DBT BULLETIN

Walking the middle path of Dialectical Behavior Therapy

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Letter from the Editorial Director

by Lynn McFarr, Ph.D.

One year. One year since DBT Bulletin went live. One issue published and presented to the community at ISITDBT. One issue was privately handed to Marsha Linehan at her retirement. The “Letters to Marsha” issue was full our letters of love, admiration, and gratitude written by colleagues, clinicians, and DBT participants alike. I was moved to tears many times reading those letters. Along with the passing of the incomparable Perry Hoffman, Ph.D., it truly is the end of an era. This issue gives honor to the passing of Dr. Hoffman, AND marks the start of a new chapter and our new Editor-in-Chief, Erica Rozmid, Ph.D. In the spirit of the new, we offer the DBT Bulletin Volume 2 Issue 1, complete with a call to principles over protocol, a student’s perspective on phone coaching, more irreverence than you thought you could handle, research article on DBT and interpersonal violence and a student spotlight to boot. We will also be releasing the supplement which will contain the abstracts from all of the posters from ISITDBT. We sincerely hope you enjoy.

Meet the Editors!

Greetings DBT Community! We are thrilled to present you with our second volume of DBT Bulletin. We have curated this journal to showcase the latest research and clinical topics in DBT. Thank you to Dr. Lynn McFarr for her Editorial Director's column and mentorship in our second annual issue! Thank you to the researchers, clinicians, and students who contributed to DBT Bulletin.

Thank you to Dr. Perry Hoffman who was a huge inspiration and tremendously impactful to the entire DBT community. We have a wonderful tribute to Dr. Perry Hoffman on Page 4.

Hollie Granato. Ph.D.
Editor-in-Chief

Erica Rozmid. Ph.D.
Editor-in-Chief

Editorial Board

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

Devil's Advocate:

Principles over Protocols

Charles Swenson, M.D.

DBT is an evidence-based therapy loaded with protocols. There is a protocol for how to review a diary card and determine treatment targets for a session. There is a protocol for managing a suicide risk assessment and suicidal crisis. Now there is a protocol for doing prolonged exposure for individuals with PTSD. Protocols specify the treatment strategies and how to do them; for instance, when encountering polarized situations in therapy, there are the dialectical strategies. It is incredibly helpful to have so many clearly stated protocols in a treatment of emotionally dysregulated individuals, to keep the therapist on track and adherent to the model.

It is not uncommon for the indicated protocol to be a mismatch for the particular client or the particular presentation of the that moment. For instance, what if the therapist wants to apply the specified steps for reviewing a diary card with someone who has learning difficulties and struggles to understand the function of the card or for the person that arrives in an emotional crisis and can barely sit still? What if the therapist is confronted with a situation where a dialectical intervention is called for but none of the specified dialectical strategies are a good fit? Therefore, it may be unduly rigid, like putting a straight jacket on the treatment, to push ahead and to apply the specified protocol, when it is clearly not a good fit.

Foreseeing these problems, Linehan emphasized that DBT is a principle-based treatment with protocols. The protocols emerge from the principles. We deliver the principles of the treatment to the client via the protocols, and if the protocols don't fit the moment, the therapist can draw upon the principles to come up with a better matched intervention. I oriented a 22-year-old woman with learning disabilities to the diary card. She was overwhelmed with the amount of detail on the card. In particular she said she could not possibly give a 0-5 rating to her emotions. It made her feel stupid, as if she should be able to do that. In such a moment, the operative principles underlying the diary card are crucial to understand. The diary card functions as a way to monitor treatment outcomes each week, to build the skill of self-monitoring in the client, to allow for accurate communication between client and therapist, and to provide the information to set up the agenda for the session. None of those principles require a 0-5 rating scale. I told her the 0-5 scale was not necessary and I asked how she would rate her own emotions. She said she either feels bad, feels like shit, or wants to die. That's all. We changed the rating scale to just have those three points. Later in treatment we expanded on the scale.

