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We at the DBT Bulletin hope your summer is in full swing. The world is opening back up and hopefully the virus is contained enough to enjoy some sun and time with people you care about. Including family. This issue has two articles that discuss the role of family in DBT, two articles on the importance of considering diversity in the DBT framework and two articles that reflect the creative enhancements of cognitive work, via media and the manifestation of metaphors and through direct cognitive strategies. Each does a lovely dialectical dance of honoring the givens of DBT while expanding the horizons. This is exactly what we want this publication to be and I hope you enjoy these articles as much as I have.

I want to give special thanks to the people who make this publication possible, particularly Dr. Marget Thomas and Dr. Aly DiRocco who, along with a stellar group of editors, work tirelessly to make this happen. Thank you.

-Lynn McFarr

Applying DBT to Teens AND their Families: Tips for Managing Family Sessions

by Alec L. Miller and Jill H. Rathus

According to a recent review article of 26 studies evaluating psychosocial interventions for self-injurious thoughts and behaviors in youth, Glenn and colleagues (2019) determined DBT with Adolescents to be the only Level 1 (well-established) intervention. A Level 1 intervention is defined as "significantly superior to medication or other active treatments in 2 or more independent research studies" (See McCauley et al. 2018; Mehlum et al. 2014).

While treatment manuals, clinical, theoretical, and empirical articles have all described adaptations made for adolescent DBT (Miller, Rathus, Linehan, Wetzler & Leigh, 1997; Miller, Rathus & Linehan, 2007; Rathus & Miller, 2015), treatment developers have written less about family therapy with suicidal adolescents (Fruzzetti et al., 2021; Miller, Rathus & Linehan, 2007; Miller et al. 2002; Woodberry et al. 2002).

DBT for adolescents prescribes that the adolescent's therapist also serves as the family therapist, since the teen's treatment targets, skills deficits, and family-related goals are familiar to the therapist, and the established alliance with the teen provides a trusting context in which the teen can be more open to receiving feedback and changing behavior. Because of the high dysregulation that often results in escalating family conflict, combined with the fact that many DBT therapists may not be trained in family therapy, many DBT therapists who treat adolescents are reluctant to invite parents into family sessions.

"Should we schedule a family session? The teen says 'no' and I'm inclined to agree since I don't really know how to conduct such a session/I'm afraid it will blow up/the last time the teen stormed out and would not return!"

These are common concerns expressed among many adolescent DBT therapists. Below are some tips and guidelines that we hope will provide a structure that will help alleviate concerns and encourage holding family sessions. In addition, we refer you to Fruzzetti et al.'s (2021) recent book chapter that provides some excellent additional strategies to employ with families.

General Structure for Initial Session:

1. Orient family to session structure and family session "guidelines."

a. Start with a relationship building/balancing exercise: explain that each session will start with a mindfulness practice (i.e, "gratitude round robin") geared toward relationship building and balancing the typical focus on what is not going well. This is intended to help build positive affect and rapport among family members--and even with the family therapist. Each participant briefly turns to each other in the meeting to acknowledge something they appreciate about the other's behavior during the past week. One common experience family therapists have working with emotionally dysregulated teens and their families is, shortly after the session starts, conflicts erupt between family members that are hard to de-escalate and it becomes punishing for all parties involved. This exercise sets the tone for a more positive session.

b. Focus on How vs. What: further explain that the first session will focus on the process of "how" we will address problems and less focus on "what" the problem is. This will require a review of several DBT skills necessary to conduct a family meeting in which people are able to remain gentle, non-judgmental, compassionate, validating and dialectical.

2. Review KEY skills necessary to employ family sessions.

a. We recommend the family therapist set the stage with the family by writing down and listing several key skills on a dry erase board (or virtual white board) necessary for an effective family session. These typically include:

i. Observe and describe one's thoughts and feelings, non-judgmentally.

ii. Use GIVE skills, remaining gentle, acting interested, validating, and using an easy manner.

iii. Be curious to help achieve a more dialectical stance to honor multiple perspectives and not assuming there is only "one truth."

iv. Validate one another. Remind the family members that a) accurate expression of one's feelings will likely yield a more validating response and b) less accurate expression (e.g., silent/ignoring or highly critical expressed emotion) will often yield a less validating response. In turn, validating responses will encourage more calm, clear, and continued expression of one's feelings (Fruzzetti, 2021).

3. The family therapist serves as a skills coach to each family member and orients the family members at the outset that she or he will interrupt, as needed, in order to provide in-vivo coaching to ensure the aforementioned skills are being activated whenever possible.

4. The first family session typically will involve practicing observing, describing, and validating one's own and the other's feelings. However, the validation practice in the first session typically starts with less conflictual topics, e.g., what foods they don't like, movies they like or don't like, etc., to ensure they can display effective validation skills, before allowing the family to address their own more emotionally laden agenda items.

5. Usually by the end of session 1 or session 2, the family therapist helps firm up the agenda items and invites each family member to contribute to the agenda.

6. If a family member gets dysregulated during the session, consider using the "revolving door" technique (Fruzzetti et al., 2021). This technique is used when one family member gets too dysregulated to be effective in the session. You can say: "I can see that you are getting pretty dysregulated or upset right now. In order to make sure our session continues to be effective I'm going to send the rest of your family out and help you re-regulate so we can actually express how you're feeling in a way that your family can hear it." Then you can excuse the rest of the family, and work with that identified person to use skills and regulate their emotions. Make sure to orient family to this

ACCURATE EXPRESSIONS OF EMOTION WILL LIKELY LEAD TO A MORE VALIDATING RESPONSE.

technique in the first family session.

