT community and less alone in whatever dandelions grow in your garden. We are honored to highlight a spectrum of submissions, ranging from clinical exploration of DBT topics to lived experiences of skills and advocacy and artistic endeavors.

This issue's specific topics highlight key issues facing clinicians, such as when to end treatment, tools for accurate expression, DBT supervision, and a deep dive into outcomes measurement. This issue also features one author's experience with the "Dandelion Story" through both written and artistic expression, as well as a powerful piece on lived experience with DBT skills practice, and recent BPD advocacy efforts by NEABPD and Emotions Matter. Finally, we are thrilled to announce our Student Spotlight Award winner: 10,000 gold stars to Kate Conroy!

We have enjoyed celebrating our skills practices together as DBT friends and colleagues for years. It is now our honor to serve the DBT community as Co-editors. Here's to another fabulous ISITDBT, and to seeing where the DBT Bulletin, our collaborations and community take us next.

Stay Dialectical,

Andrea Gold & Hollie Granato

Lingering... When It May Be Time to Say Good–Bye in DBT: Preventing Harm in DBT Treatment

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Dialectical behavior therapy (DBT) was intended to be a time-limited set of cognitive and behavioral treatment approaches. Individuals often present to DBT therapists and programs after multiple treatment efforts where ineffective approaches for the client continue despite obvious ineffectiveness. Time-limited contracts with contingencies on extensions may assist in providing needed motivation for both practitioner and client alike (Carmel et al., 2016; McMain et al., 2018).

All psychotherapies may contribute to unintended problematic outcomes arising from possible misapplication or mismatches of the psychotherapy approach, the treatment provider, and transactional effects of both on the client. Given the desperation of clients seeking DBT services it is critical to select the most robust treatment that is most likely to be effective in the least amount of time. When treatment efforts have been ineffective, it is similarly important to stop so that clients' do not become demoralized should they attempt treatment again. Here, I draw from personal and consulting experiences when the DBT treatment relationship has gone on too long and may be causing more harm than benefit.

Ethical Obligations

All helping professions major codes of ethics expect the termination of a treatment relationship when the treatment is no longer considered effective (AAMFT, 2021, Principle II; APA, 2017, Standard 2.01; NASW, 2021, 1.16).

Irrespective of the clinician's remuneration model, clients still pay for treatment with psychological effort and time. Clients who are not making progress in treatment also unintentionally block treatment for others. Preventing harmful treatment is foremost protecting the client against unnecessary costs or harm without the desired benefits. Secondarily, ending harmful or ineffective treatment protects the clinician against possible regulatory complaints, professional discipline, professional discouragement, and/or other litigious actions.

Linehan (1993) plainly outlined the contingency that 'more treatment is dependent on having made progress with previous DBT efforts.' This is in contrast with what many clients have experienced prior to DBT: the more behaviorally problematic they are, the more that treatment is offered.

The prevailing popular belief is that longer durations of psychotherapy are necessary for adequate treatment results; however, this notion has been empirically challenged (McMain et al., 2018). While Linehan's principle-based programmatic contingency aligns well with major professional codes of ethics, most clients have typically experienced an increase in service provisions when they have struggled to achieve their goals. It bears reminding that orienting clients to these new contingencies at the beginning of services (and throughout services) is required given the pervasiveness of the belief that "more is more!"

Resisting Iatrogenic treatment with DBT Processes

Treatment with DBT has a number of built-in processes designed to reduce iatrogenic effects including: using explicit and detailed (micro) orientation in pretreatment (and throughout treatment), targeting slow progress and other therapy interfering behaviors (TIBs), assessment of TIB in pre-treatment, weekly peer consultation, use of irreverent/direct communication styles, contingency management including the use of self-involving self-disclosure, and the use of aversive contingencies (with care), which can include pausing the treatment (or a mode of the treatment) for up to 4 weeks (DBT treatment vacation) if intractable significant TIBs remain. In rare instances, it may also be reasonable and compassionate in DBT to end the treatment prior to the contracted duration.

To continue or not to continue in DBT?

Nested within the framework of 'informed consent' is the expectation that professionals have oriented clients to the expected frequency of sessions and the length of a proposed treatment prior to commencement of services. This normally involves outlining the length of time anticipated before ending or establishing another contract. In DBT, the treatment duration has typically been 12 months (although 6 months has demonstrated similar or superior outcomes – see McMain et al., 2018). Evaluating whether another treatment contract should be established needs to be discussed at least 2/3 of the way through the current contract. Whether another contract is going to be established should not be a surprise to

the client, clinician, or DBT consultation team.

"Sufficient progress" is unique to each client. For some, regularly attending appointments, putting effort into the solutions proposed, and not routinely attacking the treatment provider may represent significant progress. Other clients may have begun treatment with such skills already acquired and they go on to obtain behavioral control over self-injurious behavior. Although progress is client specific and idiographic - some progress must occur.

Some services have DBT program-wide contingency management that involves specific minimal attendance targets (beyond the four-miss rule). For example, in order to be considered for an additional treatment contract 80% attendance must be maintained. Still some services intervene early with poor attendance to prompt a (problem-solving) meeting with the DBT director or team leader if it falls below an arbitrary number. The extent to which an additional contract is viable is a discussion and collaboration between the clinician and client (along with the DBT consultation team) that needs to occur well before the treatment contract ends.

If another contract is not to be established, a specific taper phase may be helpful for both the clinician and client (i.e., two bi-weekly meetings followed by a final session 4 weeks later). It is important that the clinician clarify the contingencies during this taper period regarding phone coaching and how the clinician will respond to a crisis (e.g., I will not extend our treatment if you have a suicide/self-harm crisis during this taper down period).

If an additional treatment contract is established, it is important to specify a length of time until evaluation of the service (i.e., 8, 16, 24 weeks) and available modes of treatment. An open-ended treatment contract with no specified time period for evaluation and determination for further sessions is a recipe for problems. Open ended contracts are especially problematic for clients who are particularly motivated by access to the therapist's attention. When the treatment results in clients making slow progress, therapists find it difficult to find motivating contingencies to generate new skillful behavior as the client is often satiated on the therapists' attention. This can result in both parties experiencing discouragement, lack of creativity, and inching closer to 'burn-out.'

New or existing goals and targets on subsequent DBT contracts need to be reviewed collaboratively . Additionally, consideration should be given to other behavioral and cognitive treatment approaches that may be more appropriate given the nature of the client's current problems (i.e., Prolonged-Exposure, Panic Control, Unified Protocols, Behavioral Activation, etc.) as opposed to assuming ongoing DBT is the most appropriate fit. Empirically supported treatments that are parsimonious (with respect to effort and cost for client) should be favoured.

Even clients who formally end in DBT may benefit from future short "booster" sessions approximately 4 weeks in duration for a specific problem or task. These time limited brief sessions may be a better substitute than longer durations of treatment where focus could be lost. Also, consideration could be made for some clients who may benefit from a formal end with 'soft landing qualities.' In such a situation, clients may be encouraged to call and leave messages about good news or progress in their life (they can request a call back as well). This can be helpful when a learning history has been established for these clients where when they are in crisis - they obtain assistance. With this latter strategy, clients should be oriented that this approach is a professional service and that contacts will be documented like any other service. Additionally, documenting the rationale for such interventions is crucial to justify the proposed treatment plan and to avoid any unwelcomed perception of a dual relationship post termination that otherwise could raise liability concerns.

Clinician factors problematically maintaining clients in therapy

Despite both professional guidelines and Linehan's directions, many clients who have not made reasonable progress are maintained in ineffective psychotherapy for months or years at a significant personal and financial cost to them (and others).

Failing to act on this problem is often governed by clinicians' own faulty beliefs, difficulty managing and tolerating their own (and their clients') emotion, clinician skill deficits, and problematic contingencies.

It is reasonable to stop now and consider your own current caseload and under what conditions are some clients continuing to receive services. Would you be able to identify the goals, targets, and method of achieving the client's stated goals? What has the length of time in treatment been? Is there a lapsed treatment contract end that was never evaluated? Might fresh eyes and slightly different approaches help? How often have you discussed the status of the treatment with your consultation team?

As with most things in DBT, there are any number of effective potential solutions. Below are several common clinician factors that maintain clients in treatment when it may be problematic to do so. Truthfully, some of the most experienced, skilled, and well-meaning clinicians can fall into traps with extending clients in DBT when this practice may be questionable. There are likely many more barriers to terminating treatment when it is effective to do so, and I encourage you

to read this as inspiration and continue these conversations on your team.