I worked with an adolescent boy with depression and self-cutting behaviors who did not speak more than two sentences in the first three months of therapy. He sat sideways to me, never made eye contact, and always seemed angry. Figuring that this was a profoundly stuck situation, I reached for

the dialectical strategies, but none of them seemed to fit. He scoffed at metaphors, there was nothing to "extend," and every verbal intervention fell flat. After trying too hard to get him to engage with me, I just fell into moment by moment, "trial and error therapy." One day, having given up on efforts to engage him, I just talked. I talked about my two-year-old son, who I was holding one day when a car hit us from behind. Suddenly the client looked piercingly at me and demanded to know what happened to my son. I explained it to him, he seemed satisfied, the ice was broken, and from that point on we engaged in conversation for the next year. What was that strategy? It wasn't in the book, but it was dialectical in its function in that it led to a conversation that could include both him and me. I named the strategy "being the dog," in that I generated behaviors as a dog in training might, and waited for him to reinforce one of the behaviors by speaking with me. This became one of many additional dialectical strategies for me. Once a therapist understands a set of principles, it is possible to generate many more strategies/protocols.

To practice adherent DBT, one needs to know and be able to practice all of the protocols, including all strategies and skills. These are the forms of the treatment, and a therapist should master the forms. But the forms are there to serve the functions of the treatment. Or, in other words, the protocols are the servants of the principles. The competent DBT therapist is someone who has mastered the protocols and forms, but also comprehends and draws from the principles and functions.

Tribute to Dr. Perry Hoffman

To me, Perry seemed a force of nature.

Not in the usual way the term is used for a person with an oversized personality. But in the way spring always comes--she felt quiet, incredibly full of energy, positive, unstoppable. Like there just weren't barriers, whatever the thing was, the thing was going to happen. I remember asking about her age and the hilariously tactful yet mysterious way she dodged the question. How changed I felt after listening to a person with BPD address an NEABPD audience and explain the pain she'd experienced, on stage as a colleague and co-equal to other presenters.I remember taking a red eye from Seattle to NYC for an NEABPD sponsored thing, and her letting me and my daughter sleep on her office floor. I remember all her amazing graciousness in hosting the connect the dots calls, making sure every person had the littlest thing that might help them. Her enthusiasm, the way she would light up. The gesture she did when she'd wave off things as unimportant.

Her laugh. such a good soul. so much dedicated hard work to such great effect. i'm not ready at all to say goodbye.

-Kelly Koerner, Ph.D.

Perry was my lifesaver. Fifteen years ago, I entered her office, feeling safe with a therapist for the first time. Perry exuded safety and warmth, along with boundaries that never felt intimidating or harsh. I used to say that Perry was the only clinician I never tested, because her persona didn't allow it. I worked with Perry for 4-5 years and in one of our last sessions, Perry told me to stop calling myself a "borderline" because I no longer met criteria for BPD. This statement, so unlike the stigma and association with BPD, is one I carry with me to this day. It has influenced my own work with clients diagnosed with BPD and continues to encourage me every day to see beyond a client's diagnosis. Perry was my greatest support in my quest to join the DBT community. Her unwavering faith in me allowed me to get through school and trainings, even as I struggled to let go of my own maladaptive behaviors and learn to regulate my emotions.Today, as a trained DBT therapist, in private practice, Perry remains my role model in every way. I will forever be grateful for the opportunity to have worked with her in both a personal and professional setting. Thank you G-d for the gift of Perry.

-Pessie Reches, LCSW

Research Insights

Impulse-Control Emotion Regulation Difficulties, Distress Tolerance, and Non-Reactivity to Inner Experiences: A DBT Framework to Examine Psychological IPV Perpetration

Elizabeth C. Neilson, MSW, MPH, PhD[1], Brandi C. Carey, BS[1], Jonathan D. Davidson, BS[1], Abigail E. Mohr[1], & Natasha K. Gulati, MS[2]

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Approximately 70% of dating relationships among college-aged adults contain psychological intimate partner violence (IPV; Shorey et al., 2012). Psychological IPV includes insults, humiliation, name-calling, and attempts to control through coercion and intimidation by an intimate partner, such as a spouse, dating, and/or sex partner (Black et al., 2011; Breiding et al., 2015). Dialectical Behavior Therapy (DBT) has been applied as a treatment for perpetuators of IPV (Fruzzetti & Levensky, 2000). The purpose of the present study was to examine the relations between three clinical targets of DBT – impulse-related emotion regulation (ER) difficulties, distress tolerance, and mindfulness – with psychological IPV perpetration within a non-clinical sample of men at risk for IPV.

