

DBT Bulletin

Walking the middle path of Dialectical Behavior Therapy

VOLUME 1, ISSUE 1-DROPOUT ISSUE

Letter from the Editorial Director



**Dr. Lynn
McFarr**

So it is finally happening. This publication has been brewing in the back of my brain since I stepped down as the Editor of *Advances in Cognitive Therapy* after eight years. I loved the more casual nature of that publication and I wanted something similar for the DBT community. Actually, I wanted ANY publication specifically for the DBT Community. I envisioned it as somewhere between *The Behavior Therapist*, *Cognitive and Behavioral Practice*, and *Schizophrenia Bulletin*. From the *Behavior Therapist*, I wanted the casual approach, thought pieces, the student perspective, and a place for publications that didn't quite fit in with the mainstream journals. From CBP I wanted the bridging of research data into clinical practice. From *Schizophrenia Bulletin* I wanted research articles, the first person perspective, and the yearly supplement with all of the abstracts from that year's

conference for people who were unable to attend (and a neat publication citation for students!). I had discussed this with Marsha Linehan who was in favor but wanted to make sure that certified DBT therapists were involved in the publication. They are. Overall, I think we are close. I hope to get closer with further issues.

This could not have happened without the tireless efforts of many key players. Most notably, our Editors-in-Chief, Hollie Granato and Miriam Wollesen who are just as invested in building community as I am. In addition, Shireen Rizvi, Kate Comtois, Sara Landes, Janice Kuo, Caitlin Ferriter, and the large network of former BRTC students who helped recruit submissions and support us. I am especially grateful to everyone who submitted articles for our first issue on Drop Out in DBT. I hope you enjoy this as much as we enjoyed putting it together.

Lynn McFarr, Ph.D.

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Meet the Editors

Greetings DBT community! We want to thank everyone who contributed to our first issue of the DBT Bulletin. When we began discussing this project, our dream and ultimate mission was to provide the DBT community - clinicians, researchers, and students alike - with a resource for cutting edge and up-to-date perspectives on DBT that range from many diverse perspectives in the DBT community. Thank you to Lynn McFarr for her Editorial Director's column and fearless mentorship throughout this process. Thank you to the researchers, clinicians, and trainees across the nation who contributed perspectives on client dropout. Stay tuned as future issues continue to take shape. Our next issue will focus on sexual violence, and we urge you to consider submitting. Thank you and happy reading!

If you have any ideas or suggestions for future issues, please let us know here: dbtbulletin@gmail.com



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Call for submissions

Our next issue will focus on sexual violence.

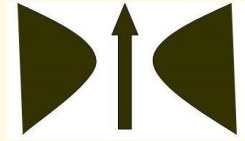
Submissions include research articles, clinician perspectives, and trainee thought pieces. Submissions should be 500-700 words.

Email all submissions and questions to
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Devil's Advocate: Re-Conceptualizing the Dreaded Dropout

Sara J. Landes, Ph.D.

Central Arkansas Veterans Healthcare System



Attendance in DBT is an often-addressed therapy interfering behavior, as the treatment works better when the client attends. Providers strive to determine how to get clients engaged in treatment to avoid the dreaded dropout. In DBT, dropout is defined as missing 4 consecutive sessions of individual or group therapy. Given that rates of dropout from DBT in the community are high, ranging from 24-58 percent, work has been done to identify what might predict dropout. In this seminal issue of the DBT Bulletin, articles will discuss aspects related to dropout among adult clients as well as adolescent clients, providers' perceptions of the role of telehealth to address treatment barriers that may lead to dropout, and how data on treatment length could lead to reconsidering whether a client is considered a treatment dropout vs. treatment completer.

Given the scope of articles in this newsletter, could it be useful for providers to reconceptualize dropout in terms of treatment (or team or provider) failure? In my experience, providers, including myself, tend to think that the *client* drops out of treatment. This usually leads to me to examine the reasons why a client might have stopped attending treatment, such as insufficient commitment to change, competing demands on their time, more powerful reinforcers for ineffective behavior, or logistics problems they were not able to solve (e.g., lack of transportation). I am less likely to focus on what the DBT team or I did wrong. I write this knowing full well that one of the central assumptions of DBT is that clients cannot fail in DBT. So I wonder, how can we as DBT teams and providers see dropout as a treatment dropout that resulted from treatment failure, as opposed to client failure? (Or should I say, how can we remember that this is a central assumption of DBT and how can we put it into practice over and over?) I see options for how to do better in the Clinician Perspective section by Dr. Orris. I encourage other providers and DBT teams to read and consider, how can we come back to this assumption of DBT and figure out how we as providers and teams can do better in how we think about and react to dropout.