Clinician Factor (cognitive variable): Believing that they, the clinician, is the only person who can assist the client

Potential Solutions (Cognitive modification/Defusion):

Ask yourself:

- How might someone's life be influenced by the presence or absence of a particular person?
- How do you understand the role the universe or larger forces might play in assigning you such a significant responsibility for a client?
- In what ways does thinking that you are uniquely responsible for a client impact your effectiveness?
- What personal costs might come with believing that you are the sole individual responsible for a client's well-being?
- Will you lose motivation to assist others if this belief persists?
- How long is it helpful to think this way?
- What part of the dialectic is left out?

Clinician Factor (cognitive variable): Believing the client will succumb to suicide or worsening outcomes if the treatment is ended or modified

Potential Solution(s) (Cognitive Modification/Defusion, Exposure to feared outcome, Consultation-team):

Ask Yourself:

- How might continuing to see the client impact their level of risk?
- Has the client's risk changed over the course of their treatment?
- How do you balance the needs of different clients when considering the effectiveness of ongoing treatment for one individual?
- How might focusing on this thought help you guide the client toward their ultimate life goals?
- Is any one person responsible for someone's suicide?
- Am I assessing the problem that is causing suicide behavior or have I started to believe (erroneously) that suicide is the problem (instead of treating suicide as the solution to another problem)?
- What would I tell a person on my team with my set of circumstances?

Complete:

- An imaginal exposure story as part of a Cope Ahead plan. Imagine a client death by suicide with other feared outcomes (e.g., being blamed by your employer, reported to a regulatory body, civil litigation, clients not wanting to be treated by you, etc.). Read the story repeatedly each day until it becomes less provocative. Share the story on DBT Consultation Team

- Convene a DBT consultation team to review treatment progress up until this point, relevant history, attempts at intervention with the client, current concerns, possible solutions, and agreed upon solutions to implement

Clinician Factor (emotion variable): Fearing the client's response to the clinician modifying or ending ineffective treatment

Potential Solution(s) (Exposure and Problem-solving):

Ask yourself:

- What are all the potential client responses? Write them down.

Complete:

- Practice identifying your emotion, the urges attached to the emotion, opposite actions for the emotion
- Role play with a colleague the feared outcome repeatedly with various techniques (validation while maintaining one's stance, turning the tables, practicing opposite action, being a broken record, being willing to negotiate [consequences/plans], irreverent communication when faced with dysfunctional behavior, dialectical strategies [metaphors, paradox, dialectical assessment, etc.]). Use multiple iterations with multiple confederates to both experience different emotions and practice responses
- Obtain feedback from colleagues, incorporate effective feedback into new role-plays
- Practice mindfulness to current emotions after role playing
- Block rumination and worry by noticing the mental behavior and mindfully distracting from it (remember worry and rumination feels like problem-solving but they are not problem-solving).

Clinician Factor (Skill deficit): Being unskilled or unbalanced when having difficult treatment discussions about altering treatment or ending with clients

Potential Solution(s) (Skill acquisition, strengthening, generalization, and Problem-solving):

Evaluate:

- What do you need to say? How will you say it? What interpersonal skills are needed?
- What DEAR MAN rehearsals are needed for asking or saying no?
- What balance is needed between GIVE skills and Irreverent or direct communication?
- Role play with a colleague and video record the interaction. What is working/not working?
- Show the recording or role-play in front of others. Obtain feedback on

what needs to be learned or practiced. Incorporate the feedback and repeat the role-plays to obtain further feedback.

Clinician Factor (consequences as variables): Not wanting to stop treatment because of needed or wanted remuneration

Potential Solution(s) (Contingency clarification, Contingency management, Problem-solving):

Consider:

- If I persist with this client, then it is unlikely the client will benefit
- If there is further decline or stagnation, then the client will grow discouraged with DBT and perhaps all forms of treatment
- If such decline continues, there may be a regulatory complaint

Complete:

- Problem-solve obtaining new clients with colleagues and professional networking groups
- Discuss your problem with your DBT consultation team

Ask yourself:

Are there other time limited CBT treatments to offer if ending with clients is routinely problematic?

Conclusion

Ultimately, clinicians must prioritize both ethical standards and clients' well-being by ensuring that therapy remains beneficial. By making use of DBT assessment and change strategies applied to the clinician along with supervision and consultation, the clinician can maintain effective practices throughout the course of treatment and minimize the risk of harm. It is of utmost importance for clinicians to remain mindful of when it is necessary to end treatment with a client and to collaborate with their team to fully conceptualize what may be occurring in the therapeutic process. Each clinician must carefully consider the unique functions and influencing factors at play for both themselves and the client throughout treatment to ensure that decisions are grounded in a thoughtful, individualized approach embedded in the ongoing support of their DBT consultation team.

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Tell Me What You Want, What You Really, Really Want: A Handout for Practicing Accurate Expression

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I originally made this handout with the goal of helping one particular family change their communication patterns during moments of dysregulation. The handout has since been useful for a variety of clients and providers, so I'd like to invite everyone to consider using and sharing it.

Origin Story

A few years ago, I was working with a family that was very committed to learning skills and practicing new behaviors. The identified client was a young adult in full model Dialectical Behavior Therapy (DBT). Her parents were eager to learn how to support her progress in DBT, and they were actively learning through books, workshops, and occasionally joining sessions to practice skills. The client and I worked to eliminate life-threatening behaviors (LTBs) by instead consistently using skills to regulate emotions. The client became quite certain that she wanted to stay alive and build a life worth living. The one LTB that was difficult to extinguish was infrequent, vague communications about suicide. During increasingly rare moments of dysregulation, the client would, unintentionally, default to communicating to her parents something like "I don't deserve to live" or "I wish I didn't exist". Given her history, her parents would understandably become quite fearful and then jump to problem-solving or safety planning, when validation and/or physical comfort would have more effectively supported the client's emotion regulation. Both the client and her parents clearly recognized this pattern. The client desired to express herself differently and her parents likewise wanted to respond differently. They just needed a structured way to practice until accurate expression became the new default. Hence, I collaborated with the client and her parents to create this handout.

Handout Structure and Use

This handout was designed to provide a framework for practicing accurate expression of emotions and needs. It was intended to be used in dyads, with one person expressing and the other responding. The expressor can state what they are feeling and what would be helpful in that moment (e.g., "I feel fear and I need validation"; "I feel sadness and I need physical comfort"; "I feel anger and I need time alone"). The responder can then look below the corresponding needs on the list to read an effective response, briefly described in parentheses, to reinforce the accurate expression by providing what the expressor needed.

Non-Verbal Communication

In my accurate expression utopia, everyone would have a copy of this handout within arm's reach to use when the need arises. For example, an electronic copy could be used as a computer home screen or saved as a favorited photo on a cell phone, or a laminated hard copy could be kept on the refrigerator or coffee table. A laminated copy of this handout can also be useful for individuals who have difficulty using verbal communication when distressed. The expressor can use a marker to check off the emotion(s) and corresponding need(s), and the responder can provide what is needed without having to rely on spoken cues. Pro tip: if using a laminated copy, individuals will want to invest in a "wet erase" marker (i.e., the kind used on projector transparencies) rather than the "dry erase" markers commonly used on whiteboards and glass.

Increasing Complexity

Ideally, dyads first practice with this handout in moments of low distress and with relatively straightforward needs. Expressors and responders can alternate roles, and they can provide feedback to each other about specific phrases that are most helpful as well as language to avoid. I like to encourage playful practice as well, to bring an easy manner to skills practice while still rehearsing the structure of accurate expression. For example, an expressor may lightheartedly declare "I'm feeling under-sauced, and I need you to pass the ketchup!" or "I'm feeling love, and I need a big, squishy hug from you!"

With practice, dyads may be able to increase the complexity of use to reflect more of what is needed in real-life situations. The expressor may indicate multiple needs and may even indicate the preferred order by numbering the items on the handout. For example, the expressor may state "I feel fear and I need: 1. validation, 2. reassurance, 3. problem-solving, and 4. accountability." The responder can then say something like, "Of course you feel fear, that would be a scary situation for just about anyone [validation], and I'm sure that we can get through this [reassurance]. Let's figure out the first step together [problem-solving], and then I'll check

in with you later to see how it's going [accountability]." Indeed, the ultimate goal is for clients to become so practiced at accurate expression that they can express themselves spontaneously and naturally, perhaps only referencing the handout again in particularly difficult moments or novel situations or relationships.