Growing literature has examined the association between IPV perpetration and constructs consistent with DBT skills modules. Emotion regulation is a multi-dimensional construct and includes impulse-control difficulties, which is defined as one's ability to control or manage impulses when experiencing a negative emotion. Impulse-control difficulties are associated with IPV perpetration (Stappenbeck, Davis, Cherf, Gulati, & Kajumulo, 2016; Watkins, Maldonado, & DiLillo, 2014). Cluster analyses of a sample of batterers revealed that approximately half the sample was clustered as "impulsive", characterized by chronic anger and use of IPV as a means to regulate negative arousal (Tweed & Dutton, 1998). Further, distress tolerance, one's ability to experience aversive psychological states, is negatively associated with psychological IPV perpetration (Shorey et al., 2017). Dispositional mindfulness is indirectly associated with IPV perpetration, while certain facets of mindfulness, such as nonjudging, are associated with IPV perpetration (Horst et al., 2013; Ngo et al., 2018)..Because IPV perpetration may involve anger, urges to control one's partner, and inaccurate beliefs regarding the utility of violence to regulate emotions, nonreactivity to one's inner experience – allowing thoughts and feelings to come and go without reacting to them – may be particularly relevant to IPV perpetration (Dutton, 2007; Fruzzetti & Levensky, 2000; Langhinrichsen-Rohling,

McCullars, & Misra, 2012; Tweed & Dutton, 1998). This current study utilized three constructs within DBT to examine how these three constructs– distress tolerance, impulse-control ER difficulties, and the nonreactivity facet of mindfulness – synergistically contribute to psychological IPV perpetration. It was hypothesized that for individuals with low distress tolerance and low nonreactivity to inner experience, impulse-control ER difficulties would be positively associated with psychological IPV perpetration.

Method

Participants

Cisgender men (N = 101; M = 24.8, SD = 2.90; Range: 21-30) were recruited for an alcohol administration study examining alcohol intoxication and violence against women. Eligibility criteria included having a) an interest in female sex partners, b) >2 female sex partners, including an instance of condomless sex, in the last six months, c) >1 heavy episodic drinking episode (>5 drinks/two hours) within the past six months and d) 5 to 25 drinks per week on average. Inclusion criterion related to drinking are consistent with required criteria for alcohol administration (NIAAA, 2005).

Procedure and Measures

After providing informed consent and a brief physiological assessment, participants completed background measures prior to alcohol administration. Impulse-control ER difficulties were assessed utilizing the Impulse Control Difficulties subscale of the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), distress tolerance was measured with the Distress Tolerance Scale (Simon & Gaher, 2005), and nonreactivity to inner experience was assessed with the Nonreactivity to Inner Experience subscale of the Five Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). The Revised Conflict Tactics Scale-Short Form (Straus & Douglass, 2004).

2assessed psychological IPV perpetration frequency. Participants were compensated $15/hour for their time. Study procedures were approved by the University of Washington's Institutional Review Board.

Data Analysis Plan

Data analyses were conducted in SPSS. Distributions of variables were examined for outliers, and residuals were examined for non-normality. Predictors were centered and interaction terms were computed. Moderation analyses were conducted using multiple linear regression in which all two-way and three-way interactions were modeled as predictors of psychological IPV perpetration. The Benjamini -Hochberg procedure (Benjamini & Hochberg, 2000) was utilized to decrease the false discovery rate. Significant interactions were graphed and simple slope analyses were conducted at one standard deviation below (low) and above the mean (high).

Results

Approximately 70% of the sample reported perpetrating an act of psychological IPV at least once against a partner. Moderation analyses suggested a significant three-way interaction predicting psychological IPV perpetration (ß = -.18; see Figure 1). Contrary to the hypothesis, for men reporting either low levels of both non-reactivity and distress tolerance or high levels of both non-reactivity and distress tolerance, the association between impulse-control ER difficulties was not significantly associated with IPV perpetration. However, for men with low distress tolerance and high levels of non-reactivity to inner experience, impulse-control ER difficulties were positively associated with psychological IPV perpetration [$t(100) = 2.37$, $p < .05$]. For men with high levels of distress tolerance and low levels of non-reactivity to inner experience, impulse-control ER difficulties were also positively associated with psychological IPV perpetration [$t(100) = 3.51$, $p < .01$].

