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THE DBT BULLETIN

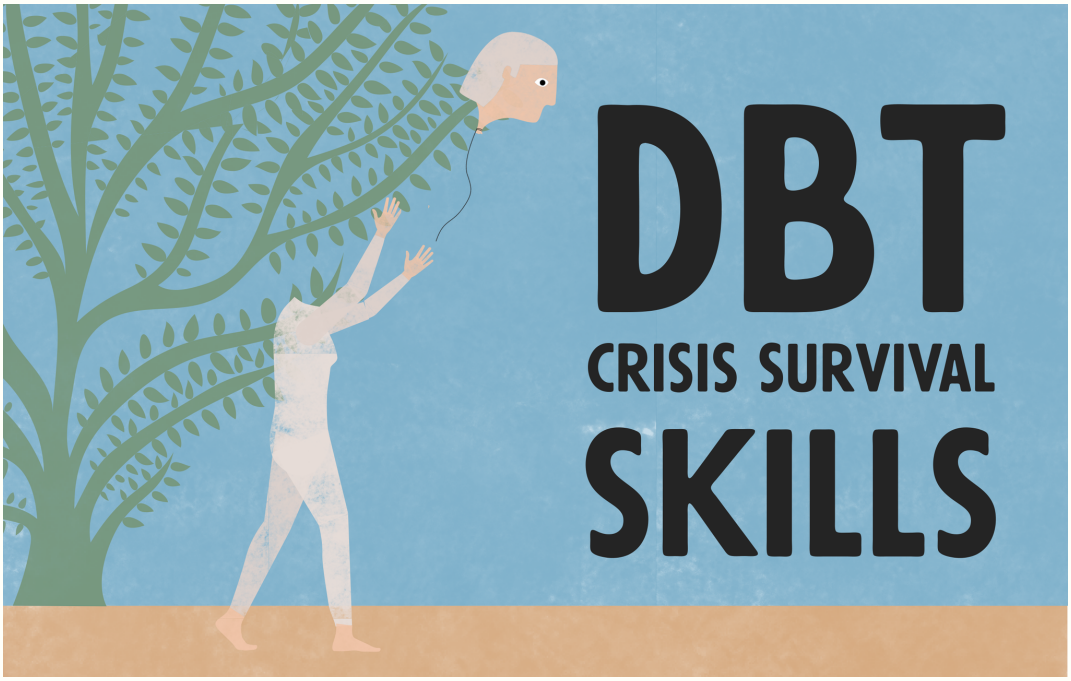

Illustration by Jesse Finkelstein,Psy.M.

Letter from the Editors

Welcome to year three of the DBT Bulletin. Like all of you, our editorial staff have been grappling with the dual impact of Covid-19 and the civil unrest in the wake of George Floyd's killing. Never in our history have DBT skills been more necessary to negotiate our day to day lives. From the call to arms for providing quick, engaging skills lessons over Youtube, to thoughtful pieces on BLM and cultural humility in the context of DBT, to the very real struggle of keeping teams connected over Zoom, and adolescent IOPs functioning online, this issue is a reflection of our times. As we celebrate ISITDBT in our brave new virtual world, this will be the first time we do not distribute hard copies of the Bulletin at the conference. Although we will miss seeing you all in person, we look forward to broadened appeal of an online conference which opens the door to greater inclusion. We would also like to take a moment to congratulate Dr. Hollie Granato on her promotion to Supervisory Editor and welcome Dr. Marget Thomas, Research Director, and Dr. Aly DiRocco, Postdoctoral Fellow, both of CBT California, who have joined as Co-Editors-in-Chief of the Bulletin. Our thanks to Dr. Erica Rozmid as she steps down. Thank your Dr. Rozmid for your service. Thank you also to our editorial staff who continue to provide excellent feedback on submissions. Finally, we would like to congratulate Alexandra Klein, MA, and Alexis Adams-Clarke M.S., our Student Spotlight winners, who were awarded registration at ISITDBT. The DBT world looks forward to great things from you both!

