Dialectical Behavior Therapy in College Counseling Centers: Practical Applications and Theoretical Considerations

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Dialectical Behavior Therapy in College Counseling Centers:
Practical Applications and Theoretical Considerations

by

Carla D. Chugani

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
in Curriculum and Instruction with an emphasis on
Counselor Education and Supervision
Department of Leadership, Counseling, Adult, Career, and Higher Education
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DEDICATION

To the end of suffering.
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This dissertation would not have been possible without the support and encouragement of my family and friends. I especially wish to acknowledge my parents, Drs. Diane and Harry Chugani, who raised me to ask questions, seek better answers, and to always focus on helping those who are in need. I also wish to acknowledge many mentors from the last several years who have been instrumental in my life: Dr. Bethany Helfman, who encouraged me to pursue my goal of becoming a counselor, Drs. Jon Brunner and Michael Ghali, whose patience and encouragement were instrumental in my ability to learn and begin to research the practice of DBT, Drs. Herbert Exum and Caroline Wilde, who have been guiding forces since the first day of my doctoral study, Dr. Carlos Zalaquett, who has never ceased to challenge me to strive for something better than what I thought I might be capable of, and Dr. Jennifer Wolgemuth, who introduced me to qualitative methods, pushed me when I was scared, and in doing so, opened up a world of new possibilities for my research. I am eternally grateful.
CONFLICT OF INTEREST DISCLOSURE

I wish to disclose the following conflict of interest: I was hired by Behavioral Tech, LLC as a consultant in April, 2015. While this conflict was not present during the development of the first two articles presented in this dissertation, I disclose it here because I believe that it pertains to the dissertation as a whole.
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ABSTRACT

Authors over the last two decades have discussed the myriad of challenges present in managing college students with severe mental health disorders. During the same time period, Marsha Linehan developed dialectical behavior therapy (DBT) as an empirically sound intervention for individuals with suicidal and self-injurious behaviors and this treatment grew to be an evidence-based practice for a range of challenging clinical issues. I argue that one solution to continued increases in college students who present for treatment to their college counseling centers with difficult-to-treat mental health issues, including but not limited to, borderline personality disorder (BPD), is to implement DBT programs on college campuses. As such, the purpose of this dissertation is to address both practical and theoretical issues in the implementation of DBT in college counseling centers.

In chapter two, I begin by presenting an overview of DBT as a comprehensive treatment model and a review of the research to date related to DBT in college counseling centers. In chapter three, I offer a detailed account of the program development and implementation process of the DBT program housed in the college counseling center at Florida Gulf Coast University. In chapter four, I present an investigation of current trends and barriers to implementation of DBT in college counseling centers. Finally, in chapter five, I present a qualitative inquiry of the experience of BPD as told by individuals who have been successfully treated with DBT. I argue that understanding client experiences and behaviors in context is critically important if one is to be able to respond empathically and compassionately. In essence, these chapters represent my
attempt to synthesize two areas that I believe are required for successful implementation of DBT programs that provide good quality care: 1) Navigating the complexities of implementing DBT in college counseling centers as practice setting and 2) Appropriate management for clinician biases and tendencies to stigmatize BPD clients, which interferes with their ability to provide care that is both effective and compassionate.
CHAPTER ONE
INTRODUCTION

One of the things that I love most about the scientist-practitioner model is that I am afforded the opportunity to learn in many ways. Working as a counselor and learning first hand about the difference that Dialectical Behavior Therapy (DBT) can make in the lives of young people who are suffering and who have suffered terribly, was the primary impetus for my interest in helping college counseling centers implement DBT programs. Long before I learned anything about implementation science, I faced many of the challenges reported in this area of literature as I tried to build my own DBT program in the counseling center for the students of Florida Gulf Coast University (FGCU). The questions that I ask in this dissertation are borne from the experience of trying to answer questions that arose organically throughout the implementation process at FGCU: How could we take the standard DBT model (a time and labor intensive treatment) and fit it into a college counseling center that operated on a brief treatment model? How could I secure funding to get the appropriate level of training for my colleagues and myself in a treatment model that many consider to be outside of the scope of services for a college counseling center? How could I help my DBT teammates manage the understandable frustration that often accompanies working with individuals with Borderline Personality Disorder (BPD) when this may not have been a clinical service that they wished to provide?
The articles that comprise this dissertation attempt to answer many of the questions that I faced and those that I suspect many other college counselors will face as they attempt to implement DBT programs. In the practice of DBT, the concept of dialectics is central. In the context of treatment, dialectics are a way of understanding the nature of reality. Specifically, reality is viewed as constantly changing and having elements of interconnectedness and conflict. Linehan (1993a) explains, “Reality is not static, but is comprised of internal opposing forces (“thesis” and “antithesis”), out of whose integration (“synthesis”) evolves a new set of opposing forces” (p. 32). Although the articles presented here could be considered as two distinct lines of research (one focused on DBT in college counseling centers, the other on understanding the experience of BPD as told by individuals who have been successfully treated with DBT), I believe that they inform one another and thus, the purpose of this dissertation is to bring them together to reach a synthesis.

In order to achieve this synthesis, I offer four articles to the reader over the course of four chapters. Chapter two presents a review of the literature related to the application of DBT in college counseling centers and the implications for practice that can be gleaned from the studies reviewed. Chapter three presents practical considerations in the implementation of a DBT program on a college campus. Specifically, I present the iterative process of the development of the FGCU DBT program and offer several suggestions to the reader, based on the lessons that I (and my teammates, without whom the program would not have been possible) learned. Chapter four presents an investigation of current trends and barriers to DBT implementation in college counseling centers. Finally, chapter five presents an investigation of the experience of BPD, as described by individuals who have been successfully treated with DBT.
With regard to chapter five, it is important to note that the purpose of this study was to understand the experience of BPD, an issue that is not limited by practice setting. Although this study does not directly address college counseling issues, it does address an issue that is fundamental to the practice DBT, regardless of treatment setting: understanding client experiences in context as a way of developing greater compassion, clinical skill, and reduced stigmatization of individuals with BPD. The collective aim of the chapters presented here is to assist the reader in answering a question that I consider to be the synthesis of many conflicting questions of my own: How do I manage the considerable practical challenges and seemingly innumerable details required in implementing a DBT program in a college counseling center while still continuing to be present and able to offer compassion and empathic understanding to individuals with BPD?

**Theoretical Perspective**

Before I can begin to discuss the reasons for which I believe DBT is an appropriate treatment to implement in college counseling centers, I would like to first briefly orient the reader to the theoretical underpinnings of this dissertation. Epistemologically, I have always been drawn toward pragmatism. I have always found DBT to be a very pragmatic approach to dealing with complex psychological issues because it emphasizes a hierarchical method of treatment planning (e.g., always focusing on the most lethal, therapy-interfering, or quality of life interfering behaviors) and is infused with the idea that one should focus on ‘doing what works’ rather than rigidly adhering to principles to the point that more harm than good results.

As a treatment approach, DBT incorporates elements of dialectical philosophy, cognitive, behavioral, and biosocial theories, and Zen practice (e.g., mindfulness). Linehan (1993a)
explains that the development of DBT actually arose from her failed attempts at applying a
strictly behavioral approach to the treatment of suicidal behavior. In essence, Linehan (1993a)
found that pure behavior therapy (a change-oriented approach) was not sufficient and patients
often found this to be quite invalidating to their experiences. While patients do need to change
(e.g., because self-injury does not solve their problems in the present), they also need validation
of the reality that these behaviors do, in some ways, make sense (e.g., self-injury can reduce
emotional arousal and is a highly effective, although maladaptive, means of emotion regulation
in the short-term). Thus, the balance between acceptance (of reality as it is in the moment) and
change became the fundamental dialectic in DBT. In practice, DBT therapists select from a
variety of interventions included in the treatment model. Many of the interventions included in
the DBT model are not novel in their own right although many have been adapted or refined to
better suit the needs of suicidal and self-injuring individuals. Rather, other theorists, notably,
Beck (cognitive therapy), Skinner (behaviorism), and Meichenbaum (cognitive-behavioral
modification), first pioneered these techniques.

Along with the incorporation of cognitive and behavioral theories, Linehan (1993)
developed a biosocial theory of the development of BPD, which asserts that BPD “is primarily a
dysfunction of the emotion regulation system” (p. 42). Linehan (1993a) explains that individuals
with BPD possess biological vulnerabilities that transact with extreme, invalidating
environments. As these transactions occur, a cycle of dysfunction results where individuals are
continuously invalidated, thus causing more emotional vulnerability, which triggers more
dysfunctional coping behaviors (e.g., cutting, suicide attempts, etc.), which are likely to elicit
further invalidating experiences. I have made special mention of biosocial theory and the
integral role of the invalidating environment here because one of the issues that I attempt to
address with my research is the ways in which clinicians and other helping professionals may end up perpetuating the invalidating environment when they do not view client behaviors in context.

The question, “what is the function of the behavior?” is one that is central to the practice of DBT. One can only answer this question by viewing behavior in the context in which it originally presented. For DBT therapists, this involves conducting a behavioral chain analysis in which an event is broken down into tiny pieces (antecedents, vulnerability factors such as not getting enough sleep, food, etc., cognitions, emotions, behaviors, bodily sensations, environmental factors, and consequences) that form the “links” of a behavior chain. While behavioral chain analysis can be tedious for both client and therapist, it is a vital part of working toward solutions to client behaviors that are more likely to be effective. In essence, in order to solve a problem, one must first know what the problem is. In the case of dysfunctional behavior, chain analysis permits the therapist to know what problem the client was trying to solve with a particular behavior. Once the function of behavior is understood, it is simply a matter of generating alternatives for how to solve the problem at hand (solution analysis).

An additional function of behavioral chain analysis is that it offers therapists the opportunity to see the ways in which client behavior might be understandable (often necessary if one wishes to provide validation). In addition to reducing the likelihood of generating effective solutions for client problems, failure to understand client behavior in context can result in a recreation of the invalidating environment within the therapy session. A brief example helps to illustrate this phenomenon: Suppose an individual with BPD presents for treatment at her local mental health agency. She is seen for intake by a staff therapist, to whom she discloses that she has a history of suicide attempts. As therapy progresses, the client becomes increasingly
attached to the therapist. When he decides to take a vacation, she is despondent and attempts suicide. The therapist views the suicide attempt as an attempt to manipulate him and refers the client to a new therapist. In this case, the therapist has decided (independently of any actual evidence) that the function of the client’s suicide attempt is to manipulate because he felt manipulated. Linehan (1993a) explains that, “therapists make a very fundamental but quite predictable cognitive error: They observe the consequences of behavior and attribute that consequence to internal motives on the part of the patients” (p. 64). This cognitive error sets the therapist up to blame the client for having the very problems that brought her to treatment in the first place.

Unfortunately, assumptions that individuals with BPD are manipulative or attention-seeking are quite common among clinicians and other health care professionals and this has been documented in the literature (e.g., see Nehls, 1998 for a review). In addition, Linehan (1993a) notes that no other clinical population seems to be able to elicit incompetent behavior from otherwise competent clinicians as individuals with BPD. I believe that in some cases, the function of labeling BPD clients in a pejorative manner is to be able to put distance between them and us, or, as Linehan (1993a) states, “such terms create emotional distance from and anger at borderline individuals” (p. 18). She explains that one of her main goals in the development of DBT was to create a theory that is both “scientifically sound and nonjudgmental and nonpejorative in tone” (Linehan, 1993a, p.18) because this would lead to both effective treatment and compassion toward the client. Thus, the purpose of this dissertation is to promote in practice the same goals that Linehan (1993a) had originally set out to achieve in the development of DBT.
Statement of the Problem

The needs of college students have been evolving for some time now and more college counseling center directors have reported a number of concerning issues. More students are arriving on campus who present with severe psychological problems (Gallagher, 2014). Dialectical behavior therapy (DBT) is an evidence-based treatment that was originally developed to treat individuals with suicidal and non-self injurious behaviors (Linehan, 1993a) and is an established evidence-based practice for the treatment of individuals with Borderline Personality Disorder (BPD; Substance Abuse and Mental Health Services Administration (SAMHSA), 2006).

