DBT BULLETIN

VOL.9 IS.1
JULY 2025

DBT BULLETIN
www.dbtbulletin.org

Editor's Letter

Dear DBT Community,

Summer is upon us! And so is the 9th volume of our DBT Bulletin. We enjoyed an embarrassment of riches for this issue. As DBT therapists using our "check the facts" skill, however, we take issue with this idiom and note that the word "embarrassment" in this situation is unjustified and does not fit the facts. Rather, we feel all delight (and no shame) knowing there are so many in our community willing to make such creative, wise, and useful contributions to the Bulletin. It is our (Andrea Gold and Ashley Maliken) hope that you, too, find many gems within the following pages to use in your own practice of DBT and share with your professional and personal networks.

This issue brings various tools and perspectives on supporting the systems and communities in which our clients are embedded. Fruzzetti explores transactions in family systems, motivating us to treat both sides of the transaction when it comes to children's life-threatening behaviors and parents'/caregivers' trauma-related problems. Chriki shows us how to apply dialectical dilemmas to enhance parents'/caregivers' perspectives of their children's behavior, helping loved ones move from judgment to understanding. There is also an emphasis on tools to help clinicians improve their targeting and assessment of common clinical presentations. For example, Barak helps us think more about lying as a target behavior in DBT.

Following up from our last issue and Harry Bruell's writing on BPD legislative advocacy, Julie Frantsve-Hawley and Abby Ingber ask us as a community to zoom out and consider tackling the "Wicked Problem" of access to DBT from a broader, policy level. We also have the opportunity to zoom in, and connect with the intimate experiences of emotion as part of our wise minds through the poetry of Schueller and Reese. Fehling similarly encourages us to bring art back into the therapy space, connecting music and DBT skills. In DBT, our brand is crisis. We are better equipped than most to help our clients' experiencing crisis, and Philippopoulos and colleagues empower us to bring that expertise to our transgender and gender non-confirming clients. Finally, Robinson offers tools for making supervision in DBT feel more accessible, in the hopes that we can continue supporting adherent dissemination of this life-saving treatment.

Happy reading, dear DBT community. See you in the fall!

With gratitude and loving kindness,
Ashley Maliken & Andrea Gold

Why is My Child Acting This Way?! Helping Parents Understand Their Children Through the Lense of the Dialectical Dilemmas

Lyvia Chriki

Collaboration Practices

"I don't get her. She's trying to find ways to kill herself, then an hour later texting me about spring break! Is she messing with me?!"

The case presented here, of Maya, is a composite based on real clinical cases, with identifying details changed to protect the confidentiality of individuals. Maya grappled with a history of anxiety and depression. Starting in her early teens she engaged in self-harm, suicidal behaviors, and spent time in residential programs. At seventeen, Maya lived at home and her parents described her mood as a roller coaster, feeling they were "walking on eggshells". While her parents were devoted, they struggled to understand her and respond to her in ways they felt good about. They felt shame about their own parenting and frustration at their daughter's "lack of follow-through." Maya's parents also expressed bewilderment, a common enough sentiment DBT therapists hear from parents of teens and young adults with chronic emotion dysregulation.

Rather than grasp at straws further, they sought out parent guidance.
While evidence-based parenting interventions are generally well established (Michelson, 2013; Lebowitz, 2020), we are still working to clarify the best ways to help parents of teens and young adults within the context of DBT, especially when children refuse treatment or family work (Berk, 2023; Zalewski et al, 2023). Early research in this area suggests great potential for parent-only DBT-based interventions (Berk et al, 2022). In the case below I illustrate how Linehan's model of the dialectical dilemmas (Linehan, 1993; Manning 2011) can provide a centering organizational framework in DBT-parent guidance.

Emotional Vulnerability and Self-Invalidation. Maya's parents were scared of their daughter's "wrath". When angry, she blamed them for her challenges. In-session chain analyses of events from the parents' perspectives revealed this was usually prompted by their efforts to help in the face of a problem, like struggling with an assignment. She would turn down suggestion after suggestion, quickly becoming angry and screaming, "You just don't get it!" She would curse, slam doors, and list their wrongdoings over the years. They argued back that things cannot all be their fault, that there is a reason she was sent away, that she needs to "take responsibility". At the same time, they generally avoided making requests or having expectations of her for fear of her reaction and because of their own shame and guilt. Thoughts like "Her life does suck and it is our fault!" and "How can we ask more of her?!" regularly plagued her mother.

Adding to their confusion, Maya's parents also reported there were times she did acknowledge the need to work harder. Maya identified a desire to work harder and focus more, knowing she could succeed if only for these missing pieces. Maya's parents were happy to hear this. And, it seemed inevitable that Maya would again get overwhelmed, fail to complete another assignment, and more conflict would ensue.

This is a clear illustration of one of the dialectical dilemmas in DBT. Maya was wavering between her experience of *emotional vulnerability,* feeling at the mercy of her emotions and angry at the world, and *self-invalidation*, taking on all the blame, oversimplifying her problems and how to solve them. All-or-none thinking kept her stuck. In her experience she had no choice but to either blame the world or blame herself. And though her parents' intentions were to try and extricate her from the pendulum, they were stuck on it with her.

Understanding Maya's "stuckness" and how they may be adding fuel to the fire was powerful. Maya's parents began to see that Maya may be feeling shame. They were then able to acknowledge and validate Maya's difficulties before jumping to problem solving and worked to disengage more calmly from arguments about blame. Instead of fragilizing her, they gained confidence in setting some clear and reasonable limits – when possible, with her collaboration – while also validating her experience. They realized that avoiding observing limits actually validated the invalid – that she was helpless and incompetent. They focused on encouraging Maya to take small, concrete steps towards goals and praising her on these. They were able to validate this was hard while expressing confidence in her.

Active Passivity and Apparent Competence. Sometimes Maya

communicated distress yet refused to address the issue. During the day, she would send texts with pictures of her cuts. Her mother would get very scared and call Maya immediately, but Maya would not pick up. Mom would then drive to school to get Maya, sometimes taking her for an outing to help her feel better.

At times, these texts and other expressions of intense distress were sent shortly after Maya and her mother had a pleasant conversation. Chain analyses completed with the parents showed that frequently these conversations were focused on planning around school. Maya would seem enthusiastic discussing her plans to tackle an assignment she was working on. Her mother would report that Maya may have mentioned some nervousness but had not appeared nervous, making statements like, "It'll be hard but I got this!" Moments later Maya would send a message saying she was giving up and should just drop out.

We explored how Maya was likely stuck between feeling more helpless than she was and seeming more competent than she truly was. When sending distressing texts to mom and refusing to then respond, Maya was actively communicating there was a problem yet was being passive about problem solving. This might be due to skill deficits or fear of directly communicating vulnerability. On the other hand, it was easy to expect Maya to express herself accurately because she was generally very bright and articulate, and she may struggle to do so when anxiety is high. When anxious, she may not know how to put into words how she feels on the inside, especially when wanting to make her mother proud.

Understanding this helped both parents become more centered, less judgmental, and more effective in their responses to Maya. Instead of jumping in to rescue, they worked to drag out new behaviors of directly asking for help and accurately expressing emotion. "It sounds like things are really hard right now. I'm here. If you want my help, let me know" was mom's new response to the scary texts. In conversations around school, they started paying close attention to Maya's facial expressions and signs of anxiety. They began regularly reflecting to her, "You don't look nervous, and it would totally make sense if you are. Do you think you might be anxious about this?" This opened up possibilities for conversations on Maya's experience and helped them all feel more connected and in tune with one another.

Unrelenting Crisis and Inhibited Grieving. When mom received texts with acute expressions of distress, Maya would frequently come home later in a better mood, seemingly having forgotten the distress she signaled. Her parents did not dare bring up the issue for fear of "rocking the boat". There were times when things were peaceful for stretches of time, and parents would be relieved they were finally getting a break.

Inevitably, a crisis would catch them off guard. Out of the blue they would get a call from the school saying that Maya needed to be taken to the ER because she reported hopelessness and high urges to overdose on her medication. When this happened, dad, who was often critical, seemed to soften. Sometimes they said the time in the hospital felt nice, because finally they were all talking. When Maya would come home, they backed off and tried to give her space. Inevitably another crisis ensued. Cycling between inhibiting her grieving – avoiding discomfort and feelings of loss – and then finding herself in crises, was being reinforced by Maya's parents. Understanding the function of avoidance and accommodation and their role in reinforcing crisis related behaviors motivated Maya's parents to do things differently. They worked on sprinkling in validation in daily interactions. They began addressing important issues when they arose in a validating and direct manner, practiced radical acceptance of their daughter's distress as well as their own, and worked to model openness to emotions.

Conclusion

When we feel confused by our patients' behaviors in DBT, we often draw on the dialectical dilemmas to help elucidate our patients' behaviors and respond more effectively. Parents like Maya's see these extreme behavioral patterns in their children but cannot make sense of them, and oftentimes, end up inadvertently reinforcing them. If we can help parents recognize and understand these patterns, they can work to decrease reinforcement in the hopes of decreasing emotion dysregulation. What's more, parents have their own dialectical dilemmas and may also need validation before they are ready to change. They come to us frustrated, shameful, willful. They are perplexed by us telling them to validate a child who violates house rules and to observe limits when their child is suffering. Labeling the behavioral patterns can be validating and motivating, as it puts a name to their experience with their child and helps them understand their role in treatment. Using this model in parenting work can provide clarity on what is needed and can help us and the parents stay dialectical in the process.

References

Berk, M. S., Rathus, J., Kessler, M., Clarke, S., Chick, C., Shen, H., & Llewellyn, T. (2022).

Pilot test of a DBT-based parenting intervention for parents of youth with recent self-harm. *Cognitive and Behavioral Practice, 29*(2), 348-366.

Berk, M. S. (2023). Dialectical behavior therapy with parents of youth at risk for suicide. *Clinical Psychology: Science and Practice, 30*(4), 377–380

Lebowitz, E. R., Marin, C., Martino, A., Shimshoni, Y., & Silverman, W. K. (2020). Parent-based treatment as efficacious as cognitive-behavioral therapy for childhood anxiety: A randomized noninferiority study of supportive parenting for anxious childhood emotions. *Journal of the American Academy of Child & Adolescent Psychiatry, 5*9(3), 362-372.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* Guilford
press.

Manning, S. Y. (2011). *Loving someone with borderline personality disorder: How to keep out-of-control emotions from destroying your relationship. Guilford Press*.

Michelson, D., Davenport, C., Dretzke, J., Barlow, J., & Day, C. (2013). Do evidence-based interventions work when tested in the "real world?" A systematic review and meta-analysis of Parent Management Training for the treatment of child disruptive behavior. *Clinical Child and Family Psychology Review,* 16, 18–23.

Zalewski, M., Maliken, A. C., Lengua, L. J., Martin, C. G., Roos, L. E., & Everett, Y. (2023). Integrating dialectical behavior therapy with child and parent training interventions: A narrative and theoretical review. *Clinical psychology: Science and practice, 30*(4), 365.

Treat *Both Sides* of the Transaction: Life–Threatening Behaviors in Children Affect Their Parents AND Parent Trauma–Related Problems Affect their Teen and Young Adult Children

Alan Fruzzetti

National Suicide Research Foundation, University College Cork and National DBT Training Team, Ireland

Dialectical Behavior Therapy (DBT) has an extensive empirical basis for adolescents and adults. However, because of the typical structure of mental health services in the U.S. and internationally, only DBT with adolescents regularly includes a parent or family intervention component, and few studies even note the number of individual clients who live with parents or anything about the well-being of those parents. Even fewer intervene directly to help parents and caregivers improve their well-being (even vis-à-vis their children). Thus, most DBT programs intervene either exclusively, or almost entirely, on the individual client (adolescent or young adult) side of the transaction between them and their parents and other caregivers. But parents may be distressed and reactive and likely do not understand the experiences and behaviors of their teen or young adult child. This, in turn, leaves them less emotionally available and more vulnerable to invalidate their children (Fruzzetti et al., 2005; Linehan, 1993). Despite its potential utility, the parent and caregiver side of the transaction is often neglected in DBT (and most other treatments), even when adolescents and young adults live with and spend a very large amount of time interacting with their parents/caregivers.