Lynn McFarr, Ph.D.
Editorial Director

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Reflections on Cultural Humility and DBT

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In my multiple roles as an instructor, mentor, supervisor, and therapist, it seems like now, more than ever, conversations regarding social justice, equity, and cultural humility have permeated my every day activities. These culture-infused discussions with my students, colleagues, and clients easily jump out to me as being some of the most challenging I've had to date; it has required a level of humility, vulnerability, and discomfort that most of us would prefer to shy away from. "*What should I do if I am angry with a client/supervisor for making a culturally insensitive comment to me?*" "*How do I make a repair when I've committed a microaggression?*" These are a mere sampling of questions that are raised from week to week. While I do not always have the answers, these questions inevitably elicit discussions on the practice of cultural humility or, the "*process of reflection and lifelong inquiry, [that] involves self-awareness of personal and cultural biases as well as awareness and sensitivity to significant cultural issues of others*" (Yeager & Bauer-Wu, 2013, p. 8).

The Intersection of Cultural Humility and DBT

Cultural humility requires a deliberate reflection of our values and biases alongside an awareness and sensitivity to the culture of others (Yeager & Bauer, 2013; Tervalon & Murray-Garcia, 1998). This process is, quite frankly, uncomfortable. Following my frequent culturally insensitive missteps within the therapeutic relationship, my attempts to engage in these reflections have felt humiliating at worst and humbling at best. But here is the good news: I have learned that core DBT principles such as assuming that the therapeutic relationship is one between equals, that the therapist is fallible, and the practice of non-judgment, are critical facilitators of the process of cultural humility. When simultaneously versed in these principles, the practice of cultural humility has led to the repair of therapeutic ruptures and reaching of syntheses in the midst of polarizations. I remember vividly an instance in which I found myself angry at a client, "Lisa," for making a highly detrimental (in my view) family-related decision which I fundamentally disagreed with. Not surprisingly, we quickly found ourselves polarized on the issue. I simply could not understand how she could believe that her decision was "effective" or within her "wise mind." It was through a combination of the aforementioned DBT principles and stumbled attempts to reflect on my biases and assumptions, that I was able to realize that my perception of her poor decision was largely because it conflicted with my own

cultural values regarding the role and function of family- but not hers. I was self-focused rather than other-focused. Upon taking time to mindfully and reflexively listen, and become aware of the key cultural values that informed her decision-making, we were able to work through the polarization, and find a synthesis.

We all walk into the therapy room nested within our own unique cultural worldviews. When I am with my clients I carry with me my various cultural identities- e.g., a 2nd generation Taiwanese-American, a mother, an academic. The transactions that we have with our clients transcend beyond our behavioral exchanges; they are inevitably informed by the attitudes, values, and practices from various cultural intersections. Therefore, when polarizations emerge in therapy, I bring to mind that moment with “Lisa,” reminding myself of the importance of exploring the intersection of different cultural worldviews at play in the therapy room using a mindful, non-judgmental, other-focused curiosity.

Some Final Thoughts

As we often say in DBT, “Do you want to be right, or do you want to be effective?” I ultimately believe that, at its core, the practice of cultural humility requires a conscious choice to let go of being right and instead, choosing to be effective. Our cultural values are what we know and, what we often assume as right. As both experts in and servants of the mental health community, let us choose instead to be effective- to be vulnerable and accept our fallibility, in the service of honoring and responding to our clients as equals.

Delivering an Adolescent Comprehensive DBT Intensive Outpatient Program via Telehealth During the Covid-19 Pandemic

Stephanie Clarke, Ph.D., Anaid Atasuntseva, Ph.D., & Michele Berk, Ph.D.

Stanford University School of Medicine & Stanford University

Along with many other DBT programs, the global COVID-19 pandemic has resulted in much adapting within our clinic. RISE, a collaboration between Children's Health Council, a community mental health center in Palo Alto, CA, and the Division of Child and Adolescent Psychiatry at Stanford University School of Medicine, is an adolescent IOP with a comprehensive DBT program embedded within it. In March 2020, our team launched a telehealth version of RISE in response to the COVID-19 pandemic. Given the lack of empirical evidence for virtual delivery of adolescent DBT programs, we had many considerations related to safety and fidelity to address within a telehealth format. This article will briefly address how we addressed these considerations, along with lessons learned.

Safety concerns we experienced during the transition to teletherapy ranged from logistical issues (e.g., what to do if a teen "left" or walked off camera when emotionally-dysregulated?) to clinical issues (e.g., would our treatment still be effective at managing and reducing self-harm and suicidality?). To address logistical issues, we required parents to appear on camera at the start of each IOP day to confirm they would be at home with the teen and immediately reachable by phone. If a teen left, the co-leader immediately contacted the teen's parent. Similar to treatment provided in person, parents were our key collaborators in safety planning by restricting access to lethal means and closely monitoring youth.

