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DBT BULLETIN

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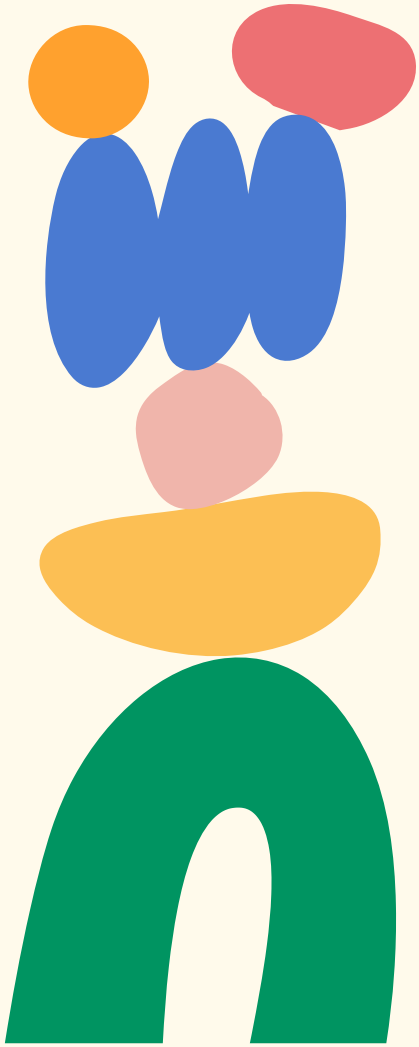

Editor's Letter

AS WE ROUND OUT another year in this pandemic, I am both sad not to be distributing hard copies of the DBT Bulletin to ISITDBT conference attendees, and happy that the "lemonade out of lemons" is the virtual experience has expanded reach both of the conference and of the bulletin. We launched at ISIT four years ago, we love ISIT! Like many of you, I miss the in-person energy, the chatter, and the ease of participation when surrounded by like-minded colleagues. The struggle to fully participate in the virtual world is real. And the use of the participate skill is vital. Like the conference, this issue covers a wide range of content related to the world of DBT, from the much needed inclusion of antiracism to team agreements, to front line perspectives of a psychopharmacologist, to a randomized study (by a high schooler no less!). For the antiracism piece, I reflected on the powerful mindfulness we all participated in for the ISIT 2020 conference, and noticed positive judgements about the work moving forward and impacting the way we conduct team. For the solution analysis paper, I found myself wanting to engage in the thoughtful and lively discussion. Does she understand that yelling may reinforce her parents beliefs? For the qualitative study, I was very curious about how the next steps to increase engagement have landed, especially during the pandemic. I did a round of applause for the the student spotlight winner, Meela Salamat. And for the radical acceptance cards deck I was so curious how one could program the deck online like virtual poker! All in all, from wherever you are standing on the globe, we hope you use the participate skill both with the conference and with this issue. I want to thank, once again, our fantastic core team of editors, Marget Thomas, Aly DiRocco, Jesse Finkelstein, Hollie Granato, and Associate Editors Janice Kuo, and Skye Fitzpatrick for bringing their participate skills to the fore. Happy reading!

Lynn McFarr
CBT California

Qualitative Evaluation of an Adolescent Dialectical Behavior Therapy (DBT–A) Program

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AFTER MULTIPLE DECADES of Dialectical Behavior Therapy (DBT) research focusing almost exclusively on quantitative methodologies, an increasing number in recent years are now moving towards qualitative and mixed methodologies for the purposes of better understanding the nuances of the client experience. Recent such studies within DBT have focused on young adult populations (Chugani et al., 2017), consumer experiences of the DBT+DBT-PE stage-based protocol (Harned and Schmidt, 2019), and more recently, adolescents participating in DBT Skills Groups (Pardo et al., 2020).

Despite this important progress in the field, no known qualitative study has conducted a qualitative evaluation of a comprehensive DBT-A program as outlined by Miller, Rathus, and Linehan (2007). As with other mental health care, the overall success of a DBT-A program is not solely dependent upon non-contextual, formal delivery of the programmatic and clinical content. DBT's conceptual framework recognizes that client motivation and commitment can and do vary, and how we communicate and relate to teens and caregivers creates a humanistic, "lived experience" impression of the program that can have a direct effect on adolescent treatment outcomes. When taken together and viewed through a DBT conceptualization lens, we posit that how DBT-A programs engage with all participating family members, and how the program as a whole is perceived in turn by those family members, serve as a potential set of Tier 2 (i.e., "Therapy-Interfering Behavior") issues to be tracked, managed, and minimized by the program itself. In recognition of this issue, our comprehensive outpatient DBT-A program conducted a qualitative research study to serve as a quality improvement project for the program.

Method

Participants

The study consisted of a total of 10 total DBT-A participants. Five participants were past or present adolescents in the program, while five participants were past parents. None of the ten participants were from the same family. Adolescent ages were between 18 and 21 years at the time of the focus group, though all participating adolescents had started the program when under the age of 18.

Inclusion and Exclusion Criteria.

To be eligible, participants must have successfully completed the 20-week Multi-Family Skills Group, and also been actively under the care of an individual DBT-A clinician through that period of time. Participants deemed to be too psychologically vulnerable to participate via a pre-focus group screener were to be excluded at the time of the focus group. No participants met this exclusion criteria.

Procedures

DBT-A Program Setting

The DBT-A program in question functions as a "comprehensive" outpatient DBT-A program, with all four components — individual psychotherapy, weekly multi-family skills group in which parents and adolescent meet together (MFSG), after-hours access to primary therapist for skills coaching, and weekly consultation team meetings. It should be noted that this study was completed prior to the COVID-19 pandemic, and that both the clinical treatment and focus groups were all conducted in person.

Qualitative Study Design

The current study used a focus group methodology. Prior researchers have found that the casual and collaborative environment of a focus group setting can lead to discussion that offers a deeper understanding of the topic at hand (Schwab & Syed, 2015), and have argued that focus groups may be the most effective tool for uncovering reasons behind program success or failure in a specific setting (Morgan, 1993a).

Focus Group Facilitation Procedure

The study consisted of two separate focus groups. Focus Group A was comprised of the five past adolescent program participants, while Focus Group B was comprised of the five past parent program participants. Each of the two focus groups was led by the same pair of departmental clinical faculty members, one male and one female, who volunteered to assist with the study. Neither faculty member was part of the DBT-A program.

For each focus group, facilitators led discussions using various question prompts falling in the following five categories: Image (e.g., "What were your initial impressions of the program?"); Engagement (e.g., "Was there any particular factor or moment you recall that

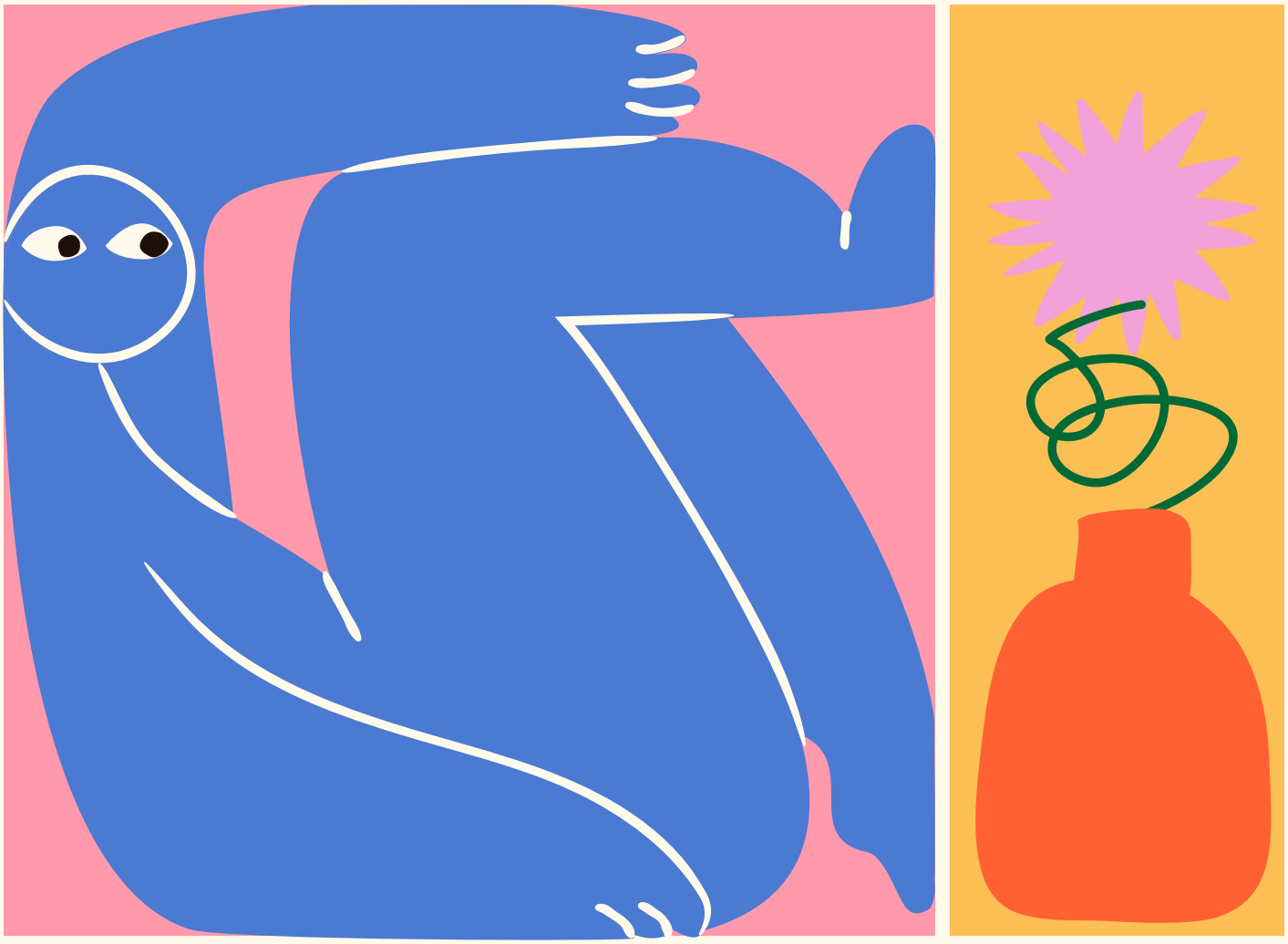
drew you into, or out of, the process of program participation?"); Skills (e.g., "What do you think about how the skills were presented to you?); Communication/Interaction (e.g., "How would you characterize the communication between you and the clinicians on the DBT team, either inside or outside of sessions?"); and Outcomes (e.g., "How have the lives of you and/or your teens/caregivers changed since participation in the DBT program?). Questions were fielded and follow-up questions asked as appropriate by the facilitators until they felt all participants had said all they wanted to in each of the categories, and then moved to the next category. Once all categories had been explored, the facilitators asked if there were any other important points to be made, or important issues that had been missed, before ending the focus group.

Data Collection Procedure

The data collection process consistent of recording and transcribing audio recordings of both the adolescent and caregiver focus groups. Once transcribed, the two focus groups were analyzed separately given the assumption that the adolescent and caregiver experiences should be understood separate from one another.