Uses in Therapy

The accurate expression handout can also be useful in therapy sessions. Clients can initially practice identifying and articulating emotions and needs with their therapist, who may be most equipped to immediately reinforce this effective communication. Loved ones can then be invited to a session to practice using the handout under the guidance of the therapist, who can model its use and provide feedback as clients and loved ones learn to use it together. After an initial therapist-facilitated tutorial, clients and loved ones can then practice regularly on their own. Personally, I've found this handout helps me to pivot in a session when I notice that a client is stuck in active passivity behaviors and I'm unclear which response(s) from me the client might find helpful. For example, a client might arrive to session and say something like "everything sucks and there's nothing I can do!" I can pull out the handout and say something like "I really want to understand what you're feeling and lean in to help you, and I need a bit of guidance about how to proceed, please." Finally, I often provide this handout as supplemental material when covering the interpersonal effectiveness module in skills group. I've found that it provides a nice little menu of emotional needs that clients may request from their loved ones (using DEAR MAN with GIVE and FAST, of course). There are a variety of ways for clients, loved ones, and therapists to use this handout to practice accurate expression skills, and I hope you'll give it a try.

Practicing Accurate Expression

If we can clearly communicate what we need, then other people can better help us.

When we are distressed, it is hard to 1) even know what we need, and 2) effectively communicate our needs.

Intentional practice helps to strengthen our accurate expression skills.

You can practice accurate expression below by saying or checking off what you feel and what you need.

If you have more than one need, you can list the order by writing numbers on the lines.

For example: I feel fear and I need 1. validation, 2. physical comfort, and 3. distraction.

I feel:	I need:
____ Anger	____ Validation (Communicate understanding and acceptance of my experience)
____ Disgust	____ Encouragement (Cheer me on, tell me that I can do it)
____ Envy	____ Reassurance (Say we'll get through it, I have the skills to cope, you still love me)
____ Fear	____ Problem-solving (Help me figure out what to do and/or how to do it)
____ Guilt	____ Physical comfort (Give me a hug, hold my hand, sit next to me, hand me a stuffie)
____ Jealousy	____ Distraction (Find an activity we can do to take my mind off something)
____ Happiness	____ Accountability (Help me commit to and follow through on a plan)
____ Love	____ Time alone (Give me time and space to think and feel on my own)
____ Sadness	____ Skills coaching (Suggest things that I can do to cope with my emotions)
____ Shame	____ I don't know (Help me figure out what I need)
____ I don't know	____ Something else (Let me describe what I need in my own words)
____ Something else	

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Learning to Love My Garden, Dandelions and All

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We are inundated with images of who we should be — advertisements for weight-loss supplements, photos of influencers showcasing idealized lifestyles, movies where love is effortless and family members support each other unconditionally. As a kid, I believed these images were the models for how my life ought to be. They were symbols of an adult life I didn't have access to, but a future I was determined to have. Adults around me would ask what I wanted to be when I grew up, and I would say "a doctor," not because I wanted to save lives, but because I knew they would be impressed. When they asked me who I had a crush on, I would pick my best friend, a girl with blonde hair who was always nice to me and shared her My-Little-Ponies. The adults would smile a proud smile, and I would smile in return, happy with the image of my future self I'd created in their minds.

A few years later when I developed an unfamiliar attraction to other boys in my class, I dismissed it as part of a phase I would soon grow out of. I grew up in a home where "gay" was a four-letter word, only uttered in hushed tones. The occasional gay character I saw on television was there for comic relief to distract from the seemingly more important conflicts of the straight protagonists. I didn't want my name to be whispered, and I didn't want to be laughed at. Though as I got older, and my attraction turned into desire, the future I had envisioned became increasingly blurrier. Like many gay kids, my mind was flooded with questions like, "how will my parents react?" and, "is there still hope that this will change?" But probably the most gnawing question, keeping me up at night with its magnitude, was "how will I bear life being harder than I thought?"

Reflecting on this formative period of my life, I often recall Marsha Linehan's retelling of the Dandelion Story (Linehan, 2014, p.406), originally included in the book Song of the Bird, by the spiritual teacher Anthony De Mello (1984, p.65-66). The story describes a new homeowner who is motivated to keep a pristine lawn. As dandelions grow in his yard, he pulls them, but they continuously grow back. He tries whatever he can think of — using herbicides, hiring landscapers, re-sodding the lawn. Despite his best efforts, the dandelions keep returning. Eventually, when his options are exhausted, he writes a letter to the Department of Agriculture for guidance. After a few months, he receives a response in the mail that recommends the following: "Learn to love the dandelions" (Linehan, 2014, p.406).

The man's behavior is not surprising. It's natural to want control over our lives and our desires, and to try to eliminate the barriers that threaten that control. For me, it was a tall order to learn to accept (or even love) something about myself that I had been told time and time again was unacceptable. I knew I would have to grieve the idea that my future would not look anything like the models I had grown up admiring. At the same time, and more frighteningly, I worried about the weeds ahead of me — the potential disapproving faces, rejections, and losses. Even if I could learn to accept who I was, I could not justify sacrificing the relationships that mattered most to me.

And so, I too began fighting against my proverbial weeds. I lowered my voice an octave when talking with other boys at school, I kept up the charade of my celebrity crushes, I dated girls (well, one girl). I kept my family at arm's length for fear that they would see me too closely. As hard as I tried, I didn't know how to love the person I was, and I couldn't recognize the person I was pretending to be. When I finally built up the courage to confide in a friend, I remember lamenting to her about coming out to my family. I said, "they'll be so disappointed. It's not like I chose to be gay." My friend looked at me, puzzled, and said, "they might be upset. But saying 'it's not my choice' sounds a lot like 'it's not my fault,' and there's nothing wrong with who you are."

That moment was a turning point for me. Maybe it took being accepted by someone I love, or maybe I needed permission to not defend who I am. Despite the years of hiding, I still heard slurs whispered towards me in the school hallways, and my grandparents couldn't hide their disappointment when I told them I still hadn't found the 'right Greek girl' to marry. I found that I was disappointing others either way, and I was tired of clambering to avoid their disappointment. Slowly, I started telling people I was gay. Some people cried, some created distance, and others shrugged and swore they already knew. My mom was one of the criers. I remember her saying, "life is going to be so much harder for you now." She was right, in a way. After that year, I lost some people and some things in my life that were important to me. With time, I also gained things that helped make carrying that loss less burdensome.

The Dandelion Story reminds me that my coming out experience contained both loss and gain. The moral teaches us that, although life is full of painful experiences, fighting against our pain

only leads to both pain and suffering. There has been real pain associated with embracing my identity – with losing relationships with loved ones, with being rejected and judged. As a kid, anticipating that loss, I suffered pretending to fit into a world that would not always accept me, and frantically trying to avoid its judgment. Eventually, I abandoned my suffering, and made the choice to embrace the pain. Today, I have an extraordinary partner who supports and loves me. My parents have recently begun referring to him as my "boyfriend" instead of my "friend." I have a community of remarkable friends who see me for who I am, instead of who I used to pretend to be. There have also been relationships that I have lost, uncomfortable Thanksgiving dinners, and disgusted looks when I kiss my partner in public. Taken together, the landscape of my life looks different than what I had dreamt of when I was kid. The terrain is uneven, the dandelions are abundant, and some of what I had wanted to grow never took root. There is certainly disappointment in that and, even still, I really do like the way it looks.

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Learn to Love the Dandelions

Art by Christopher Georgiadis

Addressing Stigma around BPD through Legislative Advocacy in California

Harry Bruell

NEABPD and Emotions Matter

How do you fight the stigma against Borderline Personality Disorder (BPD)? The answer is a little like the African proverb that asks, "How do you eat an elephant? One bite at a time." One place to start is removing the tremendously stigmatizing language about BPD in California state law.

My BPD journey is through my daughter Taya, who died by suicide in 2016. Taya struggled with mental illness in the years before she died and we believed she had BPD. However, her therapists and psychiatrist refused to diagnose her, adhering to outdated and stigma-influenced beliefs that young people could not have BPD. One therapist even said, "Oh, you don't want that diagnosis of BPD." After her death, we found her writings and shared them and our story with BPD experts who confirmed that she most likely had BPD.

Through my journey of learning about BPD, I met Paula Tusiani-Eng of Emotions Matter and Abby Ingber of NEABPD. Paula and then Abby told me about the California law that stigmatized BPD. Section 1001.36 of the California Penal Code allowed people charged with a crime to instead go through a pre-trial diversion program if the action was related to the individual's mental illness and certain other conditions are met. The law allows all 240+ diagnoses covered by the DSM to be eligible for pre-trial diversion except Pedophilic Disorder, Anti-Social Personality Disorder, and BPD. BPD is not defined by criminal behavior; rather, the hallmark feature of this condition is emotion dysregulation.