While DBT may be a useful means of addressing the mental health needs of students who present with suicidal or self-injurious behavior, or other difficult-to-treat clinical issues, DBT programs can be difficult to implement in college counseling centers because such centers typically operate on a brief treatment model and may not have the variety of resources needed to offer higher levels of care. An additional implementation issue that is less frequently considered in the context of implementation is that of adhering to the spirit of the DBT treatment model (i.e., providing compassionate, evidence-based care). Individuals with BPD attract considerable stigma and this has been documented to reduce empathy in treatment providers charged with assisting these individuals (e.g., Markham & Trower, 2003). Research is needed to assist college counseling professionals in implementing DBT as well as to help all professionals working with individuals with BPD develop and maintain empathy and compassion for these individuals so that treatment can be delivered effectively and in a manner that is consistent with DBT principles and philosophy.
The Significance of the Problem

Recent media coverage has included increasing numbers of suicides on college campuses, and recent literature reflects the increased need for mental health services that are adequate to treat students who are suicidal or living with other serious mental illnesses. Turner, Leno, and Keller (2013) found that suicide is the second leading cause of death for American college students, after accidental injuries. In addition, the National Survey of College Counseling Centers, a survey that has been conducted annually for over three decades under the sponsorship of the American College Counseling Association, continues to find that college counseling center directors are reporting increases in the numbers of students presenting for treatment with a variety of mental health issues. In the most recent survey, the majority of directors surveyed reported that there continue to be increases in the number of students who arrive on campus already taking psychiatric medications (86% of directors) and who have severe psychological problems (94% of directors; Gallagher, 2014). Directors also reported that over the last five years, they had observed increases in students presenting with anxiety, depression, crises requiring immediate response, learning disabilities, psychiatric medication issues, sexual assault on campus, self-injury issues, and problems related to sexual abuse earlier in life (Gallagher, 2014).

In addition, the methods with which college counseling centers attempt to address the rising need for comprehensive mental health care on campus may not be adequate given the range and severity of needs of those students with more severe forms of psychological disorders. Gallagher (2014) reports that the most common method by which centers have attempted to address the aforementioned increases is by increasing training to the institution’s faculty and staff in responding helpfully and making appropriate referrals. While this is not likely to be an
iatrogenic solution, it is also not likely to address the real issue: college students are in need of
good quality mental health care to address serious psychological disturbances.

Unfortunately, there may be a variety of challenges to implementing a comprehensive
mental health treatment program in a college counseling center. Mowbray and colleagues (2006)
note that historically, the mission of college counseling centers has been more developmental in
nature (i.e. providing guidance). These authors further explain that the provision of therapeutic
services has not typically been considered to be part of the institution’s overall educational
mission. While the missions of an institution and its counseling center will likely be grounded in
the historical context of the development of higher education institutions, these do not address
the practical realities that these institutions now face and may have been facing for some time.

More than two decades ago, Gilbert (1992) wrote about the challenges associated with
more college students presenting with personality disorders on campus. He notes that college
counseling centers face serious ethical dilemmas when they attempt to treat students with
inadequate resources. The author notes that some centers opt to simply provide stabilization
services (i.e., treatment focused on managing crises as they arise and helping the student finish
his/her education). He explains that while offering crisis stabilization is not unethical, “it is
infinitely less preferable to securing the type of treatment that is really needed, and potentially a
considerable strain on a counseling center if enough students are handled in this fashion”
(Gilbert, 1992, p. 697). Gilbert (1992) notes that providing therapy services in this manner may
even be analogous to enabling mental health issues to continue or worsen, because the services
provided are not sufficient to address the problems at hand.

With regard to personality disorders, Gilbert (1992) notes that for students with BPD,
brief treatment approaches are likely to do more harm than good, due to the nature of borderline
pathology (e.g., the tendency to form intense emotional attachments and to go to great efforts to avoid abandonment). Although he asserts that in some cases, the most ethical way for centers to proceed is to decline to provide services outside of their scope, the author also acknowledges that in cases where students are not able to access mental health services off-campus, centers are faced with an even thornier ethical dilemma (i.e., treat a student knowing that one does not have the appropriate resources/services to do so or allow the student to fend for him/herself, knowing that the student does not have the means to access the needed services elsewhere).

Many of the issues discussed by Gilbert (1992) have intensified over the last 20 years and the pressure to find ways of assisting students with serious psychological issues continues to mount. In many cases, students who are in severe distress can withdraw from their institution under medical leave. However, the issue remains of how to manage students who will not withdraw voluntarily and wish to continue with their courses. Prior to 2011, institutions sometimes removed students from campus when that student posed a direct threat to him/herself under Title II of the Americans with Disabilities Act (ADA). However, a recent revision of Title II defines “direct threat” as “when an individual poses a direct threat to the health or safety of others” (Americans with Disabilities Act of 1990, 2011). These changes represent a significant issue to contend with for public institutions of higher education around the nation. Thus, as an increasing number of students with serious psychological problems present for treatment, institutions may be increasingly obligated to do something to assist them (whether linking to appropriate and accessible services off-campus or providing such services on-campus), as removing them from campus when they pose a direct threat to themselves is now considered to be a violation of the student’s rights under the ADA. While addressing all possible methods of managing these issues on college campuses is outside of the scope of this project, I do attempt to
address the provision of DBT as one option for college counseling centers that wish to provide
direct assistance to students in need, at the level of care that is actually required in more serious
cases. Further, I will address both practical considerations in the implementation of DBT
programs as well as theoretical issues associated with DBT implementation in general (i.e., the
issues that arise when clinicians are not interested in working with individuals with BPD and/or
have biases that reduce their empathy for this population).

Overview of the Literature

Efficacy of DBT

More than 20 years ago, Linehan (1993a) published the treatment manual for DBT,
entitled, “Cognitive-Behavioral Treatment of Borderline Personality Disorder.” While DBT was
never developed specifically to treat BPD, many of its efficacy studies include BPD as an
focus on BPD originated because Linehan wanted to recruit the most severely suicidal
individuals possible for her studies and as she did so, she found that many of them met criteria
for BPD. At present, DBT is considered to be an evidence-based practice for the treatment of
BPD, with more than 30 randomized-controlled trials, many of which were conducted
independently of the treatment developer, demonstrating the efficacy of the treatment model.

In addition, the field of DBT research has expanded over the years, with the treatment
being successfully applied to a variety of difficult-to-treat, complex clinical populations. For
example, two of the efficacy studies noted above (Linehan, et al, 1999; Linehan, et al., 2002) are
focused on drug-dependent women who also meet criteria for BPD. Several studies have also
found promising results for individuals with bulimia nervosa or binge eating disorder (Hill, Craighead, & Safer, 2011; Telch, Agras, & Linehan, 2001). Notably, anorexia nervosa is not included in the research on the standard DBT model. To address this issue, Lynch developed Radically Open DBT (RO-DBT), which characterizes anorexia nervosa as a disorder of “over-control” (in contrast to disorders such as BPD, or binge eating disorder, which are characterized by impulsivity). Lynch and colleagues (2013) studied RO-DBT with a sample of severely underweight (mean BMI=14.43) individuals meeting criteria for anorexia nervosa and found that the treatment was associated with significant improvements in weight gain, along with reductions in eating disordered symptoms and increases in quality of life related to the eating disorder.

Another particularly exciting break-through in the field of DBT research is the development of the integrated DBT–Prolonged Exposure (DBT-PE) protocol. The development of BPD in adulthood has been associated with multiple different types of pathological experiences in childhood (e.g., emotional or sexual abuse, neglect; Zanarini, et al., 1997) that may also result in the development of post-traumatic stress disorder (PTSD). While there are several empirically-validated treatments for PTSD (notably, Foa’s prolonged exposure), it can be extremely difficult and dangerous to conduct this type of treatment with a suicidal, self-injuring individual. The reason for this risk is, unfortunately, also the cause of continued risk to the client if one does not treat her PTSD. Linehan (1993a) conceptualizes suicidal and self-injuring behaviors as primarily a means of escaping overwhelming, painful emotional experiences. Thus, symptoms of PTSD (e.g., flashbacks, nightmares, etc.) can be a primary antecedent for suicidal behavior, which then makes the individual considered to be too high risk to receive treatment for PTSD!
The solution to the aforementioned problem was to develop a protocol that integrated DBT, which is known to be effective in stabilizing and reducing life threatening behavior, and PE which is an evidence-based treatment for PTSD (Foa, Hembree, & Rothbaum, 2007). Melanie Harned developed the DBT-PE protocol and no treatment manual is currently in print although training in the model is available. DBT-PE is a one-year treatment, during which the individual will be able to receive PE when she meets a number of criteria including (but not limited to) not being at immanent risk of suicide, being able to abstain from suicide attempts and self-injury for a period of no less than two months, and being able to control urges to engage in these behaviors in the presence of cues for them. Recent research comparing DBT-PE to standard DBT with a sample of adults who met criteria for BPD, PTSD, and who had both a recent and recurrent history of self-injury found that the rate of PTSD remission was doubled among those who completed the DBT-PE protocol (Harned, Korslund, & Linehan, 2014). In addition, those who received DBT-PE were 2.4 times less likely to commit suicide and 1.5 times less likely to self-injure.

From the original research base to recent developments, it seems clear that DBT is a promising intervention for individuals with complex mental health disorders. However, the results presented here are mainly derived from tightly controlled research settings funded by large government grants. In many ways, DBT represents a ‘higher level of care’ that clinicians are ethically obligated to recommend only when it is the most parsimonious option given the presenting problems. DBT is quite challenging to implement in real-world settings, especially those that are not designed to offer comprehensive mental health treatment to high-risk clients, such as college counseling centers.
DBT on College Campuses

To date, only two studies have demonstrated the application of the standard DBT model in a college counseling center (Engle, Gadischkie, Roy, & Nunziato, 2013; Pistorello, Fruzzetti, Maclane, Gallop, & Iverson, 2012). For the most part, the research related to DBT in college counseling centers has focused on adapted models emphasizing the group skills training component of DBT (while the standard model includes individual therapy, group skills training, telephone coaching, and team consultation). One type of adaptation involves providing DBT skills training groups to students with BPD or BPD traits as an adjunct to individual therapy provided outside (Meaney-Tavares & Hasking, 2012) or inside (Chugani, Ghali, & Brunner, 2013) the counseling center. These models represent adaptations of DBT that may adhere more closely to the functions of treatment that the standard DBT model is designed to achieve. In chapter five, I present the adapted-comprehensive DBT program developed at FGCU as an option for adapting DBT in a manner that achieves the original functions of the treatment.

An additional development in the field of DBT in college counseling centers is the use of brief DBT skills training groups for college students with emotion dysregulation or impulsivity. For example, Rizvi and Steffel (2014) piloted eight-week skills training groups that included either the mindfulness and emotion regulation skills or solely emotion regulation skills from the standard DBT group skills training protocol (Linehan, 2015). These authors found that students in both groups achieved significant improvements in emotion regulation, DBT skills use, affect, and occupational and social functioning. Fleming and colleagues (2015) also piloted an eight-week DBT skills training group that was adapted for treatment of college students with attention deficit-hyperactivity disorder (ADHD). These authors found that students who received the DBT group intervention (as compared with those who were provided with DBT handouts, but
did not receive an in-vivo intervention) demonstrated better treatment response rates and better clinical improvements in their rates of ADHD symptoms, executive functioning, and quality of life.