Data Analysis Procedure

The authors used a classical content analysis (see Onwuegbuzie, Dickinson, Leech, & Zoran, 2009 for a description) approach to identify distinct content themes within each focus group transcription. Procedurally, each question/major theme was marked down on a new page of a word document. Each time this theme or question was addressed, it was noted on its corresponding page. The comment made was either noted by summarizing the main point of the participant, or with a direct quotation. If a comment was similar to a previous comment already made, it was simply marked down as a repeated thought. This specific strategy allowed the analyst to mark down direct quotations from the participants, as well noting the frequency with which specific themes arose. For convergent validity purposes, three separate reviewers, none of whom were members of the DBT-A program, read and summarized transcript themes independently. The three reviewers then met to synthesize theme findings and resolve coding discrepancies. Finalized themes were those that were both a) topics related to program delivery given that evaluating the quality of the program was the initial purpose of the study, and b) meaningfully endorsed



by a majority of each focus group's participants.

Results

Qualifying themes are presented in Figure 1, including representative quotations for each theme from each focus group. Themes fell into 3 broad domains, driven largely by the facilitators' question categories and the quality-improvement based goals for the study: Program Outcomes, Program Strengths, and Program Areas of Growth.

Overlapping themes across both the adolescent and parent focus groups were as follows: Program Outcome Themes: "family cohesion" and "comfort in shared support." Program Strength Themes: "connection with individual therapist," "24/7 crisis management," "comprehensive structure," and "validation and mindfulness most credited with positive change." Program Areas of Growth Themes: "improving dynamism of multi-family skills group presentation," "greater medication integration into therapy," and "manage initial expectations."

Non-overlapping themes (i.e., only occurring meaningfully in one focus group) were as follows: Adolescent focus group only: "helped teens build a life worth living." Parent focus group only: "maintain and manage multi-family skills group enrollment."

Discussion

General Discussion

It is notable that while the majority of the themes overlapped across both focus groups, it was the consensus of the transcript reviewers that the tone of the focus groups was quite different. The "spirit" of the adolescent focus group was centered on the idea that they felt they were on a path towards "Building a Life Worth Living," in a way that transcended the daily application of DBT skills – a theme that resonated more deeply with them than with the parents. In contrast, the language used by parents suggested more intellectualization, emotional distance, and less clarity than the adolescents - not only about how their kids improved over the course of the program, but also how they themselves benefited. These data are consistent with many of our DBT clinicians' anecdotal clinical experience, which is that, while parents typically present with more "apparent competence" and initial treatment motivation than the teens, the adolescents ultimately demonstrate a clearer and more meaningful connection to their goals for treatment and the program itself. Parents were surprisingly vocal about the need for infusing more "dynamism" into the delivery of the MFSG. This may actually be related to an intuitive understanding they have about what they might need in order to feel more committed and connected to the program along the way. Similarly, adolescent focus group members were particularly strong in their emphasis on the importance of managing initial expectations – again, a theme related to better managing participant commitment.

Study-Informed Changes

Based on the feedback described above, several changes to our DBT-A program have either been made or are in process.

They include:

To increase dynamism in the multi-family skills groups

- Transitioned from an adapted version of Alec Miller and Jill Rathus's original MFSG manual to Rathus and Miller's (2014) DBT Skills Manual for Adolescents
- Moved to annual team-based discussion about leaders for multi-family skills group leaders to ensure that leaders are optimally motivated to lead for the coming year
- Currently considering ways to implement video skill vignettes and other multi-media into curriculum in order to increase sensory-based interest and behavioral modeling opportunities of group content

To manage multi-family group enrollment

- Improved mindfulness of this issue has led us to actively troubleshoot solutions once we know any group enrollment will soon drop below three families
- Work to delay restart of a new group until we have at least four families when possible

To manage initial expectations and parent commitment

- Created a new "family orientation session" designed to slow down commitment process, provide forum for orienting parents to the value of their authentic participation, secure their commitment to parenting-specific treatment goals, and engage in "devil's advocate" and other commitment strategies as appropriate
- Made a team-wide commitment to increase willingness to identify situations in which parents are sufficiently committed to treatment but adolescents are not, and refrain from enrolling the family despite parental pressure until sufficient commitment is given, or another appropriate synthesis is found.

Future Directions

Based on these findings, we posit that qualitative research methodologies continue to show promise for the purpose of practical quality improvement of DBT programming, and reduction of program-level therapy-interfering behavior. We believe it has additional value for the field by providing contextual and humanistic markers for better understanding how therapeutic change

Participant-Identified Program Outcomes

Salient Themes	Adolescent Support	Parent Support
Helped teens build life worth living	☑ "I have **things that I want to do now**... I have confidence in my ability to have a life in general." "I would say the biggest difference is... that **I'm not dead.**"	-
Family cohesion	☑ "...having the parents there is really **beneficial for the whole family dynamic.**"	☑ "...**our daughter appreciated that we were doing it....** worthwhile, even for that reason."
Comfort in shared support	☑ "I learned about what **peer support** is like... amazing, very enlightening."	☑ "...you feel isolated... being with people who are struggling... I found it very **heartening.**"

Participant-Identified Program Strengths

Salient Themes	Adolescent Support	Parent Support
Connection with individual therapist	☑ "I'd be like, wow this guy... **we actually have a connection.**"	☑ "...it's their secret exclusive relationship, and **my daughter is thriving in that.**"
24/7 crisis management	☑ "Pager phone calling was very very **extremely helpful** to me the first couple months of doing DBT..."	☑ "We just felt that we could pick up the phone at any point in time and get a response. And **we did.**"
Comprehensive structure	☑ "...the way DBT is structured and the way they always **bring it back to mindfulness was beautiful**...."	☑ "...**the integrated approach.** I think the psychiatrist, psychologist, and the group is really what we needed."
Validation and mindfulness most credited with positive change	☑ "You hear about mindfulness and you're like... wonderful... then you're like, **this helped me.**"	☑ "Validation, that was **the biggest outcome...** the biggest switch to make."

Participant-Identified Areas of Growth

Salient Themes	Adolescent Support	Parent Support
Improve dynamism of MFSG presentation	☑ "if they could have anecdotes or something, something more like examples of how people apply skills in their lives...in a serious way"	☑ "I sometimes found it to be just really kind of dry... **it was not something that was moving me.**"
Greater medication integration into therapy	☑ "I'm trying to get off of a medication that I was put on without knowing that the withdrawal symptoms could be as awful as they are. **Maybe some of this could have been avoided.**"	☑ "...**a little more discussion with parents about what that** [medication] **means.** I have this daughter who was fourteen, fifteen, sixteen, whose brain is still developing and there was a reluctance to put her on medication."
Manage initial expectations	☑ "The first maybe ten times you do this, you're gonna feel really uncomfortable. There should be an emphasis of, 'you've gotta have some **patience** here. **This is not overnight**...."	☑ "I was a little apprehensive because **it was a new thing for me.**"
Maintain and manage MFSG enrollment	-	☑ "At the end it was just two families and **that was much weaker.**" "We started off as...five families and by the end...we were down to three families and then..one family would be missing, and that did change the dynamic a lot."

occurs, as well as identification of clinical, programmatic, and systemic barriers to optimized DBT programming.

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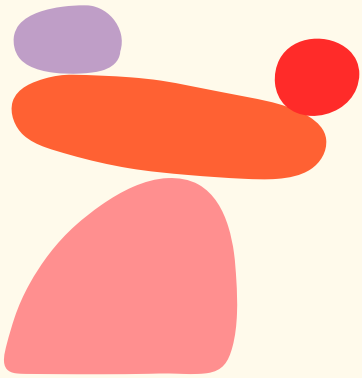

Treating Test Anxiety Using Mindfulness and DBT Skills: A Video-Based Approach with High School Students

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ACCORDING TO THE MOST recent data available from the National Institute for Mental Health, 32% of US adolescents met criteria for an anxiety disorder, and these numbers have likely increased during the coronavirus pandemic. Further, teens' use of unhealthy coping strategies to combat mental health symptoms, such as self-medicating with substances, or even considering suicide, are on the rise. Suicide is now the second leading cause of death in adolescents (CDC, 2021), and Nepon and colleagues (2010) found that 70% of people attempting suicide have an anxiety disorder. Therefore, understanding and managing anxiety is an important avenue for research, especially in adolescents.

A major source of anxiety for adolescents is school, namely the intense pressure to perform at a high level in high school to ensure admission to a good college and secure the path for a successful career. This "culture of achievement" (McCarthy, 2019) sets teens up to compare themselves to others, compete for top spots in their classes, and work long hours to complete assignments and study for exams, sacrificing adequate sleep, nutrition, and downtime. As a result, the rate of test anxiety specifically is between 10% and 40% (Gregor, 2005; Lothes et al., 2019) with test scores being considered a main measure of intelligence. Recent data show that an increasing number of college students are seeking help for general anxiety as well as for test anxiety (Beiter & McCrady, 2015; Lothes et al., 2019). Nevertheless, research on test anxiety has declined over the last 50 years (Von Der Embse et al., 2013) suggesting that as more adolescents are struggling, less is being learned about how to help them. This study aims to explore test anxiety in high school students specifically, and to evaluate a potential avenue for intervention.

Test anxiety is defined as "an emotional state that has psychological and behavioral concomitants, and that is experienced in formal testing or other evaluative situations" (Duesek, 1980, p. 88). This differs from general anxiety, which is a combination of worry and avoidance that spans various contexts (Lothes et al., 2019). Students suffering from test anxiety often find that it reduces their ability to learn and to retain information, which could result in poor grades (Vitasari et al., 2010). In circumstances where there are potential consequences for poor performance, such as on standardized tests, test anxiety can feel debilitating (Spielberger & Vagg, 1995; Zeidner, 1998). Furthermore, when grades suffer, students' anxiety increases, exacerbating the problem.

Given the negative impact test anxiety can have on an adolescent, it is important to distinguish what protocols might work best to ameliorate symptoms. Though there is little research on specific interventions for test anxiety, the effectiveness of mindfulness practice for reducing anxiety seems convincing (Lothes & Mochrie, 2017; Spijkerman et al., 2016). Mindfulness is one's connection to the present moment, on purpose, and without judgment or attachment (Linehan, 2015). It is the process of being able to notice and engage in cognitive, emotional, or physiological experiences, without losing control (Bishop et al., 2004). Mindfulness has been shown to increase self-efficacy and decrease anxiety (Metwally, 2020), making it a viable option for intervention to help reduce symptoms of test anxiety.

Mindfulness can involve various activities including focusing on one's breath, meditating, or doing a soothing activity such as coloring (Linehan, 2015). In a study with college students, those who completed a coloring task showed a significant decrease in test anxiety and increase in mindful awareness (Carsley & Heath, 2019). Another study with college students demonstrated that daily mindful breathing practices and cognitive reappraisal resulted in significant reduction in test anxiety, and mindful breathing increased positive thinking (Cho et al., 2016). Similarly, group training sessions of mindfulness-based techniques resulted in a significant reduction of test anxiety, suggesting that mindfulness classes within a school can greatly aid students struggling with test anxiety (Beyrami & Abdi, 2009).