The whole transactional model for emotion dysregulation is relevant to DBT clients with severe and chronic emotion dysregulation, in particular those who engage in suicidal behaviors and non-suicidal self-harm, along with other problematic and sometimes dangerous behaviors (Fruzzetti et al., 2005, 2010, 2023; Sturrock & Mellor, 2014). In several recent studies we have found that after a child's non-suicidal self-injury or suicide attempt, parents report significant stress- and trauma-related reactions, including high rates of PTSD and other trauma-related problems. For example, in an internet study of more than 400 family members, the most common traumatic event (Criterion A) parents (about 2/3 of the sample) identified was a suicide attempt by their child with BPD or related problems (Fruzzetti et al., in prep). Participants also identified that the most common types of potentially traumatic events were suicide threats (81%), non-suicidal self-injury (74%), and suicide attempts (62%). Similarly, parents whose teenage and young adult children (ages 14-22) were being treated in a residential DBT program reported high levels of distress and trauma-related problems (a combination of Criterion A and PCL-5 scores at or above 33). In one sample, 90% of parents met these criteria, and in a second sample, 82% did (Fruzzetti, in prep). Although PCL-5 scores are not equivalent to a PTSD diagnosis per se, scores 31-33 indicate "probable" PTSD. Moreover, the main point is not whether they met full criteria for PTSD, but rather that PTSD-related problems were extremely common.

And, even among adults, there has long been evidence that poorer family functioning is associated with greater suicidality, even when people otherwise report similar levels of clinical distress (Keitner et al., 1987). Together these studies suggest that parent distress and trauma-related problems are likely very common among adolescents and young adults with life-threatening behaviors in DBT treatment programs.

Of course, increased distress in parents can significantly affect their capacity to be effective parents, especially for their very vulnerable kids. From a fear conditioning perspective, increased parent escape and avoidance behaviors (dysregulated emotions), including attempts to overcontrol their children to manage their fear, are not surprising. Moreover, the transactional perspective predicts and highlights the impact of fear conditioning on parenting, and consequently on their children via invalidating responses (Shenk & Fruzzetti, 2011).

However, the most standard interventions for parents of youth in DBT are limited to multi-family groups and standard DBT skills, and almost exclusively only when children are under 18 years of age. To be sure, data from programs that include multi-family groups are very positive for teenage clients. At the same time, these interventions may not be sufficient or sufficiently

comprehensive for those parents with PTSD and other trauma-related problems related to a Criterion A index traumatic event of their loved one engaging in suicidal and non-suicidal behavior. Moreover, appropriate PTSD treatments for them are difficult to access due to both availability in general (particularly in some geographic locations) and cost in particular. Most families experience significant financial struggles related to paying for care for their children, severely limiting their ability to pay for their own treatment. Stigma (and judgments toward parents) also may inhibit both the broad availability of these services and parents' energy to seek them out even when available.

For these reasons, it is important for DBT therapists to: 1) stay non-judgmental and dialectical about parents (and their children), in particular employing both mindfulness and relationship mindfulness (i.e., staying curious) (Fruzzetti, 2022); 2) fully incorporate the transactional model into our thinking to develop a compassionate and effective intervention plan that includes collaboration with parents and their teen and young adult client (cf. Fruzzetti & Payne, 2020; Fruzzetti, 2018); 3) develop a repertoire both to assess and to treat trauma-related problems in parents when needed; and 4) facilitate DBT parent/family skill development and DBT family therapy to help transform parent-child transactions in ways that are good for both.

With respect to treating trauma-related problems in parents, it may be possible to do this efficiently in a group format, if all parent (only) members report experiencing stress- and trauma-related reactions in response to their child's dangerous behaviors. There is increasing evidence for the utility of treating trauma-related problems in group formats in general (cf. Castillo et al., 2016) and using DBT in particular (Iverson et al., 2009). For parents, interventions and skills are needed to: 1) understand the transactional model, with emphasis on not blaming kids or parents; 2) reduce stigma (and loneliness), especially by employing interpersonal skills to reduce shame, asking for non-judgmental understanding among adults friends and family members, and telling others about their experiences (not about their children, but about their own experiences); 3) reduce fear conditioning by practicing mindfulness, in particular noticing (multiple times every day) that their child really is safe *right now*, and any fear that they have is the understandable, but problematic, result of fear conditioning from prior dangerous events; and 4) improve self-care, both ABC please skills and building/renewing relationships and finding joy.

However, this kind of parent intervention group program is not always feasible for multiple logistical and financial reasons for many DBT programs. For other parent, couple and family problems, many DBT programs refer parents and partners to Family Connections (FC) programs (Fruzzetti & Hoffman, 2002, 2023). Standard FC is evidence based (more than a dozen published studies) and is always free to participants. In some locations it is available in-person, and it is also available virtually in all locations. FC studies consistently demonstrate that participants show reduced burden, distress, and grief and increased empowerment.

However, not all FC participants have stress- and trauma-related problems, so attention to these issues is minimal in standard FC. For this reason, another free access Family Connections program, *Managing Suicidality and Trauma Recovery* (FC-MSTR) was developed by Fruzzetti and colleagues to: 1) help parents reduce their trauma-related (and other) distress, 2) improve relationships between these parents and their children, as well as overall skillful parenting, in particular by reducing invalidating responses, aversive control reactions, increasing emotional support and validating responses, and consequently, 3) help reduce emotional distress, isolation and risk in their children, and 4) increase connection between kids and their parents. The FC-MSTR program addresses all of the interventions suggested above in a no-cost group program that is offered in-person or online through the National Education Alliance for BPD (NEABPD). FC-MSTR includes evidence-based psychoeducation, individual DBT skills to manage attention and emotion, modified exposure strategies to reduce fear conditioning, and DBT parent and family skills to improve relationships, along with significant peer support from other parents. A recent open trial suggests that the program is feasible and effective in reducing PTSD severity. Parent participants also reported high satisfaction and showed significant reductions in problems with dysregulated emotion, burden, depression, anxiety, and overall stress (Au et al., in review). In addition, a randomized clinical trial evaluating FC-MSTR is nearly completed. More information about the FC-MSTR program may be found here: MSTR Information.

Fortunately, both DBT programs and the FC-MSTR program can help parents reduce PTSD and related problems, which in turn can benefit their relationships and responses with their

children, their overall parenting, and in turn, reduce risk and improve outcomes for their adolescent and young adult children. Indeed, it is generally more effective to treat both sides of the transaction.

References

Au, J. S., Porter, N. P., Wilner Tirpak, J., Payne, L., Kaplan, C., Fruzzetti, A. E. (in review). *An education and skills program for parents experiencing stress- and trauma-related distress following their children's non-suicidal self-Injury and/or suicide attempts.*

Castillo, D. T., Chee, C. L., Nason, E., Keller, J., C'de Baca, J., Qualls, C., Fallon, S. K., Haaland, K. Y., Miller, M. W., & Keane, T. M. (2016). Group-delivered cognitive/exposure therapy for PTSD in women veterans: A randomized controlled trial. *Psychological Trauma: Theory, Research, Practice, and Policy,* 8(3), 404–412. https://doi.org/10.1037/tra0000111

Fruzzetti, A. E. (2022). Dialectical thinking. *Cognitive and Behavioral Practice, 29*, 567-570. DOI: 10.1016/j.cbpra.2022.02.011

Fruzzetti, A. E. (2018). DBT with parents, couples and families to augment Stage 1 outcomes. In M. Swales (Ed.), *Oxford Handbook of Dialectical Behaviour Therapy*. London: Oxford University Press. DOI: 10.1093/oxfordhb/9780198758723.013.19

Fruzzetti, A. E. (in preparation). *Distress and trauma among parents of adolescent and young adults in a residential DBT program.*

Fruzzetti, A. E., Harned, M.S., Liu, J., Valenstein-Mah, H. (in preparation). *Trauma exposure and trauma-related problems among family members of self-harming and suicidal individuals with borderline personality and related problems.*

Fruzzetti, A. E., & Hoffman, P. D. (2002; 2023). *Family Connections: A manual for family members of people with borderline personality and related problems. New York: National Education Alliance for BPD.*

Fruzzetti, A. E. & Payne, L. (2020). Assessment of parents, couples, and families in dialectical behavior therapy. *Cognitive and Behavioral Practice, 27*, 39-49. doi.org/10.1016/j.cbpra.2019.10.006

Fruzzetti, A. E., Shenk, C., & Hoffman, P. D. (2005). Family interaction and the development of borderline personality disorder: A transactional model. *Development and Psychopathology, 17*, 1007-1030. DOI:10.1017/S0954579405050479

Fruzzetti, A. E., & Worrall, J. M. (2010). Accurate expression and validation: A transactional model for understanding individual and relationship distress. In K. Sullivan & J. Davila (Eds.), *Support processes in intimate relationships* (pp. 121-150). New York: Oxford University Press. DOI: 10.1093/acprof:oso/9780195380170.003.0005

Iverson, K., Shenk, C., & Fruzzetti, A. E. (2009). Dialectical Behavior Therapy for women victims of domestic abuse: A pilot study. *Professional Psychology: Research and Practice, 40*, 242-248.

Keitner, G. I., Miller, I. W., Fruzzetti, A. E., Epstein, N. B., Bishop, D. S., & Norman, W. H. (1987). Family functioning and suicidal behavior in psychiatric inpatients with major depression. *Psychiatry, 50*, 242 255.

Linehan, M. M. (1993). Cognitive–behavioral treatment of borderline personality disorders. New York: Guilford.
Shenk, C. & Fruzzetti, A. E. (2011). The impact of validating and invalidating responses on emotional reactivity. *Journal of Social and Clinical Psychology, 30*, 163-183. DOI: 10.1521/jscp.2011.30.2.163

Sturrock, B., & Mellor, D. (2014). Perceived emotional invalidation and borderline personality disorder features: A test of theory. *Personality and Mental Health 8*, 128–142.

Tackling a Wicked Problem: How Stakeholders Can Unite to Improve Access to Comprehensive DBT

Julie Frantsve-Hawley and **Abby Ingber**

National Education Alliance for BPD (NEABPD)

Comprehensive Dialectical Behavior Therapy (DBT) changes—and saves—lives. When DBT is delivered with fidelity to the treatment model, there is robust evidence to support that people with Borderline Personality Disorder (BPD) experience reduced self-harm, suicidality, and hospitalizations. DBT includes four core modes of treatment: individual DBT therapy, DBT skills group training, phone coaching, and a consultation team. In comparison, many mental health providers offer "DBT-informed care," which adopts selected skills and modes but excludes other crucial components. While DBT-informed approaches can be beneficial for some conditions, research overwhelmingly confirms that the most robust outcomes for those with BPD and other disorders with emotion dysregulation stem from comprehensive DBT programs.(DeCou et al., 2019; Gillespie et al., 2022; Hu et al., 2024; Panos et al., 2014; Stoffers-Winterling et al., 2022; Storebo et al., 2020; van Ballegooijen et al., 2025) Despite its effectiveness, comprehensive DBT remains out of reach for many.