Additionally, given the article on DBT in a brief form (6 months), are we at times mislabeling treatment dropout? Is it possible that a lot of those clients who were categorized as dropping out were actually done with treatment? An alternative way to consider dropout, especially dropout that occurs as treatment has progressed, is that the client improved enough so as to not need additional DBT (and likely did not know how to skillfully end the relationship). This alternative way of thinking is supported in part by the increase in the number of studies that provide evidence that 6 months of DBT is effective (Koons et al., 2001; McMair et al., 2018; Rizvi et al., 2017). This could be evaluated with DBT trial data depending on the frequency of measurement or with chart review. Having recently taught the dialectical strategy of asking what is being left out, I believe it is critical for us to consider what we are missing as DBT researchers and clinicians related to dropout. There is a call to research for secondary analyses to evaluate most appropriate treatment length and how to best understand where is the line between factors impacting treatment dropout, treatment failure, and treatment completion.

Research Insights: Factors Related to Dropout in a Comprehensive Dialectical Behavior Therapy Research and Training Clinic

Alexandra M. King, M.S., Molly St. Denis, B.A., & Shireen L. Rizvi, Ph.D., ABPP
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Dialectical Behavior Therapy (DBT) has demonstrated efficacy for treating Borderline Personality Disorder (BPD), and has been shown to have lower dropout rates compared to other treatments for BPD (Chalker, et al., 2015), with one meta-analysis finding a dropout rate of approximately 27.3% across 16 studies (Kliem, Kröger, & Kosfelder, 2010). Reducing dropout is a high-priority target for DBT, as it is believed that clients who complete treatment have more practice utilizing skills to create a life worth living (Linehan, 1993). Gaining a better understanding of risk factors for dropout may improve clinicians' ability to effectively target these factors and further reduce dropout risk. However, the existing research on dropout in DBT is limited. Studies of dropout in psychotherapy more broadly have found various demographic factors such as lower income (Pugach & Goodman, 2015), younger age, unemployment, and lower education (Fenger, Mortensen, Poulsen, & Lau, 2011) to predict dropout. One study found that Axis I comorbidities, therapeutic alliance, and number of suicide attempts were predictive of dropout in DBT (Wnuk, et al., 2013). The purpose of the present study was to further explore the relationship between demographic factors (income, age, employment, and other related factors), client characteristics (relationship between number of comorbidities and number of suicide attempts), and process factors (therapeutic alliance) to attrition in an outpatient DBT program for individuals with BPD.

Method

Study participants were 86 adults with BPD in a comprehensive 6-month DBT program in a university training clinic (see Rizvi, Hughes, Hittman, & Vieira Oliveira, 2017 for study details). Participants were 75.6% female and 79.1% white, with an average age of 29.13 years ($SD=9.15$, Range: 18 to 59). Therapeutic alliance (measured with Working Alliance Inventory; Horvath & Greenberg, 1989), number of comorbidities (assessed with Structured Clinical Interview for the Diagnostic and Statistical Manual, 5th edition; First, Williams, Karg, & Spitzer, 2015), borderline symptoms (measured with Borderline Symptom List-23; Bohus, et al., 2009), and number of suicide attempts (measured with either Suicide Attempt Self-Injury Interview; Linehan, Comtois, Brown, Heard, & Wagner, 2006; or Self-Injurious Thoughts and Behaviors Interview; Nock, Holmberg, Photos, & Michel, 2007) were examined for differences between treatment completers and dropouts. Additionally, given findings from previous research showing relationships of demographic factors to dropout, several demographic factors such as age, employment income, student status, and how far clients lived from the clinic were also analyzed in relation to dropout. For continuous variables, differences between completers and dropouts were tested using independent samples t-tests. For categorical variables, differences were tested using the Pearson χ^2 test.

Results

A total of 25 participants dropped out of treatment (29.07%), defined as missing four weeks in a row of either individual or group therapy (Linehan, 1993). Most of the clients who dropped out stopped individual and group treatment at the same time ($n=16$); for the rest, dropout rates were comparable between individual and group. On average, participants had 2.8 comorbid diagnoses ($SD=1.85$). Most participants had a history of suicide attempts (65%) and for those clients, the mean number of lifetime suicide attempts was 12.36 ($SD=28.65$) and the median was 2. Clients lived an average of 14 miles from the clinic and median household income was between \$20,000-\$29,999.