In addition to mindfulness, research has explored using techniques from dialectical behavior therapy (DBT; Linehan, 1993) to treat test anxiety in college students (Lothes et al., 2019). Gratz and colleagues (2005) demonstrated that DBT skills training can reduce overall anxiety in a clinical population, Nasizadeh et al. (2015) showed that DBT training can significantly improve test anxiety in female high school students in Iran, and Lothes and colleagues (2017, 2019) determined that DBT mindfulness skills

training could reduce general anxiety as well as test anxiety in college students, and increase awareness.

This study seeks to investigate test anxiety in high school students specifically, to determine if teaching certain coping strategies, including meditation and specific DBT skills, can help decrease test anxiety and increase mindfulness. This study utilized an easy-to-access collection of videos, and the adolescents watched and practiced at their own pace over a ten-day period. The specific hypotheses included:

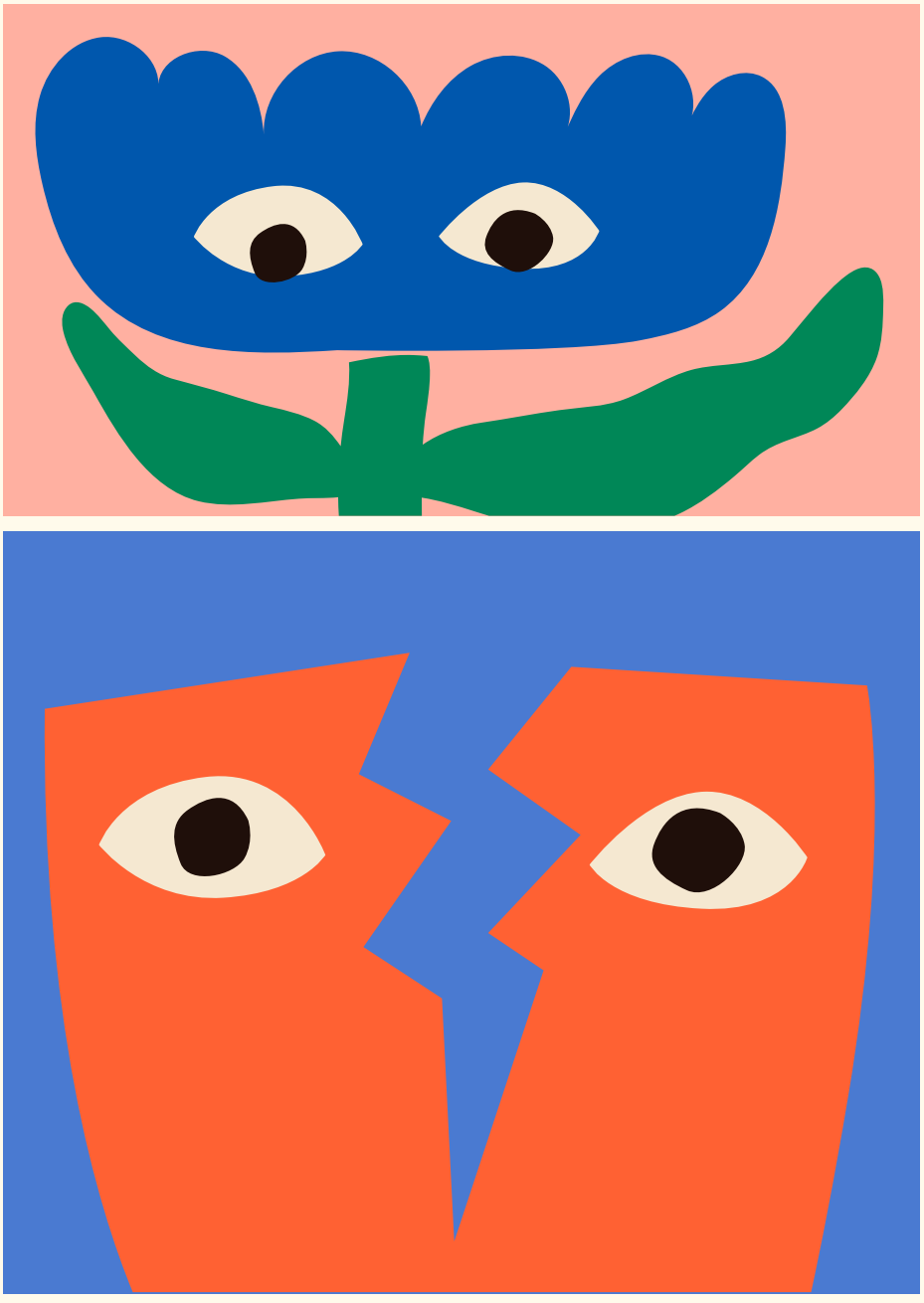
H1: The treatment group will see a significant reduction in levels of test anxiety, while the control group will show no significant reduction.

H2: The treatment group will show significant improvements on self-reported mindfulness and awareness, while the control group will show no improvement in mindfulness scores.

Method

Upon IRB approval, students were asked via email to volunteer for a research study. The study was explained and they and their parents electronically signed informed consent and assent forms. The incentive for participation was extra credit in a science class or inclusion in a raffle for a gift card. Given the coronavirus pandemic, and closure of physical school buildings, all data were collected electronically and all interventions were delivered via online videos.

Students who agreed to participate in the study (N=96) were randomized to the control group or the treatment group and asked to complete baseline measures of test anxiety and mindfulness via PsychSurveys. At midterm season, approximately four weeks after baseline measures were collected, the treatment group watched a series of videos over a 10-day period using the EdPuzzle website. Videos were no longer than 20-minutes per day and EdPuzzle provided data ensuring the videos were watched in their entirety, without skipping, and with safeguards to ensure engagement (needing to click a button or answer a question at random time points during the video). The videos focused on learning ways to manage anxiety while studying, just before testing, and during a test. The videos covered three main areas: 1) psychoeducation of test anxiety and mindfulness; 2) DBT skills such as What and How of mindfulness, States of Mind, paced breathing, progressive muscle relaxation, self-soothe, check the facts, PLEASE skills, imagery, and mindfulness of both emotions and thoughts; and 3) meditation practice focused on mindfulness to one's breath, thoughts and/or emotions and guided imagery. After this treatment phase, all participants in both conditions completed the measures again, online via PsychSurveys, and then measures were collected one last time approximately two months later, around final exams. The control group had no intervention or outreach except for reminders to complete the measures at the three time points.



Measures

The Westside Test Anxiety Scale (WTA; Driscoll, 2007) is a 10-item self-report scale with good reliability and validity. A sample item is: "I worry so much before a major exam that I am too worn out to do my best on the exam." Students rate each item on a 5-point Likert scale from 1-Not at all or Never True to 5-Extremely or Always True. An average item score suggests one's level of test anxiety from low to extremely high.

The Five-Facet Mindfulness Questionnaire-15 (FFMQ-15; Baer et al., 2012) is a measure of 5 elements of mindfulness, including: Observing, Describing, Acting with Awareness, Non-Judging of inner experience, and Non-Reactivity to inner experience. A sample item is "I find myself doing things without paying attention." Items are rated on a 5-point Likert scale from Never/Rarely True to Always/Very Often True. The total score was used for comparison in this study.

Results

Data Analysis

The analyses were conducted through IBM SPSS Statistics 27. Power analysis was calculated with G.Power version 3.1. Significant results were defined as = .05. As preliminary analysis, independent sample t-tests were used to determine if there was a significant difference in each measure including sub-items at baseline between control and treatment groups. Pearson correlation coefficients were calculated to analyze the associations between measures.

To examine the treatment effect, the score difference between Time 1 and Time 2 was calculated to explore the immediate treatment effect, and then score difference between Time 1 and Time 3 to examine the long-term treatment effect. Independent sample t-tests were conducted to see whether two groups differed in score changes. Second, mixed analyses of variance (within-subjects factor: time, between-subjects factor: treatment conditions) were used to explore the interaction effect between time and treatment conditions.

The power analysis indicated that for 25 individuals in the treatment group and 29 in the control group, the power is 68% for FFMQ-15 and 60% for WTA.

Preliminary Analysis

Fifty-seven individuals participated in this study. Three of them completed the baseline evaluation only and thus were excluded from analysis. Analyses used data from the 54 completions at

Table 1. Descriptive statistics for treatment and control groups

	Treatment			Control		
	N	*M*	*sd*	N	*M*	*sd*
Age	25	15.56	1.19	29	15.93	1.13
Grade	25	10.32	1.15	29	10.79	.98
FFMQ-15:Total Score_T1	25	46.44	7.92	29	46.24	8.27
FFMQ-15:Total Score_T2	25	49.32	8.37	29	45.17	8.68
FFMQ-15:Total Score_T3	18	47.72	8.41	23	46.61	7.49
WTA _T1	25	3.20	.96	29	3.17	.85
WTA _T2	25	2.68	.80	29	3.21	.73
WTA _T3	19	2.68	.95	23	3.22	.85

Table 2. Independent sample t-tests between groups in score change

	Time 2 – Time 1				Time 3 – Time 1			
	t	df	p	Mean Diff	t	df	p	Mean Diff
FFMQ-15	2.52	52	.02	3.95	-0.10	39	.92	-0.17
WTA	-3.34	52	.00	-0.55	-1.95	40	.06	-0.46

time point 2 and 41 at time point 3. The descriptive statistics are provided in Table 1.

All dependent variables met the assumptions of normality. As expected, FFMQ-15 was negatively correlated with WTA ($r = -.438$, $p < .01$). The results of independent sample t-tests at baseline showed that none of the measures was significantly different between two groups; thus, baseline equivalency was satisfied.

Treatment effects

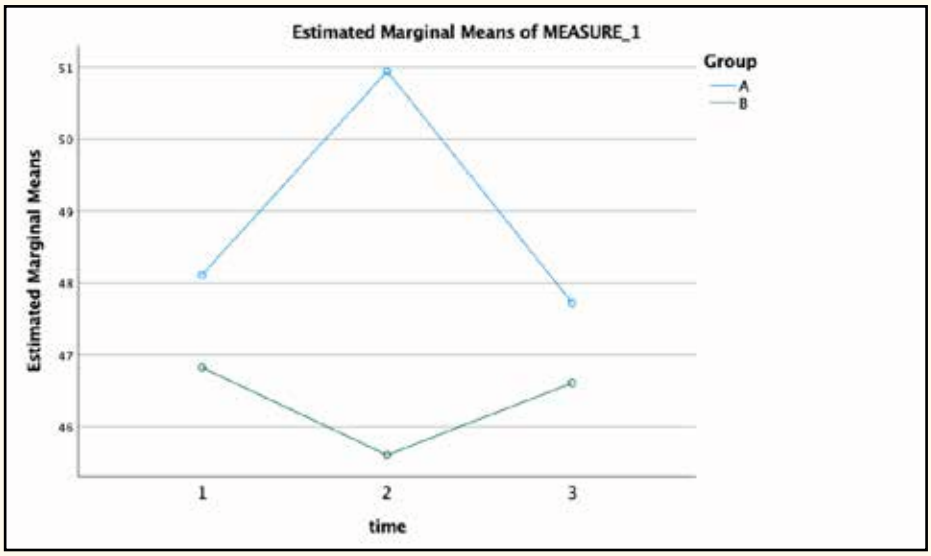
The independent samples t-tests results (Table 2) demonstrate from Time 1 to Time 2, the treatment group significantly increased their FFMQ-15 total scores, $t(52) = 2.52$, $p = .02$, and significantly decreased their WTA scores, $t(52) = -3.34$, $p = .002$. From Time 1 to Time 3, the score changes were not significant between treatment and control groups for all measures. No significant results were found for the control group.