Understanding Stakeholders' Perspectives. At the National Education Alliance for Borderline Personality Disorder (NEABPD), we recently launched initiatives to better understand the complexities surrounding access to comprehensive DBT. We partnered with Pepperdine University's Master of Science in Organization Development (MSOD) program to conduct focus groups with 23 individuals across three profile groups—lived experiences, clinicians/researchers, and organizations—to learn their perceptions of the challenges associated with access to effective BPD treatment and their ideas of what would improve the landscape. Collectively, there was a general alignment on the core challenges. Here we describe key themes that emerged from these interviews to inform ongoing BPD advocacy efforts:

Financial & Insurance Barriers. Inadequate commercial and public insurance reimbursements are leading factors in the access issue. Insurance systems and reimbursement structures often fail to recognize or fairly compensate for the comprehensive nature of DBT, leaving gaps that make treatment unaffordable. As a result, individuals frequently struggle to find programs that accept their insurance, and many pay significant out-of-pocket costs; some families indicated that they have resorted to extreme measures like refinancing their homes to afford care. Clinicians and researchers likewise note the challenge of keeping practices solvent when reimbursement rates are low or inconsistent.

Provider Capacity & Training Gaps. Lack of provider availability and a shortage of adequately trained clinicians further restrict access to comprehensive DBT. Provider shortages in certain regions create deserts where no comprehensive DBT programs exist.

Stigma & Diagnostic Challenges. Organizational stakeholders emphasized that BPD is still not recognized on par with physical illnesses, and the stigma attached to both BPD and mental illness discourages understanding and access to treatment. Many people with lived experience spoke about the difficulty of receiving a proper diagnosis; delayed or inaccurate diagnoses add to emotional distress and postpone entry into effective care.

System Navigation. Even after a diagnosis, patients and families face the emotional toll of navigating an under-resourced system. Individuals often experience difficulty locating programs that both deliver comprehensive DBT and accept their insurance. The resulting search process is draining and disheartening, as families confront long wait-lists, uncertain coverage, and confusing reimbursement policies—all while coping with urgent clinical needs and the high stakes of untreated emotion dysregulation.

There was a palpable sense of unity among the focus groups around the shared goal of increasing access to evidence-based care and improving the lives of those with BPD, and unanimously agreed on the destination: wider, affordable access to comprehensive DBT. However, there were strikingly different roadmaps offered for getting there. Some urged an immediate push for new billing codes, others argued for state-level parity legislation first, while still others championed large-scale workforce grants or national anti-stigma campaigns. Each proposal addressed a real barrier, yet none could stand alone. This lack of a single, universally endorsed strategy can potentially stall collective

momentum, splinter advocacy energy, and even cause well-intentioned groups to work at cross-purposes. Based on these interviews, it became clear that increasing access to comprehensive DBT fits the classic definition of a "wicked problem," which demands a multi-stakeholder, systemic approach rather than a single, linear solution.

Why Access to DBT Is a "Wicked Problem". The term "wicked problem," first coined by Horst W. J. Rittel and Melvin M. Webber, refers to a complex issue that is difficult to solve using traditional strategies (Rittel & Webber, 1973). Wicked problems are multifaceted, involve multiple stakeholders with varying perspectives, and often defy straightforward definitions. They have no clear end state, and efforts to address one aspect may exacerbate other elements.

In other words, expanding comprehensive DBT will demand a coordinated, system-wide response that synthesizes policy change, fair reimbursement, workforce growth, and persistent anti-stigma efforts—no single lever will suffice. The focus group participants confirmed this tangled web of insurance hurdles, provider shortages, and stigma while also pointing to several first steps: create dedicated insurance codes and cost-effectiveness evidence that make DBT's value unmistakable to payers; fund loan-forgiveness, scholarships, and stepped-care approaches to expand the trained clinician pool; and launch public-awareness campaigns—powered by those with lived experience and family voices, and partnerships with allied mental-health groups—that showcase states already achieving comprehensive DBT coverage as replicable models. Though these ideas differ in detail and consensus, together they map the multi-stakeholder, iterative route required to tackle this wicked problem and guide the next phase of work.

The focus groups revealed that, although stakeholders hold different views on how to move forward, they agree on the need for a shared roadmap. Because access to DBT is a "wicked problem," that roadmap cannot be a one-size-fits-all fix; it must weave together multiple, complementary solutions—policy, reimbursement, workforce, and stigma reduction—within a single, coordinated strategy. A trans-organizational framework can supply this coordination, aligning diverse efforts under one strategic umbrella and giving stakeholders a common goal and sense of momentum.

Trans-Organizational Systems: A Roadmap to Change. A trans-organizational system forms across multiple entities to tackle complex challenges that exceed the scope of any single organization (Ainsworth & Feyerherm, 2016; Clarke, 2005). It convenes diverse stakeholders—including clinicians, advocacy groups, researchers, payers, government agencies, and those with lived experience—to develop a collective vision, align on strategies, and coordinate cohesive actions.

Such an initiative could bring people together in regular summits to present the latest information on DBT outcomes and cost savings, publish a comprehensive report on BPD, and plan a national awareness campaign to reduce stigma. A trans-organizational system would promote the message that sustainable solutions require a united front to change insurance policies and eradicate outdated assumptions about BPD. A holistic approach that draws on trans-organizational collaboration may include coordinated advocacy that unifies professional societies, advocacy groups, and dedicated clinicians. It could also raise the visibility of lived-experience voices by encouraging them to speak at policy forums and legislative hearings.

The Insurance Coding Journey. One concrete way that NEABPD is tackling the "wicked problem" is by pursuing new insurance codes that accurately reflect the unique elements of comprehensive DBT. NEABPD explored submitting an application for insurance codes specific to comprehensive DBT to two code-developing entities: the American Medical Association (AMA) for Current Procedural Terminology (CPT) codes and the Centers for Medicare & Medicaid Services (CMS) for Healthcare Common Procedure Coding System (HCPCS). As part of this process, NEABPD consulted with relevant professional societies and implementation experts to prepare a comprehensive coding application. We will submit the application to the appropriate national coding authority once the content is finalized and aligned with stakeholder consensus.

Using a dedicated DBT code could streamline reimbursement and more accurately reflect the multimodal nature of the treatment. Such a code would officially recognize DBT as a distinct treatment and lay the groundwork for more consistent reimbursement. By advocating for a code for comprehensive DBT, we hope to achieve several key outcomes: 1) increase access to care, 2) increase reimbursement from both public and private health insurers, 3) expand the workforce capable of delivering comprehensive DBT, and 4) generate valuable data for long-term

observational research. Our ultimate goal is to reduce barriers to care and ensure broader access and standardized quality of care in DBT, thus significantly improving treatment outcomes for those with BPD and other disorders characterized by emotion dysregulation.

Conclusion

Although hurdles remain—particularly around reaching consensus on insurance solutions, combating stigma, and increasing access to evidence-based care—progress is within reach if key players collaborate, use robust data to make their case, and deliver a united message to policymakers and the public. The dedication of clinicians, organizations, insurers, policy advocates, and people with lived experience will be critical for expanding DBT access, improving the lives of those who need it most, and tackling our wicked problem.

To help confront this wicked problem, consider reaching out to the NEABPD Advocacy Committee (Get Involved in Advocacy), whose mission is to improve the quality of life for people with BPD and their families by focusing on three priorities: (1) expanding insurance coverage for evidence based treatment, (2) reducing stigma, and (3) educating insurers, policymakers, clinicians, and the public. You can lend your voice and expertise by emailing advocacy@neabpd.org. Your engagement can make a meaningful difference.

Acknowledgments

We want to acknowledge the Pepperdine Graziadio Business School Graduate Executive Consulting Team—Davy Koszka, Brittany Erway Soto, Jannette Munoz, Eric J. Espinoza, Cha Vang, Janezee Bond, Bethel Zelalem, and Stephen Pile—for their invaluable contributions to the qualitative interviews.

References

Ainsworth, D., & Feyerherm, A. E. (2016). Higher order change: a transorganizational system diagnostic model. *Journal of Organizational Change Management, 29*(5), 769-781.

Clarke, N. (2005). Transorganization Development for Network Building. *The Journal of Applied Behavioral Science, 41*(1), 30-46.

DeCou, C. R., Comtois, K. A., & Landes, S. J. (2019). Dialectical Behavior Therapy Is Effective for the Treatment of Suicidal Behavior: A Meta-Analysis. *Behav Ther, 50*(1), 60-72. https://doi.org/10.1016/j.beth.2018.03.009

Get Involved in Advocacy. National Education Alliance for Borderline Personality Disorder. Retrieved May 1, 2025 from https://www.borderlinepersonalitydisorder.org/bpd-advocacy/

Gillespie, C., Murphy, M., & Joyce, M. (2022). Dialectical Behavior Therapy for Individuals With Borderline Personality Disorder: A Systematic Review of Outcomes After One Year of Follow-Up. J *Pers Disord, 36*(4), 431-454. https://doi.org/10.1521/pedi.2022.36.4.431

Hu, F. H., Xu, J., Jia, Y. J., Ge, M. W., Zhang, W. Q., Tang, W., Zhao, D. Y., Hu, S. Q., Du, W., Shen, W. Q., Xu, H., Zhang, W. B., & Chen, H. L. (2024). Non-pharmacological interventions for preventing suicide attempts: A systematic review and network meta-analysis. *Asian J Psychiatr, 93*, 103913. https://doi.org/10.1016/j.ajp.2024.103913

Panos, P. T., Jackson, J. W., Hasan, O., & Panos, A. (2014). Meta-Analysis and Systematic Review Assessing the Efficacy of Dialectical Behavior Therapy (DBT). *Res Soc Work Pract, 24*(2), 213-223. *https://doi.org/10.1177/1049731513503047*

Rittel H.W.J., & Webber M.M. (1973). Dilemmas in a general theory of planning. *Policy Sci, 4*, 155–169. .

Stoffers-Winterling, J. M., Storebo, O. J., Kongerslev, M. T., Faltinsen, E., Todorovac, A., Sedoc Jorgensen, M., Sales, C. P., Edemann Callesen, H., Pereira Ribeiro, J., Vollm, B. A., Lieb, K., & Simonsen, E. (2022). Psychotherapies for borderline personality disorder: a focused systematic review and meta-analysis. *Br J Psychiatry, 221*(3), 538-552. https://doi.org/10.1192/bjp.2021.204

Storebo, O. J., Stoffers-Winterling, J. M., Vollm, B. A., Kongerslev, M. T., Mattivi, J. T., Jorgensen, M. S., Faltinsen, E., Todorovac, A., Sales, C. P., Callesen, H. E., Lieb, K., & Simonsen, E. (2020). Psychological therapies for people with borderline personality disorder. *Cochrane Database Syst Rev, 5*(5), CD012955. https://doi.org/10.1002/14651858.CD012955.pub2

van Ballegooijen, W., Rawee, J., Palantza, C., Miguel, C., Harrer, M., Cristea, I., de Winter, R., Gilissen, R., Eikelenboom, M., Beekman, A., & Cuijpers, P. (2025). Suicidal Ideation and Suicide Attempts After Direct or Indirect Psychotherapy: A Systematic Review and Meta-Analysis. *JAMA Psychiatry, 82*(1), 31-37. https://doi.org/10.1001/jamapsychiatry.2024.2854

Finding Balance in the Beat: Using Music to Teach and Practice DBT Skills

Kiki Fehling

kikifehling.com

When I was a kid, music helped me through my first depressive episode. Singing along to the latest emo band's emotionally evocative lyrics connected me to the pain I was feeling. It also connected me to the singer in our shared lived experiences. Music helped me feel less alone, and made my struggles less scary. I also learned how a wisely-picked song could prompt a desired emotional state for becoming a character in a play, energize me before a sports game, or enhance my memorization of facts for a test. (Whenever Britney Spears' "...Baby One More Time" plays, I still hear some of the matching state-capital mnemonics I created in elementary school!) Music became a useful mental health tool I used over and over.