Only two of the variables were significantly different between completers and dropouts: income ($t(50.61)=2.48, p=.02$) and student status ($\chi^2(1)=4.06, p=.04$). Average household income for treatment completers was between \$30,000-\$50,000 while the average income for dropouts was between \$10,000-\$30,000, with a medium effect size (Cohen's $d=.60$). Of treatment completers, 40% were students at baseline, while only 17% of treatment dropouts were students, with a small-medium effect size ($d=.37$). Although these were the only statistically significant results, this sample is relatively small and the tests were underpowered. Other results approached significance: treatment completers' therapists had slightly higher alliance ratings than treatment dropouts ($t(48.52)=1.80, p=.08, d=.45, power=.45$), and completers were also slightly more likely to be unemployed ($\chi^2(3)=3.08, p=.08, d=.22, power=.52$).

Discussion

Results from this small study showed comparable dropout rates to those found in previous research (Kliem, Kröger, & Kosfelder, 2010), and suggest areas for further exploration. Students were more

likely to complete the treatment than non-students, and most of the student clients attended the university that houses the clinic. This finding suggests that proximity or age may be important; however, since residence distance from the clinic and age were not significantly related to dropout, there may be other aspects of being a student that are related to completing treatment (e.g., more flexible schedule, the class-like setting of group being consistent with their schoolwork structure, or feeling more comfortable in a university setting). Additionally, the finding that lower income was associated with dropout has not been previously found in DBT, but has been found to correlate with dropout from treatment in general (Pugach & Goodman, 2015). Clients with lower income may drop out because of practical obstacles (inflexible work schedule or financial costs associated with transportation) and/or subjective experiences in treatment. To address such issues, DBT therapists could adapt interventions to specific sociocultural experiences of low-income clients.

These variables, as well as the other variables tested (alliance, comorbidities, BPD symptom severity, suicide attempts, and demographic factors) should be tested in larger samples with more power to assure that these findings are not unique to this sample. Factors related to dropout remain an important area of study, so that they can be targeted effectively in treatment. Although many of the factors identified in this study are demographic characteristics, they could serve as cues for therapists to pay attention to for increased risk of dropout. Further research into the mechanisms underlying the relationship between these factors and dropout could provide therapists with more specific targets to address with clients, to reduce the likelihood of dropout.



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Research Insights: DBT-Brief: A Comparison of Standard Year-Long DBT to Six-Month DBT Across Treatment Outcomes

Hollie Granato, Ph.D., Miriam Wollesen, Psy.D., Kristen Kochamba, Psy.D., Brittany Tolstoy, Ph.D., & Lynn McFarr, Ph.D.
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DBT has received worldwide recognition as the treatment of choice for BPD, especially for patients with self-injurious behavior (British Psychological Society, 2009; Commonwealth of Australia, 2013). Most of the research on DBT evaluates standard 12 month DBT and there is less research regarding the effectiveness of other abbreviated forms of DBT. Although, standard DBT is shown to be both clinically and cost effective, it is lengthy and can require substantial resources from the provider and patient (Wagner et al., 2014; Pasioczny & Connor, 2011). Preliminary research suggests that DBT presented in a six month format may be effective for reducing distress, non-suicidal self-injury (NSSI), and suicidal ideation (Rizvi et al., 2017). The only randomized control trail to date, compared DBT in a six month format (DBT-B) to treatment as usual (TAU) with 20 female veterans meeting criteria for BPD. The study found that when compared to TAU, the DBT-B group had significantly greater reductions in suicidal ideation, hopelessness, depression, and anger expression. (Koons et. al., 2001). Furthermore, Stanley and colleagues (2007) conducted a study with 20 patients diagnosed with BPD who received six months of DBT-Brief (DBT-B) and found significant reductions in NSSI and suicidal behavior and ideation. Finally, there is a current trial being conducted that examines the clinical and cost-effectiveness of six month DBT compared to standard 12 month DBT while investigating which patients are more likely to benefit from shorter treatment versus longer treatment (McMain et al., in progress).

The current study has important implications for clinicians' ability to determine who might be an appropriate candidate for DBT-B. For clients present-

ing with lower borderline symptom severity, DBT-B could be a cost effective and less time intensive option to consider. Clients were not randomly assigned, but instead completed either DBT-B or standard 12 month DBT based on their collaborative assessment with their therapist. Therefore, this study aims to evaluate DBT-B outcomes in a private practice setting specifically to determine 1) If DBT-B outcomes are similar to those of standard 12 month DBT and 2) what characteristics predict who is placed into DBT-B compared to standard 12 month DBT. It was hypothesized that DBT-B will be equally effective to standard 12 month DBT across all treatment outcomes and that participants with higher baseline borderline symptom severity will more likely to complete standard 12 month DBT than those with lower baseline severity.