General structure for second session and beyond:

1. Start with "gratitude round robin" to continue to enhance the ratio of positive to negative exchanges between family members.

2. Review family session guidelines (i.e., key skills to be applied during the session).

3. Weave in more advanced validation skills training (see Rathus & Miller, 2015, pps.171-179 and Fruzzetti et al., 2021, p. 375-376) to learn how to increase validating responses and decrease invalidating responses.

4. Based on the adolescent's target hierarchy that includes family links, DBT family therapists conduct family chain analyses (Miller et al. 2007; Fruzzetti et al., 2021). This helps the family members collaboratively identify how links in each of their respective behavior chains intersect and often reciprocally influence the other. Through a behavioral lens, family members can learn how each person's behavior may have adversely influenced the other and with greater mindful awareness, develop positive solutions for links on the chain to yield better outcomes for all. Reviewing key links in the chain together can lead to better validation and problem-solving and solution analyses to avert the target behaviors in the future.

Other DBT Family skills are described elsewhere by Fruzzetti et al., (2021) and they include: 1) relationship activation which involves spending more non-negative time together and engaging in shared pleasant activities with awareness and connection; 2) accurate expression, which involves expressing primary emotions and reactions gently and clearly rather than attacking or blaming, and 3) relationship mindfulness, which involves being fully present and focused when listening to a family member.

After reviewing the above guidelines, we urge Adolescent DBT therapists to act opposite to their anxiety. Resist the common urge to avoid/delay/postpone family sessions until "after everyone is completely skilled up," and consider orienting teens and parents at the outset of treatment that family sessions will be scheduled at some regular frequency (i.e., at least 1x/module minimum and sometimes greater frequency if parents' behavior shows up as key links in the adolescent's chains regarding Stage 1 targets).

We have provided the reader with some tips and guidelines based on DBT principles, behavioral family literature, and our clinical experience. Note also that as in all modes of DBT, the therapist incorporates DBT strategies throughout, such as validation and problem solving, reciprocal communication and irreverence, dialectics, and commitment strategies. To date, this modality is less well developed than the others and it has not been subjected to rigorous empirical study, although has been included as a mode in the adolescent DBT randomized trials. That being said—we hope you will incorporate more of it into your work, and that you'll reap the rewards as our clients and their family members have! have!

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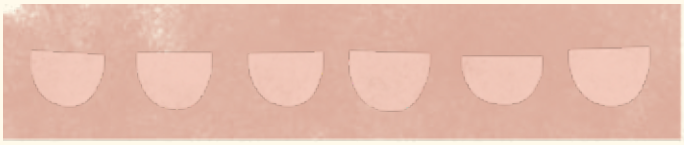
CLASS
RELIGION
SEXUALITY
ABILITY
RACE
GENDER
NATIONALITY

Towards an Intersectional DBT Skills Training

by Rachel Weiler, Hannah Steinberg, Alix Simonson, Abigail Thacher, and Sanno Zack

In 2020, injustices that have hidden in plain sight for far too long seemed to finally break into national consciousness. The subjugation of Black and Indigeneous People of Color (BIPOC), Asian hate crimes, as well as discrimination against transgender individuals and others across the gender spectrum has been at the forefront. Between the murders of George Floyd, Breonna Taylor, and too many other Black Americans; the violent attacks on transgender people including Iyanna Dior; and the unequal impact of COVID-19 on marginalized communities, the nation seems to be ready to reckon with our long history of oppression and inequity. To meet this moment, the mental health professions, including the DBT community, are beginning the work of acknowledging and rectifying mental health disparities that have plagued our field since its inception (Pierson, Arunagiri, & Bond, 2021). Mental health practitioners must shift our conceptualizations, treatment protocols, and research to acknowledge the impact of culture, identity, and power structures on psychological wellbeing. In particular, we must improve our delivery of care to individuals with marginalized identities, including gender minorities.

DBT practitioners face a dialectical dilemma between remaining true to the well-studied treatment protocol and cultrally translating the treatment to better "fit" oppressed or minority group patients. While DBT in principle seeks to be tailored to individual experiences, the treatment is normed on majority-culture populations. The original RCTs, which demonstrated the efficacy of DBT, primarily studied White, female patients; other diversity factors, such as sexual orientation or transgender identity, were rarely reported (Bolden et al., 2020). Multiple studies



have indicated that DBT is effective across a variety of cultures (Bolden et al., 2020); at the same time, there is strong evidence suggesting that patients with oppressed or minority identities see greater symptom improvement when evidence-based treatments are translated to fit their cultural experience than when standard treatment protocols are followed (Hall et al., 2016). Further treatment development and research is needed to guide DBT practitioners in finding the synthesis between rigid protocol adherence and idiosyncratic cultural translations.

In the service of pursuing this synthesis, the aim of the current Clinical Perspective is to share an ongoing project of the Stanford Adult DBT Program to better understand the experiences of transgender and gender non-binary (TGNB) patients in DBT with an eye toward developing an intersectional, culturally attuned treatment modification. Members of the Stanford DBT team noticed that many LGBTQ and particularly TGNB patients were being referred for DBT. The Stanford DBT Consultation Team was aware of the elevated suicide risk for TGNB-identified individuals reported in the literature (Haas et al., 2010; Haas, Rodgers, & Herman, 2014), and hypothesized a conceptual fit between the DBT model and TGNB experiences of suicidality.