Discussion

The current investigation suggests that constructs of clinical relevance to DBT synergistically contribute to psychological IPV perpetration within a sample of moderate to heavy drinking men. The high proportion of psychological IPV perpetrators within the sample is notable and attests to the prevalence of IPV perpetration within populations that use substances at high levels and/or have substance use disorders (Leonard, 2005). Contrary to hypotheses, impulse-control ER difficulties was not associated with IPV perpetration for men low in distress tolerance and nonreactivity. While speculative, it is possible that the confluence of low distress tolerance and low non-reactivity to inner experiences together contribute to IPV perpetration to such an extent that impulse-control ER difficulties do not have a unique effect on psychological IPV perpetration. Hypothetically, men with these tendencies may be highly reactive with very low thresholds for distress, thus increasing their likelihood to perpetrate psychological IPV regardless of the degree of impulse-control difficulties. For men with differing levels of distress tolerance and nonreactivity to inner experience, impulse-control ER difficulties were positively associated with IPV perpetration. For example, an individual with high distress tolerance and low non-reactivity may be able to tolerate distress generally, however in the context of negative emotions within a romantic and/or sexual relationship, the tendency to react without thinking may synergistically interact with impulse-control difficulties and result in psychological IPV perpetration. This suggests that a comprehensive intervention targeting all predictors is necessary to address perpetration. It is notable that impulse-control ER difficulties, a consistent predictor of IPV perpetration, was not significantly associated with IPV perpetration for men with high levels of both distress tolerance and non-reactivity to inner experience. It is possible that distress tolerance and nonreactivity to inner experience ameliorate the association between impulse-control ER difficulties and IPV perpetration.

These results suggest support for DBT as an intervention for psychological IPV perpetration. Future research should include interpersonal effectiveness as a predictor of IPV perpetration and the transaction of these processes over time. For example, high levels of emotion dysregulation have been associated with IPV perpetration when both partners were dysregulated (Lee, Rodriguez, Edwards, & Neal, 2019). Future work should continue examining these associations in more diverse samples as well as clinical populations. Such research into these mechanisms could provide therapists with specific targets to address IPV perpetration with individuals and couples.

Funding and Conflict of Interest Statement:

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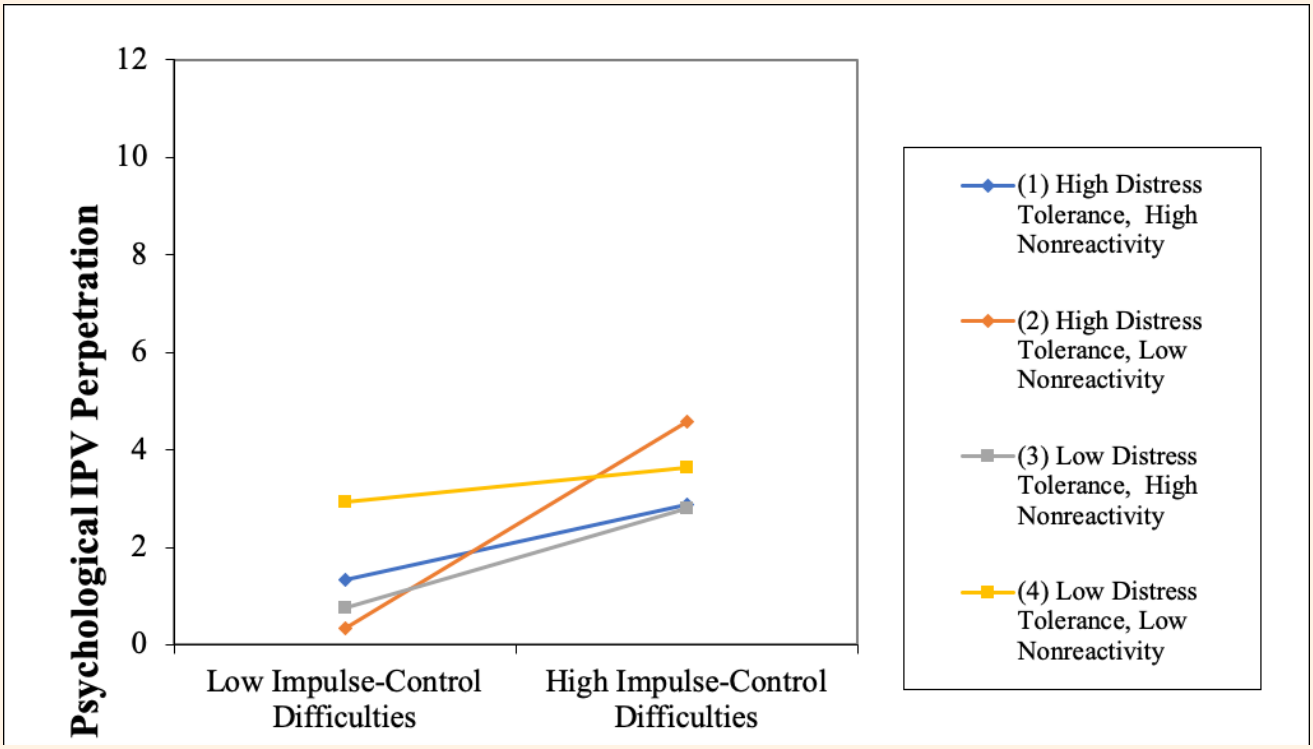