Figure 1 shows how mean scores for treatment and control groups changed across three time points. A significant time condition interaction effect was found for FFMQ-15, $F(2, 78) = 4.70$, $p = .012$. Pairwise comparisons indicated that for the treatment group, FFMQ-15 was significantly increased from Time 1 to Time 2 by 2.83 points, and then significantly decreased from Time 2 to Time 3 by 3.22 points.

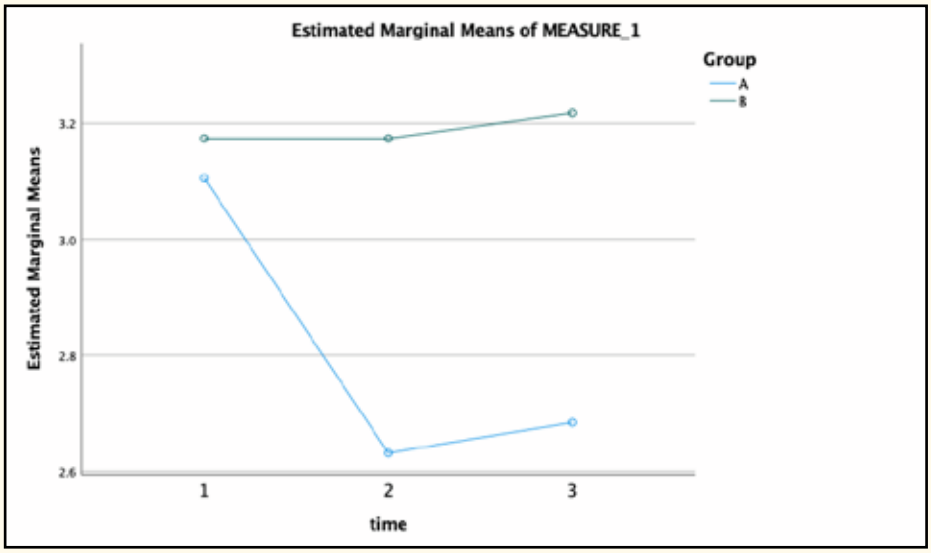
Analyses also revealed significant interaction effect for WTA, $F(2, 80) = 3.65$, $p = .03$. Pairwise comparisons indicated that for the treatment group, WTA were significantly decreased from Time 1 to Time 2 by .47 points, and significantly decreased from Time 1 to Time 3 by .42 points. The control group showed no significant change through all time points.

Figure 1. Time condition interaction

FFMQ-15



WTA



Discussion

This randomized controlled trial sought to explore whether a mindfulness-based intervention, including DBT core mindfulness skills, taught via videos could help reduce test anxiety and increase mindful awareness in high school students. Both of these hypotheses were supported as the treatment group showed a significant reduction in self-reported test anxiety over time and a significant increase in mindfulness compared to no change in the control group.

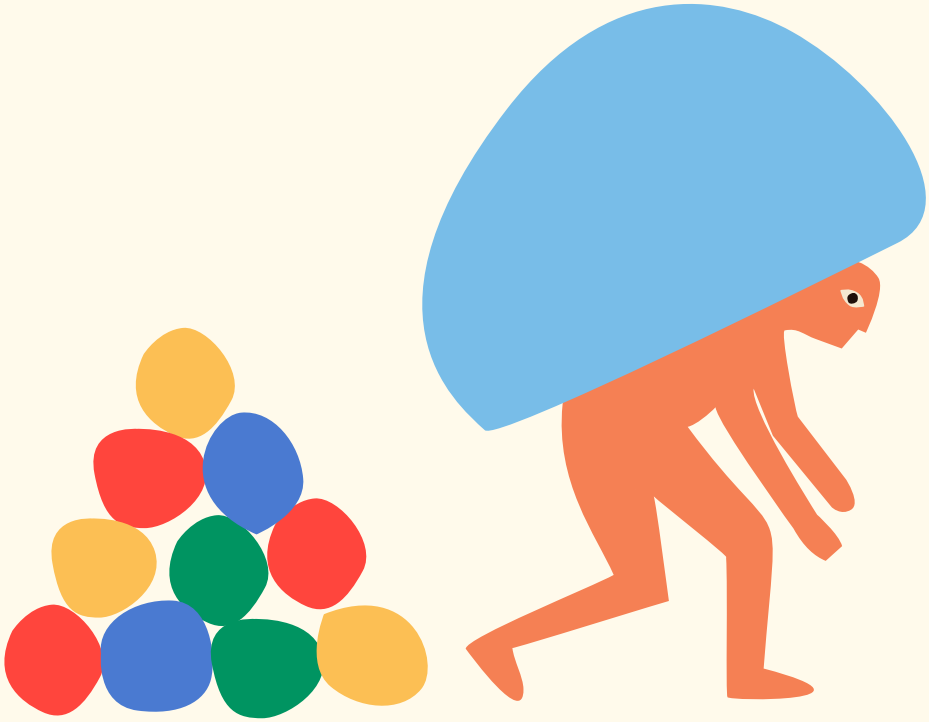
The findings show that a brief course of intervention focused on teaching mindfulness, meditation, and DBT skills can significantly reduce test anxiety and, even more exciting, that the reduction in test anxiety may last over time. In addition, it demonstrated that this intervention strategy also significantly increased mindfulness after the intervention phase, although those improvements did not hold over time. Additionally, the self-report measures completed during time 2 occurred around midterms and spring break, while time 3 collection occurred a week before final exams. Given the stress of finals and chaos at the end of the academic year, it is possible that students were less mindful as a result of these situational factors. Nevertheless, test anxiety was likely highest

at these points, compared to baseline measures at the start of the semester, so the significant improvements to test anxiety suggest a very good effect of this intervention.

Due to the pandemic, all intervention and data collection occurred through inexpensive or free modalities, and all videos were readily available on YouTube. This suggests that no significant investment is needed for schools to implement this program and students who have internet connection can access this material at any time, at their convenience. This helps reduce some barriers to treatment in lower income or more rural areas with less access to care. In addition, a trained mindfulness instructor or DBT clinician is not needed, as all information is viewed electronically from pre-recorded videos.

Important considerations and future directions include the sample size, standardization of intervention videos, an actual exam component, or a daily mindfulness practice. A larger sample size would improve the power of statistical analyses, which were acceptable for the current study but would be improved with a larger sample size. Second, while the use of EdPuzzle and embedded questions helped control the video-based intervention as much as possible, there was no way of knowing that the students were actually watching the videos sent to them or not. Replicating the study in a more controlled environment for the intervention phase would help ensure that videos are watched in a consistent manner and therefore, would allow for more confidence in the conclusions. Another area of future direction may be to consider an actual exam condition and the impact of these interventions not only on lowering test anxiety but also on measures of academic performance, such as grades. Finally, it would be interesting to see if a daily, regular practice of mindfulness compared to the one-time intervention produces different, more long-term benefits on mindful awareness. The current study provided the videos over a 10-day time frame for students to watch. Future studies might look at whether providing a daily mindfulness practice or measuring how frequently a participant is utilizing mindfulness skills impacts the long-term efficacy of the intervention.

There is little research available regarding test anxiety in high school students, and this study contributed to this much needed area of exploration and provided a valuable starting point for future study. This is one of the first studies to explore the use of mindfulness and DBT skills to treat test anxiety in high school students, and the first that we know of to utilize video-based interventions. Thus, this study is a hopeful start and suggests that relief from test anxiety may not be that difficult to achieve for this population.



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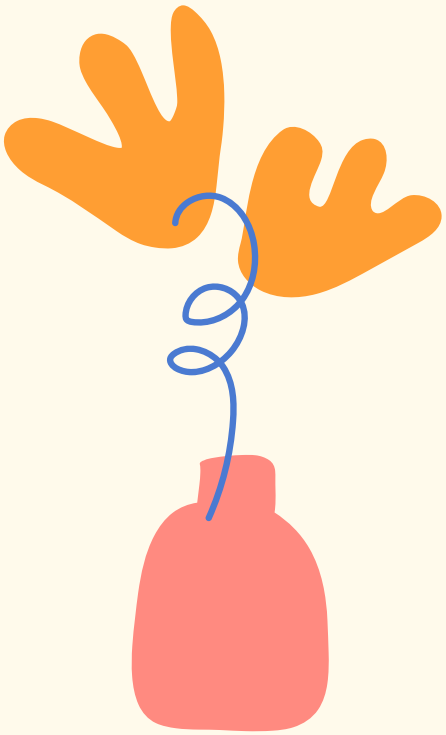


Where Would You Intervene and Why?: A Conversation on Solution Analysis

Marget Thomas, *Evidence Based Therapy Partners*
Sara Meldon, *Wake Kendall Group*
Kristen Roman, *CBT/DBT Associates*
Molly Stern, *Rutgers University Graduate School of Applied and Professional Psychology*

DBT IS ANCHORED in chain and solution analysis, however, solution analysis can be overlooked in training and practice relative to the precision and depth of assessment called for by chain analysis. Solution analysis is the process of identifying points of intervention in a behavioral chain analysis and collaboratively identifying and evaluating solutions. In identifying controlling variables, the DBT therapist assesses whether the client is lacking particular skills, whether certain ways of thinking or ways of responding to particular emotions interfered in the moment, or whether there are contingencies at play that outweigh the client using more effective behavior. Solutions broadly fit into four corresponding categories: **enhancing skills and motivation**; **modifying cognitions**; **exposure to emotions**; **problem-solving;** and **changing contingencies**.

In our experience, a curious dialectical tension can emerge when it comes to solution analysis: on the one hand, solutions can be oversimplified as a list of skills to be followed or a general approach to "feel the feelings," while on the other hand, therapeutic progress can seem to be stymied by the elusiveness of finding the "right" solution. Furthermore, potentially effective solutions can be lost when too many solutions are offered, and important links can be missed.

Here, Marget Thomas (Evidence Based Therapy Partners), Sara Meldon (Wake Kendall Group) and Kristen Roman (CBT/DBT Associates), three psychologists who trained in DBT with Shireen Rizvi's lab at Rutgers University a decade ago, discuss perspectives on how to approach solutions on a chain analysis provided by Molly Stern, a current doctoral student on the DBT-RU team. The chain and conversation are condensed for space.

Sara: I wish we had a few more links, but this is such a prototypical chain!

Marget: Yes, an emotion-driven behavior when things haven't gone the way you expected.

Sara: I'd usually start by asking: "Accepting that the prompting event happened exactly how it did, what skills can you use to not end up yelling at your parents?"

Kristen: Yes, I'd start very close to the behavior, looking to right before and really slowing it down to understand those links more. What she's feeling in her body, what thoughts are going through her mind, so I could help this client get better at knowing the warning signs that she's losing control of her anger. She could practice observing heat in her body, urges, and thoughts, so then she could practice using distress tolerance skills in those contexts.