The bulk of safety management outside of programming relies on the written safety plan and phone coaching, and neither of these changed. Anecdotally speaking, we did not experience a noticeable increase in self-harming or suicidal behavior once we went virtual. In some cases parents were better able to implement safety precautions because they were home more and there was less access to dangerous items (e.g., teens were unable to drop into the local drugstore after school and buy razor blades). Due to families spending much more time together, we increased focus on strategies to reduce family conflict. With regard to effectiveness, there was not a noticeable difference in teens' participation in modes of treatment: teens attended psychotherapy, engaged with their therapists, learned skills, completed homework in multi-family skills group, and used phone coaching.

Electronic forms of communication are familiar to teens and seemed to be more anxiety-provoking for providers. Additionally, virtual meetings allowed us to meet clients' pets (often part of their life worth living) and

introduced new ways of getting to know teens (e.g., engaging in conversations about room decorations). The ability to see the teen in their "natural" environment provided new perspectives on the teen's functioning and additional avenues for supporting skills generalization.

While we have found it to be more challenging to engage teens over telehealth, we have not found it to be insurmountable. We have taken more time to do ice-breakers to increase peer connection. The virtual format has also completely removed concerns about teens engaging in problematic side conversations or behaviors during program as there is no format to do so. While group leaders use the chat function to give praise and corrective feedback, we have changed settings so that teens cannot chat one another.

We also use interactive capabilities within telehealth including a white board to continue our behavioral reward system where teens get stamps for on-task behavior and participation. We do not allow teens to participate from their beds, citing sleep hygiene, which helps teens remain more alert and active in groups. We have teens turn in phones and electronics not needed for IOP access to parents, thus limiting distractions.

Our experience of providing our DBT IOP via telehealth opened our eyes to the potential gains of continuing to offer telehealth even after it is safe to resume in-person services, which include opening access to treatment for families who live in rural parts of the country or have unique circumstances (e.g., ill parent, other child in need of care, no transportation) that would preclude participation in an IOP such as ours. An important next step is to empirically examine the virtual delivery of DBT to test the accuracy of our observations. In many ways, DBT is particularly well-suited for telehealth delivery due to already having out-of-session elements (e.g., phone coaching) and its focus on generalization to the natural environment. In our experience, the DBT frame (e.g., function over form, problem assessment and solving to navigate challenges) helped us quickly and effectively adapt to telehealth.

#BlackLivesMatter – Living the Hashtag

Aditi Vijay, Ed.M., Ph.D.
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#BlackLivesMatter is a hashtag that came about in the wake of the murder of Trayvon Martin in 2012. It was adopted to affirm that Black Lives do indeed matter, even in a society that does not treat Black Lives with respect. In the 8 years since Mr. Martin's death, we have seen countless more killings of Black girls, boys, women and men with minimal, if any, consequences, thus underscoring the need for this movement. #BlackLivesMatter is an important movement with similarly important implications for our work as therapists. Without a deeper appreciation of the historical treatment of the Black community or the movement itself, we run the risk of behaving in ways that can actively harm our Black clients. It is possible to be a compassionate DBT clinician and deliver an adherent, evidence-based treatment that is also harmful for the client in the room.

For example, if you ask a Black client to use Radical Acceptance to accept a difficult circumstance at work, are you actually asking them to accept a situation that cannot be changed? Or are you asking them to accept a version of institutional racism, which would be functionally invalidating? The historical context of the Black community, ranging from the enslavement of Black people, the violence of lynch mobs in the Reconstruction era, segregated neighborhoods and inequitable education, are all relevant to the current life experiences of Black Americans. As mental health professionals, it is incumbent upon us to learn about this history in order to work effectively with our Black clients.

Adopting an Antiracist Stance

Racism, defined as policies and structures designed to elevate one group of people over others, is morally wrong; there is no "either/or" or "both/and" with respect to racism. The dialectics of racism may be evident in individual choices and behavior. For example, one can act in a well-intentioned manner and still uphold a racist structure or policy. One can profess love for everyone and still say something that is a racial microaggression.