Figure 1: The Interaction of Impulse-Control ER Difficulties, Distress Tolerance, and Nonreactivity to Inner Experience on Psychological IPV Perpetration

Clinical Persepctive

5 Tips for Practicing Irreverence: A Guide to Becoming the Ultimate Irreverence Champion

Esme A.L. Shaller, Ph.D.

Irreverence refers to a lack of respect for things that are usually taken seriously. When I began my training as a therapist, there were a number of conventions that I found myself naturally irreverent toward: nodding sweetly, going slowly, "therapist voice" (I know you know what I mean). When I learned DBT it was a revelation that not only could irreverence be acceptable, it could be effective! AND based in science?! Boy, was I relieved. Even if you tend to be a more reverent person by temperament, I know you too can leverage irreverence to supercharge your DBT. It is my hope that these tips help both the naturally irreverent and those of you who are using full-on opposite action to improve your perfectly destabilizing comments. They just might make your session. Irreverence can feel like a real clinical stretch— I hope the following tips can inspire you to venture into irreverent territory more frequently.

#1: You don't have to be naturally funny

When you're newer to DBT, irreverence can feel like pressure to be witty or clever. Remember, though—the goal of irreverence is to keep the client off balance, to increase memory, and to leverage the element of surprise. Sometimes this is funny, but often irreverent comments are just weird (C: If you don't call me at 3 PM I'll kill myself. T: What if I have diarrhea?) or unorthodox ("I'm asking about your hook up because I'm making a sex map to tell all my clients the best outdoor spots"). You don't have to be a stand-up comic; in fact, Marsha herself notes that irreverence is often delivered in a style "similar to that of a straight man in a comedy team."

#2: You do have to be kind

Humor isn't required; kindness and that soft cushion of validation and understanding surrounding your irreverent comment are essential. Practice constructing comments that shock and redirect and at the same time lack the edge of meanness, of "I told you so." This dialectical balance is central and will allow you to be more irreverent than you previously thought possible. Irreverence is not the opposite of kindness; it grows from it.

#3 You don't need to already have an alliance

Embracing irreverence can feel like walking a tightrope with no net. Because of this, many novice DBT therapists think it is wise to hold off on using irreverence "until the alliance is established." What magic will you use to establish the alliance in the meantime? Alliances are established by *being helpful.*

We are most helpful when we are not repeating negative and/or ineffective interactions our clients have had with others.

Surprise them! Irreverence provides the opportunity to rewrite the script for how therapy can be helpful to our clients. Being irreverent is a great way to catch our clients' attention and show them we have something new to offer after previous disappointing results in treatment. Nine times out of ten, this reels them in.

#4 It doesn't have to land right every time

What significant relationship in your life has not included missteps or situations where you needed to explain yourself? Apologies give us the opportunity to learn something new about another person. Irreverence is an absolute gift in this area. If you have a specific fear about irreverence, it's often that we will say something wrong and will hurt or anger your client. Such is life! Such are relationships!

We do our clients with BPD no favors if we curate everything we say to them like an influencer's Instagram. Real relationships are messy, and if our clients want to have satisfying ones, they need to be able to survive and mend after inadvertent invalidation. Avoiding irreverence to avoid this eventuality means we are letting a very potent therapeutic tool lay untouched in the drawer. If an irreverent comment goes sideways? Own it and make a repair. Explain your intent. Be grateful for the additional therapeutic work you got to do today.

#5 Role-playing is your best friend

How do you get to the Carnegie Hall of Irreverence? Practice, practice, practice! C'mon, I know you are all good behaviorists. We can't develop a new behavior without practicing it! Irreverence especially is a stylistic strategy that improves with time and application. Role-play with your consultation team, in a mirror, over Zoom with a buddy from grad school. Do a round robin in team and see who can come up with the most unexpected response to a provided client comment. How many different ways can you reframe one statement in an unorthodox manner? Who is the champion of using a confrontational tone? Then, steal all the great things your teammates came up with! Ta-da!