Our team was not the first to wonder about the potential overlap between the TGNB experience and the DBT model. Sloan, Berke, and Shipherd (2017) propose DBT's biopsychosocial model of the interplay between emotion sensitivity and pervasive invalidation from the environment as a good fit for making sense of the common transgender experience of emotion dysregulation and suicide attempts. They link the concept of the invalidating environment to the Gender Minority Stress model. Based on Meyer (2003)'s Minority Stress Model, the Gender Minority Stress model theorizes that chronic experiences of misgendering; body dysphoria; structural manifestations of the gender binary system such as binary bathroom options; identity-based rupture with families

of origin; explicit invalidation of transgender and nonbinary identities; and gender-based violence all contribute to elevated stress and worse overall health and mental health for TGNB individuals. From a DBT perspective, Gender Minority Stress can be seen as a pervasive gender-invalidating environment. Gender invalidation may then lead to deficits in emotion regulation skills and reinforcement of ineffective emotion regulation strategies. DBT, which directly targets emotion dysregulation, may therefore be a good fit for many TGNB individuals (Sloan et al., 2017). Skerven and colleagues (2019) further developed this working-theory by suggesting ways to tailor DBT to address the needs of LGBTQ+ clients who have experienced stigma by increasing their skills to affirm their own sexual orientation and gender identity. Building off of this, recent research by Cohen and colleagues (2021) highlighted the effectiveness of culturally translating DBT to Affirmative DBT with sexual minority veterans, resulting in decreased emotion dysregulation and symptoms of depression. They updated the Emotion Regulation module to acknowledge the uniquely invalidating environment faced by sexual minorities in a heteronormative culture, added a handout on minority stress, and updated skills to address sexual-minority-specific psychological processes that can drive distress (Cohen et al., 2021). Taken together, these contributions to the literature indicate that DBT may be effective and useful for individuals with diverse gender identities

and sexual orientations, if sensitively updated in an appropriate cultural translation.

As very little research had been conducted to guide the Team in translating DBT to the needs of TGNB patients, we began by formally designating one DBT Skills Group as an LGBTQ-Affirming group. This change was announced to patients already in the group and new patients interested in beginning DBT Skills Training. Patients opted into the LGBTQ-affirming group or joined another transdiagnostic DBT Skills Training group that fit with their schedule.

This approach by itself increased the sense of group safety, not only for LGBTQ participants, but for other oppressed minority groups. One individual who had not been open about their sexual orientation in

DBT Skills Training came out as gay on the sign-up sheet for the LGBTQ-affirming group. Another long-time group member, who did not identify as LGBTQ, requested to join the affirming group because they reported they hoped it would be more welcoming to them as a person of color. A third long-time group member began sharing about experiences of racism in the LGBTQ-affirming group, which they had not shared in previous groups. A few patients self-selected out of the LGBTQ-affirming group, but were retained in other DBT Skills Groups in the clinic.

Our team has not made extensive changes to the content of DBT Skills Training for the LGBTQ-affirming group to date. However, group leaders regularly use LGBTQ-specific situations to demonstrate new skills. For example, over the winter holidays, group leaders used the example of going home to visit family members who are inconsistent in using correct pronouns to illustrate Interpersonal Effectiveness skills.

Our lab is currently conducting focus groups with TGNB group members to generate qualitative data capturing members' subjective experiences of DBT and the LGBTQ-affirming group. By beginning with a qualitative approach, we can include the voices and subjective perspectives of TGNB participants as we map out our knowledge of the point of contact between treatment and patient. In the words of theorists Glaser and Strauss, qualitative research is "the discovery of theory from data" (Cho & Lee, 2014). Our research team hoped that by starting with this pre-theoretical approach, we could partially inoculate ourselves against making inaccurate assumptions about our TGNB patients' experiences of DBT as we developed generalizable hypotheses. For example, while validation appears to be a major source of goodness-of-fit between DBT and TGNB experiences as hypothesized by our Team, we heard from participants that normalization of trans and non-binary identities was just as important. As one participant put it, "I felt validated just—in and of itself by just being treated as normal. … I don't want to be singled out and thought of as special… You're just treated like another human being and … with respect." Using ongoing focus group data to generate hypotheses, our team is undertaking a pilot study using quantitative methods to examine mental health outcomes for TGNB group members, including suicidality, emotion regulation strategies, and overall experiences of psychological distress. Finally, we hope to adjust the DBT Skills Group protocol to reflect what we have learned about TGNB experiences of DBT.

Additionally, our team is also in the process of developing a similar approach aimed at understanding the experiences of racial minority participants with elevated dropout rates to pilot adjustments to DBT protocols that could better serve BIPOC patients. Consolidating the findings from these two research projects, our team hopes to be able to suggest enhancements to DBT Skills Training to include a more diverse range of examples and skill applications and to incorporate societal systems of oppression into the DBT account of the invalidating environment.

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The Use of Media to Enhance DBT Skills Groups in Residential Juvenile Justice Settings

by Zoe Berko, Malia Fredrickson and Lindsey Morelle

This practice-oriented piece will draw on our clinical team's experience facilitating DBT skills groups with adolescents placed by Family Court at Red Hook Residential Center, a non-secure residential juvenile detention center operated by the New York State Office of Children and Family Services that is located in the Hudson Valley. Our facility houses a culturally and geographically diverse population of male and transgender youth aged eleven to eighteen who typically come from multi-stressed families, and present with multiple co-morbidities in the context of complex trauma. We offer a weekly DBT skills group that is facilitated by two licensed clinicians with support from direct care staff, who also provide skills coaching to youth in the milieu. In addition, our facility has an interdisciplinary DBT consultation team comprised of direct care staff, clinicians, counselors, a teacher, and the facility director.