Racism is a public health issue (APA, 2020). The impact is widespread and profound; it affects economic growth, educational achievement, mental and physical health for people of all races and backgrounds. In 2020, it has been impossible to ignore the impact of racism from the murder of George Floyd and the disproportionate effects of COVID-19 in the Black community. The antidote, I believe, is deliberately adopting an antiracist stance. Antiracism is an active and conscious choice to act against structures and policies that perpetuate racism (Patterson, 2020). Scholars argue that there is no neutrality possible; we either act in ways that support or oppose racist policies and structures (Kendi,

2020). If we are able to accept that racism and antiracism are about the policies and structures that we support, as opposed to "being" racist, it may allow us to evaluate where we, ourselves, are in this journey. Utilizing the DBT notion of accurate expression offers a way to evaluate our own individual behaviors with a nonjudgmental stance, descriptively, to allow us to move towards meaningful change. For example, in a situation where a skills group leader realizes that they rarely ask the one group member who is Black to share during group, and then acknowledging that it is problematic. Accurate expression and descriptive mindfulness allow for the group leader to find a way to process what they have done and then return to group to make the repair. This way of processing is intended to offer an alternative to feeling guilty about it, possibly overcompensating, or worrying about the judgments of others in the group.

As therapists, we must embody antiracism in our work and our lives. The development of the field of psychology has been largely influenced by Western researchers and clinicians; psychotherapy is grounded in this tradition, and is also steeped in Western culture and white supremacy. #BlackLivesMatter was introduced because our society was not valuing Black Lives. In psychotherapy, this same dynamic is reflected in the idea that our theoretical frameworks are separate from culture. Below are some ideas about ways in which we can change what we are doing to value Black Lives in our practices.

The Myth of Behaviorism as Acultural

We, as therapists, and the therapy itself, are all influenced by the society and cultural context within which we exist. Behavioral principles do not exist in a vacuum; a behavioral approach and behaviorism are still infused with culture. Becoming aware of the cultural underpinnings of therapy is helpful for us to get a better sense of what we bring into the room and an awareness of what is being left out of the conversation. Of course, a range of behaviors exist within all societies and cultures, however what is considered to be normal, appropriate or effective differs widely. As an example, a therapist with an emerging adult client may place a certain value on independence without an acknowledgment or understanding of how it fits with the existing family structure or dynamic still imbues a cultural value. The therapist may be unaware that this is a value associated with certain cultures and an opportunity to learn about the client may be lost. In order to complete a thorough chain and solution analysis, we must be aware of the assumptions of behaviorism and ask questions about different contexts to fully understand the behaviors.

As therapists, this subtle dynamic permeates our work from standard assessments and case conceptualizations to treatment and outcome measures. From an assessment that evaluates the way in which the client identifies culturally, the degree to which they identify, and the cultural components that are important to them.

For example, standard intake measures tend to ask questions about a family including a mother, father, and siblings. This reinforces a heteronormative culture and does not allow space for other family structures. Instead there may be

space to ask about who they consider to be their family.

Reimagining this first contact in terms of asking about the client's culture could lead to a richer therapeutic relationship. Not finding a way to do so may send the message that those aspects of life are not welcome in this therapy room and inhibit the development of the therapeutic relationship. In order to aspire to an antiracist stance as DBT clinicians, we need to rest on the foundation of basic behavioral principles while remaining open and welcoming of learning about cultural differences.

Microaggressions in Therapy: "I don't see color"

The relationship between a therapist and client is at the core of any successful therapeutic outcome. The nature of validation is a core tenet of DBT. A microaggression, or "verbal, behavioral, and environmental indignities that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Pierce, 1970; Sue et al. 2007) is a consequential invalidation. In a therapy setting, microaggressions may manifest as comments such as "I don't see color" or "We are all a part of the human race." A different form of a microaggression may be assuming that all members of the Black community identify as "Black" or "African-American" as opposed to asking the person how they identify. Not asking about this communicates to the client that this is not a safe place to discuss being Black in America. Whether this is unintentional or simply a lack of awareness or education, these behaviors could harm Black clients. It is therefore the job of therapists to "try harder and do better".

As we learn more about microaggressions and the experience of being Black in America and how that translates into psychopathology and therapy, we are likely to feel intense discomfort, which is a cue for us that we need to learn more. This would be a place to utilize the didactics portion of DBT consultation teams to start the process of educating oneself. Educating ourselves on the nature of racial microaggressions and the ways in which it manifests in a therapy room is critical in order to adopt an antiracist stance in our clinical practice.