Despite the aforementioned developments in the use of DBT skills training for college students with emotional dysregulation or ADHD, overall, research in this field is limited and mainly comprised of smaller-scale studies. The body of research related to DBT in college counseling centers is discussed at length in chapter two and as such, I do not present it further here. In addition, it seems clear that if college counseling centers are adapting DBT for implementation in their centers, more research is needed to clarify which adaptions are most efficacious and feasible for use in this practice setting. I discuss these issues further in chapter four.

Intersection of DBT and Stigmatization

Linehan (1993a) notes that a primary goal in the development of DBT was to create a treatment that was both scientifically sound and compassionate. While individuals with mental health disorders have long been stigmatized in our society, literature has demonstrated that individuals with BPD may elicit even more stigma than individuals with other diagnoses. Much of this research has been conducted with health care professionals such as psychiatric nurses. For example, Markham and Trower (2003) used a questionnaire that contained descriptions of various patient behaviors, with each description being linked to a diagnosis of BPD, depression, or schizophrenia. The authors studied the ratings of these challenging patient behaviors as assigned by mental health nurses and found that in comparison to depression and schizophrenia, nurses had more negative responses to the descriptions of patients with the BPD diagnosis. In
addition, they found that nurses were more likely to view patient behavior as within the control of the patient when the diagnosis was BPD, as compared with depression or schizophrenia.

Rivera-Segarra and colleagues (2014) examined stigmatization experiences of adults with BPD living in Puerto Rico and found that their participants reported experiencing a high level of attributed personal responsibility. This finding, although told from the perspective of the client rather than a healthcare professional, is quite similar to Markham and Tower’s (2003) report that individuals with BPD tended to be viewed as being more in control of their behaviors. Markham and Trower (2003) conclude that as these ‘attributions of control’ were inversely related to sympathy, it may be helpful to address such attributions as a method of improving sympathy for patients. However, it may be more difficult to address attributions of control due to the particular nature of borderline pathology.

Linehan (1993a) asserts that individuals with BPD typically display several distinct behavioral patterns that she conceptualizes as ‘dialectical dilemmas’. These patterns are described as dialectical dilemmas because they present behaviors representing opposing perspectives within the same individual. One dialectical dilemma that can be particularly problematic in terms of attributions of control is known as “apparent competence vs. active passivity” (Linehan, 1993a). Linehan (1993a) defines active passivity as, “the tendency to solve problems passively and helplessly, rather than actively and determinedly, as well as a corresponding tendency under extreme distress to demand from the environment (and often the therapist) solutions to life’s problems” (p. 78). Thus, while individuals with BPD appear to possess the capability of being active problem solvers, they can be quite passive in the sense that they do not focus on solving their own problems. Linehan (1993a) notes that an issue that may consequently arise in therapy is that the client’s internal beliefs regarding her ability to solve her
own problems are discrepant from those of the therapist. In other words, the therapist attributes problem-solving capabilities to the client that the client does not believe she possesses. This can become frustrating for the therapist, who does not understand why the client will not try to solve problems, and very invalidating for the client, who does not understand why the therapist is asking her to do something that she does not know how to do.

On the opposite side of the dialectic from active passivity, Linehan (1993a) notes the tendency of BPD clients to display a behavioral pattern known as apparent competence. She defines apparent competence as, “the tendency of borderline individuals to appear competent and able to cope with everyday life at some times, and at other times to behave (unexpectedly to the observer) as if the observed competencies did not exist” (p. 80). Linehan (1993a) notes that behavioral competencies for individuals with BPD are extremely mood and situation dependent. For example, a client may be able to assert herself appropriately when she is in a generally good mood and in a situation that is not particularly invalidating, but she might not be able to demonstrate the very same behaviors when in an invalidating situation that triggers a negative mood state.

Although the behavioral patterns noted by Linehan (1993a) often make accurate assessment and attributions of client control and capabilities difficult, I argue that simply being aware of the occurrence of such patterns and the ways in which they might interfere with therapy is critically important if one wishes to approach therapy nonjudgmentally. Unfortunately, awareness may not be not sufficient to maintain a nonjudgmental stance because many of the behaviors associated with BPD may exacerbate stigmatization of the client by the therapist (Avriam, Brodsky, & Stanley, 2006). For example, therapists may want to distance themselves emotionally (or physically) from clients who have broken items in their offices, threatened to file
reports with their professional licensing boards, or any number of other understandably distressing behaviors. In these cases, Aviram and colleagues (2006) note that a dialectic arises where the therapist’s desire to escape client behaviors is logical (in the sense that it is self-protective) and, this desire to escape may end up exacerbating the situation and/or escalating client behaviors that were interfering with therapy in the first place (because individuals with BPD tend to be particularly sensitive to rejection).

While implementation of DBT programs does not eliminate the occurrence of situations that may lead to further stigmatization of individuals with BPD, it does include components of treatment that are designed to help clinicians in managing these situations appropriately. For example, DBT case conceptualization includes analysis of high priority behavioral targets (e.g., life-threatening behavior) as well as secondary targets (the dialectical dilemmas) which can be helpful in understanding when and how clinicians are mis-attributing client control or capabilities and thus, strategically target those areas for improvement in session. In addition, DBT therapists are required to participate in weekly team consultation. The team serves many functions and some of the most important of these are to hold therapists within the treatment model and to help therapists search for non-pejorative interpretations of client behavior. Thus, while DBT (or any treatment model) is not likely to address the broader issue of the stigmatization faced by individuals with BPD, it may be particularly well developed to address these problems within the context of therapy because it acknowledges that they will occur and includes strategies for their management.
Summary

The issues surrounding effective DBT implementation are varied and complex. The purpose of this dissertation is to present a focused view of the issues that are important for consideration when implementing a DBT program in a college counseling center as well as some of the theoretical issues that are important in implementing effective DBT programs in general. I assert that although implementation of such programs on college campuses may be difficult due to the nature of this particular practice setting, it may also be an important part of the solution to the issue of continued increases in college students who are in need of appropriate mental health care for serious psychological disorders. I believe that offering young people the opportunity to access affordable, evidence-based, and compassionate care has the potential to make a profound difference in the trajectories of their lives.

Within the area of DBT implementation, I present two strands of inquiry that I believe are important synthesize. First, I discuss practical issues related to DBT in college counseling centers including a review of findings to date, program development and implementation, and current trends and barriers to implementation. Next, I discuss the experience of BPD as reported by individuals who have been successfully treated with DBT, including the importance of viewing client experiences and behaviors in context, which may help reduce the stigmatization that these individuals face. Taken together, this research aims to address the importance of considering practical and theoretical issues if one is to implement DBT programs that adhere to both the method and the spirit of the treatment.
CHAPTER TWO

DIALECTICAL BEHAVIOR THERAPY IN COLLEGE COUNSELING CENTERS:
CURRENT LITERATURE AND IMPLICATIONS FOR PRACTICE

Note to the Reader

This article comprising this chapter was published in April, 2015 by the *Journal of College Student Psychotherapy* and as such, cannot be reprinted here. Permission was granted from the publisher to include the abstract below along with the following: This dissertation is derived in part from an article published in the *Journal of College Student Psychotherapy* on April 15, 2015, available online:


Abstract

This paper examines the topic of Dialectical Behavior Therapy (DBT) applied in college counseling centers. Trends in mental health issues on college campuses are briefly reviewed in support of the increased need for evidence-based treatment of severe mental health issues. The article next presents an overview of the standard DBT model and reviews research regarding DBT in college counseling centers, focusing on clinical outcomes and adaptations made for the college counseling setting. Finally, there is a discussion of implications for practice, barriers to implementation and outcome measurement, and areas for future research.
CHAPTER THREE
ADAPTING DIALECTICAL BEHAVIOR THERAPY FOR COLLEGE COUNSELING CENTERS

Note to the Reader

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Introduction

The issue of how to serve college students best who present with severe and complex mental health issues remains a challenge. While some college counseling centers may have the
option to refer these students to off-campus psychological services, many others are faced with
difficult treatment decisions when appropriate referral sources are not available or students do
not have the means to access them. One treatment approach which offers promise for assisting
such students is Dialectical Behavior Therapy (DBT), an evidence based treatment for
Borderline Personality Disorder (BPD) as well as several other severe mental health issues. This
paper outlines the rationale for the development of an adapted DBT program within one college
counseling center and provides practical suggestions for the implementation of DBT programs in
other college counseling centers.

**Literature Review**

**Evidence of Increasing Psychopathology on College Campuses**

The rise in psychopathology among college students has been documented (Benton, Robertson, Tseng, Newton & Benton, 2003; Twenge, DeWell, Lacefield & Schurtz, 2010). The
most recent National Survey of College Counseling Directors (Gallagher, 2012) lends further
support to these findings with 88% of directors reporting a continued trend of increasing
numbers of students with severe psychological problems. Directors reported that 39% of
students presented with severe psychological problems and of those students, 6% present with
problems so severe that they cannot remain in school or can only do so with intensive support
and intervention. Directors noted increases in a number of psychological issues including, but
not limited to, eating disorders (26%), crises requiring immediate response (73%), and self-
injury issues, such as cutting to relieve anxiety (40%).
Kuentzel, Arble, Boutros, Chugani, and Barnett (2012) surveyed an ethnically diverse sample of 5,691 undergraduate students and found that 12.8% reported at least one incident of non-suicidal self-injury (NSSI) with 3.4% engaging in NSSI during the past year. In a study examining the moderating role of BPD between deliberate self-harm and emotion related factors, Gratz, Breetz, and Tull (2009) found that of 392 undergraduate students recruited via a psychology course, 25.5% demonstrated clinically relevant levels of BPD. Of those students scoring in the clinical range for BPD, 39% reported a history of deliberate self-harm compared with 21% of the students scoring below the clinical range. While self-harm behavior has been studied often through the lens of BPD, these data suggest that students who do not meet criteria for BPD may also present with high rates of this behavior (Gratz et al., 2009; Kuentzel et al., 2012). Linehan (1993a) posited that self-harm is a powerful method for regulating emotion. Thus, students who present with deliberate self-harm or other risky and impulsive behaviors often associated with severe mental health issues may benefit from treatments aimed at increasing both emotional and behavioral regulation.

**Rationale for DBT in the College Counseling Setting**

Marsha Linehan developed DBT (1993a, 1993b) for treatment of chronically suicidal individuals and, it has since become a best practice in treatment of BPD. Linehan explains BPD as a disorder of emotional, behavioral, cognitive, interpersonal, and self dysregulation. Group skills training, a component of DBT, addresses these areas of dysregulation and didactically presents adaptive skills designed to enable participants to achieve increased regulation across all targeted domains. Specifically, DBT skills training groups includes four modules of skills (mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness) that
correspond to the various areas of dysregulation (Linehan, 1993a, 1993b). In addition to group skills training, the standard DBT model includes individual therapy, phone coaching as needed (to assist individuals in generalizing skills learned in therapy to the natural environment, particularly in crisis situations), and a weekly consultation group for the therapists (Linehan, 1993a). Randomized controlled trials have demonstrated the efficacy of DBT with women with BPD (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006) and substance dependent women with BPD (Linehan et al., 1999). DBT has also been adapted for use with several other diagnoses including substance use disorders (Axelrod, Perepletchikova, Holtzman, & Sinha, 2011; Dimeff & Linehan, 2008), treatment resistant Major Depressive Disorder (Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009), Binge Eating Disorder (Telch, Agras, & Linehan, 2001), Bulimia Nervosa (Hill, Craighead, & Safer, 2011; Safer, Telch, & Agras, 2001), and Binge Eating Disorder or Bulimia Nervosa and BPD (Chen, Matthews, Allen, Kuo, & Linehan, 2008). Further, DBT has been adapted for use with varied clinical populations including suicidal adolescents (Rathus & Miller, 2002), adolescents who self-injure and their parents (Nixon, McLagan, Landell, Carter, & Deshaw, 2004), depressed older adults (Lynch, Morse, Mendelson, & Robins, 2003), and individuals with BPD on inpatient units (Swenson, Sanderson, Dulit, & Linehan, 2001). Finally, while the standard length of DBT treatment is one year, several studies have demonstrated efficacy with time-limited DBT skills training groups targeting BPD (12 weekly sessions; Soler et al., 2009), self-injuring adolescents (eight weekly sessions; Nixon et al., 2004), and treatment resistant Major Depressive Disorder (16 weekly sessions; Feldman et al., 2009).