As a group, adolescents are widely acknowledged to be particularly complicated to treat (Levy-Warren, 2000). Juvenile justice-involved adolescents bring an additional and unique set of population-specific and institutional challenges to the provision of DBT treatment. Population specific challenges include the high prevalence of complex (including early relational) trauma (Dierkhising et al., 2013) and related insecure attachment styles that leave adolescents distrustful of adults, as well as the stigma of therapy felt by many young men who view therapy as reserved for "crazy" people.

Fox and colleagues (2020) outline the institutional challenges commonly faced by residential juvenile justice settings to providing DBT treatment. These include: the omnipresent need to balance safety and treatment, with safety often prioritized over

PROS AND CONS

treatment; insufficient clinical resources for effective DBT implementation; limited opportunities for skill generalization to the real-life scenarios that youth will encounter upon return to the community; and, the need to adapt DBT materials to be "culturally relevant" in order to promote buy-in and to meet the treatment needs of juvenile justice-involved youth.

At Red Hook we benefit from a high level of administrative support and clinical resources. However, we too, are challenged with presenting DBT materials in a manner that meets the needs of our group, which is heterogenous in terms of age (both chronological and developmentally), diagnosis, and language fluency (e.g., ESL). Our group membership is also constantly evolving with new admissions and releases to the community. The typical length of stay at Red Hook is from six to eight months. Accordingly, the dose of DBT treatment can be consistent with the twenty-four week DBT skills training program outlined in Rathus and Miller's (2014) DBT Skills Manual for Adolescents. However, in settings that house youth serving longer sentences, and where attendance of groups is mandatory, DBT skills groups can shift from a time-limited to an open-ended (i.e., four year) treatment.

Taken together, these population and institutional challenges call for a high level of creativity to enhance and maintain treatment engagement in DBT skills groups. In the absence of an established DBT Skills Manual for Juvenile Justice-Involved youth, this piece aims to share our approach to adapting materials for this population to maximize engagement and skills acquisition, particularly emphasizing our use of media for teaching Pros and Cons and DEAR MAN.

Among the most relevant DBT skills for juvenile justice-involved teens are the crisis-survival skills, such as Pros and Cons, that support the reduction of impulsive mood-dependent behaviors. Some of our teens are affiliated with street gangs. These teens endorse street code values, such as the imperative to respond to perceived disrespect with physical aggression to protect themselves both physically and psychologically (Anderson, 2000). Overtime, through practice of the Pros and Cons skill, our teens are able to shift from the immediacy of reactive aggression to buying time to consider the bigger picture of what they are putting on the line if they act impulsively. Relatedly, our group talks less about building a "life worth living" and more about a building "a life that one is now unwilling to put on the line through impulsive actions."

To bring the Pros and Cons skill to life in a novel way for our population, our team has used the interactive reality series You Versus the Wild to demonstrate its use in a radically different environment from their home communities. This Netflix series sees British survival expert Bear Grylls parachuted into various unforgiving environments such as jungles and deserts where he must complete a specific mission guided

by the decisional choices of the audience (here, our DBT group participants). We first review the Pros and Cons skill and then apply it to one of the twenty two minute episodes. For example, in the episode, "Lost on Snow Mountain," Grylls must survive twenty four hours on a freezing mountain in the Swiss Alps. We pause at each decisional juncture and weigh the short- and long-term pros and cons of the two proposed courses of action as a group. Should Grylls shelter in place (static survival) or keep moving in search of food and shelter (dynamic survival)? Should Grylls shelter in the rock cave overnight or build an igloo? How should Grylls signal the location for pick up by the helicopter - should he mark out a huge SOS sign in the snow or prepare a fire to set alight the next morning?

At each decisional dilemma, teens and staff engage in a lively debate and then vote on how to proceed. Sometimes, we make the wrong choice and Grylls has to send up a flare and be airlifted to safety. After practicing this skill "in the mountains", we are ready to come home and apply pros and cons to scenarios in the facility (e.g., school/program refusal) and the community (e.g., whether to use marijuana --a violation of aftercare terms resulting in readmission to detention). In this latter scenario, we also weave in material on exit strategies (termed "cool decisions and smooth moves") to help youth extricate themselves from high-risk situations while saving face in front of their peers (Casarjian, 2017).

Another area that many of our teens struggle with is getting their needs met, oscillating between use of behavioral threats to control their environment and passive resignation grounded in their underdeveloped interpersonal effectiveness skills. Our team has used the reality TV show Shark Tank to teach DEAR MAN. Each episode features entrepreneurs from across the US who come to the Tank to pitch their business proposals to a team of investors (the Sharks) in the hopes of securing investments to build their businesses. We begin by reviewing DEAR MAN and then introduce the Sharks. The self-made-man bios of many of the Sharks hold great appeal for our teens. For example, Daymond John, the founder and CEO of FUBU Apparel, author, and motivational speaker, got his start handing out flyers for two dollars an hour. We then watch and breakdown several pitches in terms of the extent to which the entrepreneurs use the components of DEAR MAN.

We are on the lookout for physical and verbal indicators of confidence, whether the entrepreneur gave a well-prepared and succinct presentation about the business and clearly identified their request. Lastly, we dissect the negotiation process and the extent to which the entrepreneurs are willing to "give to get" or walk away empty handed when a deal is offered. We then shift to behavioral rehearsal of DEAR MAN through role-playing of facility and community-based scenarios, such as requesting an additional phone call from one's counselor or a one-off extension of

DEAR MAN


SHARK
TANK


Dear Man,
DESCRIBE
EXPRESS
ASSERT
REINFORCE
How to get what you want
MINDFUL
APPEAR CONFIDENT
NEGOTIATE

curfew when on aftercare supervision to attend a family dinner.