I hope at least one of these tips resonated with you. If none did, maybe you are already the Ultimate Irreverence Champion (UIC) and you don't need to worry about it at all (for those keeping track, that's me calling your bluff). However, if this landed with you, I *command* you to go forward and spread more irreverence wherever you practice (I am omnipotent!). Irreverence is one of the most creative parts of DBT and an extremely reinforcing skill for clinicians. Please go forth irreverently and plunge in where therapists and angels fear to tread!

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Student Voice

Phone Coaching in DBT

Melissa Gasser- Doctoral Student, University of Washington

As a graduate student in the University of Washington's Clinical Psychology Ph.D. program, many of my interaction with clients have consisted of our in-person sessions. However, once I joined the in-house DBT practicum in my third year, phone coaching added a new dimension to my clinical work. Not only do I believe that it was beneficial for my work with DBT clients at the time, but it also helped me to develop a clearer sense of my own clinical approach that has persisted after completing the practicum. A lot of therapists and trainees alike fear phone coaching. However, what I quickly learned was that phone coaching not only greatly enhanced treatment but also offers therapists the chance to develop their skills and refine their identity as a clinician.

Part of the rationale for phone coaching is that it allows for more frequent, and often quicker, access to skills coaching than a client would otherwise typically receive. This increases the generalization of skills, extending to situations where a client is in crisis or otherwise reporting high levels of distress. Through phone coaching, I provided timely skills coaching to address the client's immediate distress and obtained pertinent details that may have been forgotten by the time we did a chain analysis on a given behavior in session. These phone calls and text messages supplemented the didactic material from skills group by enabling me to clarify and tailor the content to a given client and their situation. Generalizing the skills and addressing possible ruptures in the therapeutic relationship was accomplished more quickly through phone coaching . Furthermore, phone coaching provided a creative opportunity for me to implement small scale contingencies, such as using humorous text messaged gifs as rewards.

Intertwined with these benefits, though, is the subject of response latency. These days, many of us carry around our phones with us everywhere; relatedly, there is an implicit social expectation of quick responses, particularly to messages communicating distress.

Student Spotlight Award Winner

Hannah Frank, M.A.

Hannah Frank, M.A. is completing her predoctoral internship at the Warren Alpert Medical School of Brown University, where she works at Bradley Hospital in the Pediatric Anxiety Research Center's (PARC) Partial Hospital Program for OCD and related anxiety disorders.

What drew you to DBT?

I have worked closely with my supervisor, Dr. Andrea Gold, to immerse myself in learning the principles of DBT. Given my background and interest in the dissemination and implementation of evidence-based treatments for anxiety disorders, I am particularly interested in identifying ways to adapt treatment for diverse subpopulations. In particular, I am interested in the subpopulation of youth in our partial hospital program with anxiety and OCD who have co-occurring severe emotion dysregulation, self-destructive behaviors, and borderline personality disorder for whom Dr. Gold is developing a novel adaptation of DBT (DBT-X) augmenting exposure therapy.

What is some advice you would give trainees who are just starting out in DBT?

As someone who is relatively new to DBT, the most useful thing has been to fully embrace DBT as a lifestyle. Prior to beginning training with Dr. Gold, she asked me whether I was ready and willing to make a commitment to implement the principles of DBT in my own life. I took a few days to think about this because I knew this was not a commitment to make lightly. When I said yes, I was ready to fully jump in. Having adopted this stance allows me to be radically genuine with my clients as we grapple with similar difficulties and rewards of applying DBT to our own lives.

Dr. Andrea Gold was asked to describe a memorable moment with Hannah. Dr. Gold described that “she looks for opportunities to practice exposure all day, every day. For example, she coached me while I was hanging a piece of art in my office to make it “crooked”, as an opposite action to perfectionism. And then provided a radically genuine validation that she had challenged herself to do the very same opposite action the night before!”

STAY TUNED!

📅 Save the date!

- The next ISITDBT conference will take place in Philadelphia on November 19, 2020.

📧 Email us!

- Submit your piece to be featured in the March 2020 DBT Bulletin issue by January 30, 2020 at **dbtbulletin@gmail.com**