To date, few studies have examined the efficacy of DBT in college counseling centers, however, those that have offer promising results. Pistorello, Fruzzetti, Maclane, Gallop and
Iverson (2012) conducted a randomized controlled trial with suicidal college students who had at least one lifetime incident of self-injury or suicide attempt and met at least three diagnostic criteria for BPD. Treatment duration was seven to 12 months (students who were not able to attend treatment due to summer vacation or other breaks were still included) and students received either standard DBT or optimized treatment as usual (O-TAU). The O-TAU condition was a psychodynamic approach to treatment of suicidality, and an expert in this approach supervised trainees in delivering individual and group therapy during the study. Pistorello et al. (2012) conducted assessments measuring depression, suicidality, NSSI, BPD criteria, social adjustment, and use of psychiatric medication at pretreatment, three, six, nine, 12 (post-treatment), and 18 (follow-up) months and found that the DBT condition yielded significant results across all measured domains in comparison with the O-TAU condition. Meaney-Tavares and Hasking (2013) developed an eight-week skills training group based on DBT that was implemented successfully in an Australian college counseling center with students who met criteria for BPD. These authors found significant decreases on measures of depression and BPD symptoms as well as significant increases in adaptive coping skills.

Chugani, Ghali, and Brunner (2013) examined the effectiveness of an 11-week DBT skills training group provided as part of an adapted DBT program in Florida Gulf Coast University’s (FGCU) Counseling and Psychological Services (CAPS). Subjects were students who demonstrated high levels of emotional dysregulation and had been identified by a CAPS clinician as presenting with a cluster B personality disorder or clinically significant cluster B traits that were the primary focus of attention in treatment. The students received either treatment as usual (TAU) or attended the DBT skills training group in addition to standard individual therapy. The TAU condition consisted of the treatment students would normally
receive upon presenting for services, such as weekly non-DBT individual therapy and referrals for non-DBT group therapy and/or psychiatric services as deemed appropriate by the primary therapist.

Chugani et al. (2013) found that students who participated in the DBT group demonstrated significant increases in adaptive coping skill use and significant decreases in maladaptive coping skill use as compared with the TAU group. In addition, students who participated in the DBT group demonstrated a trend for improvement in emotion regulation \((p = .052)\) as compared with the TAU group. Although it appears that DBT in college counseling centers is becoming increasingly popular, little has been written regarding how to develop and implement a DBT program that meets the needs of these centers and the students they serve. As many college counseling center directors have continued to report increased numbers of students who present with severe psychological disorders (Gallagher, 2012), more intensive interventions such as DBT may be a useful means of serving such students.

The purpose of this paper is to offer information and lessons learned regarding development and implementation of the DBT program at Florida Gulf Coast University (FGCU). At the time of this writing, FGCU’s CAPS employed 13 clinical staff members (including three directors), two doctoral interns, four master’s level interns, one psychiatrist, and serves 14,077 undergraduate and graduate students. During 2012, 1,206 students presented for services at CAPS and received a total of 9,464 sessions. All enrolled students are eligible to receive CAPS services and the center does not have session limits. The average number of appointments per student during the 2012-2013 academic year was 7.38.
Program Development and Implementation

The development and implementation of the DBT program at FGCU included three phases. Phase one consisted of initial steps in program development and adaptation of the standard DBT model. Phase two included program evaluation and expansion. Phase three included obtaining intensive training in DBT and the development of a comprehensive treatment model.

Phase One: Initial Steps in Development and Adaptation

DBT was identified as a model of choice when the counseling center director observed that increasing numbers of students were presenting for treatment with complex, multi-diagnostic issues. An interested clinician volunteered to serve as the DBT team leader and the center staff agreed to participate in some initial training consisting of reading Linehan’s treatment manuals (1993a; 1993b), completing Behavioral Tech’s 20 CEU online course on DBT skills training, and attending a two-day customized consultation with a Behavioral Tech trainer. Following the training, interested staff members began holding weekly DBT consultation meetings. In DBT, there is an assumption that therapists treating suicidal individuals need support and thus, the whole team meets on a weekly basis to discuss cases and obtain assistance in strengthening skills in the practice of DBT. The consultation team meeting is a time for individual therapists to consult with group therapists regarding the progress of shared clients.

The CAPS DBT team leader developed content outlines based on Linehan’s (1993b) manual for a 14-week DBT skills training group. The team leader made content selections from Linehan’s (1993b) skills training manual based on clinical experience. The team discussed the logistical considerations believed to be most important for college students: 1) Leave a few
weeks at the beginning of each semester for students to settle into class schedules before taking on additional commitments; 2) Make allowances for any holidays or breaks; 3) Schedule the group at a time that does not conflict with class schedules; and 4) End the group before final exam week to allow students extra time to study. The program began with a 14-week, 90-minute skills group. Group participants received a binder containing all of the skills training handouts and homework sheets (Linehan, 1993b). Snacks were provided during each group session. However, standard DBT phone coaching was not provided during the initial development period because providing students with the option of contacting their primary therapist outside of business hours is beyond the scope of services for CAPS. Linehan (1993a) designed phone coaching to meet several objectives, including, but not limited to, assisting clients in generalizing the skills they learn in group therapy to their everyday lives by allowing them to reach their therapist as needed to obtain coaching in implementing the skills (see Linehan, 1993a for a full description of procedures for DBT phone coaching). Initially, students were asked to call their primary therapist or one of the DBT group leaders during office hours to obtain skills coaching. In the event that students experienced a crisis after hours, they were instructed to call a talk-line available to all university students.

After the pilot group was completed, group leaders collected feedback from the participants. Of particular interest was feedback on which skills were found to be most and least helpful. Based on the feedback received and scheduling challenges inherent in fitting a 14-week group into a 16-week semester, the team decided to reduce the group length to 11 sessions per semester. This was achieved by excluding skills that participants and leaders observed to be least effective and by layering skills from the Distress Tolerance and Emotion Regulation modules. See Chugani et al., 2013 for a complete outline of the 11-week protocol.
Phase Two: Program Evaluation and Expansion

After pilot testing the 11-week protocol, the team agreed that this format seemed to work much better for the center. The reduction in the number of sessions allowed for more time at the beginning of each semester to recruit group participants. In addition, the format allowed the students time to adjust to their class schedules before beginning to attend weekly group therapy. The next step was to conduct preliminary research to evaluate the efficacy of the protocol (see Chugani et al., 2013). Although there were specific inclusion and exclusion criteria for participation in the study, all students who were identified as being clinically appropriate for DBT treatment were included in the DBT program (refer to Table 1).

Table 1. Current Inclusion and Exclusion Criteria

<table>
<thead>
<tr>
<th>Inclusion:</th>
<th>Exclusion:</th>
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<tbody>
<tr>
<td>Demonstrates dysregulation in at least two of the five domains targeted by DBT. The severity of the dysregulation must be enough that DBT is clinically appropriate.</td>
<td>Hostile or antisocial behavior which would contraindicate participation in group therapy.</td>
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<tr>
<td>Demonstrates two or more skills deficits in core areas addressed in skills training.</td>
<td>Unwilling to agree to DBT program treatment contract.</td>
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<tr>
<td>Actively commits to and complies with treatment modalities recommended by the primary therapist (including individual, group, pharmacotherapy, and/or ancillary supports such as AA.</td>
<td>Unwilling to agree to participate in recommended components of treatment (e.g. requests individual therapy but refuses to attend group sessions).</td>
<td></td>
</tr>
<tr>
<td>Actively commits to the following goals at minimum:</td>
<td>Drops out of either individual therapy or group therapy (group participants are allowed a maximum of three absences from group per semester).</td>
<td></td>
</tr>
<tr>
<td>Reduction in suicide attempts, ideation, NSSI and/or other self-destructive and potentially lethal behaviors (e.g. purging).</td>
<td>A necessary exception to the rule related to absences is in the event that a student goes home from winter or summer break and is unable to attend appointments for a reasonable, pre-arranged, and specific period of time.</td>
<td></td>
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<tr>
<td>Reduction of behavior likely to destroy or interfere with therapy.</td>
<td>In the event that a student drops out of the program via 4 misses, they are eligible to return to DBT at the beginning of the following semester.</td>
<td></td>
</tr>
<tr>
<td>Increasing skills. *Note: In the event that a student is unable to make these commitments, continue to treat in the pretreatment phase until such time when commitments can be elicited.</td>
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</tr>
</tbody>
</table>
During this time period, FGCU’s CAPS offered skills training groups once each fall and spring semester. The skills group typically began with eight to twelve members and ended with six to nine members. Members of the DBT team met weekly for a one hour DBT consultation meeting and members of the team offered DBT informed therapy to students in the skills training group. Students were able to access skills coaching by contacting their primary therapist or the team leader during business hours. As the program continued, interest grew and more students elected to return to the group for multiple semesters. After the second year of operation, the program was expanded to offer three skills groups per year (one each in the fall, spring, and summer semesters). DBT group leaders observed that the program had begun to develop a “group culture” with more experienced DBT participants assisting and validating newcomers to the group. Clinically, team members agreed that the DBT program was a valuable resource for the students it served. When research suggested that the program was improving clinical outcomes with students who presented with BPD or BPD traits as a primary focus of clinical attention (Chugani et al., 2013), the DBT team leader realized that the next step would be to attend the DBT Intensive Training.

**Phase Three: Intensive Training and Development of a Comprehensive Treatment Model**

CAPS partnered with Behavioral Tech to co-host the first DBT Intensive Training in the State of Florida. Co-hosting the training allowed for the team to schedule the training sessions during weeks that were historically slow for the center (minimizing the impact that the event would have on service provision) and reduced travel related costs. The six members of the DBT team, and the center’s director and psychiatrist attended the intensive training (the psychiatrist was only able to attend part one of the two-part training event). A part-time clinician and the
Student Affairs case manager served as administrative volunteers for the event and, in doing so, were able to access in-depth DBT training without making the on-going time commitment that would be expected for a regular DBT team member. Having the director, psychiatrist, and case manager receive training in DBT was invaluable because, often, these individuals are involved in the treatment of the center’s most complicated cases. Additionally, having a key administrator with a working knowledge of the needs of a DBT team has yielded support and additional time for the team to continue to work on improving capability.

Receiving intensive training in DBT allowed the program to continue to develop into a model that follows the standard DBT model more closely. Within the DBT team, some members now offer standard DBT individual therapy (see Linehan, 1993a) while others have adopted a DBT-informed approach to therapy in cases where a student is participating in DBT skills training. In addition, the program accepts referrals from center clinicians who are not part of the DBT team. Each clinician is responsible for making an agreement with students regarding how and when accessing skills coaching from the primary therapist is appropriate. With permission from the CAPS center director, one team member began providing standard, 24/7 DBT phone coaching. Because this service was beyond the scope of the services provided by CAPS, this licensed therapist provided phone coaching on a volunteer basis and under a separate insurance policy.

Additional changes include contracting with a call center that has accepted a DBT skills-focused protocol for the program’s participants (being pilot tested at the time of this writing). When a student calls the talk-line (available 24/7) and identifies as a DBT client, the counselor accesses a DBT skills-focused list of questions designed to assist students in identifying appropriate and effective skills to practice in the moment. Talk-line counselors screen for the
“24-hour rule” (DBT phone coaching is not provided within 24 hours of NSSI or suicide attempt so as to avoid reinforcing those behaviors inadvertently) and either proceed with the DBT skills protocol or, if the student has engaged in NSSI within the last 24 hours, proceed with the usual protocol that any student caller would receive. Additionally, students have the option of submitting a sheet containing relevant information (history of self-injury/suicide attempts, medications, reasons for living, strengths, key support individuals, etc.) to be accessed as needed by talk-line counselors. Therapists work with students on an individual basis to determine whether such information should be submitted to the talk-line.