Overall, we have found novelty to be the key to engaging and sustaining engagement in DBT skills groups. Our aim is that our teens should enter the room with their curiosity peaked. One way we achieve this is through our playful use of images on the smart board at the outset of each session to guide participants in identifying their current emotional state. For example, "Which one of these Cartoon Network characters best captures how you feel right now?" or "Which one of these car brands are you feeling like now and why?" Lively and playful discussion ensues and we are then able to set the emotional tone for our skills group.

To close, we want to note that we realize that not all facilities are able to hold groups in rooms with access to smart board for media. There are times when we need to hold our DBT skills group on the housing unit without access to media. At these times, we improvise. For example, we transform our blue rug in the center of the group circle into an ocean filled with print outs of predatory sharks (representing risk factors) across which youth are coached to surf the wave standing on our (stand-in) snow sled. Or we use a plastic toy boat floating in a tub of water to teach about youth and staff therapy-interfering behaviors to bring alive the metaphor of sinking or drilling holes in the boat. Eventually the boat capsizes under the weight of the Lego pieces placed one by one onto its deck by youth and staff in acknowledgement of the therapy interfering behaviors in which they engage.

This approach supports our community to develop shared metaphors grounded in DBT principles such that direct care staff (in their role as skills coaches in the milieu) are overhead asking teens, "Are you drilling holes in your boat here?" At times, we creatively meld low and high tech activities. For example, we developed a DBT Chutes and Ladders game to review skills acquisition. This game called upon teams of staff and youth to demonstrate knowledge and behavioral mastery of skills to climb the ladders and avoid falling down the chutes or challenges our teens will face upon return to their community. It is our experience that adapting DBT materials in a creative manner brings out the richness of this treatment model in a way that meets the unique treatment needs of juvenile justice-involved youth.

Through our DBT consultation team and experimentation, we continue workshopping new and innovative ways to bring the material alive to teens. We hope this can serve as an inspiration in your setting and to your team to both incorporate ideas gleaned from our experiences as well as continue sharing new innovative ways of teaching the skills to both youth and adults with the broader DBT community.

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Cultural Dialectics in Dialectical Behavior Therapy

by Lisa Bolden and Lizbeth Gaona

Introduction

The concept of cultural dialectics has recently been introduced to the literature for DBT therapists providing clients with DBT-Accepting the Challenges to Exiting the System (DBTACES). DBT-ACES is a second stage DBT treatment that aids clients in obtaining self-sufficiency via a living wage employment and breaking free from the dependence of social services or psychiatric disability payments (Comtois, Kerbrat, Atkins, Harned & Elwood, 2010); Bolden, Gaona, McFarr, & Comtois, 2020). Cultural dialectics, a concept which refers to a client's experience with a dialectical dilemma in which they are struggling to observe treatment goals due to their cultural values, is also applicable to standard DBT. This piece will further define cultural dialectics and provide recommendations in the area of multicultural practice for DBT clinicians.

DBT-ACES and Cultural Dialectics

The goals of DBT-ACES are focused on aiding the client towards continuing to pursue their life worth living while utilizing the standard DBT skills of mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation skills as a second stage DBT level program. The intervention was developed in 1999 by Harborview Mental Health Services where clients who completed standard DBT were eligible to apply to receive the intervention (Comtois et al., 2010). The end goal of DBT-ACES is for clients who are financially dependent on public social services to be able to break free from such dependence by becoming gainfully employed and obtaining a standard living wage that would in turn engender an improved quality of life. Outcomes of DBT-ACES have been positive as clients have demonstrated greater odds of being employed or going to school and have reported a higher subjective

quality of life (Comtois et al., 2010). In DBT-ACES, the concept of cultural dialectics has been described as a dialectical tension that arises when a client's cultural values, norms, or beliefs are on one end of the dialectic and DBT-ACES goals are on the other end of the tension. As practitioners we aim to place race and culture at the forefront of clinical work to counteract colorblindness, and encourage a client's self-efficacy and determination (Sue & Sue, 1999). Furthermore, we need to conceptualize a client's interaction with the environment from a multicultural, systemic perspective that includes the transaction between race, social class and cultural factors (Boyd-Franklin, 1989).

One example described in Bolden, Gaona, McFarr and Comtois (2020) was a case in which a Latina client struggled to pursue living wage employment (a DBT-ACES work as therapy requirement) because of familial values and obligations. In this example, the client's value of being of service to her family was on one side of the dialectic and adhering to DBT-A ES treatment was on the other side of the dialectic. Although the client valued both her family and her treatment, she found herself struggling to adhere to DBT-ACES.

Cultural Dialectics in DBT-ACES at Harbor UCLA

Dialectical Tension	DBT-ACES Treatment Goal
Familism/Parenting Role vs. Self-Sufficiency Caregiver vs. Pursuing Grand Ambition	Career Activities (10 hours a week by 4 months of treatment, 20 hours a week by 8 months)
Traditional Gender Roles vs. Pursuing Grand Ambition Education or Training vs. W2 Employment	Work as Therapy

Cultural Dialectics in Standard DBT

Before expanding on cultural dialectics in DBT, it is important to note that DBT has been described as being both culturally competent and culturally malleable (McFarr et al., 2014; Bolden, Gaona, Comtois & McFarr, 2020). That is, the flexibility of the DBT modalities fit well with diverse clients and there is also room for improving the delivery of a more culturally responsive DBT (McFarr et al., 2014; Bolden & Gaona, 2020; Bolden, Gaona, Comtois & McFarr, 2020).