The Advocacy Committees of both Emotions Matter and NEABPD agreed to take on the fight to remove this stigmatizing language, and I connected with the California Council of Community Behavioral Health Agencies (CBHA). CBHA agreed in the fall of 2022 to sponsor legislation to fix the problem. Dr. Sara Masland, with Emotions Matter, wrote a robust background piece laying out the scientific and clinical rationale for the bill.

To change the law, we would need to find a legislator to introduce a new bill in either the State Assembly (called the House in other states) or the State Senate. The bill would have to pass through one or two committees in each legislative body, be voted on by both the full Assembly and full Senate, and then be signed into law by the Governor.

To search for potential opposition, we approached the most likely defender of the current law, the District Attorneys Association. After discussions, they agreed to stay neutral on our bill. Seeing a relatively clean pathway, we approached more than 20 legislators, and Assemblymember Gregg Hart (37th district) agreed to serve as the bill's author.

AB 1412 proposed to remove the exclusion of BPD from mental health diversion and had its first hearing in the Assembly Public Safety Committee on April 11, 2023. Asm. Hart introduced the bill, I told my story, and CBHA provided powerful testimony. The Committee passed the bill 6-0 and sent it to the Appropriations Committee, which passed it 13-0. The full Assembly voted 66-4 in favor on May 22, 2023, sending the bill to the Senate. The Senate process was relatively smooth, though a handful of Senators voted against the bill due to overall disapproval with the diversion program. One told us that he was against any efforts to "expand diversion" and wanted to be tougher on crime. The Senate votes were 4-1 in the Public Safety Committee and 30-9 for the full Senate. A minor amendment, unrelated to BPD, necessitated another floor vote in the Assembly on September 12, 2023. It passed its final legislative test 66-3 and went to the Governor's desk where he had a month to decide whether to sign it.

Throughout the legislative process, Emotions Matter and NEABPD coordinated a large grassroots effort to build support for the bill. Twelve state or national organizations wrote letters of support (and none opposed) along with 77 individuals. When the bill went to the Governor, Emotions Matter and NEABPD mobilized hundreds of people to call the Governor's office. On October 10, 2023, Governor Newsom signed AB 1412 into law, removing the stigmatizing language and allowing people with BPD to be eligible for pre-trial diversion.

Advocates across the country celebrated the win. People with lived experience mobilized because the stigma in this legislation was an invalidation of all people with BPD; they are not criminals and should be seen and heard on par with other disorders. An advocate with lived experience wrote, "People with BPD can start to be seen as people born with an illness, rather than as people born as criminals." Another noted, "Therapy is the single most important factor that created real change in the trajectory of my life. It helped me live the productive, happy life I am living today. I wish therapy had been forced upon me sooner by the courts, so that

I would have gotten better quicker and not had to endure years of suffering." According to Emotions Matter, this is the first time a law in the US has been passed to address BPD.

We learned, though, that our fight was not over. A legislative aid casually mentioned to us in an advocacy meeting that pre-trial diversion was not the only place in California law that used the same stigmatizing language about BPD. With his help and additional research, we found the language in three parts of California law concerning eligibility for Incompetent to Stand Trial (IST) and in funding of diversion programs. The Advocacy partners - CBHA, Emotions Matter and NEABPD - agreed to try for a sequel in the 2024 legislative process and remove these remaining pieces of stigmatizing language. Assemblymember Hart once again stepped up as author and introduced AB 3077 earlier this year.

AB 3077 sailed through the legislature, passing out of two Assembly committees on votes of 6-0 and 11-4 and then the full Assembly on May 2, 2024 on a vote of 63-7. The Senate Public Safety Committee approved AB 3077 by a vote of 4-1 and it passed the full Senate on August 27, 2024 on a vote of 29-11. Some minor changes required it to have a final vote in the Assembly on August 28 where it passed 62-10. In the three days after those last votes more than 550 advocates submitted letters to the Governor urging him to sign it. However, the bill ran into a challenge with part of Governor Newsom's administration who believed the expansion of Incompetent to Stand Trial to people with BPD would overextend the capacity and resources of state psychiatric hospitals. We engaged in several meetings with Administration officials as well as other statewide advocacy organizations to both educate them about BPD as well as to find a middle ground on bill language. Unfortunately, we were not successful, and the Governor vetoed the bill on September 28, 2024 due to concerns about the cost of expanding the IST program.

Governor Newsom's veto on AB 3077 will not stop our work. We will follow up with all partners this fall to provide additional education on BPD and seek new bill language for the 2025 legislative cycle that will assuage his concerns about costs. We have educated many people - legislators, top Government officials, and statewide association leaders - about BPD through this process. Fighting stigma is a daunting task and, like eating an elephant, we are taking it one bite at a time.

Using DBT Skills to Cope with BPD Symptoms: Lived Experience Perspectives

Saadia Ali, Desiree Caminos, Jennifer Chesley, Alyssa Gross, and Cathleen Payne

Lived Experience Committee, National Education Alliance for Borderline Personality Disorder

Marsha Linehan developed dialectical behavioral therapy (DBT) to treat people with borderline personality disorder (BPD), "a diagnosis that she would have given her young self." The chief characteristic of BPD is intense and dynamic moods that are difficult to control and endure. These extreme feelings can catalyze a range of harmful coping mechanisms, which often lead to a vicious cycle of painful feelings and maladaptive behaviors. Marsha Linehan famously said that people with BPD are like people with "third degree burns over 90% of their bodies; lacking emotional skin, they feel agony at the slightest touch." As members of the Lived Experience Committee at the National Education Alliance on Borderline Personality Disorder, we have each come to deeply appreciate the access we have to the treatment of DBT. Having benefited immensely from its skills and paradigms, we are happy to share some specific examples of how we use DBT to cope.

Saadia—Wise Mind

A microexpression can flip my mood from cheerful to disconsolate. I've been called 'dramatic' and 'sensitive' more times than I can count. Eventually, I came to utterly discredit my "emotional mind" to avoid that kind of judgment from others. My "rational mind" was effective at school and work, but my relationships felt hollow. The paradigm of "wise mind" helped me understand that emotions have a place: they offer valuable information that can supplement my rational conclusions. As a person who struggles with emotion regulation, I know not to rely entirely on my feelings when deciding how to act or react. At the same time, though, it's important to consult and consider how I feel about something.

For example, on a recent Wednesday afternoon, I felt the urge to binge-drink. Impulsive and self-destructive patterns of behaviors are a symptom of BPD. My reasonable mind said: "Don't drink. Are you stupid? You have three classes tomorrow. Finish your homework." This voice was loud and abrasive. My emotional mind said: "I'm scared. I'm miserable. My life feels unbearable. I need to numb myself to cope." This voice was loud and whiny. I sat down on my couch and tried to hear what my wise mind was saying. In a calm, understated voice, my wise mind opined: "You don't deserve to feel like this. Drinking won't make you feel better. Call someone who cares about you." I called a friend who encouraged me to avoid either extreme behavior. I took a shower and watched a movie. I stayed sober. No one even noticed that I didn't do my homework.

Jen—Temperature: The 'T' in TIPP

Realistically, DBT skills not practiced in a safe and regulated state are going to be much more difficult to perform effectively in times of dysregulation. However, consistency has never been my strong point. And in the spirit of transparency, I want to share an easy tool I've employed in various moments of distress that has never failed me: DBT TIPP skills (temperature, intense exercise, paced breathing and paired muscle relaxation). Truly, you can't mess it up. When crises pop up—despite doing our best to intervene early in hopes of avoiding reaching a certain tipping point—it can sometimes seemingly come out of nowhere. I can get triggered quite easily, and before I've had time to mentally process, the emotion hits me like a ton of bricks. The trouble is, if by this time I'm sitting anywhere north of 7 out of 10 on the distress tolerance scale, there are typically few accessible techniques at my disposal to survive it.

Utilizing temperature allows me to flip the script entirely by taking action to change my body chemistry in that exact moment. I grab a bucket, a large mixing bowl, fill up my sink with ice cold water—or simply stand under the shower head if I can't manage anything more—and submerge my face for just a few seconds (or to the extent that I can tolerate it) to activate the dive reflex. And just like that, my heart rate slows, breathing becomes steady, emotions quiet down, and coherent thoughts return; it's as if suddenly my brain is back online. Of course, what you do next will determine whether or not you're able to stay down from the come down, so to speak. But that's a topic for another day.