Re-educating Ourselves

In order to begin the process of education, we must evaluate where we are (observing/describing mindfulness and self-compassion are critical here) and acknowledge the racist beliefs, practices and policies in our own lives. Remember, adopting an antiracist framework means that we are looking at the broader themes to ensure that we support policies/practices that work towards dismantling racist structures.

We then must acknowledge that our history captures one perspective and White supremacy is inherent in much of what we have learned and believe. We have to work through this in order to learn and appreciate other cultures. This same process is reflected in the ongoing conversation in our broader culture as we discuss the appropriate place for Confederate monuments and statues.

Thus, if we want to truly honor Black Lives, to show the Black community that their lives truly do matter to us, it begins with our own re-education. We must examine and challenge our assumptions up to and including the history we have been taught. It is not my intention to present this community as a monolith, simply to suggest that we may not know as much as we think we do. As an example, in the summer of 2020 when Google searches for books on race increased exponentially, the bestselling authors on the Black experience were white authors. Think about that for a moment, we were all looking for information about the experience of the Black community but not from them? What level of invalidation would that be coded as? As such, I am not recommending any specific books as many such lists exist; rather, I'd ask you to think about how to start reading and learning about this community in a way that allows for the deepening of your clinical practice. Learning does not need to be confined to books! Another step would be to learn about how Black people describe their own experience. Try examining who you follow on social media, or whether websites you frequent have a diversity of contributors.

If you were to prioritize an antiracist framework within your own clinical practice, what would change about your work – from your daily routines, to your marketing, outreach, and trainings? In terms of our materials, how do the resources we use and share with clients and students/trainees – handouts, experiential exercises, materials for sessions – reflect an antiracist stance?

Finally, we must consider what we ourselves bring into a therapy room by virtue of our position within society and within the therapy room. This acknowledgment of ourselves is critical to be able to discuss differences with clients in an open, direct manner to be able to build the relationship and work toward the same goals.

Living the hashtag...

Let's start with an acknowledgment that none of what is written here is easy to read or implement. If it made you uncomfortable, I understand, it made me uncomfortable to write it and yet that is the exact work that we must do in order to create an inclusive practice of therapy. Dismantling the structures of white supremacy are critical to supporting and valuing Black Lives in our actions. Living the hashtag means incorporating these notions, an antiracist stance, into our lives off the internet.

#BlackLivesMatter #SayTheirNames

Making Skills Widely Accessible During the Covid Crisis: The DBT-RU YouTube Channel

Shireen L. Rizvi, Ph.D., ABPP & Jesse Finkelstein, Psy.M.

Rutgers University

Within days of receiving the news that our university would not be returning to in-person classes following spring break in March, everyone was scrambling to put out a million fires all while managing their own anxieties. Graduate students, in particular, were faced with new and challenging circumstances. In addition to managing the demands of being a student, these novice clinicians had to quickly transition to phone and video sessions, something for which they had never been trained.

Those of us trained in DBT knew immediately that we were in a “crisis” and knew what was needed - crisis survival skills to help us cope with the vast amounts of uncertainty and fear. However, most of the students in the Rutgers doctoral (Clinical Psy.D., School Psy.D., Clinical Ph.D.) and masters programs have no formal training in DBT. As a way to synthesize our own need for skills use with the needs of our broader community, we decided a "Contribute" (wise mind ACCEPTS) was in order. We sent an email to the student listserv to let them know we would be putting on a webinar teaching key Dialectical Behavior Skills the next day, offering to record the session for anyone that could not attend live.

In one hour on a Friday morning, we taught Wise Mind ACCEPTS, IMPROVE the Moment, and PLEASE as well as provided an introduction to mindfulness to the trainees. The skills were introduced as being for the them, not for their clients, as we wanted to ensure that the students were seeing these as tools that they themselves could use to cope with the current situation as effectively as possible.

The response to the webinar was overwhelmingly positive. One student wrote in a follow-up email “As clinicians, it's so easy to focus on how our clients are being affected without considering that we also need support. Thank you for being that support!”

Considering the encouraging feedback we received on how useful mental health trainees found these skills in managing the stress of the pandemic, we realized this was an opportunity to easily broaden our reach and provide information about these skills to the general public. We took the audio recording of the teaching and paired it with unique illustrations to create a series of videos. From there, we created animated videos for additional DBT Distress Tolerance Skills, including TIP, Radical Acceptance, and Self-Soothe. Our goal was to disseminate these skills in as friendly and accessible a way as possible.