Sara: I might ask if she has a distress tolerance kit, whether she thought to use skills at all in that moment or how else we could increase access to them (enhancing skills).

Kristen: Let's say your client is brand new, what skills would you suggest?

Sara: I'm thinking STOP, and when she takes a step back, TIP skills like paced breathing, or maybe an exercise she could do on the street.

Kristen: She could go get a cold soda from the food truck for temperature.

Sara: That's a great idea. Maybe she could play a distracting game on her phone to try to let some time pass before calling her parents.

Kristen: You know, anger can be so hard to come back from. I might take the same solution of the distress tolerance skills, but intervene right when she learns her car is towed, before she calls her dad (solutions to avoid a second prompting event/decreasing vulnerability). I work with a lot of young adults who call their parents before they're ready for the conversation. I would really want her to use the distress tolerance skills first to get the emotion down so that she is less vulnerable to reacting in response to Dad.

Sara: It seems like in this chain the earlier you can intervene, the more effective it could be for her.

Kristen: Yes, and early in treatment, no matter the emotion, if it's heightened, let's use distress tolerance skills. And then later, let's understand these emotions better (emotion regulation skills).

Marget: Shifting from focusing on the behavior itself to helping the client understand, *how did you get to anger and yelling?*, and asking if the emotions of shame and anger directed at her parents were justified.

Kristen: Right, it may be the wrong target.

Marget: I might try to help her assess whether there was another emotion that was more primary or justified in the moment, more closely related to the prompting event.

Kristen: Anger might be primary, but stemming from the blocked goal of accessing her car, and less her parents causing this problem. I might do a cope ahead because anger is so hard to slow down, so imagining ahead of time might help her to use skills when distressed

Marget: Yes, or perhaps rehearsing gentle avoidance when angry.

Kristen: Yes, opposite action all the way, relaxing her body, willing hands, relaxing her face and jaw.

Marget: Although these thoughts of "I'm a baby" and "it's their fault" are prominent, I may be more likely to highlight the impact of these thoughts, their judgmental nature, how they fuel shame, than to directly challenge them (nonjudgmental stance).

Kristen: There is a risk with cognitive modification here; she might say "you don't get it." She might need radical acceptance of "you so badly want to know how to solve these types of problems and you don't yet." And that makes sense.

Marget: Validating the sadness, the difficulty (emotion exposure).

Sara: That's where increasing radical acceptance as a solution would help block her sadness and disappointment from turning to shame and then anger.

Kristen: The other skill we haven't talked about is dialectical thinking about why her parents act this way (cognitive flexibility). Getting curious about why parents do things for their kids. Why her dad may have sounded panicked or was trying to help even though she didn't want him to.

Marget: Or dialectics around "I don't know exactly how to solve this *and* I can figure it out," or dialectics about the emotional experience feeling overwhelming *and yet*, all emotions come and go. Perhaps using mindfulness of current emotion to foster that too.

Sara: If we're identifying guilt as an internal consequence here, would either of you focus on repairing or correcting after yelling at her parents?

Marget: Or the impact on her self-respect when she so desperately wants to be an adult? I might try to draw out these longer-term consequences. If we determined that the emotion of guilt was justified, we might focus on correcting and repairing (reinstating adaptive emotional behaviors).

Kristen: A potential contingencies-oriented solution could be a plan for repairing with her parents after yelling at them.

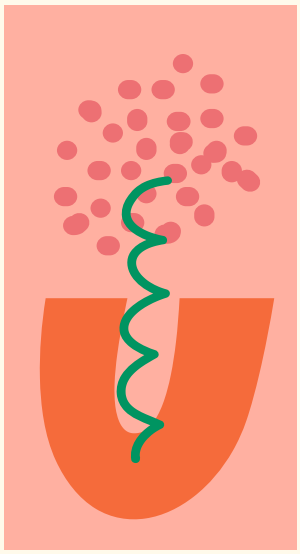
Marget: Another potential link I would be curious about would be moving earlier in the chain; were there behaviors or missing behaviors that led to her car being towed and her having no money with her?

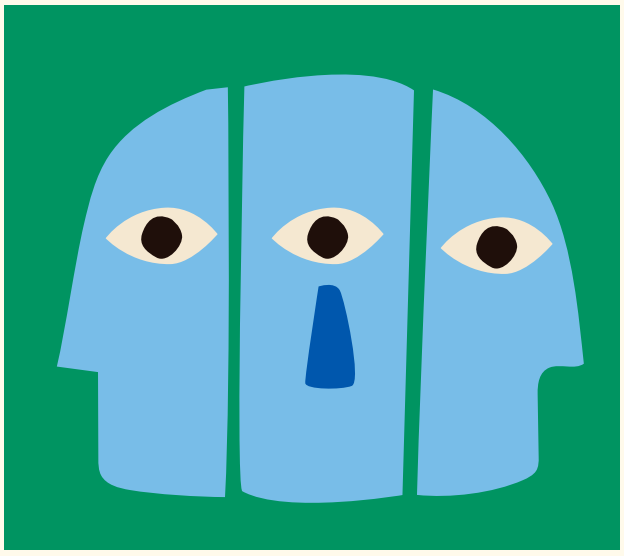
Sara: Some problem solving might be the easiest to change-- making sure she has money in her wallet when she leaves the house, checking that she's not parking in tow zones. So what gets in the way of that for her?

Kristen: It sounds like you're turning to secondary targets.

Marget: Yes. There may be a self-perpetuating pattern of unrelenting crises here, and I think I'm conceptualizing her thoughts that escalate the emotion as self-invalidating, apparent-competence thoughts. The shame is firing because she's believing she should know this already, so she's getting overwhelmed and shifting into active passivity.

Sara: There is the myth of "I should be an adult" and "I shouldn't have to ask for help." (modifying cognitions)





Marget: Yes, I might want to help her understand the pattern within her and then how it transacts with her parents.

Kristen: I agree, one of the first themes that came to my mind was her desire to be independent but it's difficult because she doesn't have a lot of life skills yet, so one bigger picture link I'd look at is ways of working on independence while building mastery. Maybe an exposure hierarchy of tasks she will start working on. I might even collaborate with the parents a bit on things she could work on now to build her independence (exposure).

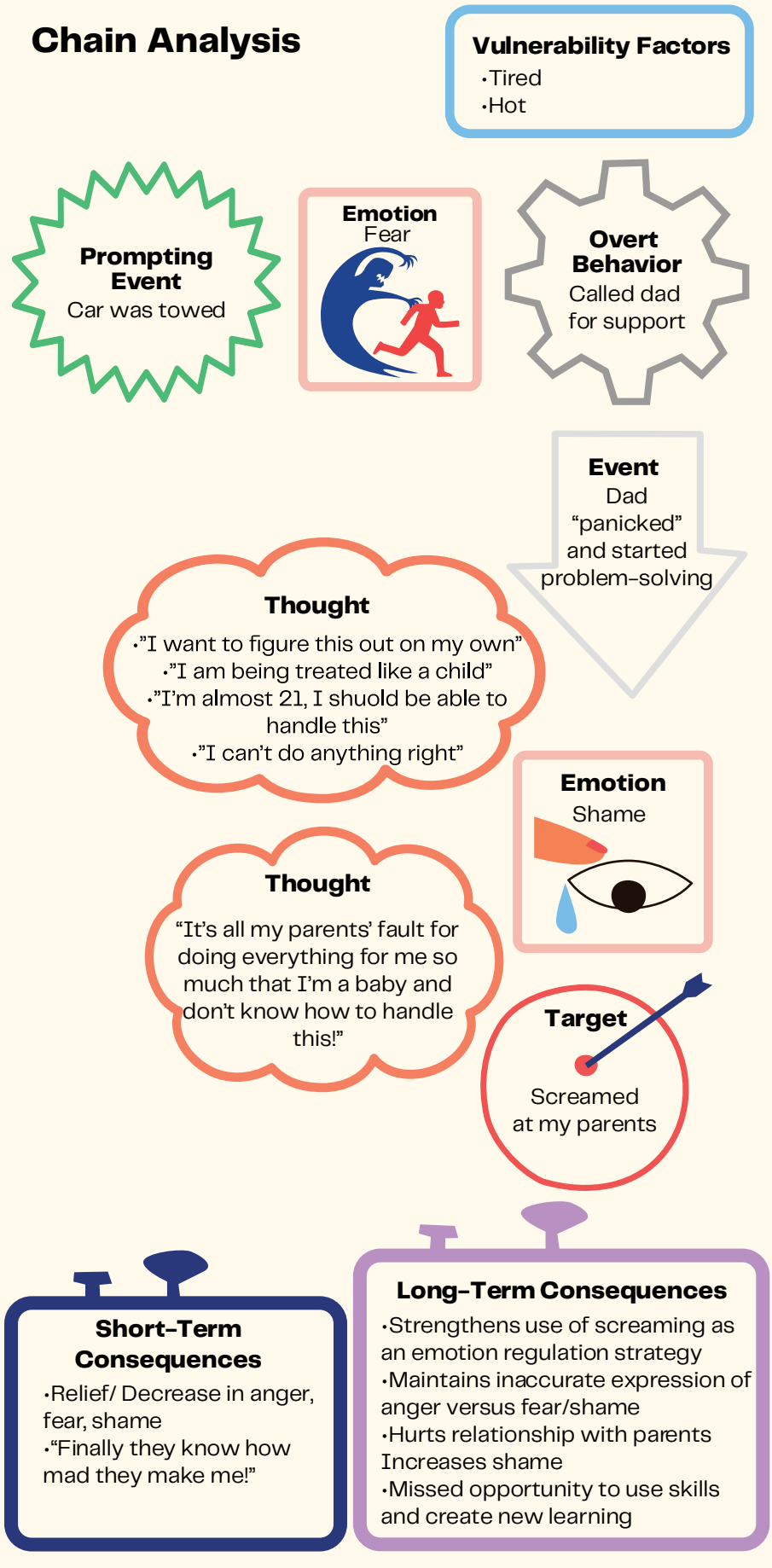
Marget: So it seems like you're focusing on the bigger picture of the mismatch between her capabilities and her life worth living goals.

Kristen: I'm kind of seeing the kernel of truth in her beliefs. You could go after the judgments about herself, but in a way, there is something accurate about it. She needs to become more capable so she can view herself that way (problem solving).

Marget: Yes, I'd validate the need for opportunities to learn and the wish to be trusted to figure it out herself. It's so hard to do that if your parents are problem solving for you (validation).

Sara: Targeting the transaction with her parents could pair well with the exposure practice around independence.

Marget: Exactly. We could bring in interpersonal effectiveness at the level of working with her to ask her parents to decrease their problem solving (changing contingencies), and then, more granularly, we could focus on the link of the urge to call Dad or how she expressed



herself there. Could she name what she actually wanted from her dad, to start to identify her objectives in a DEAR MAN? (accurate expression of needs).