The skills training group has been extended to 12 weekly, one and one half hour sessions which allowed time to present additional skills to the group as well as administer outcome measures. Additional content was also included by assigning handouts that are self-explanatory as homework assignments. For a complete outline of the 12-week protocol see Table 2.

The consultation group continues to meet weekly and has worked on formalizing additional components of the program, such as inclusion and exclusion criteria, a basic treatment contract for participation in the DBT program, and ways to broaden the scope of the program while still fitting within the center’s scope of services. For example, the team has discussed the idea of offering “drop-in” workshops on various DBT skills (available to any student who wishes to attend). CAPS staff have pilot tested a two hour mindfulness workshop, which was one of the most highly attended events in a larger workshop series presented by the counseling center. Additionally, the DBT program now includes students with severe mental health concerns (most often BPD), as well as students who do not present with personality disorders but do report a high degree of difficulty utilizing healthy coping skills within the same skills training group.
Typically, students with skills deficits attend skills training for a single semester while students presenting with BPD or other complex issues will repeat the group several times.

Table 2. 12-Week Dialectical Behavioral Therapy Skills Training Protocol.

<table>
<thead>
<tr>
<th>Session</th>
<th>Handouts</th>
<th>Practice Assignment</th>
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<tbody>
<tr>
<td>1</td>
<td>General Handouts 1 &amp; 2, Mindfulness Handout 1</td>
<td>Notice when you are in emotion or reasonable mind, try to connect with wisemind.</td>
</tr>
<tr>
<td>2</td>
<td>Mindfulness Handouts 2 &amp; 3</td>
<td>Mindfulness What and How Skills</td>
</tr>
<tr>
<td>3</td>
<td>Introduction to Distress Tolerance and Distress Tolerance Handout 1</td>
<td>Distress Tolerance Homework Sheet 1</td>
</tr>
<tr>
<td>4</td>
<td>Distress Tolerance Handouts 3 &amp; 5</td>
<td>Read Distress Tolerance Handouts 2 &amp; 4 Distress Tolerance Homework Sheet 2</td>
</tr>
<tr>
<td>5</td>
<td>Emotion Regulation Handouts 1, 2, 3, &amp; 4 (briefly review #4 and instruct participants to refer back to it during homework practice)</td>
<td>Complete Myths about Emotions (Handout 2), Emotion Regulation Homework Sheet 1</td>
</tr>
<tr>
<td>6</td>
<td>Emotion Regulation Handouts 6 &amp; 7</td>
<td>Emotion Regulation Homework Sheet 3, read Emotion Regulation Handout 8</td>
</tr>
<tr>
<td>7</td>
<td>Emotion Regulation Handout 9, How to Think and Act Dialectically (from Linehan, in press)</td>
<td>Emotion Regulation Homework Sheet 2</td>
</tr>
<tr>
<td>8</td>
<td>Emotion Regulation Handout 10, Opposite Action vs. Problem Solving (from Linehan, in press)</td>
<td>Practice Opposite Action</td>
</tr>
<tr>
<td>9</td>
<td>Interpersonal Effectiveness Handouts 1, 2, &amp; 6</td>
<td>Interpersonal Effectiveness Homework Sheet 1, complete Myths about Interpersonal Effectiveness (handout 4), review Handout 5</td>
</tr>
<tr>
<td>10</td>
<td>Interpersonal Effectiveness Handout 8</td>
<td>Interpersonal Effectiveness Homework Sheet 2, read Interpersonal Effectiveness Handout 3, refer to Handout 7 for ideas on ways to practice at least one DEAR MAN</td>
</tr>
<tr>
<td>11</td>
<td>Interpersonal Effectiveness Handout 9</td>
<td>Interpersonal Effectiveness Homework Sheet 3, practice GIVE skills</td>
</tr>
<tr>
<td>12</td>
<td>Interpersonal Effectiveness Handout 10</td>
<td>Practice FAST Skills</td>
</tr>
</tbody>
</table>

Note: This table is based on the 11-week skills training protocol from Chugani, et al., 2013.
Developing and implementing the DBT program at FGCU’s CAPS is widely regarded as improving services to our students, but it has not been without challenges. Learning to practice DBT and expanding center services to move toward a comprehensive treatment model was a significant undertaking. What follows are suggestions based on the key lessons learned over the three-year period that the DBT program has been operating.

**Considerations for College Counseling Centers**

**Practical Considerations in Program Development**

- Discuss the ways in which providing a DBT program may increase the amount of intervention and/or contact hours received by a small group of students relative to the general campus population. At FGCU, DBT participants receive two and a half hours of individual and group therapy per week (one hour of individual and one and a half hours of group) plus phone coaching as needed. Assess the number of weekly contact hours and the depth of intervention you are willing to provide to DBT participants realistically and develop your program accordingly (i.e., standard DBT vs. DBT skills group only as a adjunct to treatment).

- Have each prospective team member assess the number of hours per week he or she is willing to commit to DBT related activities realistically.

- Have each prospective team member identify components of the model in which he or she is willing to participate to ensure that the program will be sustainable in the long term. Specifically, ensure that several team members are willing to run groups, more than one individual is willing and able to serve as team leader, and all team members are
willing and able to attend weekly consultation meetings and provide standard DBT individual therapy.

- Discuss how to meet the functions that phone coaching provides. Though many may consider phone contact with students after business hours beyond the scope of services for the center, allowing some kind of access to the primary therapist in between sessions can be quite helpful in facilitating generalization of healthy coping skills, maintenance of the therapeutic relationship (this is especially important when working with individuals with BPD), and maintenance of commitment to therapy.

- Discuss the type and amount of work required from each team member to start the program and assess commitment to training. This is especially true for those interested in participating in Behavioral Tech’s DBT Intensive Training, which includes completion of homework between part one and part two of the event.

- Identify the various roles team members will need to assume for the program to operate and obtain commitments. For example, the identified team leader may oversee program operations primarily and serve as an intermediary between the team and the administration. Other team roles may include assuming responsibility for managing various areas of the team’s needs, such as training, materials, group scheduling/planning, research, or recruitment. Alternately, have all team members commit to serving as the team leader on a rotating basis (e.g., rotate each semester). Sharing the responsibility and workload in this way is not only practical, but also may foster a greater sense of collaboration as the team develops.

- Identify the needs of the staff in implementing the program and engage in an honest discussion with the center director and other key administrators regarding these. This
may include funding for training, time to read/study, extra meeting time, or funds for materials or snacks provided to students during group skills training. Be sure to include all administrative and clinical supervisors of DBT team members and obtain agreements related to appropriate utilization of time and resources.

**Considerations for Team Development**

- Engage all prospective team members in a discussion related to their concerns about maintaining professional identity while learning to practice DBT. Be aware that clinicians come to the team with a variety of training backgrounds and are likely already comfortable and skilled in other theories of treatment. Ensure that team members understand that learning DBT may require significant shifts in ideology, which can be uncomfortable and require an adjustment period. For example, DBT includes many behavioral interventions that some staff may not feel comfortable implementing. Also, DBT includes team agreements and assumptions about clients that may not conform to the previously established beliefs of team members (Linehan, 1993a).

- Obtain a commitment from all team members to observe and respect individual clinicians’ limits related to how and when to use DBT. Learning to practice DBT does not imply that team members must or should practice DBT with all students on their caseloads. However, DBT team members should be interested in practicing DBT with some of the students on their caseloads (especially high risk students who are likely to benefit from receiving standard DBT).

- Review the Therapist Consultation Agreements (Linehan, 1993a, p. 117-119). Ensure that prospective team members understand key differences between DBT consultation

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meetings and typical case consultation. Keep in mind that “the role of the DBT case consultation group is to hold the therapist inside of the treatment” (Linehan, 1993a, p.101). DBT consultation meetings are a peer support group and, though cases are reviewed and discussed, there is a generally higher level of vulnerability than in the average staff meeting. Team members may observe higher vulnerability when staff members share feelings or reactions (e.g., frustration, failure, etc.) that are impeding their use of the DBT model with students in the meeting.

- Review and discuss Linehan’s (1993a) Assumptions about Borderline Patients and Therapy.
- Discuss the willingness of team members to practice DBT skills and techniques in their own lives, including practicing on one another (e.g., a brief chain analysis when a team member is late to consultation meeting). Facilitate understanding that practicing DBT techniques with other team members is not punitive but, rather, it is meant to help staff develop and maintain a new skill set.
- Make staff participation on the DBT team voluntary. A significant investment of time and energy is required to learn any comprehensive treatment model. To the extent that it is possible, ensure that staff members do not feel pressured to participate or make commitments with which they are not comfortable.
- Make efforts to ensure that each team member has made an informed decision to join the DBT team. Prospective team members can make informed decisions by reading Linehan’s treatment manuals (1993a, 1993b), participating in introductory DBT workshops, and/or discussing the suggestions outlined here.
Considerations in Adapting DBT

• Start small, doing what you know you can manage. Work toward building fidelity to the original DBT model and doing what is needed to be effective in your environment with your student population. Use the foot-in-the-door technique (Freedman & Fraser, 1965) by starting with more limited offerings (i.e., skills group only or a protocol with fewer skills and/or homework assignments such as in the 11 vs. 12 week protocols) to which students may be more likely to be willing to commit initially. Include additional components of the model once a client base for the program has been secured. Expand the program as it gains momentum rather than trying to accomplish more than what the staff or center may be able to manage during initial development.

• Anchor expectations for the program in the present scope of the center’s operations and resources (e.g., level of training in DBT, scope of services, amount of staff time available to dedicate to DBT related activities, level of staff interest in DBT).

• Create a program that is flexible enough to accommodate students who may only need to attend the group for one semester (e.g., a student who presents with a significant deficit in coping skills) or students with BPD or other significant issues who would benefit from attending for several semesters.

• Consider other ways that team members can use their training in DBT to serve students. For example, centers might offer a mindfulness workshop or a brief workshop series focusing on interpersonal skills to the entire student population.

• Acknowledge that you are adapting an evidence-based treatment model and take measures to monitor effectiveness of your work. Conduct research to evaluate the effectiveness of your adapted program to ensure that it is meeting the needs of the
students served. This data can be used also to obtain commitment to treatment or support from key administrators.

I offer these suggestions because I believe they are practical and feasible for college counseling centers. Pilot research lends initial validation to the efficacy of this DBT program in assisting students with significant cluster B personality pathology (see Chugani et al., 2013). Anecdotally, students who participate in the DBT program are less likely to be hospitalized involuntarily and to be (or continue to be) monitored by the university’s behavioral management team.

A limitation to the information presented here is that very little research has examined methods for adapting DBT to a college counseling center. The FGCU DBT program was designed to fit the class scheduling and stated preferences of the students on our campus and, thus, this program may not represent the most useful model for other campuses. For example, colleges operating on quarter or trimester systems rather than semesters may need to divide content for group skills training sessions differently. Suggestions for future research include determining the efficacy of adapted DBT programs in college counseling centers and determining which students are likely to receive the greatest benefits from such programs.
CHAPTER FOUR

DIALECTICAL BEHAVIOR THERAPY IN COLLEGE COUNSELING CENTERS:
CURRENT TRENDS AND BARRIERS TO IMPLEMENTATION

Note to the Reader

Dr. Sara J. Landes is the second author of this manuscript and served as a mentor throughout the conduct of this study, providing guidance during the design, data analysis, and writing phases. She also provided information related to current and ongoing DBT implementation research and relevant measures. I was responsible for producing the necessary materials, including the IRB application, building the electronic survey described, cleaning and analyzing the data, and writing the manuscript (all under the supervision of Dr. Landes). Dr. Landes provided several critical reviews of this manuscript and has been an invaluable part of this project. This manuscript has been accepted for publication by the Journal of College Student Psychotherapy.