Method

Sixty-one adults enrolled in DBT treatment at a private practice were included in the study. The majority of participants were Caucasian (78%), female (71.1%), and completed DBT-B (65.9%). All participants completed the same measures at baseline and six-months/one year for DBT-B and standard DBT respectively. As part of routine clinic procedures, the data used were collected for quality assurance purposes. These measures included the Patient Health Questionnaire (PHQ-9) to assess depression, (Kroenke, Spitzer, & Williams, 2001)--, the Generalized Anxiety Disorder Scale (GAD-7) to assess for anxiety severity (Spitzer, Kroenke, Williams, & Löwe, 2006), the Difficulties with Emotion Regulation Scale (DERS) to measure six domains of emotion dysregulation (Gratz & Roemer, 2004), and the Borderline Symptom List – 23 (BSL-23) to measure borderline-typical symptomatology (Bohus et al.,



2009). The first hypothesis was analyzed using repeated measures ANOVA. Logistical regression analysis was used to understand which variable(s) best predict which participants would be candidates for DBT-B or standard DBT.

Results

Participants significantly improved their scores in the direction of lower depression, anxiety, borderline symptom severity, and emotion dysregulation from pre- to post-test, $F(2, 54) = 3.49, p < .01$. No significant differences were found between DBT-B and standard DBT on outcome measures. Lower Borderline symptom severity at intake was found to predict likelihood of being in DBT-B. Classification was acceptable with 57.1% classified correctly. Higher symptom severity resulted in a higher likelihood of completing standard DBT.

Discussion

In conclusion, both DBT-B and standard DBT resulted in significant improvement of symptoms related to depression, anxiety, borderline personality disorder symptoms, and emotional dysregulation. DBT-B may be particularly beneficial for clients with less severe borderline symptoms, while the standard DBT program appears effective for those with greater initial symptom severity. This study provides important preliminary insights on determining the necessary DBT treatment length, and for whom DBT-B may be appropriate. It is possible that some clients may be ready to end treatment at six months, and a dropout after six months of treatment could be reconceptualized as successful treatment, depending on symptom reduction and target behavioral change. Limitations of this study include a small sample size and clients were not randomly assigned to a treatment condition. Thus, more research is needed to determine how to assess for DBT-B appropriateness. Another limitation of this study was that the sample only included individuals seen in a private practice, who may present with fewer barriers to treatment and more resources from individuals presenting at other settings. Additionally, future research could use a more complex model to predict

who the best fit is for DBT-B. Specifically, future studies could further examine moderators and mediators of this relationship, including level of functioning, stage of treatment, and types of target behaviors to further determine who is appropriate for DBT-B.

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Research Insights

DBT for Youth: Who Drops Out of Family-based Programs?

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Adolescents exhibiting suicidal behaviors constitute a high-risk population. Compared with nonsuicidal youth, research suggests they demonstrate greater impairment and higher risk for treatment attrition (Barbe et al., 2004). Limited research has examined treatment retention and attrition rates for adolescents completing comprehensive Dialectical Behavior Therapy (DBT). A recent study by Germán and colleagues (2018) indicated that, compared with program completers, “dropouts” were older on average with lower levels of borderline personality disorder (BPD) symptoms. Additional research evaluating dropout for adolescents diagnosed with BPD in non-DBT outpatient settings suggests that negative attitudes toward treatment and accessibility difficulties may also contribute to treatment dropout (Desrosiers et al., 2015). For high-risk adolescents, risk for treatment attrition may vary depending on developmental, family, programmatic, and/or accessibility-related factors. This article aims to contribute to the literature for this population by summarizing demographics and attrition rates for a high-risk adolescent treatment sample.

Setting

The DBT Program for Adolescents and Young Adults at the University of California, San Francisco (UCSF) is a comprehensive outpatient service following the work of Miller and Rathus for youth aged 12-26 years with BPD symptoms. Participation includes weekly individual therapy sessions with skills coaching, weekly multifamily skills group with at least one identified caregiver, and as-needed family sessions. Caregivers attending the program also receive phone coaching from their group leader to help generalize DBT skills to outside family interactions. Youth and caregivers commit to the program until they meet the graduation criteria: completion of four skills group modules (~24 weeks; Mindfulness, Emotion Regulation, Interpersonal Effectiveness, Distress Tolerance,

and Middle Path [Miller, Rathus, & Linehan, 2004]), absence of life threatening behaviors for 2 months, and majority DBT consultation team agreement that skills are being used in all contexts. Many youth require more than 24 weeks to meet graduation criteria, and treatment length ranges from 6-12 months. The program began in 2010 and currently includes 6 clinicians and several trainees, with about 105 youth served to date.