In applying cultural dialectics to standard DBT, we can consider the case of Fatima. Fatima is a young adult, single Black American female-identified individual who has served as her ill father's caregiver for many years. Fatima struggles with level-one target behaviors of self-harm and suicidal ideation, and she often finds that she is exploring a chain analysis with her therapist due to her lack of utilizing phone coaching. Both Fatima and her therapist experience frustration as Fatima fails to utilize phone coaching despite committing time and time again that she will utilize the mode. Unfortunately, it does not occur to the DBT therapist to explore Fatima's cultural values or to include Fatima's diversity factors into the DBT case conceptualization. It is undiscovered that Fatima values self-sufficiency, individualism and an "I can do it" schema, which was modeled to her by her hardworking and ailing father. Fatima's value of self-sustainment is currently even more magnified as she desires to "pull herself up by the bootstraps" as a means not to worry her father and to reinforce to him that she "can do it" on her own. Hence, it may be helpful for the DBT therapist to consider if there are any cultural dialectics that may be influencing the lack of progress or unresolved dialectics in standard DBT.

Multiculturalism and DBT Treatment

Basic cultural competence involves self-assessment regarding matters of cultural identity, including issues of privilege (Bolden & Gaona, 2020). Cultural competency includes all aspects of individual and cultural diversity (whether racial, ethnic, age, socioeconomic, or disability, among others), which are similarly valued and encouraged. As with any psychotherapy, it is essential that we acknowledge our own basic tendencies, the way we comprehend other

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cultures, and the limits our culture places on our comprehension. It is essential to understand our own cultural heritage and worldview before we set about understanding and assisting other people (Bolden & Gaona, 2020). We hope that a culturally dialectical lens may assist the DBT therapist with pursuing multicultural awareness and gaining greater cultural competence.

The good news is that DBT is already culturally competent and perhaps cultural dialectics may continue to support clinicians to think dialectically by utilizing an individual's unique cultural values, beliefs and norms in case formulation and treatment. In hopes of doing better, perhaps DBT therapists and treatment teams can benefit from intentionally engaging conversations about cultural dialectics in the therapy room and in the consultation team.

Although DBT has been found to be an effective intervention (DeCou, Comtois, & Landes, 2019; Panos, Jackson, Hasan, & Panos, 2014), many of the randomized controlled trials have failed to include a representative number of ethnic minorities (Gaona & Amaro, 2017). This matters as studies have demonstrated that culture and ethnicity have an impact on mental health (Hwang, et., 2008; Griner & Smith, 2006). Further, cross-cultural efficacy dissemination studies highlight the importance of factoring in the impact of treatment access, utilization, and stigma to reduce and prevent DBT treatment failures (Cardemil, 2010; Collins, et al., 2011; Landes, et al., 2016).

Recommendations for Clinical Practice

Recommendations for clinical practice that may support the utilization of cultural dialectics is considering the DBT team and the Observer role within the consultation team. Both the DBT consultation team as a whole and the Observer's role function to support practicing nonjudgmental stances and adopting a mindful stance (Linehan, 1993). It is recommended that diversity discussions continue to be infused in treatment and highlighted in the consultation team and training. Further, as written, contextualism is maintained in DBT team by the use of validation, DBT assumptions about the client, and the use of description in mindfulness (Bolden, Gaona, McFarr & Comtois, 2020). The authors recommend diversity as contextualism, in that as DBT therapists consult on cases, they may be challenged to explore diversity aspects intertwined with clinical issues by considering that a cultural dialectic might be left out.

The Search for Diversity is in the Details

While universal categories are necessary to understand human experience, losing sight of specific individual factors would lead to ethical violations (Ibrahim, 1985). The most obvious danger in counseling is to oversimplify the client's social system by emphasizing the most obvious aspects of their background (Pedersen, 1986). To this end, in addition to the adoption of a cultural dialectical lens, the utilization of multicultural models in case conceptualization are highly recommended. For example, Jareb's Tripartite Model for Cultural Assessment has therapists ask the following questions during their assessment: a) Within what framework or context can I understand this client (assessment)? b) Within what context does the therapist determine what change in functioning is desirable (goal)? and c) What techniques can be used to effect the desired change (intervention)? (Jareb, 1982). Another model that may help clinicians discover diversity in the details is Hays' (2001) ADDRESSING Model. This model aids the clinicians with considering diverse factors such as the client's: a) age and generational influences, b) disability, c) religion, d) ethnicity, e) social status, f) sexual orientation, g) indigenous heritage, h) national origin, and i) gender as factors that may aid in explaining behavior and enhance culturally competent care.

Conclusion

It is the authors' hope that cultural dialectics, a concept originally introduced for DBT-ACES may also be found beneficial for use in standard DBT. The aim of cultural dialectics is to assist the clinician in exploring whether a dialectical tension related to the client's values or norms may be on one end of the dialectic and standard DBT treatment goals on the other end. Although DBT has been noted to be a culturally competent intervention, the authors suggest that the concept of cultural dialectics may assist the clinician in exploring what might be missing in conceptualization and treatment while walking a culturally humble middle path.

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NOTES FROM THE FIELD
Socratic Questioning Strategies for DBT Practitioners

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Many of us dedicated ourselves to becoming Dialectical Behavior Therapy (DBT) practitioners after we found standard evidence-based treatments like traditional Cognitive Behavior Therapy (CBT) to not fully meet the needs of the people with whom we work. While it is true that randomized controlled trials have demonstrated CBT to be an effective treatment for Borderline Personality Disorder (BPD), the CBT used in those trials was essentially DBT skills training (i.e., emphasizing emotion regulation skills training over cognitive modification). So, we all learned DBT and we use it because it works; and now much research is turning its attention to integrating CBT protocols into the context of stage one DBT. It is quite common for folks who are receiving DBT for BPD to have other co-morbid conditions that could be treated with research-supported interventions.