Introduction

Severe Mental Health Issues on Campus

College counseling center directors continue to report increases in the number of students presenting for treatment with severe psychological issues (Gallagher, 2014).
Unfortunately, there is a paucity of research related to the treatment of such issues within the college counseling setting. Gilbert (1992) notes that many centers operate on brief treatment models and may not provide services extensive enough to meet the needs of students with severe and persistent mental illness. This may result from having session limits, not having staff trained to provide intensive treatment, or from simply not offering the services because it is outside of their scope. Unfortunately, centers are often faced with difficult situations when students are in need of treatment but are unable to obtain services off-campus (Gilbert, 1992). Mowbray and colleagues (2006) echo this sentiment, noting that college counseling centers are traditionally charged with providing services to those with less severe distress, leaving students with serious mental illnesses to locate resources off-campus. These authors note that mental health treatment is often not considered to be a vital part of a university’s educational mission. Watkins, Hunt, and Eisenberg (2012) report that while college counseling centers do appear to be increasing their capacity to provide a range of clinical services, institutions frequently cannot offer the necessary support to sustain this expansion.

One means of treating more severely distressed students may be Dialectical Behavior Therapy (DBT), which was originally developed to treat individuals with high-risk suicidal and non-suicidal self-injurious behavior (Linehan, 1993a). DBT has been established as a best practice for the treatment of Borderline Personality Disorder (BPD; Linehan et al., 2006; Substance Abuse and Mental Health Services Administration (SAMHSA), 2006). Research has also demonstrated positive outcomes with DBT for treatment of several other psychological disorders including bulimia nervosa or binge eating disorder (Chen, Matthews, Allen, Kuo, & Linehan, 2008), major depressive disorder (Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009), and co-occurring BPD and substance dependence (Linehan et al., 1999).
With regard to college students, two studies support the idea that the standard DBT model, which includes four primary modes (individual therapy, group skills training, phone coaching, and team consultation for the therapists), can be implemented in a college counseling center and is effective with students with BPD or BPD traits (Engle, Gadischke, Roy, & Nunziato, 2013; Pistorello et al., 2012). Further, research has focused on the group skills training mode of DBT as a stand-alone service or as an adjunct to individual therapy (Chugani, Ghali, & Brunner, 2013; Meaney-Tavares & Hasking, 2013, Rizvi & Steffel, 2014). While DBT programs housed in college counseling centers may be an effective means of addressing the needs of a range of students who are in need of more intensive intervention, research is needed to understand how such programs are currently being implemented and for what reasons, especially given the literature highlighting the lack of extensive mental health services in these settings. Although DBT implementation has been examined in the context of other settings (notably, community-based settings), very little research has attempted to target college counseling centers.

**Dialectical Behavior Therapy Implementation Research**

The majority of DBT-focused research available has been aimed at demonstrating the efficacy and effectiveness of this intervention with a variety of difficult-to-treat clinical populations. It has only been fairly recently that investigators have begun to focus on issues associated with implementation. Herschell and colleagues (2009) conducted interviews with 13 administrators from nine different community mental health organizations that were preparing to participate in a DBT training and implementation initiative in Pennsylvania. While administrators generally expressed positive opinions about DBT and the benefit it would have
for their consumers, they also reported concerns with certain expectations associated with the
treatment model, specifically, telephone coaching and fidelity to the model. They reported a
variety of concerns related to resources to support the implementation initiative including
personnel, training (which is not reimbursable and would take time away from direct service
provision), and time (DBT is a time-intensive model that does not always fit with practice and
billing structures). Administrators also had concerns related to staff turn over and selection for
DBT training. They reported that while they were more likely to select senior clinicians who had
demonstrated a commitment to the agency, they were also concerned that participating in
training would make these individuals unavailable for other duties such as supervision.

Herschell and colleagues (2009) also note that there were concerns about whether the
agencies would receive enough DBT referrals to make the initiative sustainable. The authors
assert that given these findings, it may be helpful to work to “minimize short-term risks that
administrators associate with training” and, to work closely with stakeholders to address
financial concerns (Herschell et al., 2009 p. 991). Herschell and colleagues (2014) continued
their work with the aforementioned DBT implementation initiative by examining the
effectiveness of the training received by 64 clinicians in 10 community mental health agencies in
Pennsylvania. They found that while clinicians who received intensive training had
improvements in attitudes towards individuals with BPD and confidence in the effectiveness of
DBT, there was high staff turnover with only 55% of the original sample remaining at the end of
the two-year study period. They further note the benefits of including both more and less
experienced clinicians in training initiatives. While clinicians with more experience were more
likely to complete the training, the less experienced clinicians were more likely to demonstrate
greater gains in their attitudes, confidence, and DBT use (Herschell et al., 2014).
The concerns and challenges observed by Herschell and colleagues (2009, 2014) have been reported by other researchers as well. Swales, Taylor, and Hibbs (2012) contacted all DBT teams in the United Kingdom who received training between 1994 and 2007 in order to evaluate the extent to which these programs have been able to survive. Of the 105 programs that participated in training, 62.8% were currently offering DBT. For those programs no longer in operation, the most common reasons were lack of organizational support, high staff turnover, and lack of time allocated to the program (Swales, Taylor, & Hibbs, 2012). The authors also note that DBT programs were most likely to fail during the second year of implementation (directly after the end of formal training) as well as in the fifth year, with programs that survived beyond five years having a greater likelihood of sustainability.

With regard to challenges specific to DBT implementation, Swales and colleagues (2012) found several themes reported by both programs currently offering DBT as well as those with inactive programs: lack of dedicated time for DBT treatment, absence of buy-in from management, funding, adapting the model for diverse settings/populations, staff turnover, implementing modes of DBT designed to facilitate behavioral generalization (i.e., 24-hour telephone coaching), staff having multiple roles and competing priorities, insufficient resources, and absence of planning for implementation. In the United States, Carmel, Rose, and Fruzzetti (2014) examined barriers to DBT implementation in a large, public behavioral health system. These authors interviewed 19 clinicians (out of 34 total that participated in the training initiative) and identified several challenges: difficulties in program development, staffing, and recruiting clients for the program, lack of administrative support or investment in DBT (including low interest in service provision to individuals with BPD), time commitment involved with DBT, and lack of reduction in other responsibilities (Carmel, Rose, & Fruzzetti, 2014).
The field of DBT implementation research is nascent and those studies currently in print have mainly focused on large-scale implementation initiatives that included the DBT intensive training model (Landes & Linehan, 2012) or training that is similar in depth of content. Intensive training in DBT includes a week of in-person training followed by six months of team study, concluded by another full week of in-person training (Landes & Linehan, 2012). Although investigators are reporting similar challenges in implementation, it is unclear how these findings may generalize to college counseling settings, which may not have access to intensive training in DBT due to issues related to time, scope of service, and lack of funding or other resources.

Sauers, Mattei, and Paull (2013) presented results of an investigation of barriers to DBT implementation in college counseling centers. They conducted an online survey with 13 individuals who were offering DBT or DBT-informed treatment in their college counseling center and identified challenges to offering more modes of DBT, including institutional permission, training for staff, funding issues, phone coaching issues, staff adherence to the model, and lack of systematic support and resources. Furthermore, they note that staff experienced burnout that was severe, despite client treatment gains. They also noted a number of adaptations to the standard DBT model including offering generalist (rather than DBT) individual therapy, shortening skills training groups to fit within one semester, no or limited phone coaching, and no or less frequent team meetings. Despite these challenges, Sauers and colleagues (2013) found that participants reported that the results of implementing DBT in their centers included reductions in frequency (46.2%), intensity (23.1%), and duration (30.8%) of crises.
Given the dearth of research related to DBT implementation in college counseling centers, the current study was designed to collect information from college counseling centers that are offering DBT services as well as those that are not currently offering any mode of DBT. This study was guided by two aims: 1) To describe current trends in DBT implementation in college counseling centers (including reasons for interest in DBT, training in DBT, how DBT is currently being implemented, and factors associated with implementation) and 2) To describe barriers and facilitators to DBT implementation in college counseling centers as reported by both clinicians who are and are not currently offering or planning to offer DBT in their centers. This data may provide an avenue for understanding what is currently available in college counseling centers and what barriers (whether anticipated or experienced) might be blocking more college counseling centers from implementing DBT, despite the continued reports of increases in students presenting for treatment with severe psychological problems (Gallagher, 2014) that could benefit from this treatment.

Method

Participants

Participants were a purposive sample of current college counseling center employees (N = 107). The sample included participants from 34 of the United States and at least 80 different institutions (21 participants declined to provide their institution’s name). The states with the highest number of participants were New York (13% of sample) and Florida (10% of sample); an additional 4% of the participants were located outside of the U.S. Over ninety percent of participants were employed at a four-year institution (91.5%), with the remaining respondents
from two-year institutions. Most participants reported that their job title within the center was “staff clinician” (49.5%) or “center director” (29.9%), with the remainder reporting that their job title was “clinical director” or “other.” Fifty-six percent of participants were masters level clinicians (Counselors, 41% or Clinical Social Workers, 15%), with the remaining having doctoral level training as a psychologists (43%). Table 3 presents additional information about the position and training of the participants, presence of session limits in their centers, and information about the type and size of their institutions.

Table 3. Participant Data (N = 107)

<table>
<thead>
<tr>
<th>Variable:</th>
<th>N:</th>
<th>Valid Percent:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Job Title</strong></td>
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<td></td>
</tr>
<tr>
<td>Staff Clinician</td>
<td>53</td>
<td>49.5%</td>
</tr>
<tr>
<td>Center Director</td>
<td>32</td>
<td>29.9%</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>9</td>
<td>8.4%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>12.2%</td>
</tr>
<tr>
<td><strong>Professional Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist (Ph.D. or Psy.D.)</td>
<td>46</td>
<td>43.0%</td>
</tr>
<tr>
<td>Counselor (M.A. or M.S.)</td>
<td>44</td>
<td>41.1%</td>
</tr>
<tr>
<td>Clinical Social Worker (MSW)</td>
<td>16</td>
<td>15.0%</td>
</tr>
<tr>
<td><strong>Session Limits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>41</td>
<td>38.7%</td>
</tr>
<tr>
<td>No</td>
<td>65</td>
<td>61.3%</td>
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<tr>
<td><strong>Institution Type</strong></td>
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<tr>
<td>4-Year Institution</td>
<td>97</td>
<td>91.5%</td>
</tr>
<tr>
<td>2-Year Institution</td>
<td>9</td>
<td>8.5%</td>
</tr>
<tr>
<td>Public Institution</td>
<td>65</td>
<td>60.7%</td>
</tr>
<tr>
<td>Private Institution</td>
<td>42</td>
<td>39.3%</td>
</tr>
<tr>
<td><strong>Size of Student Body</strong></td>
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</tr>
<tr>
<td>Less than 7,000 students</td>
<td>38</td>
<td>35.5%</td>
</tr>
<tr>
<td>Between 7,000 and 15,000 students</td>
<td>34</td>
<td>31.8%</td>
</tr>
<tr>
<td>Between 15,000 and 20,000 students</td>
<td>11</td>
<td>10.3%</td>
</tr>
<tr>
<td>More than 20,000 students</td>
<td>24</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

**Procedures**

The Institutional Review Board at the University of South Florida approved all procedures and data were collected between June and August, 2014. Recruitment was achieved
via two routes. First, recruitment emails were sent directly to college counseling professionals who are known to provide DBT in their centers (19 individuals representing 9 different centers). Direct recruitment likely comprised a very small part of this sample, as we were only aware of a few DBT programs operating in college counseling centers, however, these participants may have forwarded the recruitment messages to other potential participants. Second, recruitment emails were distributed to the following listservs: the international DBT listserv (1,813 members), the DBT strategic planning listserv (98 members), the DBT for College Counseling Centers listserv (DBT-CCC; 100 members), the American Counseling Association Open Forum (41,970 members from a range of counseling disciplines including but not limited to college counseling), and the American College Counseling Association listserv (1,617 members). Participants did not receive any incentives for responding to this survey.