Participants and Attrition Measurement

Eligibility criteria include meeting a minimum of 3 of 9 BPD symptoms with current or recent suicidal behavior or non-suicidal self-injury. Prior to treatment, youth complete a comprehensive evaluation followed by 3-4 Orientation and Commitment sessions with their individual therapist. At least one of these sessions must include caregivers, and commitment to participation until program graduation must be obtained from the youth and at least one caregiver to enter treatment (the initial commitment is to complete each skill module; families are informed that reaching graduation criteria often takes longer and that they will be included in discussions regarding commitment throughout treatment). Youth are considered program “dropouts” if they miss more than 4 consecutive sessions of individual therapy, or if youth or caregivers accumulate more than 5 absences from skills group. We will describe specific reasons for absence-related dropouts below. A total of 102 youth committed to the program between March 2010 and February 2018, of which 86 (84.3%) provided consent for their information to be included in analyses.

Results

Participants ranged from 12.0-24.9 years of age. Over half of participants reported a White racial identity followed by Asian American, Latinx/Hispanic, and Black identities (see Table 1). The majority of partici-



pants self-identified as female gender, followed by male, gender-fluid, and transgender. Most participants self-identified as heterosexual, and over one-third identified as having an LGB or other sexual identity. Overall, 65 (75.5%) youth completed treatment and 21 (24.4%) were considered dropouts. The majority of program completers (N=52, 80.0%) received more than four modules before graduating. Dropout reasons included transfer to higher level of care (N=6), lower level of care (N=1), or alternative treatment program AMA (N=2); increased treatment-interfering substance use (N=1); difficult therapist transfer (N=3); decreased commitment (N=5); and absences following decreased life-threatening behavior (N=3). Adolescents who dropped out of treatment due to absences did not demonstrate differences in whether they absented out of group or individual sessions; most absented out of both modalities simultaneously. Five participants (23.8%) who had been considered dropouts later returned and completed the full program; recurring presentations for these participants were not included in analyses. Comparison of treatment completers and dropouts with chi square and independent samples t-tests indicated a significant difference for age ($t(56)=2.3, p<.05$); treatment dropouts were younger on average compared with completers. There were no significant differences between groups for race/ethnicity, gender, sexual orientation, or number of BPD symptoms.

Discussion

Preliminary analyses comparing program completers with dropouts in our sample suggested a small but significant difference in age. The direction of this difference was contrary to prior research findings (Germán et al., 2018); program dropouts were younger in our sample, on average, compared with completers. Although we did not have a large enough sample size to evaluate potential interactions between age and symptom-related or programmatic factors as related to dropout, potential reasons for this finding may include that younger treatment participants require heavier reliance on family for treatment planning and attendance, or have experienced symptoms for a shorter duration and thus may not be as motivated for comprehensive DBT compared with older participants. For high-risk teens, increased levels of hopelessness may

lead to decreased engagement (Barbe et al., 2004) due to the perception that treatment is not working or a higher level of care is required. On the other hand, these contrary findings regarding age for dropout might reflect that individual factors (e.g., motivation, hopelessness, environmental support) may ultimately be more important factors than age. Analyses did not indicate significant differences for other demographic characteristics examined, suggesting our sample may be more homogenous compared with other treatment samples. While small sample size limited group comparisons, examination of dropout rates remains instrumental for increasing retention rates in applied settings. Potential clinical implications include improved screening to better identify individuals who may not need comprehensive DBT, and additional emphasis of commitment prior to entering treatment. The UCSF DBT clinic has implemented a minimum number of commitment strategies in Orientation and Commitment, regardless of the initial level of motivation expressed, to increase engagement throughout the DBT program. Although clinicians may be tempted to accelerate Orientation and Commitment when implementing DBT, the literature suggests it is important to maintain to prevent future dropout (Desrosiers et al., 2015). Use of commitment strategies throughout treatment and at “critical periods” (e.g., when life-threatening behavior has decreased) may also be of benefit for preventing dropout. Future research evaluating treatment attrition in larger samples, including identification of potential “critical periods,” will help to improve outcomes and assist clinicians in personalizing care within comprehensive DBT for youth.

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Table 1. Participant Demographics.

	Program Completers (N=65)	%	Program Dropouts (N=21)	%
Race/Ethnicity				
White	40	61.5	12	66.7
Asian American	10	15.4	2	11.1
Black	1	1.5	2	11.1
Latinx/Hispanic	6	9.2	0	0.0
Biracial	6	9.2	2	11.1
Other	2	3.1	0	0.0
Gender Identity				
Male	6	9.2	3	15.0
Female	51	78.5	15	75.0
Transgender	1	1.5	1	5.0
Other	7	10.8	1	5.0
Sexual Orientation				
Heterosexual	37	57.8	14	73.7
Gay	3	4.7	1	5.3
Lesbian	8	12.5	0	0.0
Bisexual	12	18.8	3	15.8
Other	4	6.3	1	5.3
BPD Status				
Present criteria met	41	63.1	12	60.0
Historical criteria met	3	4.6	2	10.0
Present and historical	1	1.5	0	0.0
Subthreshold criteria	20	30.8	6	30.0
BPD Symptoms				
Fear of abandonment	36	55.4	12	60.0
Unstable relationships	43	66.2	13	65.0
Identity disturbance	33	50.8	8	40.0
Impulsivity	48	73.8	14	70.0
Suicidal behavior	58	89.2	18	90.0
Mood reactivity	55	84.6	18	90.0
Chronic emptiness	43	66.2	15	75.0
Anger problems	40	61.5	13	65.0
Dissociative symptoms	30	46.2	11	55.0
Comorbid Axis I Present	65	97.0	21	100.0
	<i>Mean ± SD</i>		<i>Mean ± SD</i>	
Age in years	17.6 ± 3.1		16.4 ± 1.8	