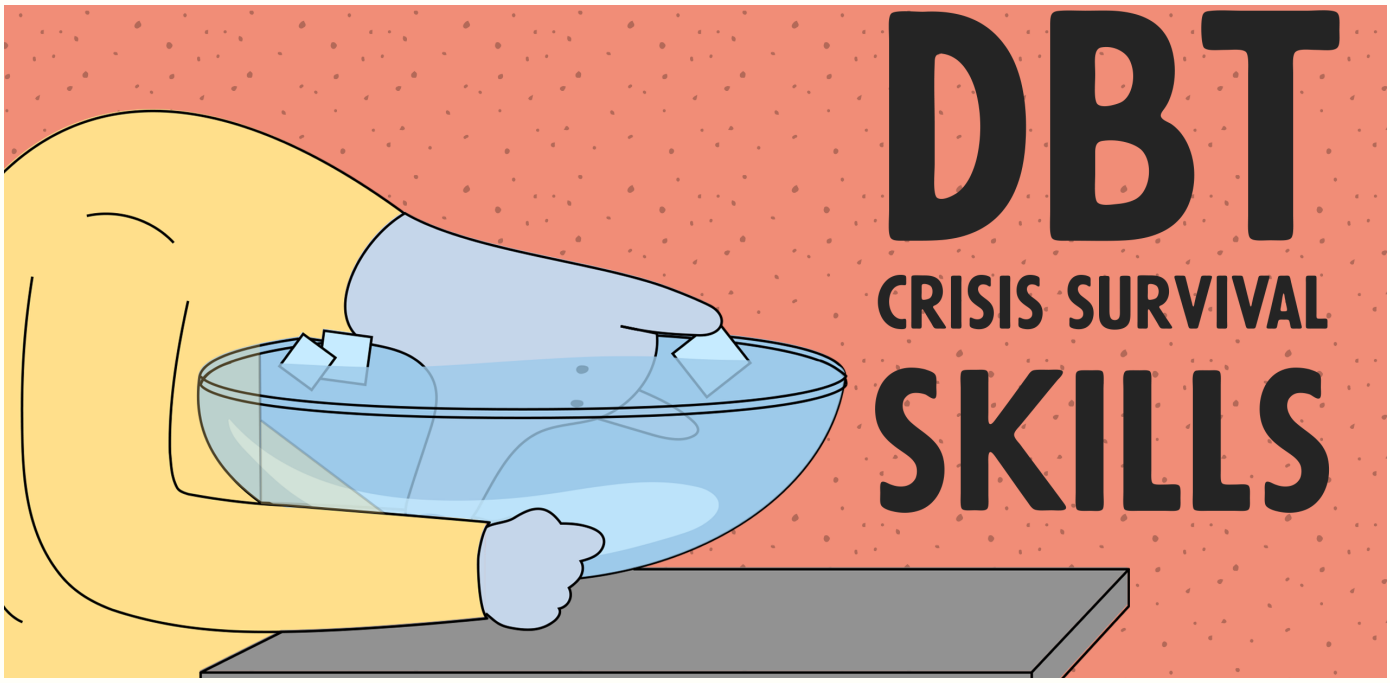

Illustration by Jesse Finkelstein, Psy.M excerpted from the DBT-RU Youtube project

As such, we uploaded the videos to a public YouTube page (youtube.com/dbtru), and to-date they have been collectively viewed over 50,000 times.

It is extremely satisfying, both professionally and personally, to hear how helpful and enjoyable people have found these videos. With relatively little effort from a career DBT researcher (SLR) and a graduate student with a prior career and background in graphic design (JF), we put together a product that appeared to have immediate positive impact. These videos have now also inspired new research pursuits designed to disseminate DBT skills using novel and effective methods. Together with colleagues, we applied for, and received, a grant from the Rutgers Center for COVID-19 Response and Pandemic Preparedness to develop a series of 14 brief DBT skills videos (expanding the repertoire of skills currently covered and enhancing the animation features) and pilot test their efficacy in improving coping among undergraduate students. This expanded project feels incredibly important, given that the mental health repercussions from the stressors of 2020 are only beginning to be realized. This study will end by January 2021, at which point we plan to make more of our videos publicly available. While the COVID-19 pandemic has strained most of us beyond what we thought possible, we have found that 2020 is a banner crop year for metaphorical lemons.