Recruitment messages were posted to the listservs every two weeks for the duration of the two-month data collection period, with the exception of the DBT strategic planning listserv, to which only two recruitment messages were posted due to the limited use of this listserv for study recruitment purposes. We chose to send recruitment messages to both college counseling focused and DBT focused listservs because at present, there is only one small listserv for college counseling clinicians that is dedicated to the practice of DBT. Only current college counseling center employees were recruited for participation in this survey. Due to this sampling method, it is not possible to give an estimate of potential respondents (we do not know how many members of certain listservs deliver treatment in college counseling centers) or response rate. However, in order to put the participation of 107 individuals who provided data pertaining to at least 80 institutions into perspective, the 2014 National Survey of College Counseling Centers, a survey of college counseling directors conducted yearly since 1981, included 275 institutions in the
United States and Canada (Gallagher, 2014). Thus, the current survey had a response of approximately one third of the number of institutions responding to the established yearly survey.

**Measures**

An online survey was used to collect all data. The first section of the survey collected basic demographic information about participants and their institutions. Participants also answered three questions related to DBT training activities they had completed, reasons for which they had implemented DBT or for which they were interested in doing so, and facilitators to DBT implementation; they were instructed to endorse all items that applied from each of the lists. In addition, participants who reported that their centers offered any primary mode of DBT, as well as those who were planning to implement a DBT program, completed the Program Elements of Treatment Questionnaire (PETQ; Schmidt III, Ivanoff, Korslund, & Linehan, 2008). Participants also completed the DBT Barriers to Implementation measure (BTI; Behavioral Tech, LLC, n.d.) whether or not they offered or planned to offer DBT in their center.

The PETQ is a self-report questionnaire that assesses the extent to which DBT program elements and characteristics have been implemented in a setting. It consists of 85 items over the course of 12 sections that assess the presence of modes of treatment, specific aspects of each mode, and other characteristics of DBT programs (e.g., tracking outcomes). Response options for implementation of different components of DBT are “yes” that it has been implemented, “some” of the component has been implemented, “planned” for components that are planned but not yet implemented, and “no” for those not implemented. The PETQ was developed as the primary assessment tool for DBT program accreditation, and it has also been distributed as a
self-assessment tool for DBT programs. For this sample, internal consistency of the scores for the 12 sections of the PETQ was generally acceptable to good, with Cronbach’s $\alpha$ ranging from .71 to .94. In three sections, the scores were below the acceptable range (section 8: $\alpha = .25$; section 9: $\alpha = .60$; section 12: $\alpha = .58$) although this may be due to small sample size or limited number of items (e.g., section 8 only two items, section 9 has 8 items, and section 12 has 3 items). No formal scoring procedures exist and no psychometric data are currently available for the instrument. As such, the measure was solely used for the purpose of providing descriptive data regarding the level of DBT implementation among institutions. Items were excluded that are not relevant to the college counseling context (i.e., questions related to adolescent treatment, as well as the sections pertaining to milieu and inpatient treatment) and one example provided with one of the items was modified from its original version for increased relevancy to the college counseling population.

The BTI is a 52-item self-report instrument that assesses barriers to DBT implementation in the following domains: team problems (e.g., team members did not get along, sporadic attendance at consultation meetings), administrative problems (e.g., funding cut, productivity demands), theoretical position/philosophy problems (e.g., difficulty adopting DBT assumptions, non-behavioral orientation), and structural problems (e.g., lack of physical space and/or materials, problems getting reimbursed). One additional section was added to further target implementation needs of college counseling staff; this section included items that we believed would be particularly relevant to the college counseling context (e.g., DBT program would only serve a small group of the total number of students served by the center).

The response options were modified from the original yes/no format to allow for greater detail and to collect information related to anticipated barriers. The BTI response options for this
survey were: 1) Not a barrier/problem, 2) A problem we overcame, 3) A problem we are currently working on, 4) A problem we could not overcome, 5) A problem I think we would have (refers to anticipated barriers), and 6) Not applicable. The BTI has been widely distributed for practical purposes, most notably, to participants of the DBT Intensive Training (Behavioral Tech, LLC) as an assessment and training tool (i.e., trainees complete the measure to provide trainers information on what barriers to address in training). For this sample, the internal consistency of the scores for each of the five sections was good, with Cronbach’s $\alpha$ ranging from .84 to .96. There are no formal scoring procedures or psychometric data for this instrument and as such, the data collected has been used for descriptive purposes only.

Data Analysis

All data were analyzed using SPSS Statistics 22 for Apple. Measures of central tendency, frequencies, chi-squares, effect sizes, and measures of internal consistency were computed. Attrition occurred (likely due to survey length) and there were some missing values. For the PETQ, cases were excluded from a particular section analysis if there were missing items present in that section. For data related to barriers and facilitators to implementation, there were three cases where two respondents from the same center provided information. To address this issue, one respondent from each site was randomly selected for exclusion from the analysis. The specific number of responses for all sections of the survey is noted in the table presenting that data.
Results

Current Trends in Implementation

Reasons for interest.

The most highly endorsed items related to reasons for interest in DBT were need for effective treatment for students who self-injure (86%), increase in students presenting with severe psychological problems (79%), need for effective treatment for students who are suicidal (76%), need for effective treatment for students with BPD (74%), and need for effective treatment for students with multiple diagnoses (64%). For the item “need for effective treatment for other mental health issues,” participants had the opportunity to specify which issues were most relevant to their centers by writing in supplementary information. Other mental health issues noted by participants included eating disorders, substance abuse, anxiety disorders, depression, bipolar disorder, trauma or post traumatic stress disorder, schizophrenia, and emotion dysregulation.

Factors associated with implementation.

In order to examine the extent to which respondent characteristics (or the characteristics of their institutions) might be associated with having implemented DBT, we performed chi-square tests (see Table 4). Three of the five demographic factors collected in this survey were significantly related to having or planning to implement a DBT program ($\alpha = .05$). First, there was a significant difference among the proportions of psychologists, social workers, and counselors who reported that their center had a current or planned DBT program ($p =< .001$, with psychologists and social workers being more likely to report having or planning to
implement DBT than counselors. There was also a significant difference among the proportion of two versus four-year institutions related to having a current or planned DBT program \((p = .049)\). In this sample, none of the participants from two-year universities reported any plans to offer DBT. Lastly, there was a significant difference among the proportions of institutions that reported a current or planned DBT program by size of student body \((p = <.001,\) with clinicians from larger schools (those with 15,000 students or more) being more likely to report having a current or planned DBT program.

Table 4. Respondent/Institution Characteristics Associated with DBT Implementation:

<table>
<thead>
<tr>
<th>Factor</th>
<th>N</th>
<th>df</th>
<th>Obtained (\chi^2)</th>
<th>(P)-Value</th>
<th>Effect Size</th>
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<tbody>
<tr>
<td>Profession</td>
<td>105</td>
<td>3</td>
<td>25.774</td>
<td>.000</td>
<td>.495</td>
</tr>
<tr>
<td>2 vs. 4 Year Institution</td>
<td>104</td>
<td>1</td>
<td>4.396</td>
<td>.049</td>
<td>.206</td>
</tr>
<tr>
<td>Session Limits (yes/no)</td>
<td>104</td>
<td>1</td>
<td>1.849</td>
<td>.174</td>
<td>.133</td>
</tr>
<tr>
<td>Private vs. Public Institution</td>
<td>105</td>
<td>1</td>
<td>1.607</td>
<td>.205</td>
<td>.124</td>
</tr>
<tr>
<td>Number of Students</td>
<td>105</td>
<td>3</td>
<td>24.507</td>
<td>.000</td>
<td>.483</td>
</tr>
</tbody>
</table>

**Training activities.**

The most prevalent training activities were reading related to DBT; 90% had read a journal article about DBT, 63% had read Linehan’s (1993b) skills training manual, and 43% had read Linehan’s (1993a) treatment manual. With regard to in-vivo training activities, 37% had participated in a lecture or seminar during graduate training and 32% had attended a full-day workshop. In terms of advanced training, 19% had received clinical supervision in the practice of DBT, 8% had attended a five-day training, 9% had attended a 10-day intensive training, and 5% had attended a five-day advanced intensive training. Overall, the mean number of training activities endorsed was 4.75 \((SD = 2.85)\). For those respondents who indicated that they offered DBT (even if only one mode) or were planning to implement DBT \((N = 35)\), only 26% \((N = 9)\)
indicated that they had participated in DBT intensive training. For this group, the mean number of training activities rose to 7.03 ($SD = 2.79$).

**Primary modes of DBT offered.**

Overall, 35 participants indicated that their center currently offered DBT (even if only one mode) or was planning to implement DBT. Of those who indicated that their center currently offers DBT, 22 participants provided information about the primary modes of DBT currently being offered in 20 different centers. In cases where two participants from the same center provided responses, the most conservative responses were included as representing that center’s services. The most prevalent primary mode of DBT offered was group skills training, with 19 out of 20 participants (95%) indicating that their center offered a DBT skills training group (see Table 5). Seven centers (35%) reported offering all four primary modes of DBT. Overall, the mean number of primary modes of DBT offered was 2.65 ($SD = 1.23$).

Table 5. Primary Modes of DBT Currently Offered (N = 20)

<table>
<thead>
<tr>
<th>Primary Mode of DBT:</th>
<th>Number:</th>
<th>Percent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Skills Training</td>
<td>19</td>
<td>95%</td>
</tr>
<tr>
<td>DBT Individual Therapy</td>
<td>13</td>
<td>65%</td>
</tr>
<tr>
<td>DBT Team Consultation</td>
<td>12</td>
<td>60%</td>
</tr>
<tr>
<td>DBT Phone Coaching</td>
<td>9</td>
<td>45%</td>
</tr>
</tbody>
</table>

**Program elements of treatment.**

Participants rated each item of the Program Elements of Treatment Questionnaire (PETQ) on a scale that referred to the extent that the particular item had been implemented in their current program. Response options were “no”, “planned”, “some”, or “yes” and these were coded as 0, 1, 2, or 3 respectively. In order to examine amount of implementation of elements in
each section, scores were created for each section by calculating the average score (0-3) of items in that section, with higher scores representing greater levels of item implementation in a particular section. In cases where two participants from the same center provided responses, the most conservative response on each item (with conservatism indicating a lower level of implementation) was included as representing that center’s implementation of the item. The PETQ includes twelve sections designed to assess the extent to which particular components of the DBT treatment model have been implemented in a setting. The section with the highest level of endorsement was program adaptation, with an average score of 2.18 ($SD = 0.99$). In contrast, the section with the lowest level of endorsement was assessment of and fidelity to the treatment program, with an average score of 0.49 ($SD = 0.67$). Table 6 presents the average scores for each of the 12 sections of the PETQ.