Thus, it's no surprise to me that music became a huge part of how I personally strengthened and generalized the DBT skills as I learned them during graduate school. Shortly after I learned the skill of Opposite Action, I had to fly to attend a family event. At the time, I was very scared of flying. When trying to figure out how I could possibly act opposite all of the way to my intense physiological anxiety, I thought of music. For the next year, every time I boarded a plane, I listened to "BO$$" by Fifth Harmony. (For those unfamiliar, some lyrics include: "C-O-N-F-I-D-E-N-T / that's me, I'm confident" [Fifth Harmony, 2015].) The song helped me access a more grounded bodymind. By the time I was leading skills groups, I was able to teach Opposite Action by playfully sharing how Fifth Harmony helped me overcome my fear of flying. It was then that I learned music could also help me teach DBT skills to others.

Over the years, I found more and more songs that connected DBT principles to real-life experiences. When I started sharing these songs through "DBT skills in pop music" posts on my social media, people reached out. One person shared how they had not been able to understand certain DBT concepts until they conceptualized them through the music of their favorite pop artist. Others admitted they had been unwilling to try DBT before, because it seemed too cognitive or complicated, but connecting it to music made it fun, embodied, and accessible. Finding and sharing new ways to integrate DBT and music has now become a regular practice of accumulating positive emotions for me.

Music has the capacity to help people act effectively and better access DBT's wisdom, similarly to the dialectical strategy of metaphors. It has certainly assisted me in practicing skills and in building a life worth living. Below, I share some of my favorite DBT-supportive songs. I hope these lists support you in learning, strengthening, generalizing, and teaching skills. I hope they inspire you or your clients to find your own favorite DBT-in-music connections—I'd love to hear from you if they do!

Songs for Practicing Opposite Action.
When someone determines an emotion's action urges are ineffective for them, music can help them act opposite to those urges all of the way. Lyrics can contradict the emotion's typical thoughts. The music itself can counter the emotion's energy. Songs can be powerful tools for opposite action.

Opposite Action to Shame (Spotify Playlist; the below lists of four songs included here are subsets of all of the songs included on the linked playlists)
- BIG by Betty Who
- ***Flawless by Beyoncé
- I'M NOT SORRY by Neoni
- Sorry Not Sorry by Demi Lovato

*Opposite Action to Love (Spotify Playlist)**
- Forget You by CeeLo Green
- Sue Me by Sabrina Carpenter
- Flowers by Miley Cyrus
- Hair by Little Mix

Opposite Action to Sadness (Spotify Playlist)
- About Damn Time by Lizzo
- Best Day of My Life by American Authors
- Better When I'm Dancing by Meghan Trainor
- Shut Up and Dance by WALK THE MOON

**Huge shout-out to Heather Stambaugh for creating the collaborative "Opposite Action to Love" playlist available on Spotify, and for sharing a version in the Spring 2021 DBT Bulletin Vol. 4 Issue 1!*

Songs for Feeling and Validating Emotions.
Music can be a helpful prompt for self-validation, emotional exposure, and simply feeling your feelings. Every person has different songs that will be

most evocative for them, but below are some suggestions. (Note: many songs throughout this article can be helpful for prompting emotions for mindfulness practice!)

Mindfulness of Current Emotion

- Bohemian Rhapsody by Queen
- jordan by Joy Oladokum
- What Was I Made For? by Billie Eilish
- Fat Lip by Sum 41

Biosocial Model — Emotional Vulnerability/Dysregulation

The below songs portray lived experiences of emotional dysregulation and mental health struggles. Fair warning: the lyrics include a handful of judgmental/ineffective statements. They may feel very validating to emotionally vulnerable folks, however. Accordingly, these songs can prompt some strong emotions.

- Feel My Feelings by girli
- Anxiety by Julia Michaels and Selena Gomez
- Saturn by SZA
- Thoughts by Sasha Alex Sloan

Songs for Teaching DBT Skills.

Finally, some songs are useful for actually teaching certain DBT skills and principles. Their lyrics can provide validation while also modeling effective skills use or behavior.

- Pink Pony Club by Chappell Roan — a demonstration of many of the interpersonal effectiveness DEAR MAN, GIVE, and FAST skills, if you look for them.
- Happiness by Taylor Swift — lessons on dialectics after a breakup. ("There'll be happiness after you / but there was happiness because of you / both of these things can be true" [Swift, 2020].)
- Gold by MILCK — a model of nonjudgmental compassion, self-respect, and the liberating power of mindfulness of current emotion. ("Sorrow into bold, pain is beautiful / when it makes you grow, turn these tears to gold" [Milck, 2020].)
- breathin by Ariana Grande — a portrayal of using one-mindful breathing to get through physiological anxiety, racing hopeless thoughts, and overwhelm ("Feel my blood runnin' / swear the sky's fallin...I can't control my mind...Just keep breathing" [Grande, 2018].)
- okay by Avery Lynch & ROSIE — an encouragement about finding groundedness in painful times through mindfulness and radical acceptance. ("Just know each time / that you're not fine / you'll be okay... just be / and you'll see / that this is one part of the human you are / and who you are is all you have to be" [Lynch & Scher, 2022].)
- Love Me More by Sam Smith — another song with lessons about mindfulness of current emotion and self-love. ("So I tried every night / to sit with sorrow / and eventually / it set me free" [Smith, 2023].)
- Anxiety by Megan Thee Stallion — a validating portrayal of anxiety, with modeling of radically genuine self-encouragement. ("It'll be ok / bounce back 'cause a bad b**** can have bad days" [Megan Thee Stallion, 2022].)
- Little Things by Brye — a master class on the ABC PLEASE skills.
- Tattoos and Therapy by Madilyn Bailey — a portrayal of the struggle with self-destructive urges and how tattoos and therapy act like alternate rebellion for the singer.
- Bandaid on a Bullet Hole by Olivia O'Brien — a review of "tricks" the singer has used to survive terrible pain in the short-term (i.e., crisis survival skills), with explicit recognition that these skills may not support long-term healing. (Special thanks to a client who shared this song with me. It can be a fun "quiz" to try to match lyrics to DBT skills!)
- What Makes A Life Good by Katelyn Tarver — a contemplation on the types of values and goals that might be a part of someone's Life Worth Living, while recognizing that figuring out one's ways for Accumulating Positives is tricky and ever-changing.
- Opposite Action by Emma Jayne — this song speaks for itself! (Personally, I really like the remix with Charlie Curtis-Beard.)

References

Fifth Harmony (2015). BO$$ [Song]. On Reflection. Syco Music; Epic Records.

Grande, A. (2018). breathin [Song]. On Sweetener. Republic Records.

Lynch, A. & Scher, R. (2022). Okay [Song; Recorded by Avery Lynch feat. ROSIE]. On The Kids Table. Avery Lynch.

Megan Thee Stallion (2022). Anxiety [Song]. On Traumazine. 300 Entertainment.

Milck. (2020). Gold [Song]. On Into Gold. Atlantic Records.

Stambaugh, H. (2021). An Opposite Action Playlist. DBT bulletin, 4(1), 32.

Smith, S. (2023). Love Me More [Song]. On Gloria. Capitol Records.

Swift, T. (2020). Happiness [Song]. On evermore. Republic Records.

DBT was Built for Crisis – Transgender and Gender Diverse People Are in One

Anastasia Philippopoulos[1], Joanne Kim[1,2], L.M. Waters[1,2], Nicoletta Starzynski[2], Mashrika Khan[2], Ayra Shafique[2], and **Brittain Mahaffey[1,2]**

[1]Stony Brook Renaissance School of Medicine
[2]Stony Brook University

Introduction

Transgender and gender diverse (TGD) people face disproportionately high rates of mental health problems, including depression, anxiety, borderline personality disorder (BPD), substance use, and self-directed violence (SDV; i.e., non-suicidal self-injury [NSSI] and suicidal behavior) compared to their cisgender peers, including their cisgender queer peers (Camp et al., 2024; Day et al., 2017; Haas, Rodgers, & Herman, 2014; Newcomb et al., 2020; Paz-Otero et al., 2021; Zimmerman, Benjamin, & Seijas-Rodriguez, 2022). Approximately 40-42% of TGD people report a lifetime suicide attempt, as compared to 4.6% of the general U.S. population (James et al., 2016), with the highest rates amongst young adults aged 18 to 24 (Herman, Brown, & Haas, 2019).

These disparities in mental health have been attributed to the traumatic invalidation that TGD individuals face, including interpersonal transphobia (e.g., discrimination occurring within social interactions, including misgendering) and internalized transphobia (e.g., experiencing shame or distress related to one's transgender identity; Hughto, Reisner, & Pachankis, 2015; Price et al., 2024). Structural transphobia has particularly been linked with heightened mental health problems and suicidality (Price et al., 2024) and, concerningly, is rising with recent regressive political trends focused on rolling back protections for TGD people. For example, recent executive orders have mandated that all federal agencies recognize only "two sexes, male and female", prohibited transgender people from enlisting in the military, and restricted female transgender athletes from participating in women's sports. Most alarmingly, recent actions have threatened federal funding for clinics and hospitals that offer gender affirming care. For a comprehensive overview of state by state and federal policies, see the recent perspective piece by Coelho, Chen and Keuroghlian (2025).

Gender-affirming care (e.g., pubertal suppression, hormone treatment, surgeries, hair removal) has been shown to improve adult mental health outcomes in this population (Almazan & Keuroghlian, 2021; Lee et al., 2021; Turban et al., 2020; Turban et al., 2022; Turban et al., 2021) and the World Professional Association for Transgender Health (WPATH) standards (Coleman et al., 2022) highlight that access to these interventions is critical for the health and well-being of TGD individuals. There is a clear link between access to these interventions and reduced risk for depression, anxiety, and suicidality, and improvement in overall quality of life (Powell, Puebla, & Lepping, 2025; Tordoff et al., 2022). Given the consequences of recent government policies targeting TGD individuals (DuBois et al., 2023; Price, Puckett, & Mocarski, 2021), there is good reason to believe that transgender Americans are in crisis and will increasingly need access to effective mental healthcare.