Des—Paired Muscle Relaxation: The 'P' in TIPP

I remember the days when my emotions felt like a tidal wave crashing over me—relentless, overwhelming, and all-consuming. The intensity of my feelings would often leave me trembling, my body vibrating with a raw energy that seemed impossible to contain. It was as if every bone, every blood cell was alive, shouting with anger, fear, or sadness, demanding to be heard.

Anger, in particular, was an emotion that I grappled with constantly. Anger can show up when we feel unseen or unheard, and that was certainly true for me. This feeling of being invisible, like my voice didn't matter, was a significant part of my journey with BPD. My anger became a manifestation of all the emotions I didn't know how to process or express.

Then I learned about TIPP, a distress tolerance technique in DBT, specifically the final 'P' in TIPP—paired muscle relaxation. There was something so powerful about tensing my muscles and then allowing myself to relax them. It wasn't just about physical release; it was about reclaiming control over my body and my emotions. It allowed me to take all the feelings that BPD threw at me, tighten them up, and then release them. Each time I went through the exercise, I would find myself coming back to my center.

Each time I engaged in paired muscle relaxation, I was reminded that I had power and I was strong. It gave me a way to process my emotions without turning to self-harm. I could focus on my breath, on the tension in my muscles, and gradually let go of the urge to hurt myself or lash out at someone else. Instead of sabotaging my relationships or neglecting my self-care, I could find a moment of peace—a small victory in the battle for my mental health.

This exercise helped me navigate the wild currents of my emotional river. Instead of being swept away by the current, I used this skill to steer myself toward calmer waters, where I could rest, breathe, and regain my strength.

Cathleen—Mindfulness

To me, mindfulness is using my five senses. When I am dysregulated, I find that my body and the rational part of my brain are completely hijacked by the intense emotional signals from the other part of my brain. There is nothing in me that can tell myself to "just go for a walk," or "just go stick your hands in ice." I'm usually too far gone to even tell myself, "just stop and think about your breath." I use these, and many other DBT skills, once the intensity of everything going on inside me decreases, but I've found that engaging my five senses is what helps me deescalate enough to allow me to access rational thought again.

I know it sounds like I'm still telling myself to do "x," but the key to this process is that I don't have to think to slightly shift my eyes. Somehow, it happens automatically when I talk (or yell). I only have to focus on seeing something that's already in front of my eyes. This is the mindfulness skill of "observe." When I can start describing what my eyes are seeing (there employing the mindfulness skill of "describe"), then I can more readily focus on the information my other four senses are giving me, which then enables me to be able to focus on my breath, take a pause, or use any number of other DBT skills.

I tend to describe surfaces first—the names of the colors, the curves or corners of shapes (flat, square, rounded, etc.), the fact that there are some words printed there, the name of a pattern in a fabric, how the threads are interwoven or the wood is smooth or the way the edges of a piece of furniture are connected and any other words I can quickly think of that I would use to describe the picture I'm seeing to someone who can't see it.

After I run through the information from my sense of sight, I touch something that is already under my fingertips and describe what it feels like (smooth, soft, rough, ridged, bumpy, etc.). That calms me down enough to turn to what I hear (music, children playing, printer printing, rain, etc.). I then check whether there is any information coming into my brain from my sense of smell. Sometimes there isn't, but just focusing on it to determine if there is anything I can describe as a smell (coffee, salty air, sweet flowers, earthy, fresh, etc.) helps haul my brain out of my emotions. I personally have a hard time describing taste, but some say that, if you have tiny blood vessels rupture when you are under stress, you can taste a bit of rust.

Alyssa—Radical Acceptance

Life is often unexpected. There are many life circumstances that I wish were different. In the past (and even sometimes in the present) I fought against those realities. Unfortunately, this created even more suffering. When I use radical acceptance, I am better able to tolerate situations as it is and to problem-solve moving forward.

Radical acceptance has come into play for me in terms of accepting my emotional dysregulation and mental health challenges. I've had to accept the struggle that comes with having certain diagnoses. I've also had to accept that not everyone has the same challenges as I do, and that my daily life looks different than others' because of my differences. Even though it often feels hard and unfair, radically accepting what mental illness has taken from me and choosing to move forward is the most effective thing that I can do.

Challenges are a part of life. There are situations that can bring up a lot of grief as we let go of our expectations and instead accept life on life's terms. Radical acceptance takes a lot of courage.

It's not easy to look the truth in the eye. In order to do so, we have to believe in our ability to meet the demands of life head on and encourage ourselves that we can do it. The first step to creating the life you want is accepting the life you already have. From that space, we can move forward.

In closing, DBT can be an extremely valuable resource for people with BPD. Our testimony in this piece establishes how useful it has been for many of us. Simultaneously, we honor that there are many paths to healing, and that this form of treatment is not the only way forward. Mental health treatment is rarely a one-size-fits-all approach. Accordingly, we hope folks will feel valid in choosing whatever works for their mind and body, regardless of whether DBT is a part of that picture.

Innovations in Dialectical Behavior Therapy Supervision: Promoting Treatment Adherence in Training and Supervision

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Effective DBT requires that clinicians apply several different (and sometimes dialectically opposed) therapeutic skills all at once (Linehan & Wilks, 2015), and benefits greatly from high treatment adherence (Harned et al., 2023). Furthermore, the principal-based approach to individual DBT sessions requires greater flexibility and adaptability from clinicians than standard manualized treatment approaches, and a high degree of fluency in dozens of DBT skills. Because of its complexities (Lynch et al., 2006), DBT may feel overwhelming to new clinicians in training, and adherence may be difficult for new practitioners. The gold-standard training model for DBT is resource intensive (Landes et al., 2012). As a result, clinicians and hospital setting administrators tend to utilize unproven, informal methods of training (Landes et al., 2016) which may prove ineffective at fostering treatment adherence (Harned et al., 2023). To address the need to increase treatment adherence, Harned and colleagues (2021a) created the DBT Adherence Checklist for Individual Therapy (AC-I) which enables clinicians to evaluate their own adherence to DBT. The AC-I is an effective tool for evaluation (Harned et al., 2023) and, therefore, is promising for use in DBT training. However, DBT training, particularly the pre-doctoral level, remains understudied, and little has been published on effective supervision and training for future DBT practitioners. The remainder of this paper focuses on the implementation of 3 years of training psychology residents at a large VA medical center utilizing the AC-I and other techniques as core elements of the training curriculum.

The components of our DBT training curriculum are outlined in Table 1. Note that many elements of our APA accredited internship program are not fully described in this paper (i.e. trainees attend professional development seminar, didactics, group supervision, and are supervised on clinical work in various clinical rotations). Our training program is 12 months in length and trainees vary from 1.5-3 days on our DBT rotation per week. Several core elements of our DBT training program are recommended for success with the integration of the AC-I into training. A DBT trainee is assigned approximately 3-4 individual DBT patients, with consideration of their training goals, time on rotation, and level of experience considered. Video review of individual DBT sessions occurs within the context of individual supervision between the trainee and a licensed clinical psychologist with extensive training and clinical experience in DBT. All of our DBT clinical supervisors are either foundationally trained or certified by the DBT-Linehan Board of Certification™. Additionally, trainees are fully integrated into the full-model DBT program and co-facilitate skills training groups while directly observed by DBT-trained staff members, participate in DBT consultation meetings and provide supervised phone coaching. The AC-I is introduced to trainees after they have had approximately 6 months of DBT training, clinical practice, and supervision.

To enhance our training program, we created a weekly 55-minute study group meeting for ongoing peer learning to house some of the additional training needs of new DBT trainees. Study group meetings were attended by trainees involved in the DBT program. This peer-led, small group format served several purposes, eliminating barriers on resources and time that were burdensome such as consistently needing a licensed clinician or supervisor to lead the weekly study group. It also represented the value of team consultation and nonjudgemental learning by not having the evaluating supervisor present. The make-up and structure of the study group has looked different across iterations based on differences in trainee numbers, experience level of trainees, etc. It is recommended to remain flexible to allow the study group to meet the needs of the program and learners. For example, we have had the study group led by three intern-level trainees, who rotate leading the meeting. In this instance, to prevent within-group drift, the trainees were asked to provide weekly summaries of what was covered at each meeting. We have also had the study group led by a postdoctoral fellow who had prior DBT training, experience

delivering adherent DBT, and training on the AC-I. We developed a syllabus to guide trainees on a week-to-week basis.