Literature Review: Perceived Risks and Benefits of Providing Psychotherapy for Suicidal Individuals via Telemedicine

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Suicide is the tenth leading cause of death in the US, with the highest rates in rural areas that lack access to evidence-based treatments.¹⁻² Moreover, dropout from therapy is a widespread problem that interferes with treatment; in fact, one in five clients discontinues treatment prior to completion³ and dropout is relatively common in suicidal individuals.⁴

Telemedicine is one method to address barriers to mental health services (e.g., transportation, provider availability) that may not only increase initial treatment access, but has the potential to reduce dropout. Providing suicide-focused interventions using telemedicine may be one strategy to decrease dropout in high-risk clients and provide timely, in-vivo treatment, which is important due to the high-risk consequences of not receiving adequate treatment. Further, elevated suicide rates in rural areas, where sufficient providers are unavailable is compounded by the fact that providers tend to not use telemedicine with suicidal patients² despite evidence of its safety and effectiveness.⁵ Instead, providers commonly refer patients to inpatient care, which often does not reduce risk.⁶

Given the demand for evidence-based treatment in rural settings and to prevent client dropout, assessing provider's attitudes toward treatment via telemedicine for suicidal individuals is needed. Understanding provider attitudes can elucidate how to improve and increase provider usage of telemedicine, and therefore increase access. The current article summarizes two studies⁷⁻⁸ that assessed providers' perceptions of the risks⁷ and benefits⁸ of delivering treatment via telemedicine based on suicide risk level.

Participants included 52 licensed professionals (76.9% female; $M_{age}=42.7$) with expertise in suicide treatment, dialectical behavior therapy (DBT), and/or telemedicine. Participants were recruited via listserves and direct emails, and completed an online survey assessing perceived risks and benefits of utilizing telemedicine with no, low, or high suicide risk patients. Providers were predominantly White/Caucasian (98.1%), and included 55.8% Doctoral-level (vs. Masters-level) professionals practicing an average of 12.6 years. Responses were double-coded separately for risk⁷- and benefits-focused⁸ papers with consistent inter-rater reliability ($\kappa = 0.68$ and $\kappa = .99$, respectively).

Gilmore and Ward-Ciesielski⁷ found that providers commonly identified three potential risk factors in utilizing telemedicine with suicidal patients. First, participants reported that telemedicine would not allow for a thorough assessment of high-risk clients, such that telemedicine would hinder their ability to read emotional or nonverbal cues. Second, participants identified lack of control over the client as a potential risk, in that they would be unable to physically detain the client or hospitalize if needed. Finally, participants identified difficulties triaging clients as a potential risk, expressing concern about difficulties arranging hospitalizations or accessing family/first responders. Furthermore, younger participants who reported higher positive attitudes towards telemedicine and more experience with technology were more likely to use telemedicine with clients at risk for suicide.⁷

Ward-Ciesielski et al.⁸ found that participants commonly identified four benefits in providing treatment via telemedicine. First, participants indicated

that increased access to services for underserved populations was a critical benefit. Second, participants highlighted that intervention via telemedicine reduces barriers by decreasing costs and eliminating the need for travel or scheduling sessions. Third, participants indicated that increased contact with the provider was a benefit of telemedicine. Finally, participants reported immediate crisis intervention as a benefit. Of note, increased access and reduced barriers were more commonly indicated for no-risk clients (as compared to low- or high-suicide risk patients), while increased contact was more frequently indicated for high-risk clients. Furthermore, participants actively treating suicidal clients reported more benefits of using telemedicine than participants who were not.