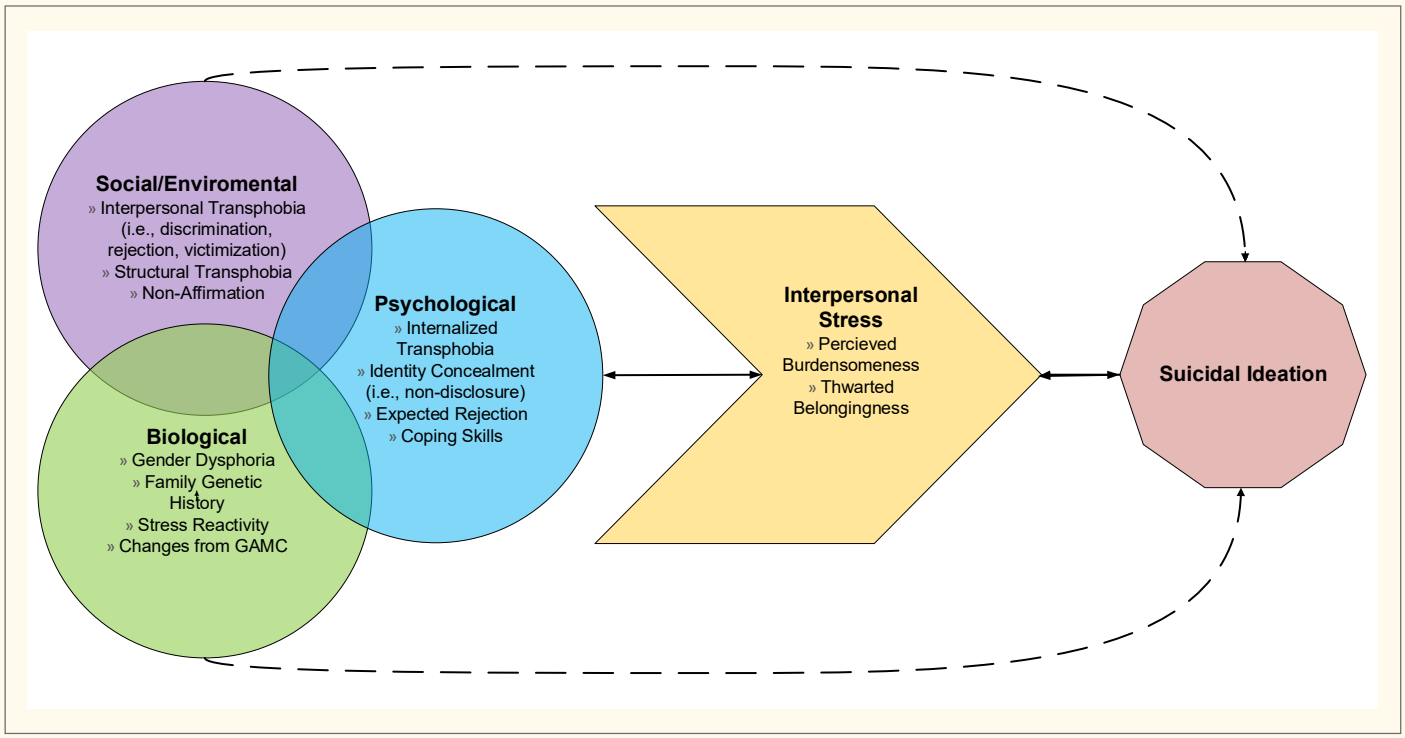
DBT: A Promising Treatment for SI in TGD People. Theories of suicidality and minority identity development provide a framework for understanding and addressing the unique stressors TGD individuals face. Specifically, interpersonal-psychological theory of suicide (IPTS; Joiner, 2005) and minority stress theory (Haas, Rodgers, & Herman, 2014; Paz-Otero et al., 2021) suggest that the experience of external stressors (e.g., discrimination, rejection) lead to SDV when in the context of internal psychological stressors like internalized transphobia, negative expectations, and non-disclosure of one's identity. These psychological stressors, in turn, increase experiences of interpersonal stressors such as thwarted belongingness and perceived burdensomeness—key risk factors for suicide. Promisingly, cognitive-behavioral interventions exist that address some of the factors highlighted by minority stress theory (Austin, Craig, & D'Souza, 2018; Bluth et al., 2024). However, they often broadly focus on sexual and gender minority (SGM) populations, without fully addressing the unique challenges that TGD people face, such as coping with gender dysphoria and navigating gender-affirming care. Additionally, CBT is not an evidence-based treatment for SI or SDV in TGD individuals (Austin et al., 2022; Pellicane & Ciesla, 2022; Wu et al., 2022), and is thus not designed to simultaneously address the factors identified in IPTS.

Because DBT (Linehan, 1993) is based on the biopsychosocial model, which dovetails well with interpersonal theories of suicide risk, it is a natural fit for the needs of TGD individuals (see Figure 1). The biosocial model highlights the interplay between emotional vulnerability and an invalidating environment, the latter of which is particularly relevant for TGD people, who often encounter stigma and interpersonal rejection (Linehan, 1993; Testa et al., 2015). DBT skills training also inherently addresses many of the psychological and interpersonal factors which mediate the link between minority stress and SDV, such as the ability to validate one's own experiences and communicate needs effectively with others. Accordingly, DBT already addresses some of the key factors thought to mediate the link between minority stress and SDV (Hughto, Reisner, & Pachankis, 2015; Puckett et al., 2018).

Unfortunately, limited data is available on the efficacy of standard DBT for this population, as most trials have historically lacked sufficient reporting on gender identity, ultimately making it difficult to assess its effectiveness for TGD participants (Harned, Coyle, & Garcia, 2022). Recently, Camp et al. (2024) examined enrollment rates, symptom outcomes, and DBT completion in a specialized program for teens. They found that, while SGM teens generally benefited from standard DBT, TGD teens tended to complete the program at lower rates than their cisgender peers. Similarly, previous research in adult populations (e.g., Beard et al., 2017), suggests that DBT is efficacious for SGM populations, but disparities may remain for specific SGM subgroups.

Adapting DBT for TGD People. To address disparities in treatment engagement, several studies have adapted DBT skills training for general SGM populations. These adaptations aim to address minority stressors—such as rejection sensitivity and internalized stigma—using standard DBT skills with examples relevant to SGM populations. Preliminary findings from small samples of SGM veterans suggest that these programs are both feasible and acceptable (Cohen et al., 2021; Skerven et al., 2021). For example, Cohen and colleagues (2021) describe participants learning to apply the "Check the Facts" skill to assess whether anticipated rejection is evidence-based (e.g., "How do you know

Figure 1. Mediation Model Linking the Biopsychosocial Model and IPTS



Note. Model linking biopsychosocial theory with the interpersonal psychological theory of suicide to illustrate that social/environmental, biological, and psychological factors mediate interpersonal stress and suicidal ideation that TGD populations face.

*Gender-affirming medical care (GAMC).

your boss will deny your request to change your email address? Have they responded this way before?"). Validation strategies (i.e., validation based on history) are also used to address internalized stigma, helping participants understand how self-invalidation can arise from chronically invalidating environments, such as those that discourage expressions of sexual identity. Similarly, Skerven et al. (2021) integrated discussions of stigma into the teaching of standard DBT skills. In this study, facilitators who identified as SGM were encouraged to use self-disclosure to model using skills such as DEAR MAN to address a workplace microaggression. However, these studies were limited by small sample sizes and were not powered to assess efficacy or examine outcomes by gender identity. Moreover, facilitators who identify as SGM or TGD may not always be available to facilitate such programs and guidance for non-SGM facilitators will be critical to increasing the accessibility of these types of programs.

Qualitative and theoretical work also suggests that DBT could be adapted to more effectively address the needs of TGD populations. Specifically, recommendations include adapting materials to explicitly address minority stress theory, discrimination, body dissatisfaction, internalized stigma, gender-affirming care, and the balance between safety and self-advocacy (Beard et al., 2017; Oransky, Burke, & Steever, 2019; Tilley et al., 2022). For example, mindfulness practices could be modified to reduce the risk of triggering gender dysphoria by incorporating gender-neutral language and offering a hierarchical, exposure-based approach—starting with non-body-focused exercises and gradually moving toward embodied practices. Emotion regulation modules might include targeted work on self-stigmatizing thoughts and internalized transphobia, encouraging participants to challenge beliefs such as "I don't deserve respect because I am trans" and develop more affirming self-narratives. Distress tolerance skills could be contextualized within the TGD experience, such as framing "contributing" as community engagement and using meaning-making to highlight the resilience inherent in surviving marginalization. Additionally, reality acceptance work could help participants explore the limitations of gender-affirming care in fully alleviating dysphoria, while using dialectical thinking to hold both the reality of ongoing challenges and the pursuit of authenticity. These proposed adaptations could improve the relevance, accessibility, and therapeutic impact of DBT for TGD individuals.

There is also a need to reduce barriers to accessing and engaging with mental healthcare that are commonly reported by TGD youth (Panchal et al., 2022; Seelman et al., 2017). Chronic invalidation in the forms of structural stigma, fear of discrimination related to gender identity, and negative experiences with providers lacking knowledge about the TGD community are often reported (Snow et al., 2019) and may contribute to TGD youth accessing or engaging with mental healthcare at suboptimal levels. Reducing these barriers may involve implementing provider training focused on TGD-affirming care, including correct use of pronouns, awareness of gender-affirming medical and social transitions, and responsiveness to minority stress. Clinics could also adopt intake procedures that allow clients to self-identify their gender and name/pronouns in a respectful, non-pathologizing manner. Ensuring visible signals of inclusion—such as gender-neutral bathrooms, inclusive signage, and representation in materials—can promote a sense of safety. Additionally, clearly advertising the availability of gender-affirming services and using inclusive language in outreach materials can communicate that a space is safe and welcoming, which may increase the likelihood that TGD youth seek out and engage with care.

Future Directions. First, in accordance with recommendations from Harned, Coyle and Garcia (2022), all future trials should follow guidelines for effectively measuring and reporting on participants' gender identity and other intersectional aspects of identity. Researchers should also include data on recruitment and retention in trials to facilitate examining potential barriers to treatment engagement for TGD individuals. Second, tailoring DBT for TGD individuals may provide an opportunity to improve access to affirming psychiatric care for this population. Interventions that are tailored to address a client's specific beliefs, values and life experiences can increase treatment engagement and produce better client outcomes (Budge, Israel, & Merrill, 2017; Pachankis & Safren, 2019). Third, too few clinicians receive formal education on working with TGD clients, leaving providers unprepared to address gender dysphoria, minority stress, and systemic discrimination. Without specialized training, even well-intentioned therapists may inadvertently contribute to higher dropout rates and poorer outcomes, underscoring the need for competency-based DBT education (Puckett et al., 2018; Singh,

2017). Training for therapists working with DBT and CBT based models should incorporate explicit instruction on core competencies for working with TGD populations, such as gender-affirming validation strategies, identifying therapy-interfering invalidation, and integrating gender-related distress into DBT coaching (Hughto, Reisner, & Pachankis, 2015). Several excellent resources exist for CBT therapists that outline best practices for culturally competent, gender-affirming care (e.g., Pachankis & Safren, 2019; Chang & Singh, 2018). Establishing structured supervision models would further reinforce these competencies by providing ongoing feedback and reflective practice, helping therapists maintain affirming care and reduce the risk of therapeutic invalidation (Singh, 2017). These models often include scheduled, competency-based supervision that integrates identity-informed case conceptualization, attention to intersectionality, role-play of affirming interventions, and supervisor self-reflection. By embedding gender-affirming principles into the supervisory process, clinicians are more likely to sustain effective and responsive care for TGD clients.

Conclusions

Although research on DBT in TGD populations is still emerging, existing evidence supports its potential effectiveness for individuals across diverse gender identities. While standardized data collection will be essential to advance this work, the high rates of mental health concerns among TGD individuals underscore the urgent need for affirming and tailored interventions. Qualitative and theoretical research suggests that DBT is well-suited to address the emotion regulation challenges and self-destructive behaviors often experienced by TGD individuals and offers a strong foundation for thoughtful adaptation. Given the ongoing mental health disparities facing this population, there is a pressing need for interventions that help TGD individuals feel safe, affirmed, and empowered to build lives they experience as meaningful and worth living.

References

Almazan, A. N., & Keuroghlian, A. S. (2021). Association between gender-affirming surgeries and mental health outcomes. *JAMA Surgery*, 156(7), 611-618.

Austin, A., Craig, S. L., & D'Souza, S. A. (2018). An AFFIRMative cognitive behavioral intervention for transgender youth: Preliminary effectiveness. *Professional Psychology: Research and Practice*, 49(1), 1.

Austin, A., Craig, S. L., D'Souza, S., & McInroy, L. B. (2022). Suicidality among transgender youth: Elucidating the role of interpersonal risk factors. *Journal of Interpersonal Violence*, 37(5-6), NP2696-NP2718.

Beard, C., Kirakosian, N., Silverman, A. L., Winer, J. P., Wadsworth, L. P., & Björgvinsson, T. (2017). Comparing treatment response between LGBQ and heterosexual individuals attending a CBT-and DBT-skills-based partial hospital. *Journal of consulting and clinical psychology*, 85(12), 1171.

Bluth, K., Bryce, A., Lathren, C. R., Park, J., Pflum, S., & Clayton, M. (2024). Reducing Suicide Ideation in Transgender Adolescents with Mindful Self-Compassion: An Open Trial. MINDFULNESS, 1-22.

Budge, S. L., Israel, T., & Merrill, C. R. (2017). Improving the lives of sexual and gender minorities: the promise of psychotherapy research. *Journal of Counseling Psychology*, 64(4), 376.