How Do We Help Each Other?: A Conversation with Andy White and Jennifer Sayrs on Keeping Teams Cohesive During COVID-19 Pandemic

Jennifer Sayrs, Ph.D., Andrew White, Ph.D., Caroline Kutschbach, B.A., & Sandra Chen, B.A.
Evidence Based Treatment Centers of Seattle, Portland DBT Institute, CBT California

The pandemic has been tough on everyone this year, including patients, clinicians, and clinic support staff. In this conversation, Jennifer Sayrs (Evidence Based Treatment Centers of Seattle) and Andrew White (Portland DBT Institute) discuss the impact of COVID-19 on their respective DBT teams. Jennifer and Andy share obstacles and experiences, and how they effectively used DBT to balance acceptance and change. This conversation has been condensed for space.

Jennifer: What's been really challenging about COVID and working from home for your team?
Andy: I think we focused a lot on the rational brain problem solving and on risk management and on making sure that clinical care was maintained and definitely struggled to do the interpersonal side. I think when all this started, we did one or two cocktail hours, and I'm realizing that was back in April. We have noticed that things that we did to make life easier—for example, a stipend to help people acquire things to use for their home offices as far as HIPAA-compliance, that was obviously very practical, but it was not relational.
Jennifer: The technical side, the practical side I think has been really challenging, for example thinking about the additional HIPAA risks. I think our staff are less worried about that, they're just trying to get by. I have had my risk management hat on all the time, thinking about what could be a problem we haven't thought of yet. For our team, though, the social part has been particularly difficult, something that we've focused a lot of time on. Our staff really miss each other a lot. It doesn't feel the same to have team on Zoom.
Andy: Virtually, yeah.
Jennifer: Yeah, and I think they're sad. Some of them are single and maybe don't have family here, so they're really just isolated, and they see clients all day and they don't have other humans to talk to, and they're home. We've hired a couple of people, so they've never even met us in person. So it's really challenging. Our staff, a lot of them have children at home too, so just juggling, trying to do work, and manage parenting, and virtual school and all that has just been difficult.
Andy: Yeah.
Jennifer: We've put more attention on the social part as a result. So I can talk about some of the things we've tried and what I found helpful, and I'd love to hear your thoughts on that too. I think one challenge is that it's unusual for us to have the same problem as our clients. Our clients will start

the session by saying, “I just can't tolerate the wildfire smoke, the political situation, and COVID, I’m afraid of getting sick,” and the therapists are feeling exactly the same way. That's been really tough. So we've talked a lot about that in team: What is it like to be enduring the same stressors as our clients? I think it has just put an extra weight on the therapist. So a few things we tried: one is keeping all of our rituals and routines in places as much as humanly possible. Making sure we stick with all the elements of team, and not sacrifice any of them because we are online. We’ve tried really hard to maintain those and I do think that helps give us a sense of normalcy. We also have happy hours. We started out weekly and after a couple months it was too much. So now we do monthly, but we do see each other in casual non-work time. It's so good to hear how people are doing. We've been mailing each other chocolates or leaving each other presents at work, too.

Andy: That's a great idea.

Jennifer: Yeah, we are allowed to be in the office, as long as we can socially distance, use hand sanitizer, wear masks, and follow the state guidelines. Sometimes people will end up being in office at the same time and that has been really nice. The most challenging time we had was when Washington, and Oregon too, had all that wildfire smoke. I noticed just a huge downturn in mood in our whole team, I felt it too, all of us were feeling hopeless and dragged down. The most challenging team meeting we had we just went around the team and everyone just said they could barely face the next day. So that was especially challenging, and we really questioned, how do we navigate this? How do we keep the conversation constructive? How do we help each other? I think the biggest lesson for me was a lesson in radical acceptance and distress tolerance. Because as their leader, I wanted to just jump in and fix it. It's scary and difficult when everyone's miserable. I felt miserable too, I didn't really feel resilient enough to jump in. What I realized -- of course, this is very in line with DBT -- what I realized is, if I could just tolerate how they are feeling, they're very resilient and skillful and can manage their way out of it. I don't have to fix it. I can just be there to support. So that was a good lesson for me.