The above dialogue illustrates some of the many options for solutions in response to a "real world" chain, all rooted in the principles of DBT. As you can see, there are often more potential solutions than one would implement. While there is no "right way" to solve a problem, there are some guiding principles DBT therapists consider in solution analysis to home in on effective solutions and to avoid creating an overwhelming list of possible solutions. When selecting links in solution analysis, consider:

- **What's most proximal to high-risk behavior** (e.g., increased mindful observation of internal experience just prior to the urge to yell and a distress tolerance plan of STOP with paced breathing and distract skills to ride the emotion wave).
- **What will make the most significant change in target behavior** (e.g., STOP when observing emotion intensity escalating, using a skills plan prior to reaching out to parents, or using DEARMAN to accurately express needs).
- **What is easiest to change** (e.g., mindfully plan ahead when traveling).
- **What the client is most willing to work on** (e.g., coaching client to get parents to increase validation and decrease problem solving).
- **What link is most closely related to the core problem occurring across chains** (e.g., if the core problem is unjustified shame and a low tolerance of shame, check the facts and emotion exposure to shame; conceptualizing behavioral patterns as secondary targets of apparent competence/active passivity and self-invalidation/emotion vulnerability may help the client and therapist in their work to decrease behaviors that elicit unwanted help from others and increase accurate expression of needs and active problem solving).

Being familiar with the four categories of solutions as well as reasons one might intervene at one point or another on the chain, can help guide the generation of solutions with a client, deepen the understanding of a client's behavior and enhance the effectiveness of chosen solutions. Any chosen entry point would offer a chance to test out hypotheses and learn over time which interventions would best help the client decrease the target behavior and address core problems. Dialectical assessment allows for evolving conceptualization and moving from focusing on one link to another over time.

Recommended Readings

Heard, H. L. & Swales, M. A. (2015). Changing behavior in DBT: Problem solving in action. New York: Guilford Press.

Rizvi, S. L. (2019). Chain analysis in Dialectical Behavior Therapy. New York: Guilford Press.

Rizvi, S. L. & Sayrs, J. H. (2017). Assessment-driven case formulation and treatment planning in dialectical behavior therapy: using principles to guide effective treatment. Cognitive and Behavioral Practice 27(1).

Open Source Anti–Discrimination Agreements

Contributing members of the team include (in alphabetical order by last name) Hollie Granato, Christopher Hawkey, Mikeala Kinnear, Blair Kleiber, Amanda Loerinc, Andrea Murray, Laura Rindlaub, and Sara Schmidt

Synthesis Psychological Consortium - DBT Consultation Team

IN THE WORDS OF the compelling piece written earlier this year by Pierson, Arunagiri, and Bond (2021), "We didn't cause racism, and we have to solve it anyways". As DBT teams strive to dismantle racism, we wanted to explore the different ways DBT therapists are collaborating in their DBT teams to evolve the consultation agreements.

Pierson, Arunagiri, and Bond (2021) have suggested a seventh, anti-racism team agreement: Therapists must assess their competencies in antiracism prior to beginning treatment with clients or as soon as possible once they enter the therapeutic relationship. This is advised for work with clients of any identity and background, and is absolutely required as preparation for working with racially marginalized clients. This agreement is incumbent on White DBT therapists without exception, and is encouraged for all DBT therapists. Therapists will share their self-evaluation of competencies in antiracism with consultation team members, in order to facilitate effective team support for therapists' growth in this competency area. Therapists will make every reasonable effort to increase their competencies in antiracism, including but not limited to: engaging in consultative discussion, openly receiving feedback from others about racist behavior, completing self-reflective exercises about race-related values, attitudes, and beliefs, increasing race-specific knowledge through educational activities, completing homework assigned by consultation team members in order to foster growth in specific antiracist competencies, and making repairs to team members and/or clients when therapist racist behavior is identified.

Our team, Synthesis Psychological Consortium, has been collaborating to create embedded anti-racism adaptations into the current team agreements, in an attempt to incorporate our commitment to this work throughout all of the worldviews we adopt on team. We would love to hear what your team is doing and how you have approached this.

Preamble: In reading the DBT agreements, our team acknowledges the variety of marginalized, intersecting identities among our team and clients. We acknowledge that dominant culture is often centered around the experiences of white, cis, male, educated, economically advantaged, hetero, able, thin-bodied, Christian, and monogomous people.

1. Dialectical Agreement: We agree to accept a dialectical philosophy: There is no absolute truth. When caught between two conflicting opinions, we agree to look for the truth in both positions and to search for a synthesis by asking such questions as, "What is being left out". *We accept a dialectical philosophy in our approach to our work with marginalized populations – we will strive try to understand all viewpoints, particularly those that differ from our own. Further, we agree to acknowledge our own bias and privilege, individually and as a team, and to continually ask ourselves and each other, what am I missing?*

2. Consultation to the Client Agreement: We agree that the primary goal of this group is to improve our own skills as DBT therapists, and not serve as a go-between for clients to each other. We agree to not treat clients or each other as fragile. We agree to treat other group members with the belief that others can speak on their own behalf. *We hold ourselves to the agreement developed by Pierson, Arunagiri, & Bond (2021)*: At times when the problem is an intransigent, high-power environment, as is always the case when the problem is enacted systemic bias, we agree to actively seek out ways to support the client through advocacy. We agree to take a dialectical stance by ensuring that consultation to the environment is done in tandem with consultation to the client, so that environmental intervention does no fragilize or disempower the client. We agree to provide functional validation (i.e., responding with action) to marginalized clients by using our own resources of privilege and power to change inequities.*

3. Consistency Agreement: Because change is a natural life occurrence, we agree to accept diversity and change as they naturally come about. This means

that we do not have to agree with each others' positions about how to respond to specific clients nor do we have to tailor our own behavior to be consistent with everyone else's. *We acknowledge that consistency is centered around dominant culture, as such, agree to thoughtfully consider input from the team that may be inconsistent with our own perspective. We agree to examine how our lived experiences of privilege deviate from that of the client, the team member, or of other parties relevant to the consultation question.*

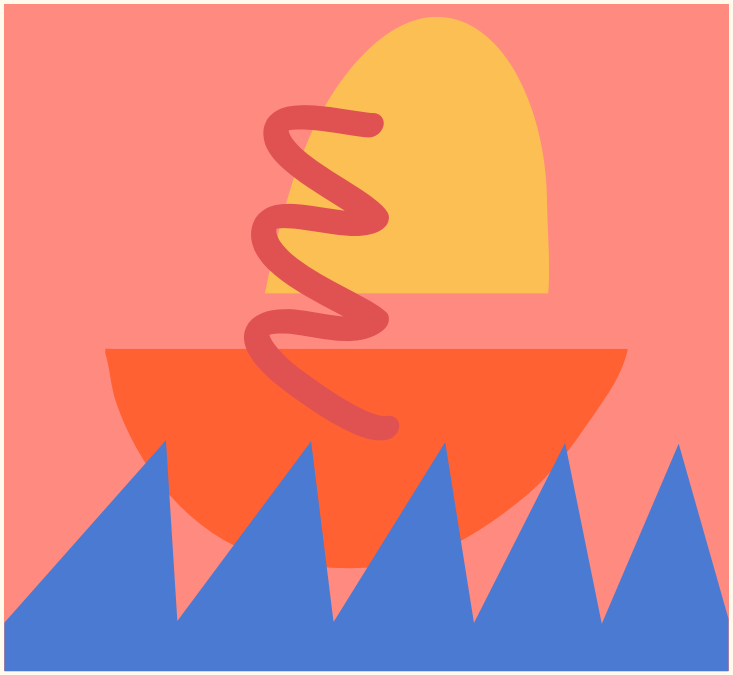
4. Observing Limits Agreement: We agree to observe our own limits. As therapists and group members, we agree to not judge or criticize other members for having different limits from our own (e.g., too broad, too narrow, "just right"). *We agree to examine implicit/explicit biases we have based on the privilege(s) we hold that are likely impacting any judgments that may arise about our own limits and those of others, particularly those from a marginalized group. At the same time, we will seek a synthesis that honors our own limits as well as assist our team members in doing the same.*

5. Phenomenological Empathy Agreement: All things being equal, we agree to search for non-pejorative or phenomenologically empathic interpretations of our clients', our own, and other members' behavior. We agree to assume we and our clients are trying our best, and want to improve. We agree to strive to see the world through our clients' eyes and through one another's eyes, *with full awareness that we do not have full access to another's experience.* We agree to practice a non-judgmental stance with our clients and one another, *and we agree that each team member and each individual client has their own unique set of lived experiences, dependent on their intersecting identities. We agree that we cannot fully understand another's lived experience. Given that all behavior is caused, we may disagree on what the problem is or how to solve a problem, and when this happens we will strive for willingness to accept that other perspectives have inherent validity.*

6. Fallibility Agreement: We agree ahead of time that we are each fallible and make mistakes. We agree that we have probably either done whatever problematic things we're being accused of, or some part of it, so that we can let go of assuming a defensive stance to prove our virtue or competence. Because we are fallible, it is agreed that we will inevitably violate all of these agreements, and when this is done we will rely on each other to point out the polarity and move to a synthesis. *We are committed to acknowledging our privilege status and the power dynamic in the room as therapists and supervisors, and acknowledge that we will inevitably engage in microaggressions – that when this happens we will strive to hold the onus of awareness of these missteps and work to repair in the room and learn, listen, and grow from these experiences.*

We invite you to email us at info@synthesispsychological.com and at dbtbulletin@gmail.com to share your work. We'd love to keep this conversation going in future issues of the DBT newsletter as this work is ongoing and ever evolving over time.

Frances Fitzgerald, LSW a DBT therapist at Jefferson Center City Clinic for Behavioral Medicine created the graphical depiction of the consultation agreements on the following page.



DBT Consultation Team

AGREEMENTS

Dialectical

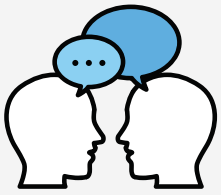
We agree to accept a dialectical philosophy: There is no absolute truth.

When caught between two conflicting opinions, we agree to look for the truth in both positions and to search for a synthesis by asking such questions as, "What is being left out?"

Consistency

Because change is a natural life occurrence, we agree to accept diversity and change as they naturally come about.

This means that we do not have to agree with each others' positions about how to respond to specific patients nor do we have to tailor our own behavior to be consistent with everyone else's.



Consultation to the Patient

We agree that the primary goal of this group is to improve our own skills as DBT therapists, and not serve as a go-between for patients to each other.

We agree to not treat patients or each other as fragile. We agree to treat other group members with the belief that others can speak on their own behalf.

Observing Limits

We agree to observe our own limits.

As therapists and group members, we agree to not judge or criticize other members for having different limits from our own (e.g., too broad, too narrow, "just right").

Phenomenological Empathy

All things being equal, we agree to search for non-pejorative or phenomenologically empathic interpretations of our patients', our own, and other members' behavior.

We agree to assume we and our patients are trying our best, and want to improve. We agree to strive to see the world through our patients' eyes and through one another's eyes. We agree to practice a non-judgmental stance with our patients and one another.

Fallibility

We agree ahead of time that we are each fallible and make mistakes. We agree that we have probably either done whatever problematic things we're being accused of, or some part of it, so that we can let go of assuming a defensive stance to prove our virtue or competence.