Camp, J., Durante, G., Cooper, A., Smith, P., & Rimes, K. (2024). Clinical outcomes for sexual and gender minority adolescents in a dialectical behaviour therapy programme. *Behavioural and cognitive psychotherapy*, 1-19.

Coelho, D. R., Chen, A. L., & Keuroghlian, A. S. (2025). Advancing Transgender Health amid Rising Policy Threats. *New England Journal of Medicine*.

Cohen, J. A., Mannarino, A. P., Wilson, K., & Zinny, A. (2018). *Implementing-Trauma□Focused Cognitive Behavioral Therapy for LGBTQ Youth and their Caregivers*. Allegheny Health Network.

Cohen, J. M., Norona, J. C., Yadavia, J. E., & Borsari, B. (2021). Affirmative dialectical behavior therapy skills training with sexual minority veterans. *Cognitive and Behavioral Practice*, 28(1), 77-91.

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., & Green, J. (2022). Standards of care for the health of transgender and gender diverse people, version 8. *International Journal of Transgender Health*, 23(sup1), S1-S259.

Day, J. K., Fish, J. N., Perez-Brumer, A., Hatzenbuehler, M. L., & Russell, S. T. (2017). Transgender youth substance use disparities: Results from a population-based sample. *Journal of*

Adolescent Health, 61(6), 729-735.

DuBois, L. Z., Puckett, J. A., Price, S. F., Kuehn, K., Lash, B., Walker, T., Holt, N. R., Allura L, R., Huit, T. Z., & Miles, M. (2023). The impact of sociopolitical events on transgender people in the *US. Bulletin of Applied Transgender Studies*, 2(1-2), 1-26.

Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014). Suicide attempts among transgender and gender non-conforming adults. Work, 50, 59.

Harned, M. S., Coyle, T. N., & Garcia, N. M. (2022). The inclusion of ethnoracial, sexual, and gender minority groups in randomized controlled trials of dialectical behavior therapy: A systematic review of the literature. *Clinical Psychology: Science and Practice*, 29(2), 83.

Herman, J. L., Brown, T. N., & Haas, A. P. (2019). Suicide thoughts and attempts among transgender adults: Findings from the *2015 US Transgender Survey*.

Hughto, J. M. W., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, 147, 222-231.

James, S., Herman, J., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. a. (2016). *The report of the 2015 US transgender survey*. National Center for Transgender Equality [NCTE].

Joiner, T. (2005). *Why people die by suicide*. Harvard University Press.

Lee, M. S., Almazan, A. N., Nambudiri, V. E., & Keuroghlian, A. S. (2021). Association between gender-affirming hair removal and mental health outcomes. *JAMA dermatology*, 157(9), 1120-1122.

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. Guilford press.

Newcomb, M. E., Hill, R., Buehler, K., Ryan, D. T., Whitton, S. W., & Mustanski, B. (2020). High burden of mental health problems, substance use, violence, and related psychosocial factors in transgender, non-binary, and gender diverse youth and young adults. *Archives of Sexual Behavior*, 49, 645-659.

Oransky, M., Burke, E. Z., & Steever, J. (2019). An interdisciplinary model for meeting the mental health needs of transgender adolescents and young adults: The Mount Sinai Adolescent Health Center approach. *Cognitive and Behavioral Practice*, 26(4), 603-616.

Pachankis, J. E., Harkness, A., Jackson, S. D., & Safren, S. A. (2022). *Transdiagnostic LGBTQ-affirmative cognitive-behavioral therapy: Therapist guide*. Oxford University Press.

Pachankis, J. E., & Safren, S. A. (2019). *Handbook of evidence-based mental health practice with sexual and gender minorities*. Oxford University Press.

Panchal, Z., Piper, C., Whitmore, C., & Davies, R. D. (2022). Providing supportive transgender mental health care: A systemized narrative review of patient experiences, preferences, and outcomes. *Journal of Gay & Lesbian Mental Health*, 26(3), 228-264.

Paz-Otero, M., Becerra-Fernández, A., Pérez-López, G., & Ly-Pen, D. (2021). A 2020 review of mental health comorbidity in gender dysphoric and gender non-conforming people. *J Psychiatry Treat Res*, 3(1), 44-55.

Pellicane, M. J., & Ciesla, J. A. (2022). Associations between minority stress, depression, and suicidal ideation and attempts in transgender and gender diverse (TGD) individuals: Systematic review and meta-analysis. *Clinical psychology review*, 91, 102113.

Powell, L., Puebla, A., & Lepping, R. J. (2025). Gender-affirming hormone therapy and impacts on quality of life: a narrative review. *medRxiv*, 2025.2003. 2011.25323442.

Price, M. A., Hollinsaid, N. L., McKetta, S., Mellen, E. J., & Rakhilin, M. (2024). Structural transphobia is associated with psychological distress and suicidality in a large national sample of transgender adults. *Social Psychiatry and Psychiatric Epidemiology*, 59(2), 285-294.

Price, S. F., Puckett, J., & Mocarski, R. (2021). The impact of the 2016 US presidential elections on transgender and gender diverse people. *SEXUALITY RESEARCH AND SOCIAL POLICY, 18,* 1094-1103.

Puckett, J. A., Cleary, P., Rossman, K., Mustanski, B., & Newcomb, M. E. (2018). Barriers to gender-affirming care for transgender and gender nonconforming individuals. *Sexuality Research and Social Policy, 15*, 48-59.

Seelman, K. L., Colón-Diaz, M. J., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: connections to general health and mental health among transgender adults. *Transgender Health, 2*(1), 17-28.

Singh, A. A. (2017). Affirmative

counseling with transgender and gender nonconforming clients.

Skerven, K., Mirabito, L., Kirkman, M., & Shaw, B. (2021). Dialectical behaviour therapy skills group including stigma management: A pilot with sexual and gender minority veterans. *The Cognitive Behaviour Therapist, 14*, e33.

Snow, A., Cerel, J., Loeffler, D. N., & Flaherty, C. (2019). Barriers to mental health care for transgender and gender-nonconforming adults: A systematic literature review. *Health & Social Work, 44*(3), 149-155.

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65.

Tilley, J. L., Molina, L., Luo, X., Natarajan, A., Casolaro, L., Gonzalez, A., & Mahaffey, B. (2022). Dialectical behaviour therapy (DBT) for high-risk transgender and gender diverse (TGD) youth: A qualitative study of youth and mental health providers' perspectives on intervention relevance. *Psychology and Psychotherapy: Theory, Research and Practice, 95*(4), 1056-1070.

Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open, 5*(2), e220978-e220978.

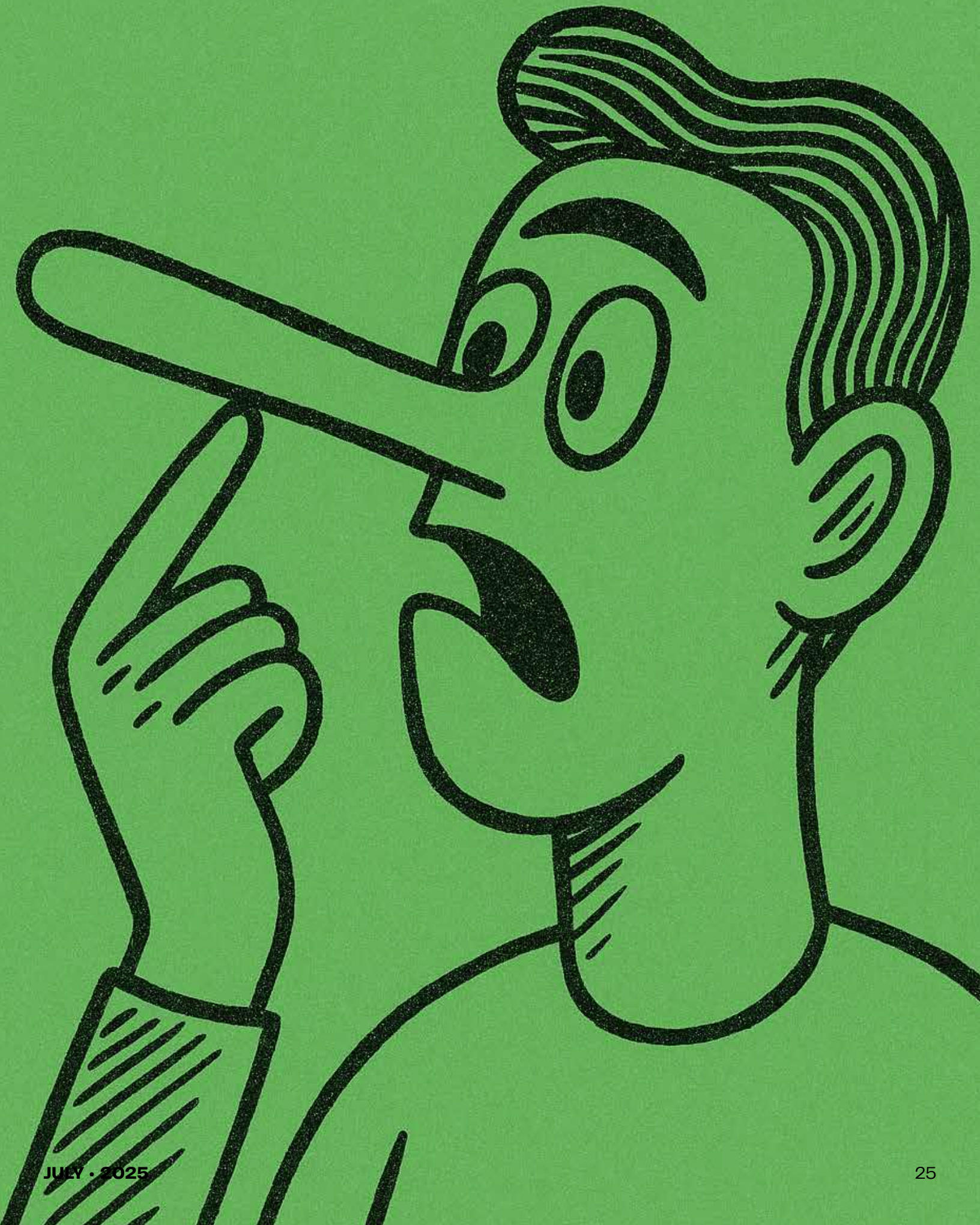
Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics, 145*(2).

Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PloS one, 17(1), e0261039.

Turban, J. L., King, D., Li, J. J., & Keuroghlian, A. S. (2021). Timing of social transition for transgender and gender diverse youth, K-12 harassment, and adult mental health outcomes. *Journal of Adolescent Health, 69*(6), 991-998.

Wu, H., Lu, L., Qian, Y., Jin, X.-H., Yu, H.-R., Du, L., Fu, X.-L., Zhu, B., & Chen, H.-L. (2022). The significance of cognitive-behavioral therapy on suicide: an umbrella review. *Journal of affective disorders, 317*, 142-148.

Zimmerman, M., Benjamin, I., & Seijas-Rodriguez, C. (2022). Psychiatric diagnoses among transgender and gender diverse patients compared to cisgender patients. *The Journal of Clinical Psychiatry, 83*(6), 43020.



Lies Through a DBT Lens: From Everyday Behavior to Pathology

Yoray Barak

AMYTEAM, Israeli Association for Dialectical Behavior Therapy

Lying is a common human behavior, yet it is often described as antisocial. Being caught in a lie can cause embarrassment and, over time, damage one's reputation and relationships. The Ten Commandments prohibit false testimony, and popular culture grapples with lying—Pinocchio, for instance, symbolizes the tension between the desire to be truthful and the temptation to conceal the truth (Ekman, 2009).