Andy: I think a lot of our urge here has been to validate by fixing things. Like if someone says this is a problem or you don't have access to something that, our validation has usually been to jump in and create a policy or system for fixing it. We often have to just say “no, we would prefer more validation--the task is difficult,” rather than anyone fixing things.

Jennifer: That's the classic problem between acceptance and change. We as seasoned DBT-ers still fall into the same trap. It's really easy to do. So learning how to just be supportive. There's no fix, no quick fix for what's going on. Have you found that you’re maybe less resilient or tired or that it's harder to lead?

Andy: I think it goes back and forth. As you were saying, keeping rituals intact is important. I think I have noticed that things where I would be should-ing myself, like saying “I should be able to be on a screen for eight hours a day and that should be totally fine.” I have had to do some acceptance on that. It is not as easy as I think it is. I have to watch out for being like, “I shouldn't be so tired, all I've been doing today is working, it's not that big of a deal.”

Jennifer: Being on Zoom takes a tremendous amount of energy. I've had a few people on our team get headaches from it, which just makes it

hard to hang in there for the rest of your day and be fully present. And there is no solution to that. Although again to our point, my team said it multiple times, it's helpful to hear that other people are having that difficulty. They don't need it fixed; they just need to know there are people to commiserate with them.

Andy: I feel a lot of this is really consistent with the idea of whether we decide to mindfully-avoid things versus cognitively-reappraise, that in the short term I could say things like, you know, this won't last forever. I can just sort of ignore it for today and it will be okay, versus I have to cognitively reappraise and say this is the long-term. So I find that has been very useful. When we had the wildfires, I was able to say this is going to last for a week or two, it'll be really sad and I feel a lot of gratitude that I am not directly being affected by the fire. It will also go away. Versus, telehealth for me now is more of a cognitive reappraisal of I will be doing this for a long time. So I will find ways to make it work. Versus, saying I just have to do distress tolerance and just get through it until it's over.

Jennifer: White knuckle. Yeah.

Andy: Right. So I noticed a lot of changing of thinking to this is no longer a white knuckling problem. This is a kind of cognitive reappraisal of what the future holds for us.

Jennifer: It's a new lifestyle and it requires really accepting the reality we are in. I was really glad you mentioned gratitude, that's been another strategy our team has used, that I have found really helpful. Remembering that there's a lot of suffering out there and I have so much privilege and good fortune, actually does help me. I have to be careful not to flip into invalidation, like, "Why are you complaining about COVID?" But if I can just notice the things I'm grateful for, that has been really helpful. I think there are a number of things that can be done to make this a little more bearable, and it helps to deeply accept that it just really stinks. Both are true! Maybe that's our theme for the day, really emphasizing the acceptance side of things and that dialectics are essential in tolerating such a difficult situation.

Andy: For sure. I think that our big lesson here has been to consistently ask the wise-mind question of what is being left out. Noticing for all of us when stress increases, we become more dysregulated and more rigid. Noticing that just because something is a really good clinical and tactical idea that when you ask what's being left out it may be that you were leaving out the interpersonal side of it, because you were focused on the risk management and on making sure patients get seen. So, when we're thinking about a change of policy, to also ask the question of what am I leaving out in making this thing happen?

Jennifer: I love that. It's constant because you can miss something if you're focused on one thing. And to validate the team leaders and managers out there, it is an awful lot to keep track of right now. That's just really, really tough so we can validate them and ourselves too.

DBT Bulletin Student Award

Alexandra Klein, M.A.

Clinical Psychology Ph.D. Doctoral Student at Case Western University, Cleveland, Ohio

Center for Evidence Based Treatment Ohio (CEBTOhio), Shaker Heights, Ohio

Alexis Adams-Clark, M.S.

Clinical Psychology Ph.D. Doctoral Student at University of Oregon, Eugene, Oregon

University of Oregon, Department of Psychology

Call for Submissions

We are seeking submissions for our upcoming Spring Issue! Submissions may be on a DBT-related clinical topic, a brief research report of DBT-related data, or the impact on DBT of a training, professional or current issue. Authors are encouraged to submit manuscripts between 750-1500 words.

We are also seeking editors for our DBT Bulletin, particularly those with experience in anti-racism work. Please email us if you are interested in being more involved in an editorial capacity.

Please email dbtbulletin@gmail.com with questions or submissions.