Because we are fallible, it is agreed that we will inevitably violate all of these agreements, and when this is done we will rely on each other to point out the polarity and move to a synthesis.

Stretch Limits

Anti-racism*

At times when the problem is an intransigent, high-power environment, as is always the case when the problem is racism, we agree to actively seek out ways to support the patient through antiracist advocacy.

We agree to take a dialectical stance by ensuring that consultation to the environment is done in tandem with consultation to the patient, so that environmental intervention does not fragilize or disempower the patient. We agree to provide functional validation (i.e., responding with action) to racially marginalized patients by using our own resources of privilege and power to change racial inequities.

Adapted from Linehan, M. M. (1993). Diagnosis and treatment of mental disorders.Skills training manual for treating borderline personality disorder. Guilford Press.

* Pierson, A., Arunagiri, V., & Bond, D. (2021, January 12). "You Didn't Cause Racism, and You Have to Solve it Anyways": Antiracist Therapist Adaptations to Dialectical Behavior Therapy (DBT). https://doi.org/10.31219/osf.io/jbzq4

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Playing the Hand You're Dealt: A Creative Tool for Teaching Radical Acceptance

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I'M A DBT THERAPIST and avid crafter, so I enjoy making props or materials to teach skills. As such, I have always had a standing offer with colleagues – if they ever have a creative idea, then I will gladly try to materialize it. In 2011, I was a practicum student at the Center for Behavioral Medicine and my then supervisor, Neal Moglowsky, took me up on my offer. Neal requested that I make a tangible set of cards to highlight the radical acceptance metaphor of "playing the hand you're dealt as skillfully as possible." I've made and shared many sets of these cards over the past 10 years, and I thought it could be useful to make to them widely available to anyone who would like to use them.

The Cards

The radical acceptance playing cards are a set of 20 oversized playing cards that depict situations or circumstances that we could benefit from accepting. The cards cover a variety of concepts, including personal (e.g., my emotions, my struggles), interpersonal (e.g., others' decisions, others' limitations), and situational (e.g., traffic, the weather).

Making Your Own Set

A PDF set of the cards is available on the DBT Bulletin website for anyone to download and create. This will be quite an enjoyable process for any lamination enthusiast. The steps for assembly are:

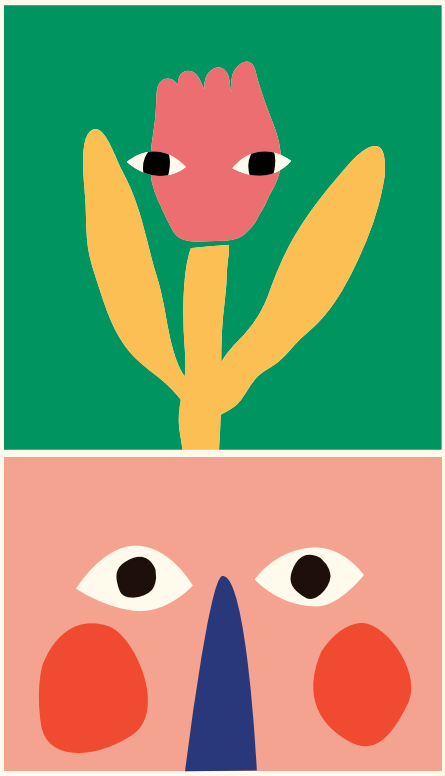
1. Print pages 1-20 (the card faces)
2. Print 20 copies of page 21 (the card back).
3. Add one card face and one card back into a lamination pouch (images facing outward on both sides) and laminate.
4. Repeat for the other 19 cards.

Obsessive attention to exactly centering the paper within the lamination pouch is optional, though practicing radical acceptance of arts and crafts imperfection is an effective alternative.

How to "Play" in Skills Group

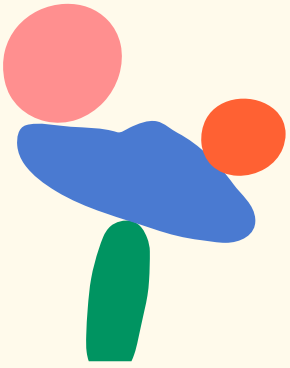
There are various ways to use these cards to highlight teaching points and generate discussion about radical acceptance in a skills group. I prefer to walk around the room, dealing the cards face down to each person. I will sometimes skip over a person or deal three in a row to the same person (always ensuring that each client ends up with at least one card). We then flip over the cards and discuss the hands we've been dealt. Some examples of discussion points are below, and the teaching points can be organically woven into the conversation:

- Validating the inherent unfairness and unpredictability of how the cards were dealt
- Discussing cards that are easier or harder for each client to accept (with the overarching spirit that there is no right or wrong answer, just individual differences)
- Noting the dialectic of accepting reality and also using skills to tolerate distress for various situations represented on the cards



My Personal Experience

I have found that these cards help to bring movement, speed, and flow to the teaching of radical acceptance. The interactive nature of the discussion seems to prevent clients from getting stuck quietly ruminating about the one thing that seems impossible to accept and then missing out on learning the nuts and bolts of the skill. In my experience, clients tend to be participatory and engaged in learning a skill that can sometimes seem quite daunting to understand and apply. This is, by far, the most effective (and fun) way that I have found to teach radical acceptance.

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The Present Moment
The Present Moment
8

DBT-Informed Yoga

Meela Salamat
The Chicago School of Professional Psychology at Anaheim

MOVEMENT HAS BEEN SHOWN to be among the most effective channels for cultivating knowledge and experiences in long-term memory (Donnelly & Lambourne, 2011). For this reason, in the last year, I have begun a quest to unite Yoga and DBT principles to help people better embody Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness skills. Yoga is a thousand-years-old science that originated in India, integrating philosophy, spirituality, and anatomy to create a mindfulness-based and holistic approach to wellness (Brennan et al., 2020). Since its introduction to the Western world and its incorporation into psychotherapy treatment, it has been studied and researched in randomized clinical trials (RCTs) and found to be beneficial in many ways (Brennan et al., 2020). Specifically, integrating a yoga practice in treatment has been shown to be effective in treating people with emotional dysregulation, trauma, body image issues, self-harming, and suicidal behaviors (Brennan et al., 2020; Perey & Cook-Cottone, 2020; Dick et al., 2014; Medina et al., 2015; Nicotera & Connolly, 2020; Friedman et al., 2018; Gard et al., 2014; Menezes et al., 2015; Gard et al., 2012). More importantly, clinicians have begun nascent research on utilizing yoga that highlights skills as part of a DBT program (Wendt & McClellan, 2020; Dick et al., 2014). There is still much to be done in terms of integrating movement like yoga to DBT and turn the model into an evidence-based practice. Below, you will read my story of integrating DBT with Yoga and two distinct examples of my classes.

I began practicing yoga in college, joining "Yoga to the People," a donation-based organization in New York City. At that time, yoga was my workout and a way to sweat away the stress from college-life. Fast-forward to graduate life at a much more stressful academic program—Psy.D at the Chicago School of Professional Psychology at Anaheim (TCSPP), where yoga became a necessary coping skill. It was the summer of 2020, in the heart of a socially distanced world with no vaccines yet available. My life had fallen apart; my 8-year marriage was over, and I was essentially cut off from my family and marginalized due to going against cultural norms as an Iranian American woman. My only source of support and coping was DBT—using skills in my own life, treating people with severe emotional dysregulation within this model, and working with my DBT family at the DBT Center of Orange County. I enrolled in a 200-hour Yoga Teacher Training at Ra University in Irvine in August 2020 to find some solace and deepen my mindfulness practice. And I ended up finding much more than I expected. Picture this: each student is separated by a masked tape on the studio floor to respect the six-foot social distancing requirement and we all wear masks if we exit our 6x6 squares. Hand sanitizers, humidifiers, open doors, and windows can be seen everywhere. Despite all the precautions keeping us separated, I felt so connected. I had found my second tribe, the first being my DBT team. Three months in, and I was a transformed Yogi.

As part of my assignments, I created a Community Project to promote equity in yoga and offer it to people who otherwise do not have access. As a graduate student, I chose to teach my fellow colleagues because I know how challenging it is to be in the mental health field as a practicum student, while completing coursework, and not having the funds to afford self-care with yoga. I invited my cohort to weekly Yoga in the Park that later became Yoga on Zoom sessions to provide access to more people. As I constructed my Yoga flows and sequences week by week, sprinkling in general mental health tips, I found myself using DBT language, because this is the only language I know.

I explored this further by practicing svadyaya (self-study) and getting curious about the ways that DBT and yoga roads cross paths, which led to integrating the two in unique Vinyasa-style yoga flows. Without hesitation, I began teaching DBT-informed Yoga flows as part of my Community Project, and the positive feedback I received on reductions in burnout reinforced my passion in continuing my research and creative outlet. It wasn't until much later that I shared one of my unique yoga flows with my DBT team—which is where I received the ultimate positive reinforcement and motivation to make this more of an established option—integrating yoga practice in DBT. From these practices, DBT Yoga was born, and it is still only in its infancy. I have created sequences that highlight the principles of DBT through movement or asanas, breath work or pranayama, and meditation or dhyana. Each asana flow is divided into five parts: warm up, Sun A, main flow, strength series, and cool down. Pranayama is instructed to be practiced throughout the flow, while dhyana is usually at the very beginning or end of class. This course is designed to

be offered to clients in addition to skills groups as an optional weekly 60-75 minute class. Additionally, it could also be offered as an option to clinicians to embody effective DBT Team principles as a way to reduce burnout, as part of weekly consultation.

To demonstrate DBT Yoga, I am sharing the three main elements of two of these sequences—one presenting Dialectics in Yoga and the other, Practicing TIPP skills in Yoga. I also have other sequences presenting specific skills like Nonjudgmental Stance, Radical Acceptance, PLEASE, Opposite Action, DEAR MAN, and Mindfulness of Others.

Dialectics in Yoga

Pranayama: Alternate Nostril Breathing or *Nadi Shodhana.*

Nadi Shodhana is a type of breathing exercise that is said to help balance the Ida and Pingali nadis, or energy channels in the body. In this practice, one uses alternate nostrils, one at a time for breathing in and out, thus making both nostrils active. This practice helps clear any blocked energy channels and brings clarity of mind by restoring the equilibrium and dialectics that exist between the Ida and Pingala nadis. The Ida nadi relating to the left nostril helps to maintain the cold and anabolic activities of the body, while the Pingali relating to the right nostril has a heating effect. When balanced, together they help to activate the Shushumna nadi. It is said, in Yoga philosophy, that Prana or life energy can circulate freely only when the energy channels of nadis are strong, balanced, and clear. This pranayama is practiced at the very beginning of class.

Asana: The theme of dialectics is interwoven into the sequence by bringing mindful awareness to the right and left side of our bodies, noticing how one side might feel more tense or stronger than the other and vice versa. Students are reminded to observe these subtle differences nonjudgmentally, one-mindfully, and effectively. During the strength series, balancing postures are meant to further highlight the dialectics that exist in our own bodies, and how we learn to accept both sides as we practice on the mat and in our lives.