Our study group is designed into two parts, phase 1 for early in the training curriculum, with a focus on review of DBT literature, therapy manuals, and learning strategies for acquisition of core DBT conceptualization and intervention skills, such as chain analysis and validation strategies. Table 2 provides a sample agenda for this phase of the weekly study group. Watching publicly available videos of DBT experts and role-play are frequently used. Additional Phase 1 discussion topics were generated by the trainees and what they felt they helpful, examples have included pretreatment strategies, and addressing therapy interfering behaviors.

Phase 2 begins in the second half of the training year, with the focus on DBT adherence using the Harned et al. (2021a) AC-I measure and publicly available learning materials, following the training recommendations described on dbtadherance.com. Table 3 provides a sample agenda for Phase 2 of our weekly study group. Additional topics are covered as time allows, and we recommend flexibility based on your trainees' interests and learning needs. Trainees have typically had the opportunity to share their session videos to rate adherence 2-3 times each in the group format with each other.

After completing their practice reviews using the DBT Adherence website, trainees began the process of using the AC-I to rate their own and each other's sessions. A typical study group AC-I review occurred over two weeks. During the first study group, a trainee would provide their most recent video recording of an individual DBT session for the group to watch in full. All attending trainees rate the session using the AC-I throughout the hour, taking detailed notes to provide the basis for their ratings on each AC-I item. The following week, the group would go through each item on the rating scale and discussed their observations and final rating scores. A typical conversation about AC-I ratings may go as follows:

Trainee 1: Let's all go on to item 6. What were your ratings for this one?

Trainee 2: I rated it adherent because I noted that I thought that I reviewed DEAR MAN with the client effectively and gave her some pieces of important information.

Trainee 3: I agree. I also rated it adherent for similar reasons. I liked how you also provided information to the client about how to identify situations where a DEAR MAN would be useful.

Trainee 1: I actually initially rated this one as adherent, but then thought about it a bit more in the context of the entire session and I think I might disagree. After watching this session I think the skill that was most needed here was radical acceptance. I think the client hasn't gotten to the point of radically accepting that her mother is cognitively declining, given the dementia diagnosis, and that her mother may not be able to follow through on the requests that the client is making of her in a DEAR MAN.

Trainee 2: Actually that's probably a good point. I tried discussing radical acceptance with this client before but I got a lot of pushback from her and I was worried that she found the discussion dismissive.

Trainee 3: I could see how repeatedly using DEAR MAN to ask for behavior change from someone with dementia could actually increase distress and frustration over the long-term.

Trainee 1: Yeah I definitely think this seems like one to bring up in your next supervision since that sounds like a tough situation. I think the timestamp was at around 10 minutes where you could have segued to a good radical acceptance discussion.

Trainee 2: Thanks I will! Ok let's move on to item 7...

Although the focus on DBT individual session adherence is merely one component of our training curriculum, it has been extremely valuable toward the goal of providing evidence-based supervision and emphasizing the importance of treatment adherence, as well as meeting the high demands of DBT clinical supervision. While data on trainee experience was beyond the scope of this paper, we believe that our trainees were able to more readily identify their own areas of strength and growth in provision of individual DBT, as well as described feeling more direction in their individual sessions when they felt stuck. We do not use the AC-I as a mechanism for formally evaluating a trainee's clinical skills, as studies have found that even fully licensed clinicians who regularly practice DBT are not fully adherent on a regular basis (Harned et al., 2021b). As such, we do not expect trainees in their first year of learning DBT to be consistently adherent. That said, it is an effective tool for supervision in understanding trainees' areas for growth.

We have encountered barriers to implementing this model of training. First, allocation of time (experienced staff to provide DBT didactic training and supervision; trainee schedules for study group) has been challenging. Second, it is not always possible to have a DBT-trained postdoctoral fellow leading the study group, which is our preferred format. This allows the postdoctoral fellow to seek supervision on leading the study group and communicate about study group progress and pitfalls. When the group has been led solely by

intern-level trainees, we have needed supervisors to guide them to stay on track with the curriculum plan, while still allowing flexibility for DBT topics of interest. As noted, we have used study group summaries as one mechanism for staying on topic and preventing within-group drift in scoring or understanding of materials. Additionally, our training model requires the use of video or audio recordings of trainee sessions for use in peer review and for rating adherence using the AC-I. While this may not be feasible for all training programs, it is recommended and in keeping with literature on importance of use of observation in supervision (Falender, 2018). In the future, we plan to further structure this model of training for dissemination, including development of supervisor and trainee written materials, as well as collect data on trainee experience and outcome.

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Table 1. Training Curriculum Modalities

	Supervision:
Individual Supervision	Weekly 60 min – review of session video recordings, case review, etc
Direct observation	Trainees observed co-leading skills training groups
Training and consultation:	
DBT study group	Phase 1 – clinical skill acquisition Phase 2 – DBT Adherence
Didactic training	Minimum 1-day DBT workshop provided
Group consultation	DBT team consultation meetings

Table 2. Weekly DBT Study Group Sample Agenda Phase 1

Topic	**Learning method**	**Length**	**References/materials**
DBT Introduction	Chapter review and discussion Trainee homework: Read 1-2 chapters per week of Doing DBT	4-6 weeks	Doing DBT: A Practical Guide
DBT Pretreatment	Review components of pretreatment Review examples of diary cards Role-play options: 1) practicing eliciting goals and target behaviors. 2) introducing diary cards to patients 3) describing biosocial model to patient	2 weeks	Clinic patient pretreatment packet Therapist pretreatment training slides Diary card examples
Validation	Watching video on 6 levels of validation Role-play: practice validating patient	2 weeks	Video: Six Levels of Validation in DBT: From Awareness to Radical Genuineness
DBT Pretreatment	Phase 1 – clinical skill acquisition Phase 2 – DBT Adherence	Phase 1 – clinical skill acquisition Phase 2 – DBT Adherence	Phase 1 – clinical skill acquisition Phase 2 – DBT Adherence
DBT case conceptualization	Review case conceptualization elements Homework: prepare and present case conceptualization to group*	1 week per trainee	Secondary targets handout Case conceptualization handouts

[a]Koerner, K. (2011). Doing Dialectical Behavior Therapy: A practical guide. The Guildford Press

[b]Psychotherapy Academy. Six Levels of Validation in DBT: From Awareness to Radical Genuineness [Video]. **Youtube.** https://www.youtube.com/watch?v=49Blk3eR5C8

*Case conceptualization presentations are done in peer study group as well as often presented in supervision, case conference, or DBT consultation team meetings

Table 3. Weekly DBT Study Group Sample Agenda Phase 2

Topic	Learning method	Length	References/materials
DBT Adherence Checklist: Introduction	Webinar review Trainee homework: Read manual	2 weeks	DBT AC-I Webinar — DBT Adherence & Fidelity[a] Review DBT AC-I Training Manual — DBT Adherence & Fidelity[b]
Practice scoring the DBT AC-I	Video review and scoring Group discussion after scoring – Trainees compare ratings to the expert ratings provided on the DBT AC-I website, discuss discrepancies	1 week for video review and 1 week for discussion Repeat as often as indicated	Practice Sessions — DBT Adherence & Fidelity[c]
AC-I group ratings	Group viewing of video session and rating using the AC-I Group discussion of ratings	2 weeks per trainee presenting 1 week for video review and 1 week for AC-I ratings discussion Repeat as often as indicated	AC-I[b]

[a] Harned, M. S., Schmidt, S. C., (2021). What the Heck is adherent DBT? A New pragmatic measure for evaluating adherence in DBT individual therapy.[conference webinar], International Society for the Improvement and Teaching of DBT 2021. https://www.dbtadherence.com/dbt-aci-webinar

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[c] The DBT Adherence and Fidelity Project. Practice Rating Sessions. https://www.dbtadherence.com/practice-sessions

Enhancing DBT Through Measurement–Based Care: Opportunities and Challenges

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Enhancing DBT Through Measurement-Based Care: Opportunities and Challenges

Dialectical Behavior Therapy (DBT) is well-established as an effective treatment for severe mental health conditions (DeCou et al., 2019; Hernandez-Bustamante et al., 2024). Measures of provider adherence, intensive training standards, and a renewable certification process further increase provider and public confidence that the DBT delivered in the community is consistent with the evidence-based model. However, these processes provide limited information about the progress of individual patients. Increasingly, clinical programs and clinicians are seeking to better understand how patients respond to treatment in real time, and the use of outcome measures has become more common (Lavallee et al., 2016; Williams-Livingston et al., 2020). However, the systematic use of measures to inform ongoing care remains limited.