Melanie Harned has demonstrated the efficacy of using Prolonged Exposure (PE) to treat PTSD symptoms in people who have BPD. Her DBT + PE protocol involves emphasizing skills use early on in treatment in order to increase readiness for trauma work, and when the initial treatment targets have been met - specifically clients have demonstrated skills use when experiencing high arousal in the face of trauma cues and have abstained from life-threatening behaviors for a minimum of 8 weeks - a PE protocol is folded into the DBT framework. In this method, DBT skills are used to facilitate PE. Inspired by Melanie Harned's work on DBT + PE, I tried to replicate this formula to apply CBT for hoarding disorder in the context of DBT. I initially failed spectacularly, and after some consultation and reformulation there was success. So, here is how it went and what I learned about using cognitive strategies with this population.

I had an individual I was working with who completed two full doses of standard, high-fidelity DBT. In many ways this transformed her life and she found herself wanting to work on other areas of her life that had been less central problems in the past; specifically, she had difficulty with excessive acquiring and difficulty discarding material objects—some might refer to this condition as hoarding. Additionally, the client had been abstinent from all life-threatening behaviors for over 12 months.

I (thinking I was brilliant) thought I could easily take Melanie's model and seamlessly have it work on the first try with this person. I am, after all, a skilled DBT therapist and I had several years of experience using Gail Steketee and Randy Frost's CBT model for treating hoarding disorder. As you might guess from my setup, this was not smooth or seamless. The basic idea was we would follow the Steketee and Frost model and use DBT skills to manage the distress of the process. The trouble I ran into was that the Steketee and Frost model was heavy on cognitive modification, and as we followed their model of evaluating these thoughts, the client experienced this as extremely invalidating, resulting in alternations between intense emotion dysregulation and emotional inhibition, neither was effective for moving the treatment of hoarding disorder forward. This was a new experience for me, as I had much success with

this protocol in the past with a different client population. Further, I have always prided myself on my Socratic skillset, as I was previously a CBT trainer for Aaron Beck, and suddenly none of it made sense.

This led me to seeking expert consultation; I called up Lynn McFarr, my prior supervisor from postdoc. Lynn demonstrated radical genuineness and validation when she commented that of course that plan was not going to easily work. Lynn quickly pointed out that you cannot use purely cognitive strategies with people who have trouble with persistent emotion dysregulation. In a moment of nonacceptance, I insisted this should work, it was working for Melanie Harned, and it should work for me. Lynn gently reminded me that prolonged exposure is essentially emotional exposure and therefore highly compatible with DBT. Whereas, as Abramowitz and Jacoby point out problems with compulsive acquiring and difficulty discarding are not treated well with exposure strategies and the evidence base tends to support a more cognitive approach to target deficits in decision making and beliefs about possessions. While there are some cognitive elements in DBT, it is better characterized as a behavior therapy + mindfulness + dialectics. Further, not all cognitive change strategies are the same.

Previously, a couple colleagues and I did a study where we gathered all the thought records we could find and used them to develop a coding system for thought records. Simply stated, a thought record could bring about change by: (1) directly asking for an alternate thought (rational responding/reframing), (2) evaluating if the thought is distorted, or (3) evaluating the facts of the situation to arrive at a more balanced thought based on the evidence. The Steketee and Frost model was mostly focused on identifying distortions in thinking, which can be experienced as invalidating—this was likely a major part of my difficulties. There are a few cognitive therapies that are used to treat people with emotion regulation problems including traditional CBT, Schema Therapy, and Mode Deactivation Therapy. After reviewing the literature on these treatments, I found that there are common elements that increase the likelihood of the effective use of cognitive strategies with this population:

- Emphasis on validation
- Emphasis on relationship
- Use of the relationship to bring about cognitive change
- Use of imagery
- Focus on cognitive shifts that will produce effective behavior
- Experiential work
- Two-chair work
- Distancing and defusion strategies

Dr. McFarr, the expert consultant I sought input from, gave a presentation on cognitive strategies and DBT at ABCT three years ago, during which she spoke about the role of cognitive strategies in DBT for BPD. She had a few concrete suggestions. In traditional CBT, cognitive restructuring is seen as an avenue towards emotional regulation; in DBT, evaluating a thought is seen as an avenue towards planning a behavioral response. She recommended I focus on getting my client regulated and into Wise Mind so that we could make wise decisions regarding discarding. Dr. McFarr further emphasized that the goal was not cognitive modification, but behavior change. This was a shift for me. It helped me to make it explicit: traditional cognitive therapists are focused on changing perspectives to see things as they are and DBT practitioners are focused on skillful behavior. The prior paradigm led to a focus on forming a balanced and accurate viewpoint and the latter focused on skillful behavior change.

A common difficulty in using cognitive strategies for clients who are triaged into DBT is that they have a high level of emotion dysregulation which can make the process of cognitive restructuring ineffective. The idea therefore is to use DBT strategies like emotion regulation training and behavioral chain analysis to create the necessary conditions for the effective use of Socratic

strategies. Further, the skills and strategies used, need to be done in a manner that is consistent with the DBT model. Lynn and I developed two new skills: the Cognitive Chain Analysis and the Socratic Dialectical Method Thought Record (I convinced Lynn to write up these great strategies in a DBT-focused chapter in our new Routledge book "Socratic Questioning for Therapists and Counselors: Learn How to Think and Intervene Like a Cognitive Behavior Therapist.") These skills involve methods for using a chain analysis on a cognition and creating the conditions for effectively checking the facts of a thoughts in a manner that is dialectical and leads to behavior change.