Dhyana: During Savassana or corpse pose, the spirit of this pose is highlighted, which is to surrender. In this flow, students are invited to surrender to the dialectics that exist in their bodies, emotions, minds, and lives. All asana are meant to prepare us for this final pose of surrender. Accepting the present moment and surrendering to it is the ultimate truth in both yoga and DBT.

TIPP Skills and Yoga

*Pranayama:*Cooling Breath or Sitali/Sitkari and Breath Retention or Kumbhaka. There are a few breathing techniques used in this sequence to highlight the different TIP skills. Sitali or Sitkari are both types of breathing exercises that cool the body and add moisture to the system, emulating the Tip the Temperature skill. Additionally, utilizing Kumbhaka techniques, students are guided through both Paced Breathing and Paired Muscle Relaxation skills. By breath retention, students can lengthen their exhales in Paced Breathing and prepare for tensing muscles while holding the breath in Paired Muscle Relaxation. These breathing exercises are practiced toward the end of class, after the main flow and standing series, before cooling down.

Asana: The flow in this class is rigorous, quick, and strength-based. It is meant to emulate the Intense Exercise skill. It is also a mandala-style flow that creates a dynamic sequence that has students moving around their mats in a circular pattern, as in the shape of a mandala. Clients are encouraged to engage in this practice utilizing the Participate skill to focus on what comes next and really embody the flow.

Dhyana: During Savassana, students are guided through a Progressive Muscle Relaxation meditation. Utilizing Observe skills, students are taught that this practice is very much like Paired Muscle Relaxation and reminded that the purpose is to one day associate exhaling with relaxing the body.

DBT-informed Yoga is currently being offered at DBT Center of Orange County as a part of the Mindfulness component of the IOP program to clients. Still, much remains to be done in this work in terms of research. My plan after becoming a Licensed Psychologist is to design and conduct my own RCT in testing the efficacy of DBT-informed yoga compared to other forms of mindfulness. The hope is to eventually standardize its protocol as a stand-alone treatment and/or as part of a comprehensive DBT program with the help of my colleagues. I am also curious to know how DBT-informed Yoga can help DBT clinicians in being more effective as a team and avoiding burnout.

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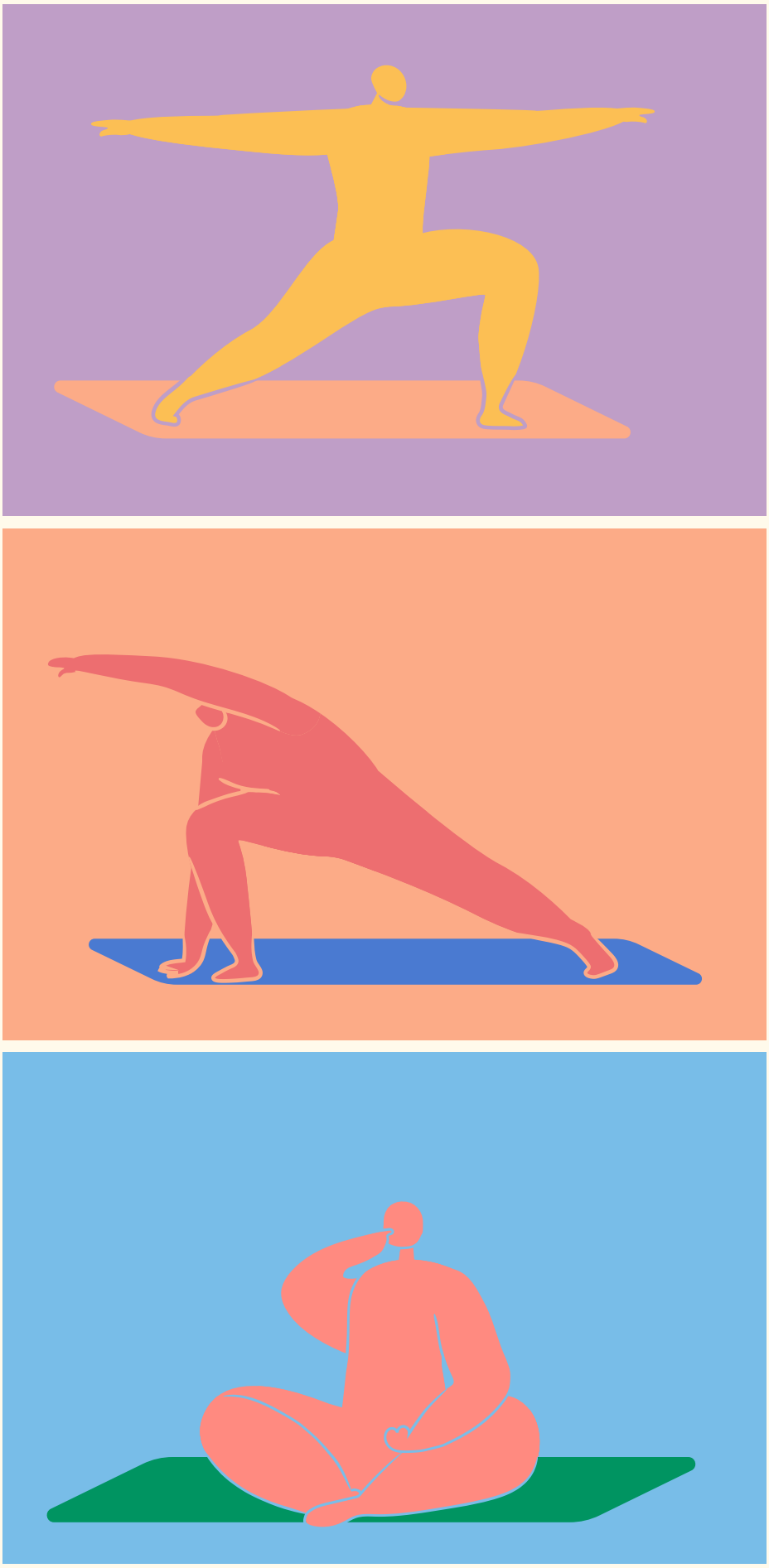

Perspectives on working with DBT therapists from the front line of Psychopharmacology

Eric Levander
David Geffen School of Medicine at UCLA

I RECENTLY MET with a transitional aged youth for an initial evaluation. Many different previous providers had reached a diagnosis of bipolar disorder, even though the young person had a long history of interpersonal chaos, affective lability, impulsivity, and suicidal ideation. They witnessed the death of their parent as a child. Later, they identified as LGBTQ. Coming from a religious upbringing that teaches against same sex relationships, they experienced significant invalidation as well as problems with anger and rage. I encouraged them to start DBT and prescribed a psychiatric medication.

One consistent challenge you most likely face as a DBT therapist is finding a psychiatrist who can provide medical treatment consistent with DBT principles. Most physicians do not want to work with people with borderline personality disorder, or even hear the words "borderline" or "suicidal." There are no FDA approved medications or treatments for borderline personality disorder. Many psychiatrists understand that DBT is an effective treatment to help individuals with borderline personality disorder. However, many knowledgeable psychiatrists never learned the principles of DBT, are unaware of how DBT is carried out, and have a hard time collaborating with DBT therapists.

Often, psychiatrists see affective instability and impulsivity as criteria for the diagnosis of bipolar disorder, rather than criteria for borderline personality disorder.

I started my DBT training during residency co-leading a skills group and later became intensively trained. For many years, I was an active member of a DBT team. Along the way I have worked very closely with many excellent DBT teams. As a result, I have been fortunate to see the benefits of effective DBT treatment, helping people with BPD move from significant distress and learn skills for a better life.

While I no longer actively participate in team, I continue to work closely with DBT therapists. Throughout my career I have been disappointed that many psychiatrists tend not to have an appreciation of how important DBT and behavioral therapy are for people experiencing affective instability and impulsivity. Psychiatrists often might not understand the importance of collaborating with DBT therapists.

I approach people who are in DBT with several guiding principles. First and foremost, I need to radically accept that people with BPD have difficult lives and are trying to get better. They are not necessarily model individuals who will respond to a six-week medication trial of Prozac. My new patient came to me for help, and I had to radically accept that they were not going to trust me or trust medications. I need to take people where they are to help guide them through this painful process. Seeing a psychiatrist and taking medications can be very scary, and many people would rather undergo chemotherapy than take a psychiatric medication.

Second, as a treating psychiatrist, I need to trust the DBT process. People with BPD often have chaotic lives and difficult relationships; they do not just get better by joining a DBT skills group. They are learning new skills which take time and practice. Psychiatric medications can help the process of learning DBT skills by allowing a person to slow down and make more effective decisions. Medications and therapy work hand in hand, and they both take time to reach their full potential.

Talking to the therapist and coming up with treatment strategies is key. As the psychiatrist, I need to validate the hard work of the person engaged in DBT. Collaboration with the therapist is especially important when dealing with a someone who has engaged in self harm. I need to have a trusting, close relationship with the DBT therapist who is my partner in assessing suicide risk. Communication with the therapist and following the principles of the 24-hour rule is essential. Ultimately, this team approach is infinitely more effective than hospitalizations, which in Los Angeles can be punitive and not at all therapeutic.

Finally, I avoid prescribing medications that pose a risk of overdose or abuse. I have treated many people with comorbid substance use disorders or significant drug overdoses who were previously prescribed medicines presenting the same risks.

As many psychiatrists are not aware of most DBT principles, it is essential for the DBT therapist to call the psychiatrist early in treatment to explain important aspects of DBT.

One obvious challenge is finding time during a busy work week to speak with the treating psychiatrist. A short message introducing yourself and asking to schedule a five minute phone conversation to go over the treatment plan

is usually the most effective approach. I am much more likely to be able to communicate with a therapist if I leave a message or get a message from a therapist with convenient times to connect. Once you have that meeting time, Dear Man the psychiatrist! Explain your objectives as succinctly as possible and reinforce why abiding by DBT principles will be in the best interest of the psychiatrist. It can be helpful to explain the importance of avoiding medications with abuse or overdose risks and the 24-hour rule.

DBT PLAYLIST

FAST Skills Playlist

DBT Bulletin Editorial Staff

- **Bulletproof** by La Roux
- **Freedom** by Beyoncé
- **Don't Start Now** by Dua Lipa
- **Control** by Janet Jackson
- **Stronger** by Britney Spears
- **Soulmate** by Lizzo
- **Freedom! '90** by George Michael
- **U.N.I.T.Y.** by Queen Latifah
- **Respect** by Aretha Franklin
- **I'd Do Anything For Love (But I Won't Do That)** by Meat Loaf
- **Brave** by Sara Bareilles–Brave
- **High Horse** by Kacey Musgraves
- **Express Yourself** by Madonna
- **Army of Me** by Björk
- **No More Drama** by Mary J. Blige

Student Award

Meela Salamat, MA
PsyD Candidate, Chicago School of Professional Psychology, Anaheim
Pre-doctoral Psychology Intern, Didi Hirsch

Recognized by DBT Center of Orange County

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- *Brief articles, less than 1500 words, are preferred.*
- *Research articles should be accompanied by a 75 to 100 word abstract with citations in APA format.*
- *Creative submissions, involving multimedia, are welcomed.*
- *Letters to the Editor, sometimes termed "Devil's Advocate," may respond to articles previously published in the DBT Bulletin or to voice a professional opinion. Letters should be limited to 500 words.*

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