This research suggests that providers perceive both risks and benefits in using telemedicine with clients with varying levels of suicide risk. While providers indicated that telemedicine can help to increase access, reduce barriers, increase contact and provide immediate crisis intervention, they also identified problems with assessment, lack of control, and difficulties triaging clients if needed using telemedicine. The low number of perceived benefits for high-risk clients displays a potential barrier to implementing telemedicine with this population. Given the increased likelihood of treatment dropout by suicidal clients⁴, this is of particular importance for future efforts to reduce treatment barriers, on part of the patient and therapist, in order to ultimately maintain treatment engagement by those in need. These findings can inform efforts to increase utilization of telemedicine and suggests the need to develop a protocol for training providers in treating suicidal clients via telemedicine using evidence-based treatments. A protocol could increase willingness and comfort with the technology in an effort to improve access and barriers to treatment and prevent client dropout.

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Clinician Perspectives: Getting Clients to Finish Line: How to Reduce Client Dropout in DBT

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I remember the first time I ran in a road race. I had tried many times in my life to build a running habit. I usually lasted about a week, never running more than a mile or two. It was Boston 1998 and a friend coerced me into running a 5K race, assuring me that it would somehow be “fun” despite my antagonistic relationship with running. She talked about the impact of having others running with you, and the crowd cheering. She talked about how fast 30 minutes passes and how exhilarated you feel at the end. She acknowledged that for a first timer, it would be physically very challenging, and that I would have to focus hard on breathing and on the road ahead instead of my beliefs about running. I expected it would be quite difficult, but we had discussed ways to make it more tolerable and things to pay attention to along the way that would improve the experience. On the day of the race, I showed up, as I said I would. I was riddled with fear and felt like I might vomit. I was sure I would have to walk the course in shame with hundreds of spectators witnessing my failure. But when the starting gun fired, I ran. I had my friend next to me for the entire race, reminding me to breathe, to notice the crowds cheering, to use positive coping thoughts, to remember the 30 minutes passes just like 30 minutes always does...until we hit the finish line. She was attuned to my

experience and when I looked especially tired she would say “it’s hard, isn’t it. I’m tired too,” and we kept running – until we crossed the line. We celebrated together and with the strangers that crossed with us. And then I was hooked. I went on to run more than 25 races, including a marathon. I remember reflecting back on this experience and noticing how meaningful it was to have someone introduce me to a new version of running. My friend helped me see the experience in a new way, and gave me the tools to approach the obstacles that used to overwhelm me. She walked through it with me, and reminded me of those tools along the way. She validated my experience and was truly in it with me.

There are three elements of DBT that I find are most instrumental in helping clients complete treatment: Orientation, phone coaching, and validation. A thorough, effective orientation and commitment phase at the beginning of treatment along with ongoing re-orientation is vital to keeping patients motivated and willing to finish the race. They benefit from knowing what is expected of them, and how we will be helping them achieve the goal. When they face obstacles to attending sessions or staying in treatment, we can circle back to the orientation, reminding them of the rewards and reminding them of the reasons they committed to the

race. And we do this while saying “I see where you are stuck, it makes perfect sense that you would have thoughts about quitting, let’s run together for a minute and see if we can move through this obstacle.” A common trap for DBT therapists is oversimplifying problem solving and thus invalidating the client in the midst of a struggle. Confirmation from the client that our validation is landing and we truly DO understand the problem and the pain are the green light for problem solving. By skipping this step, we run the risk of prompting thoughts about the therapist not understanding, about therapy not being helpful, and urges to avoid. When a client leaves session feeling invalidated or faces obstacles during the week that may interfere with their commitment to the treatment, phone coaching is our best shot at keeping them in the race. We have a chance to run with them again for a bit instead of just waiting at the next mile marker and hoping they arrive. Through phone coaching we can talk to them about what they can pay attention to, remind them of their coping thoughts, and encourage them to keep running. When clients tell me they are tired, they aren’t noticing rewards, or they are afraid it won’t be meaningful in the end, I often tell them “just put on your running shoes and come to my office. We will decide together if we are going for a run today.”



Student Voices

Amanda Loerinc, Ph.D.

Clinical psychology training sites vary greatly in terms of how comfortable they feel allowing trainees to see high-risk, suicidal clients. As a recent graduate from UCLA's Clinical Psychology Ph.D. program, I have experienced this degree of variation during my practicum experiences and pre-doctoral internship. Working with high-risk clients early on as a trainee helped increase my confidence, as well as help me improve client retention as I moved forward in training based on my development of advanced validation skills. My third and fourth year practicum experiences were spent learning DBT at Harbor-UCLA Medical Center, a low-income, community mental health outpatient facility. Not only did my clients have limited financial and social support resources, they were also diagnosed with Borderline Personality Disorder (BPD) and were chronically suicidal. Working with this population forced me to learn efficient risk assessment procedures in addition to DBT skills, chain analyses, and other techniques to reduce life-threatening behaviors and improve quality of life.