While most people lie occasionally, frequent deception in close relationships is harmful. Marsha Linehan justified revealing her psychiatric history by stating, "I didn't want to die a coward." Fear and shame often drive lying, offering short-term relief but leading to long-term social isolation, distress, and emotional dysregulation—creating a cycle of avoidance and deception (Tangney et al., 2007).

Types of Lies: From "White Lies" to Pathological Lying. Lies exist along a spectrum. At one end are "white lies"—small deceptions meant to prevent harm (Vrij, 2008). While they can serve social harmony (e.g., politeness), they may erode trust over time (DePaulo & Kashy, 1998). At the other extreme, pathological lying (pseudologia fantastica) involves chronic fabrications disconnected from reality (Dike et al., 2005).

Cultural and Ethical Influences on Lying. Cultural norms shape the perception of lying. In societies valuing social harmony, such as many East Asian cultures, withholding truth is often acceptable to avoid conflict or protect "face" (Gao, 1996). In contrast, Western cultures emphasize individual honesty, officially condemning lying while still practicing politeness-based deception (Levine, 2014).

The Neuropsychology of Lying. Lying engages complex neurological processes. fMRI studies show activation in the prefrontal and parietal cortex, which manage working memory and information processing (Abe, 2011). Truth-telling requires less cognitive effort, whereas lying demands suppressing the truth, manipulating memory, and resolving internal conflict (Ganis et al., 2003).

The amygdala, responsible for processing emotions like fear and guilt, is initially highly active when lying but desensitizes over time, making continued deception easier. This "slippery slope" effect suggests that small lies can escalate into larger ones. Moreover, frequent deception can impair memory, leading to confusion between real and fabricated events. People who lie frequently can experience "denial-induced forgetting," where repeated deception leads to distorted recollections, as the brain unconsciously suppresses or alters memories to maintain internal consistency (Vieira & Lane, 2013).

Apparent Competence and Emotional Regulation. An illustrative example of how emotion regulation and deception can intersect is the phenomenon of apparent competence. Individuals with emotion regulation difficulties may project an image of strength, independence, or success—both to others and to themselves—while privately struggling with intense feelings of inadequacy, distress, or vulnerability. In these cases, managing external impressions functions as a survival strategy, helping to preserve a fragile self-image and avoid the shame associated with perceived weakness. Selectively presenting reality, or even denying internal distress, can offer short-term emotional relief. However, over time, reliance on such strategies can become mentally exhausting, eroding self-esteem and amplifying internal suffering. The accumulation of such distortions, often described as a "snowball effect," eventually deepens the very distress it was meant to protect against (Talwar & Crossman, 2011).

Lying in the Context of Addiction. Lying is prevalent in addiction, serving to sustain substance use, avoid confrontation, or escape pressure to quit. Given the link between addiction and emotional dysregulation, deception becomes an ingrained coping mechanism, reinforcing secrecy and isolation. This deepens distress and complicates recovery (Hart et al., 2008).

Emotion Regulation: Reducing the Tendency to Lie. Since shame often underlies deception, the following well-known emotion regulation skills can help minimize the intensity of this emotion, reducing the urge to lie as a coping mechanism. By applying these strategies, individuals can weaken the emotional drive behind dishonesty and develop more effective ways to manage distress.

Checking the Facts can be particularly helpful in reducing the urge to lie, especially when driven by shame. In emotionally intense moments, shame may feel overwhelming and absolute, making deception seem like the only way to avoid judgment or rejection. However, systematically examining whether the situation truly warrants shame often reveals that the emotion is exaggerated or based on misinterpretations (Krause et al., 2020).

Opposite Action to Shame: Gradual Exposure Exercises help counter avoidance and concealment, which only reinforce shame. Engaging in small, manageable exposure exercises—such as asking an unnecessary question in a store, making deliberate pauses in conversation, or wearing unconventional clothing—demonstrates that self-consciousness is temporary and tolerable (Neff & Germer, 2013).

Problem-Solving Beyond Deception acknowledges that lying often serves as a short-term solution to deeper struggles, such as academic, financial, health-related, or addictive challenges. Instead of masking these difficulties, problem-solving encourages taking concrete steps—seeking help, making changes, and developing coping strategies—that foster long-term confidence and integrity (Gross & John, 2003).

Taking Responsibility and Openness to Repair are essential in breaking the cycle of deception. Acknowledging dishonesty and making amends strengthens trust and accountability. Environments that encourage truthfulness—even after dishonesty—promote openness, whereas punishing honesty can reinforce secrecy (Leary et al., 2007).

Debunking Shame-Related Myths helps individuals challenge rigid, self-defeating beliefs that perpetuate deception. Myths such as "People will never forgive me" or "The truth will always lead to rejection" contribute to avoidance and dishonesty. Actively challenging these assumptions fosters a shift from willfulness to willingness, reducing the urge to lie as a defense mechanism (Tangney & Dearing, 2002). By integrating these emotion regulation skills, individuals can develop more adaptive ways to manage distress, strengthening their ability to face challenges with honesty and self-respect.

References

Abe, N. (2011). How the brain shapes deception: An integrated review of the literature. *Neuroscience & Biobehavioral Reviews, 35*(3), 848–857. https://doi.org/10.1016/j.neubiorev.2010.10.002

Blanke, E. S., Brose, A., Schmiedek, F., & Neubauer, A. B. (2022). Individual differences in emotion regulation prospectively predict acute stress. *Emotion, 22*(5), 998–1013. https://doi.org/10.1037/emo0000953

Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. Gotham Books.

DePaulo, B. M., & Kashy, D. A. (1998). Everyday lies in close and casual relationships. Journal of Personality and Social Psychology, 74(1), 63–79. https://doi.org/10.1037/0022-3514.74.1.63

Dike, C. C., Baranoski, M., & Griffith, E. E. H. (2005). Pathological lying revisited. *Journal of the American Academy of Psychiatry and the Law Online, 33*(3), 342–349. https://jaapl.org/content/33/3/342

Ekman, P. (2009). *Telling lies: Clues to deceit in the marketplace, politics, and marriage* (3rd ed.). W. W. Norton & Company.

Ganis, G., Kosslyn, S. M., Stose, S., Thompson, W. L., & Yurgelun-Todd, D. A. (2003). Neural correlates of different types of deception: An fMRI investigation. *Cerebral Cortex, 13*(8), 830–836. https://doi.org/10.1093/cercor/13.8.830

Gao, G. (1996). Self and other: A Chinese perspective on interpersonal relationships. *Communication Research, 23*(4), 329–363. https://doi.org/10.1177/009365096023004001

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*(2), 348–362. https://doi.org/10.1037/0022-3514.85.2.348

Hart, C. L., Haney, M., Foltin, R. W., & Fischman, M. W. (2000). Alternative reinforcers differentially modify cocaine self-administration by humans. *Behavioural Pharmacology, 11*(1), 87–91. https://doi.org/10.1097/00008877-200002000-00011

Krause, E. D., Mendelson, T., & Lynch, T. R. (2013). The role of emotion regulation in the experience and treatment of anxiety and depression. *Clinical Psychology Review, 33*(6), 730–745. https://doi.org/10.1016/j.cpr.2013.05.004

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly.

Journal of Personality and Social Psychology, 92(5), 887–904. https://doi.org/10.1037/0022-3514.92.5.887

Levine, T. R. (2014). Truth-default theory (TDT): A theory of human deception and deception detection. *Journal of Language and Social Psychology, 33*(4), 378–392. https://doi.org/10.1177/0261927X14535916

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* Guilford Press.

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28–44. https://doi.org/10.1002/jclp.21923

Rüsch, N., Corrigan, P. W., Bohus, M., & Bruehl, A. B. (2007). Self-stigma, shame, and emotion regulation in borderline personality disorder. *Journal of Psychiatric Research, 41*(3–4), 334–341. https://doi.org/10.1016/j.jpsychires.2006.05.010

Talwar, V., & Crossman, A. (2011). From little white lies to pathological lying: Developmental perspectives. *Developmental Psychology, 47*(3), 733–743. https://doi.org/10.1037/a0023200

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. Guilford Press.

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*, 345–372. https://doi.org/10.1146/annurev.psych.56.091103.070145

Vieira, J. B., & Lane, R. D. (2013). Neuroscience of deception: A review of the evidence. *Emotion Review, 5*(2), 123–129. https://doi.org/10.1177/1754073912465174

Wu, Y., Sun, D., & Shi, H. (2022). Neural correlates of spontaneous lying and truth-telling: An fMRI study. *Neuroscience Letters, 778*, 136611. https://doi.org/10.1016/j.neulet.2022.136611

Supervision as Behavioral Therapy

Carson Robinson

Harborview Mental Health and Addictions Services
University of Washington School of Social Work

Compared to the process of becoming a DBT clinician, becoming a DBT supervisor has far fewer training wheels, such as manuals, intensive trainings, and, of course, supervision. Hopefully, if you're tasked with supervising a budding DBT clinician, you know a thing or two about doing DBT. In this article, I'll explain why being an effective DBT supervisor requires almost no expansion to your existing behavioral repertoire.

Supervision is a behavior change process, and can therefore employ all the same strategies used in psychotherapy. Essentially, supervision is therapy. There are several reasons to adopt this approach. It makes life easier, for one thing. Instead of scrambling to learn a whole new skillset, you can leverage your existing, well-rehearsed skills. Moreover, this profoundly simplifies your decisions about supervision methods; if it would help a client with behavior change, it will help your supervisee—otherwise, it's unnecessary.

Perhaps the most important reason to adopt this approach is that it compels you to use evidence-based supervision methods. If a supervisee is going to emit a new behavior with their clients, a three-stage process must occur, with specific interventions needed at each stage.

Evidence-based practices at each stage of learning: First, the supervisee must acquire the new behavior. Let's consider a supervisee who doesn't interrupt clients. To get this behavior into the supervisee's repertoire, do what you do with clients: describe the behavior, model it, and have the supervisee practice with you.

Of course, the supervisee's initial attempts at interrupting may be clunky; they might cushion their interruptions with smooth segues (an unnecessary use of brain power) or try to validate first before interrupting (which can prompt further tangential speech from the client). At this point, strengthening and fine-tuning of the behavior is needed. This happens with additional in vivo practice, with your corrective feedback.

Role-playing is a critical tool for both acquisition and strengthening. In studies of physicians learning communication skills, role-playing and feedback are associated with improvement, whereas didactic instruction is not (Lane & Rollnick, 2007; Berkhof, Rijssen, Schellart, Anema, & van der Beek, 2011). Just as DBT clinicians must activate new client behaviors in every therapy session to be adherent (Harned, Schmidt, & Korslund, 2021), role-playing a clinical skill every time you meet with your supervisee greatly accelerates their learning.

As supervisees apply their new skills with their clients, they can further strengthen their skills with your feedback from tape review. A meta-analysis (Fukkink, Trienekens, & Kramer, 2011) shows that video-based feedback improves learning across a range of helping professions. Since adherent delivery of DBT is associated with improved outcomes (Harned, Gallop, Schmidt, & Korslund, 2022), the DBT Adherence Checklist for Individual Therapy (DBT AC-I; Harned, Schmidt, & Korslund, 2021) and/or the DBT Therapist Rating and Feedback Form (Fruzzetti, 2012) can help structure your feedback to help supervisees achieve adherence (Ellem & Cawood, 2024).

Even after some improvement, the supervisee may struggle to interrupt when the client is very emotional, when the supervisee is scared, or when it's 4:00pm on Friday. The behavior must now generalize to these different contexts. To promote generalization, prompts to emit the behavior must occur in real time. This is where bug-in-the-eye (BITE) can be extremely helpful. In BITE, the supervisor delivers text-based prompts to the supervisee during a client interaction. A review of several studies shows that BITE outperforms other methods of supervision in helping clinicians learn psychotherapeutic skills (Vezer, 2021). This review also indicates that BITE is not as disruptive or aversive as clinicians expect. In my own experience, most clients consent to BITE enthusiastically, perceiving it as an effort to provide them with the most effective care possible. Given the available evidence, BITE is likely the most valuable thing you can do for your supervisees. In any given week, if you have only one hour to devote to a supervisee and must choose between reviewing tape, meeting one-on-one, or BITE, I would recommend choosing BITE in most instances.