Further, it was very validating for the client when I called upon the "falliblity agreement" and explained that things were not working because I had been willful and trying to force something I knew "should" have worked (but was not). We focused on getting regulated and making Wise Mind decisions in session about how to sort, discard, donate, and put away different items around the house; then the homework was to implement the behavior plan paired with regulation and reinforcement strategies. Instead of focusing on whether her thinking was distorted, we focused on whether keeping the items was in line with the life worth living she was building.

I am grateful to still be learning. I went from being a believer in cognitive strategies, to questioning everything, to evolving and thriving – furthering my conceptualization of integrating cognitive approaches in the context of DBT. And there was a good clinical outcome as well.

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STUDENT VOICES
A Call for DBT Family Therapy Integration Training

Lauren Yadlosky

As a trainee focusing on therapy for youth, I heard the tagline: "child/adolescent work is de facto family work" from day one. However, I quickly realized that I was being trained to work with families but far less in the actual family work. Meaning, I learned how to coach caregivers to utilize effective commands, sticker charts, positive reinforcement, etc., but I wasn't learning how to treat the family unit and its complex interrelationships.

My journey into DBT started as an extern at the Center for Behavioral Medicine, a DBT-LBC certified outpatient clinic in Brookfield, WI. Here, I received truly excellent training, and I was hooked on DBT in general and DBT-A in particular. A major concern for me was not necessarily working with the high-risk teens – but working with their families. While I worked through these anxieties in supervision and team, I realized later that the DBT I was doing mirrored my previous child/adolescent training: it included families (i.e., multi-family skills group, parent coaching, adjunctive family sessions) but fell short of comprehensive family therapy.

Formal coursework in couples/family therapy was limited and optional in my program (as it is in most), and practicum placements tended to similarly include parents adjunctively or exclusively. The more targeted family therapy training that I received on internship presented various models and techniques that increased my confidence in treating the family unit (often from a systems perspective) – but I found myself struggling to integrate these techniques with my DBT clients. I was left with a new question, "What is DBT family therapy, and how do I do it?"

Fortunately, I have targeted answering these questions on my postdoctoral fellowship at McLean Hospital's 3East Boys Residential DBT Program. The program was founded by Alan Fruzzetti, PhD in January 2017. Our model includes a strong, multi-faceted DBT family therapy component: 1) an intensive, two-day program focusing on parent skills 2) a two-hour weekly parent skills group 3) weekly family therapy 4) 24/7 parent coaching and 5) weekly family therapy supervision with Dr. Fruzzetti. Apart from providing parent coaching, postdoctoral fellows are integrated into all components.

I am incredibly grateful for this opportunity in the 3East Boys Program. The targeted DBT family therapy training and supervision that I have received so far have deepened my DBT case conceptualization skills and vastly improved my ability to intervene both individually and within the family environment. This has been so important and effective that I wish I had access to it sooner.

As a behaviorist, wishes are great, but data are better, and regarding the "working with families" part of child/adolescent work, the data are clear. Engaging families in DBT mediates outcomes for individuals (Fruzzetti et al., 2020) and strengthens relationships between teens and their parents (Payne & Fruzzetti, 2020). My personal experience aligns with these results – but the question remains: how, as a trainee, could I (and others

like me) get access to true DBT family therapy training sooner?

DBT training programs and supervisors have the difficult task of identifying if, when, and how to integrate "adjunctive," evidence based DBT supplements (e.g., DBT SUD, DBT PE, etc.) into training. However, given that "child/adolescent work is de facto family work," I believe DBT family therapy curricula and techniques are not "adjunctive" but central to comprehensive DBT. Therefore, I propose that DBT family therapy should consistently be integrated into child/adolescent DBT training more frequently and earlier, rather than relying on adjunctive and non-DBT family therapy techniques.

This may require additional training and support for supervisors who may not have this experience themselves. At the same time, current evidence suggests it could increase the effectiveness of our interventions; it would likewise help DBT therapists work more consistently within the DBT model. Of course, change takes time and can be difficult. My hope is that many more members of our DBT community will share this aspiration and make DBT-specific family therapy more the norm in the not-too-distant future.

PLAYLIST
Opposite Action to Love

Heather Stambaugh, LMHC NCC CAP

- Tears Dry On Their Own (Explicit)
  Amy Winehouse
- Love Not Loving You
  Foxes
- Stand Back
  Stevie Nicks
- It's Not Right But It's OK
  CHVRCHES
- Single Ladies (Put A Ring On It)
  Beyonce
- I'm a Survivor
  Reba McEntire
- Good as Hell (Explicit)
  Lizzo
- I'm Beautiful
  Bette Midler
- Keep it to Yourself
  Kacey Musgaves
- You Don't Own Me (Chachi Remix)
  SAYGRACE
- Bulletproof
  La Roux
- Unwritten
  Natasha Bedingfield
- OK Not to Be OK
  Demi Lovato and Marshmellow

ANNOUNCEMENTS

Call for contributions to our Fall Issue

Student Award Nominations

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

Manuscript Submissions

Submit manuscripts on a DBT-related clinical topic, a brief research report of DBT-related data, or the impact of a training, professional or current issue on DBT. Manuscript length approximating 1500 words. We are also looking for creative representations of DBT topics, skills and dialectical dilemmas, including illustrations, videos, playlists, and other media.

Editors

We are seeking editors, particularly those with experience in anti-racism work.

Please contact us, dbtbulletin@gmail.com with submissions, nominations, applications, and any questions.