Within my first year at Harbor-UCLA Medical Center, I helped one client end a violent marriage and apply to graduate school; assisted a second client in extinguishing self-harm and suicidal behavior; and worked with a third client in becoming abstinent from substances, filing a restraining order against an abusive partner, and establish pre and postnatal medical care. As part of a full DBT model training program, I simultaneously co-facilitated a weekly skills group and participated in a weekly consultation team. I fell in love with doing DBT after this year and decided to return to Harbor-UCLA Medical Center for a second year to train even more intensively in DBT by carrying a caseload of six DBT clients per week. I largely attribute my confidence and competence as a

therapist to these two years of training. Because of this confidence, I have been able to increase client retention over time.

Following my two years at Harbor-UCLA Medical Center, I returned to UCLA for a practicum at the UCLA Psychology Clinic. Due to my experiences during the previous two years, my supervisors at the UCLA Clinic allowed me to see the clinic's most high-risk clients. I was able to use my knowledge of DBT and skills training to continue to reduce symptoms of BPD and other suffering experienced by my clients. Additionally, feeling competent as a therapist and in the treatment being delivered likely has an impact on rate of client dropout. To be able to deliver a solid intervention with confidence likely increases the patient's confidence as well, and therefore decreases frequency of dropout. I strongly believe it is imperative that training programs give students the opportunity and skill set to work with high risk clients.

Now as a postdoctoral fellow, I am continuing to practice DBT with high-risk clients. I attribute my success and confidence as a therapist to the high-risk clients I worked with early on in my graduate career. I truly hope that the takeaway message from this piece is that trainees are not fragile, and will likely benefit from the discomfort that comes with learning to treat high-risk clients.

“I strongly believe it is imperative that training programs give students the opportunity and skill set to work with high risk clients.”



Student Voices

Alessandra Rizzotti, ASW

During my second year of graduate school, I received training in DBT at a community mental health outpatient clinic housed within an academic medical center. At this training center, I was expected to engage in DBT treatment that strictly adheres to the DBT model. Upon commencing my training, I was given a caseload of three high-risk clients who were previously being treated by the former year's trainees. Even if a client had already been engaging in DBT, I re-engaged the client in pre-treatment during the transition in order to confirm their commitment to working with me as the new therapist and continuing DBT treatment. My experience of this transition was intimidating and an aspect of my DBT training that particularly provided me with a wealth of experience in navigating client drop out.

I quickly learned that there are two types of DBT clients in pre-treatment: those who opt out of doing DBT and those who decide to stay. My first client had health issues that made it difficult for her to attend all group sessions, which was a reason she did not complete pre-treatment her first time the previous year. With this client, I quickly developed the skill of creative problem-solving. For example, I encouraged the client to stand up during group if she was in pain as well as take small breaks as needed if she was in pain from sitting. I learned from this experience that there is always some way to problem-solve a barrier. I also grew in my understanding of why the 4-miss rule was set at 4-misses. Another

client started pre-treatment enthusiastically with me but decided not to commit to DBT at that time due to her school schedule. This client in particular is someone I frequently consulted with the team on to assess what we missed as a team in keeping this client in treatment. While I may have felt pulled to blame myself, the team helped me to see the value of pre-treatment and how this may not have been the right time for the client to start DBT.

If you are a trainee, know that as you learn DBT you're doing it on yourself, not just on your clients. Processing the challenge of dropouts comes with practicing radical acceptance and knowing that we are all part of a bigger system. What got me through all of the challenges of DBT were my supervisor and team. Use the DBT skills just as much as you tell your clients to. My personal favorite skills and recommendations include mindfulness for one hour a day in the morning, checking the facts every time an emotion isn't serving me throughout the day, and the TIP skill at night with some exercise or a bath. I recently went to a DBT training at the clinic that I was at last year. It was great to see in the previous year I barely knew what anyone was talking about, and this year the information felt more cemented in my brain. Remember, we're constantly learning just as much as our clients are.

“Use the DBT skills just as much as you tell your clients to.”

Student Spotlight: 10,000 Gold Stars

Anastasia “Stasia” McGlade is currently a fourth-year doctoral student in UCLA’s Clinical Psychology Ph.D. program. Additionally, Stasia is currently a second year student serving as the lead extern in the Harbor-UCLA DBT training program. Prior to graduate school, Stasia received her bachelor's degree from Cornell University and completed a two-year research fellowship in a development and affective neuroscience lab at the National Institutes of Health. Stasia was initially drawn to DBT due to her interests in emotion regulation and behavior reinforcement. Broadly, her research interests include understanding the emotional, cognitive, and behavioral correlates of anxiety and mood disorders. Stasia is specifically interested in optimizing the treatment of anxiety disorders through the investigation of emotion regulation strategies and fear extinction mechanisms.



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