While DBT diary cards track daily behaviors, urges, and emotions based on individualized goals, they are non-standardized, limiting comparisons to norms or across patients. Measurement-Based Care (MBC) offers a structured way to enhance DBT by incorporating standardized outcome measures. These measures can help clinicians detect early signs of deterioration and better track the progression of symptoms over time. Importantly, MBC does not replace the individualized focus of DBT but complements it by offering a data-driven perspective that may strengthen clinical decision making. Diary cards remain central to fostering patient engagement and personalized care, while MBC adds standardized information that could optimize outcomes, particularly in intensive settings. Together, diary cards and MBC can provide a more comprehensive view of patient progress, supporting both the individualized behavioral approach of DBT and the standardized symptom tracking required for evidence-based treatment.

In this paper, we outline the purpose, components, and supporting evidence for Measurement-Based Care (MBC) and examine the feasibility of integrating it into Camden Center's DBT-embedded Partial Hospitalization (PHP) and Intensive Outpatient Programs (IOP), using our experience as a practical example. We evaluate Camden's MBC implementation strategy, including successes, challenges, and areas for improvement, and propose next steps to further align DBT practices with MBC to improve patient outcomes.

Measurement-Based Care in Practice: Current State

MBC entails the systematic and ongoing assessment of patient-reported symptoms, functioning, and overall well-being, and is specifically designed to serve as an iterative feedback loop that informs real-time clinical decision-making (Fortney et al., 2017). MBC differs from related practices, such as routine outcome monitoring and program evaluation, which focus on the overall effectiveness of a treatment or program. Instead, MBC aims to facilitate dynamic, patient-specific modifications to the therapeutic process based on real-time, data-driven insights made collaboratively with the patient. For instance, if weekly symptom measures indicate a patient's anxiety is not improving, the clinician and patient can decide together to increase session frequency, add exposure exercises to the treatment plan, or pursue further assessment to identify a previously undiagnosed condition that may require a different intervention. Extensive research has demonstrated the effectiveness of MBC in improving patient outcomes, reducing healthcare costs, and mitigating the risk of clinical deterioration during treatment (Childs & Connors, 2021; Jenson-Doss et al., 2020; Lewis, C. C. et al., 2019). MBC has also been shown to positively impact the therapeutic alliance, boost patient engagement, and is associated with reductions in symptomatology, particularly for patients identified as "not on track" or at risk of dropping out (de Jong et al., 2021).

Despite this, adoption of MBC is limited, with less than 20% of practitioners adopting it (Lewis et al., 2019). Barriers include resource limitations, provider attitudes, and organizational challenges such as administrative burden and perceived threats to autonomy (Boswell et al., 2015; Martin-Cook et al., 2021). In response, leading organizations such as the American Psychological Association (APA), Yale Measurement-Based Care Collaborative, Veteran

Affairs Association (VHA), and Joint Commission recommended a broader adoption (Barber & Resnick, 2023; Dollar et al., 2020).

Given the strong alignment between the core principles of DBT and the evidence supporting MBC, it is surprising that their integration has received limited scholarly attention. DBT emphasizes collaborative, non-hierarchical therapeutic relationships, prioritizes patient involvement (e.g., therapy interfering behaviors) and consistently uses diary cards to track progress, iteratively guiding treatment. DBT has also been shown to reduce healthcare costs by reducing psychiatric hospitalizations and emergency room visits (Comtois et al., 2007). Despite this apparent synergy, our review of the existing literature found only a single study detailing the implementation of MBC within a DBT-informed IOP for suicidal adolescents (Victor et al., 2023). Although the STAR program provides a detailed account of the positive impacts and significant challenges of the implementation of MBC within a DBT framework, a significant gap remains in research, particularly regarding adult DBT programs.

Clinical Application: MBC within an embedded IOP/PHP DBT Program

Camden Center is a dual-site multidisciplinary treatment facility providing integrated care for mental health and substance use, offering a comprehensive DBT program embedded within a broader PHP/IOP setting. The center has been tracking clinical outcomes for four years, continuously refining its approach. We are critically assessing our evolving methods for routine outcome monitoring, aiming to shape these practices into a more comprehensive MBC framework aligned with APA guidelines.

"Collect, Share, Act": A Transtheoretical Clinical Model

The "Collect, Share, Act" model, developed by the VHA, forms the basis for APA's MBC best practices recommendations (American Psychological Association, 2022). This innovative framework provides mental health professionals and clinicians with an actionable approach to implement MBC in their practices. The model emphasizes transparency, collaboration, and data-driven decision-making, embedding salient research findings into a three-phase approach to maximize MBC benefits (Barber & Resnick, 2023). Camden's relative successes, challenges, and improvements in implementing this model are detailed in Figure 1.

"Collect"

The Collect phase focuses on early introduction of MBC, selecting appropriate measures, and regularly administering them, as frequent systematic collection of patient-reported outcome measures (PROMs) improves treatment outcomes (Bickman et al., 2011; Lewis et al., 2019). Measures should be validated, symptom-specific, process-oriented, and relevant to the primary diagnosis (Jensen-Doss et al., 2020; Resnick et al., 2020).

Camden launched its Outcome Measures Program (OMP) in 2020 with one Outcome Measures Clinician (OMC), using empirically validated tools like DERS, OQ-45.2, PHQ-9, GAD-7, and PCL-5, tailored to each patient's symptoms and diagnoses. The introduction and administration of these measures included weekly sessions with the OMC for orientation and data collection and followed best practices (Table 1). Challenges such as inconsistent administration due to staffing and scheduling limitations are detailed in Table 1.

Camden addressed challenges by expanding the OMC team, integrating OMP intakes into weekly schedules, standardizing the scheduling process, and optimizing the number of weekly measures based on patient feedback and collaboration with DBT Directors.

"Share"

The Share phase emphasizes jointly reviewing patient data with clinicians and patients to enhance the therapeutic alliance (Azocar et al., 2007; Hepner et al., 2017). Guidelines recommend transparently discussing outcome data for shared decision-making (Resnick et al., 2020) and addressing discrepancies between data and patient experience (Trauer & Callaly, 2002).

Camden's initial efforts in the Share phase included weekly telehealth follow-ups with the OMC featuring graphical displays of week-to-week changes. This aligned with best practices in that there were regular discussions and visual representation of progress outcomes (Albers et al., 2022). However, because the OMC was not part of the primary clinical team, these sessions had limited impact on strengthening the therapeutic alliance within the core treatment context. Camden was also unable to consistently share results with the patient's clinical team, including the primary DBT therapist, as detailed in Table 1. To address this, Camden integrated the OMC into weekly clinical meetings to share outcome data in real time, although challenges persist in using these data directly in treatment planning.

"Act"

The Act phase focuses on using outcome data to collaboratively adjust treatment by reviewing progress trends and working with the patient to decide next steps (Adams et al., 2007; Eliacin et al., 2015; Resnick et al., 2020). This defines MBC.

Integrating validated outcome measures into DBT sessions at Camden Center remains a challenge, as there is no real-time data sharing system between therapists and patients. Instead, an OMC reviews and shares the data separately with the DBT therapist through email and team meetings, consistent with the OMP's original focus on program monitoring rather than supporting real-time clinical decision making. This structure, designed to reduce administrative burdens on clinicians, reflects a common barrier to MBC adoption. While OMP enhancements have addressed challenges of the Collect and Share phases, fully integrating outcome data into the Act phase for treatment modifications remains elusive. DBT diary cards partially bridge this gap by providing individualized feedback and real-time intervention prompts. Yet, the lack of integration between diary cards and standardized measures may result in missed opportunities to identify discrepancies between a patient's subjective report and objective outcome data. For example, a patient may report progress toward behavioral goals on their diary card, while a validated measure indicates symptom deterioration. Without the ability to compare these data points during sessions, clinicians may overlook critical cues to adjust the treatment plan accordingly.

Proposed Next Steps:

To address the gap in integrating outcome measures into DBT sessions, Camden Center has explored strategies to incorporate standardized measures while addressing barriers to clinician adoption. The proposed approach involves reviewing one validated measure, the DERS, in weekly DBT sessions along with the existing diary card. This would allow the therapist and patient to compare real-time data from both sources, enabling more informed discussions and treatment adjustments. The OMC will summarize DERS data and provide it to DBT clinicians in an accessible format on their devices. DBT therapists will then use their professional judgment, guided by the hierarchy and principles of DBT, to discuss patient progress, identify discrepancies, and determine next steps during the sessions. Integration of measurement-based care will be a recurring item on the DBT Consult Team agenda. This 6-month pilot initiative has been presented to the Camden DBT Team, who will use their dialectical agreements to conduct a qualitative analysis of the utility, feasibility, and added value of the approach, examining its impact on clinicians, patients, and treatment outcomes. This iterative process will allow for ongoing discussion and problem solving of any remaining barriers.