Analysis of supervisee behaviors: As another example of how supervision should mirror therapy: don't assume that clinical errors (like not interrupting a client) are due to skills deficits. Many

[1] For a case study of BITE in DBT supervision, see Rizvi et al. (2016).

are, and you must carefully assess the variables causing supervisee behaviors, then intervene accordingly using contingency management, cognitive modification, or exposure. Use your chain analysis skills to assess supervisee struggles, and solution analysis to build the plan. If a client is punishing your supervisee's interruptions, you can offer to lead the supervisee's favorite mindfulness exercise at the next team meeting in exchange for five interruptions within one session. If the supervisee believes their client won't tolerate being interrupted, you can challenge that assumption (I tell my supervisees that I've had clients get mad at me for not interrupting). Conveniently, role-plays function as rehearsal and exposure; research shows that clinicians feel more confident in treating suicidal clients after role-playing their risk assessment and management skills (Gryglewicz et al., 2020).

Prioritizing supervision targets: In terms of structuring your meetings with supervisees, follow the same general principles that you follow with your clients. This doesn't mean you follow the exact same protocol of the individual therapy target hierarchy. Think about the principles underlying the treatment hierarchy: the client must be alive and physically intact in order to change their life, and for psychotherapy to make a difference, the client needs to receive the treatment's active ingredients. Therefore, life-threatening and therapy-interfering behaviors must be prioritized above behaviors that only impact the client's quality of life.

Following this same logic, you must address anything that would prevent supervision from being helpful. Missing supervision meetings, avoiding important topics, in-meeting dysregulation, not following through on suggested interventions, and other supervision-interfering behaviors must be your top priority. And of course, you must be mindful of your own tendencies that make supervision unhelpful, including not watching tape, microaggressions, fragilizing, tangents, impromptu lecturing about highly conceptual topics (what I affectionately refer to as "nerding out"), not troubleshooting, not role-playing, and so on. If, for example, you are struggling to implement evidence-based supervision methods due to time and resource constraints, follow the steps of problem solving (Linehan, 2015).

In case you think I'm totally nuts: Let's address the elephant in the room. Some readers may disagree with the premise of this article because supervision can't possibly be equated with therapy; it would be totally inappropriate to treat a supervisee like a client, right?

I'll concede that, compared to therapy, supervision is much less likely to address participants' experiences with suicidality, substance use, sex, childhood trauma, and so on. But consider why we avoid certain topics in supervision. As a supervisee, I have mindfully chosen to withhold certain parts of my life (e.g., I decided not to tell my supervisor about my history with suicidal thoughts) and have also chosen to disclose things that many people wouldn't want their colleagues to know about (e.g., a turbulent romantic relationship that was all-consuming). As a supervisor, I have invited supervisees to discuss personal crises; as the dime game would suggest, these invitations are made with a low-to-moderate level of intensity, so I am quick to take "no." These decisions are based on the topic's relevance to supervision (i.e., whether the problem impacts the supervisee's clinical effectiveness) and the personal limits of the supervisee and the supervisor. And the criteria of relevance and personal limits can help replace judgmental and imprecise words like "boundaries," "inappropriate," and "unprofessional" when deciding what is effective to discuss.

Action steps to take: There are several other tools to use when operating from the framework of supervision-therapy equivalence. First, record your supervision meetings, then review them using the AC-I and/or Fruzzetti's feedback form. The latter will keep you on your toes about checking in on modes of therapy other than individual. For in-meeting prompting, keep the AC-I cheat sheet in front of you during supervision meetings. Then seek out expert guidance, including consultation with an experienced supervisor who endorses these principles.

In addition, read *DBT Teams: Development and Practice* by Sayrs and Linehan (2019), an excellent resource that covers many of the above points in greater depth. Also read the article by Edward Johnson (2019) about recommended practices for psychotherapy supervision. And next time you can sign up for a training on DBT supervision, do it. These steps will help you continue to shape your supervision practices to be more engaging, more behavioral, and more effective.

References

Berkhof, M., van Rijssen, H. J., Schellart, A. J., Anema, J. R., & van der Beek, A. J. (2011). Effective training strategies for teaching communication skills to physicians: An overview of systematic reviews. *Patient Education and Counseling*, 84(2), 152-162.

Ellem, B. & Cawood, C. D. (2024). Innovations in dialectical behavior therapy supervision: Promoting treatment adherence in training and supervision. DBT Bulletin, 8(2), 22-24.

Fruzzetti, A. E. (2012). DBT therapist rating and feedback form. https://www.pdbti.org/wp-content/uploads/2023/10/9.1-DBT-Therapist-Rating-Feedback-Form-2012-Fruzzetti-2.pdf

Fukkink, R. G., Trienekens, N., & Kramer, L. J. C. (2011). Video feedback in education and training: Putting learning in the picture. *Educational Psychology Review*, 23, 45-63.

Gryglewicz, K., Monahan, M. M., Chen, J. I., Bozzay, M., Bender, A., Gleason, L. L., Witmeier, M., Karver, M. S. (2020). *Journal of Mental Health*, 29(5), 549-557.

Harned, M. S., Gallop, R. J., Schmidt, S. C., & Korslund, K. E. (2022). The temporal relationship between therapist adherence and patient outcomes in dialectical behavior therapy. *Journal of Consulting and Clinical Psychology*, 90(3), 272-281.

Harned, M. S., Schmidt, S. C., & Korslund, K. E. (2021). The Dialectical Behavior Therapy Adherence Checklist for Individual Therapy (DBT AC-I). https://www.dbtadherence.com/

Johnson, E. A. (2019). Recommendations to enhance psychotherapy supervision in psychology. *Canadian Psychology*, 60(4), 290-301.

Lane, C. & Rollnick, S. R. (2007). *Patient Education and Counseling*, 67(1-2), 13-20.

Linehan, M. M. (2015). *DBT skills training handouts and worksheets* (2nd ed.). Guilford Press.

Rizvi, S. L., Yu, J., Geisser, S., & Finnegan, D. (2016). The use of "bug-in-the-eye" live supervision for training in dialectical behavior therapy: A case study. *Clinical Case Studies*, 15(3), 243-258.

Sayrs, J. H. R., & Linehan, M. M. (2019). DBT teams: *Development and practice*. Guilford Press.

Swenson, C. R. (2016). *DBT principles in action: Acceptance, change, and dialectics*. Guilford Press.

Vezer, E. (2021). Bug-in-the-eye supervision: A critical review. *Training and Education in Professional Psychology*, 15(3), 250-257.

To Build a Life

Abby Schueller

In the center lies the inner core,
having a high temperature,
its composition is metal,
forming the initial sphere.

Next comes the outer core,
completely surrounding the
inner core,
made of scorching hot metal,
it takes liquid form.

Following that is the mantle,
Containing really dense rock,
It floats on the outer core,
Similar to oil on water.

Less dense rock creates
another layer,
The asthenosphere,
It hugs the surface of the mantle,
Forming a larger sphere.

The least dense of the three,
the lithosphere lies above
It engulfs the previous layer,
To make another crust of rock.

On top of that,
the solid ground we live on,
named the continental crust,
containing grass and soil.

Finally, the outermost layer,
The oceanic crust,
only in certain areas,
It lies above the ground, forming
bodies of water.

The only things we see,
Are the two final layers,
Ignoring what it is comprised of,
The make-up doesn't quite matter.

My inner core is different,
My organs, my blood, my bones,
My genetic component,
To actually form a functioning human.
Then comes my outer core,
My thoughts, my beliefs, my ideas,
From having a terrible stomachache,
To having a gut-wrenching feeling.

Continuing the build, my mantle,
my brain thinks many things,
controlling my every action,
it still lies beneath the surface
On top of that, my asthenosphere,
Analyzing the actions of my mantle,
I comprehend, I learn.

The least dense, the lithosphere,
Controls my interpretations of
the analysis,
It dictates my facial expressions,
My reaction to certain beliefs.

On my surface, everyone has
the ability to see,
Inspect my continental crust,
make assumptions about me,
They see what I do,
They hear what I say.

But there are some things that
occur above the surface,
Stuff that happens in my
oceanic crust,

My cuts, my scars, my
external wounds,
All that can be seen on my skin.

What is not seen by the world,
My dense, boiling insides,
The things people are scared of,
The things I keep private from
society.
It is my truth, the real me,
That people try to ignore,
My insides, my composition,
Afraid that they will get hurt.

So I resonate with the Earth,
And its deep, dark crusts,
Its scary undiscovered parts,
That scare all but a select few.

I have my layers,
My make-up, my roots,
That I purposely shield from others,
To prevent them from getting
burned too.

But the overarching picture,
The creation of something incredible,
In which there is livelihood and
laughter,
And people living healthy lives,
one I can live too.

Despite the intimidating crust,
a masterpiece awaits,
Always in a state of change,
Constantly growing and improving.

And thus, a functioning world
is formed,
One where lives worth living are
built, through blood, sweat, and
tears, ultimately demonstrating
resilience and strength,

Two qualities I now know I have.

Tucson kinhin

Caleb S. Reese
Pathless Journey LLC

walk to avoid another splinter,
walk deliberately on one board or
should you alternate?
'do others walk as oddly you?'

your toes crack.
and though you cannot control
your bones,
you feel a pang of shame,
your body is not quite your own.

adjust your gait to fit the needs
of others,
changing your stride, count to ten,
again.

coyote howls mix with the rising
wind,
a shiver of cold jolts you back,
your mind whispering,
'try not to step on her feet.'
count to ten. cement.

tread the spongy board.
feel the rocks,
the painted-over leaf,
hidden by gray coats.
unyielding to your feet...

weathered path.
worn and creaky.
chilled in the morning
warmed during the day
cooled at night.
losing balance,
avoid twisting your ankle.
'they walk with more poise than you'.
stop. notice the thought. return to
the breath. cement.

Photo provided by author: plaques at the Redemptorist Renewal Center in Tucson, Arizona where Dr. Marsha Linehan led many silent Zen sesshins, and we continue to practice in her honor.

observe the pain in your shoulders.
reposition your hands behind
your back.
'others are more flexible than you—'
comparing once more.

walk and feel the wind,
savor its essence and breathe
its scent.
see the rock garden's arrangement
and offer a smile to the Buddha.
lower your head, despite being
clear of the branch.
judging again.

widen the exit for yourself and
those behind you.
'should you? why do you care?'
'if so, why concern yourself when others break the rules?'
who do you think you are?

walk, breathe, listen, count, focus
on the feet ahead of you.
try not to stumble.
the struggle of every kinhin.
what should be...what actually is.

CALL FOR SUBMISSIONS

The DBT Bulletin is published as a service to the DBT community. Two issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of recent advances, research findings, innovative applications of Dialectical Behavior Therapy, and diversity and professional issues related to DBT.

- *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.*

Electronic submissions should be directed to the editors, at dbtbulletin@gmail.com. Please include the phrase Bulletin submission and the authors last name in the subject line of your email. Include the corresponding author's email address on the cover page of the manuscript attachment.

STUDENT AWARD NOMINATIONS

Recognize your outstanding trainee by submitting a brief description of what strikes you about their contributions, dedication to DBT and its foundations, and promise. Award recipients receive paid registration to ISITDBT. Email your nomination to dbtbulletin@gmail.com by October 10, 2025.

ARTWORK PROVIDED BY: JESSE FINKELSTEIN

For this issue I experimented with feeding drawings into an AI engine. For more information about the artwork head to www.talkgood.org