Summary and Conclusions

Measurement-Based Care (MBC) has empirical support for improving patient outcomes, yet it remains underutilized, even in structured approaches like DBT programs that already use validated outcomes. While practical barriers to the implementation of MBC have been well documented, professional guidelines provide a roadmap to address these challenges. The authors' experience in evaluating the process of incorporating MBC into a comprehensive DBT program within a PHP/IOP setting demonstrates the value of an iterative approach.

Notably, DBT already incorporates principles and protocols that address key functions of MBC. However, it is unclear which of these functions are adequately met by DBT and which could be enhanced with the addition of MBC. Further analysis and comparison of the respective benefits of MBC and DBT, including the relative effect size and the populations most affected, could help DBT clinicians focus their resources on specific areas that are found to be improved by MBC but not DBT.

The authors have learned that a successful implementation of MBC does not happen all at once. By embracing the acceptance-change dialectic of DBT, we recommend a stepwise approach: integrating MBC in small, manageable steps and using feedback from initial efforts to guide future changes. This iterative process, supported by standardized measures, can strengthen both individualized and data-driven elements of DBT, resulting in more effective and responsive treatment.

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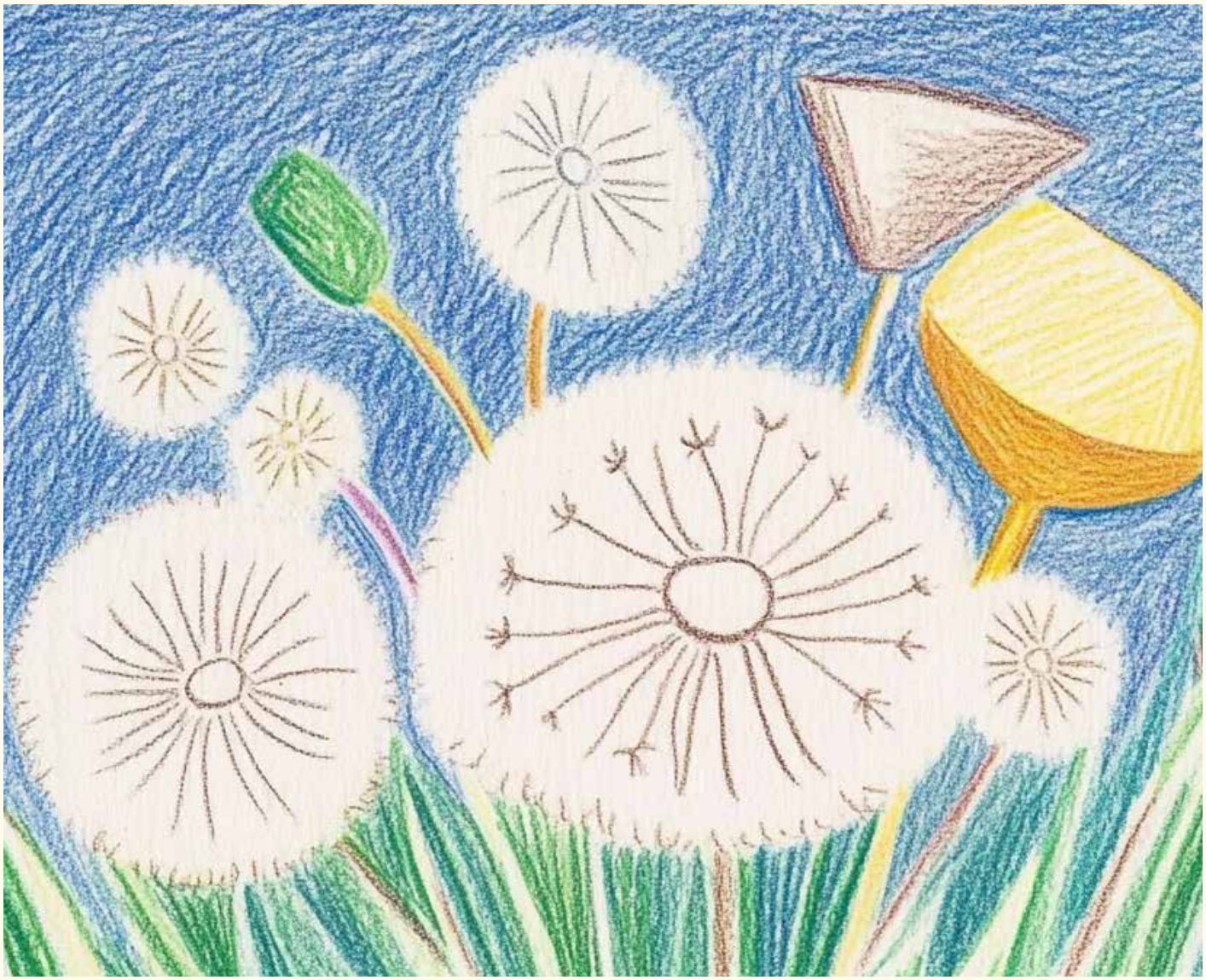
Table 1. "Collect, Act, Share" — Camden Center's Early Efforts at MBC, Successes and Challenges

Phase	Recommended Processes	Successes	Challenges & Improvements
Collect	Introduce MBC to the patient early in treatment, explaining rationale and benefits. Select well-validated patient-reported outcome measures (PROMs) that align with patient diagnoses and treatment goals. Administer measures regularly and repeatedly as standard care.	MBC are introduced in 60-minute sessions scheduled during the first week of treatment. Up to eight well-validated measures were individually selected for each patient based on diagnostic criteria and treatment program. New measures are administered during weekly 30-minute sessions with OMC .	Patients complained of burden, leading to a reduction in weekly measures from 8 to 4.
Share	Report PROM data to the patient, explaining total score(s) and individual item scores.	Outcome data are reviewed with patients during weekly 30-minute sessions with OMC noted above.	Inconsistency due to limited clinical staff lead to expansion of OMC team from one to three. Inconsistent scheduling of weekly sessions led to formal integration into scheduling protocol. Discussion with OMC rather than DBT therapist resulting in missed opportunity for relationship building.
	Engage the patient in discussion to verify that scores reflect their subjective experience and explore any discrepancies. Document the conversation and data in patient's medical record for future reference.	Discrepancies are discussed with OMC[1] and relayed via email to the treatment team when deemed clinically important. OMC adds measures and notes from sessions into EHR.	Discussion with OMC rather than DBT therapist, limiting opportunities for collaboration, comparison with diary card, and direct investigation of discrepancies. Burden on DBT therapists to regularly search for data submissions, necessitated presentation of data during team meetings and emails to treatment team.

Table 1. "Collect, Act, Share" — Camden Center's Early Efforts at MBC, Successes and Challenges

Phase	Recommended Processes	Successes	Challenges & Improvements
Act	Appraise data trajectory to determine if there is improvement, worsening, or no change. Collaboratively brainstorm possible adjustments to treatment plan with the patient. Decide on plan of action together, document, and agree on a timeframe to reevaluate.	Changes in trajectory are reviewed by OMC and shared via email and in team meetings with clinical team including DBT Therapist.	Currently no consistent system in place to support DBT therapist in collaborative discussion with patient about trajectory. Lack of data during DBT sessions prevents direct and timely use in problem-solving with patient. Shared decision-making about changes to treatment do not directly utilize timely trajectory data.

[1]The Outcome Measures Clinician (OMC) is a licensed clinician serving in a clinical/administrative role separate from the patient's clinical team. The role was originally envisioned as supportive to not add to clinician's administrative burden.



STUDENT AWARD: KATE CONROY, MS CLINICAL PSYCHOLOGY PHD CANDIDATE, UNIVERSITY OF WASHINGTON NOMINATED BY DR. VIBH FORSYTHE COX

Kate Conroy M.S. is a Clinical Psychology PhD Candidate at the University of Washington. For over two years, they have been delivering comprehensive DBT as a trainee at the Marsha M. Linehan DBT Clinic, where they also work as the clinic coordinator. Kate is a graduate researcher under the advisement of Dr. Mary Larimer. Their current research foci are related to drinking behavior and norms in LGBTQ+ spaces and they are passionate about providing quality evidence-based treatment to individuals with marginalized identities.

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