Table 6. Program Elements of Treatment Questionnaire

<table>
<thead>
<tr>
<th>Program Elements of Treatment:</th>
<th>N</th>
<th>Mean Score:</th>
<th>Standard Deviation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program Elements Specific to DBT</td>
<td>23</td>
<td>1.79</td>
<td>0.56</td>
</tr>
<tr>
<td>2. Program Consultation Team</td>
<td>23</td>
<td>1.07</td>
<td>0.90</td>
</tr>
<tr>
<td>3. Client Treatment and Support</td>
<td>21</td>
<td>1.98</td>
<td>0.70</td>
</tr>
<tr>
<td>4. DBT Tracking of Treatment Outcomes</td>
<td>18</td>
<td>1.06</td>
<td>0.62</td>
</tr>
<tr>
<td>5. Documentation of Treatment</td>
<td>21</td>
<td>2.11</td>
<td>0.88</td>
</tr>
<tr>
<td>6. Outpatient Treatment</td>
<td>20</td>
<td>1.98</td>
<td>0.84</td>
</tr>
<tr>
<td>7. DBT Adaptation</td>
<td>22</td>
<td>2.18</td>
<td>0.99</td>
</tr>
<tr>
<td>8. DBT Staff Hiring and Development</td>
<td>20</td>
<td>1.00</td>
<td>0.93</td>
</tr>
<tr>
<td>9. Program Description</td>
<td>18</td>
<td>1.33</td>
<td>0.56</td>
</tr>
<tr>
<td>10. Training of Providers and Support Staff</td>
<td>19</td>
<td>1.77</td>
<td>0.78</td>
</tr>
<tr>
<td>11. Provides Ongoing Supervision</td>
<td>19</td>
<td>1.58</td>
<td>1.19</td>
</tr>
<tr>
<td>12. Assesses and Facilitates Fidelity of Program</td>
<td>19</td>
<td>0.49</td>
<td>0.67</td>
</tr>
</tbody>
</table>
Barriers and Facilitators to Implementation

Barriers to implementation.

Respondents who indicated that they offered or planned to offer DBT as well as those who do not offer DBT programs provided barriers to implementation data. Table 7 provides a comparative view of barriers to implementation as endorsed by these two groups, with the specific number of responses for each item noted. In this table, only barriers that were endorsed by at least 50% of at least one of the groups were included. Further, items in Table 5 were considered to have barrier qualities if they were rated as any of the following response options: 1) A problem we are working on, 2) A problem we could not overcome, or 3) A problem I think we would have. Figures 1 and 2 provide further detail regarding types of barriers from the most highly endorsed barriers from each of five BTI domains for each group (those who offer/plan to offer vs. do not offer DBT). The following barriers represent the most highly endorsed barrier for each domain of the BTI for both groups: productivity demands, not willing to take phone calls, lack of individual therapists, and no time for team meetings. Notably, three of these four barriers represent three of the four primary modes of DBT.
Table 7: Frequently Endorsed Barriers to Implementation by Group*

<table>
<thead>
<tr>
<th>Item:</th>
<th>N: Have DBT</th>
<th></th>
<th>N: Do not have DBT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team Barriers:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty meeting with each other/sporadic attendance at consultation meetings</td>
<td>19</td>
<td>68.4%</td>
<td>35</td>
<td>17.2%</td>
</tr>
<tr>
<td>No formal commitment to learning, implementing DBT from some team members</td>
<td>19</td>
<td>36.8%</td>
<td>39</td>
<td>51.2%</td>
</tr>
<tr>
<td><strong>Administrative Barriers:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productivity demands</td>
<td>18</td>
<td>66.7%</td>
<td>39</td>
<td>61.6%</td>
</tr>
<tr>
<td>No release time provided for learning and implementing a new program</td>
<td>18</td>
<td>55.5%</td>
<td>38</td>
<td>60.5%</td>
</tr>
<tr>
<td><strong>Theoretical/Philosophical Barriers:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not willing to take phone calls or extend limits when needed</td>
<td>19</td>
<td>47.4%</td>
<td>38</td>
<td>68.5%</td>
</tr>
<tr>
<td>Non-behavioral orientation</td>
<td>18</td>
<td>39.0%</td>
<td>39</td>
<td>61.6%</td>
</tr>
<tr>
<td>Non-dialectical orientation</td>
<td>18</td>
<td>33.3%</td>
<td>40</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>Structural Barriers:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of individual therapists</td>
<td>18</td>
<td>72.2%</td>
<td>42</td>
<td>71.4%</td>
</tr>
<tr>
<td>Clients accustomed to treatment they have had, and are resistant to change</td>
<td>18</td>
<td>44.4%</td>
<td>39</td>
<td>56.5%</td>
</tr>
<tr>
<td>Lack of space/materials</td>
<td>18</td>
<td>27.8%</td>
<td>37</td>
<td>51.3%</td>
</tr>
<tr>
<td><strong>Other Issues (Specific to College Counseling):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not enough team members/staff interest to form a DBT team</td>
<td>18</td>
<td>50.1%</td>
<td>40</td>
<td>80.0%</td>
</tr>
<tr>
<td>No time to hold weekly team meetings</td>
<td>18</td>
<td>77.8%</td>
<td>41</td>
<td>80.6%</td>
</tr>
<tr>
<td>Lack of resources and/or funding for training in DBT</td>
<td>18</td>
<td>61.2%</td>
<td>42</td>
<td>78.6%</td>
</tr>
<tr>
<td>Lack of staff interest in treating students with Borderline Personality</td>
<td>18</td>
<td>38.9%</td>
<td>41</td>
<td>56.1%</td>
</tr>
<tr>
<td>Lack of evidence based manual for DBT in college counseling centers</td>
<td>18</td>
<td>55.6%</td>
<td>40</td>
<td>30.0%</td>
</tr>
<tr>
<td>Offering DBT is considered to be beyond the center’s scope of services</td>
<td>18</td>
<td>55.6%</td>
<td>41</td>
<td>70.8%</td>
</tr>
<tr>
<td>DBT program would only serve a small group of the total number of students served by the center</td>
<td>18</td>
<td>39.0%</td>
<td>41</td>
<td>51.2%</td>
</tr>
</tbody>
</table>

*Note: Items were considered to have barrier qualities if they were rated as any of the following response options: 1) A problem we are working on, 2) A problem we could not overcome, or 3) A problem I think we would have. The barriers included here are those that were endorsed by at least 50% of either group. In addition, N indicates the total number of respondents who answered each item, while the percentage indicates the percentage of respondents who endorsed each item as having barrier qualities, as defined above.
Figure 1. Highly Endorsed Barriers By Domain (Have DBT group)

Figure 2. Highly Endorsed Barriers By Domain (Do not have DBT group)
Facilitators to implementation.

Sixty-one participants provided information regarding possible facilitators to DBT implantation in their college counseling centers. The most highly endorsed facilitators to implementation were as follows: staff interest in DBT (82%), staff expertise with DBT (80%), DBT program models designed for college counseling centers (79%), staff experience with DBT (77%), DBT training programs designed for college counseling centers (77%), and funding for DBT training (75%). The least endorsed facilitators to implementation were requests for DBT from students (49%), ability to collect outcome data (46%) and leadership/administrative support (39%).

Discussion

The purpose of this study was to gather data related to DBT implementation trends as well as barriers and facilitators to implementation in the college counseling context, and several interesting findings are apparent. Of those respondents who provided data about their existing DBT programs, the most prevalent primary mode of DBT offered was group skills training. This finding is consistent with barriers to implementation data indicating that the other primary modes of DBT (individual therapy, phone coaching, and team consultation) may be more challenging to implement for some college counseling centers. Although recent research provides preliminary support for the effectiveness of DBT group skills training as a stand-alone treatment for a range of mental health disorders (Neasciu, Eberle, Kramer, Wiesmann, & Linehan, 2014; see Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2014 for a review) as well as for the use of group skills training only (Rizvi & Steffel, 2014) or as an adjunct to individual therapy (Chugani, Ghali, & Brunner, 2013) with college students, it is important to note that the vast majority of the
research base supporting the efficacy of DBT is related to the standard DBT model, which requires that a program must implement all four primary modes (individual DBT therapy, skills training, phone coaching, and team consultation). In addition, implementation of a DBT program (even if only a skills training group) would likely require at least some training beyond reading activities in order to maintain model fidelity, which relatively few participants in this sample had completed.

The finding that 35% of centers that have existing DBT programs are offering all primary modes of DBT lends some support to the idea that full DBT programs may be feasible for implementation in college counseling centers (see Engle, Gadischke, Roy, & Nunziato, 2013; Pistorello et al., 2012), especially if strategic adaptations are made to facilitate implementation for this setting (see Chugani, in press). Indeed, the section of the PETQ with the highest mean score was DBT adaptation. This is not surprising given the wide range of barriers to implementation endorsed by respondents, especially those that seem to indicate a poor fit (whether real or anticipated) between the standard DBT model and the college counseling context (e.g., a DBT program is considered beyond the center’s scope of services and would only serve a small group of the total number of students served by the center).

There are several issues with approaching DBT implementation via adaptation. First, what constitutes an “adapted” DBT program is not clearly defined. In other words, we do not know where the line is between “adapted DBT programs” and programs that have strayed so far from the original model that they should no longer be considered as DBT programs. Second, data related to what adaptations are most effective is not currently available. Third, adapting any treatment model without first learning the original model may not result in the development of a program that adheres to the original functions that the treatment was designed to achieve. In
DBT, learning the full treatment model ideally consists of participating in a 10-day intensive training (Landes & Linehan, 2012). In this sample, only one quarter of the respondents from programs who offered or planned to offer DBT had completed the intensive training. Finally, the section of the PETQ with the lowest mean score was that which pertained to assessment and facilitation of fidelity to the treatment program. We believe that that centers with adapted DBT program should track outcomes to ensure that they are achieving comparable clinical results to those reported in the literature. Furthermore, given the recent findings from a pilot study indicating that suicide was the second leading cause of death on campus (Turner, Leno, & Keller, 2013), it is critically important that more research is conducted to clarify what adaptation of DBT is best suited for college counseling centers and, to establish the efficacy of such a model.

Our findings indicate some interesting observations related to factors that are associated with DBT implementation. There was a significant difference in DBT implementation or planned implementation by size of student body, with larger institutions (those with at least 15,000 students) being more likely to have a current or planned DBT program. This finding is not surprising, given that such institutions may be more likely to have larger counseling centers, more resources/funding, and more distressed students to serve. However, we do not believe that DBT programs are best housed only on larger campuses for two reasons. First, the size of the student body that the center must serve may create varied implementation issues. Although smaller centers may have fewer staff with which to implement a program, they may also have fewer students to serve and the ability to offer all four modes of DBT to those students who are truly in need of this level of care. In contrast, larger schools may have more resources, but find that offering all four modes of DBT is not feasible, due to issues such as lack of a sufficient number of individual therapists. In this case, we suggest the idea of a university-community
partnership (this model is discussed further in the section, “Implementation Solutions”). Second, smaller schools located in areas where DBT treatment is not available in the community may particularly benefit from DBT programs, because they will offer treatment to students who are unable to access these services elsewhere.

We also found a significant difference in the relationship between having a current or planned DBT programs and the three main categories of professional training included in this survey, with mental health counselors being less likely to report that their center had a current or planned DBT program in comparison to social workers or psychologists. Counselors represented 41% (N = 44) of our total sample and yet, only three counselors reported that their centers offered or planned to offer a DBT program. The reasons for this finding are unclear, as college counseling centers are often comprised of clinicians from a variety of training backgrounds, including counseling, social work, and psychology. It is possible that counselors receive comparatively less exposure to DBT during their professional training programs, as the majority of DBT researchers are psychologists. More research is needed to clarify the reasons for which more counselors may not have been involved in DBT programs in college counseling centers.

With regard to barriers to implementation, many of the barriers reported here have been observed in other settings. For example, issues related to program development, lack of administrative support for DBT, and the time commitments associated with being on a DBT team have been reported by clinicians in behavioral health settings (Carmel, Rose, & Fruzzetti, 2014). In addition, many settings are likely to have difficulty implementing components of treatment that do not include direct client contact, as they can interfere with productivity demands and are not usually covered financially (e.g., a clinician in an agency or private practice
cannot bill insurance for time spent in consultation team). Concerns related to taking phone coaching calls have also been noted elsewhere (Herschell, et al., 2009).

Interestingly, this study found that some of the most frequently reported barriers to implementation are those associated with delivering the majority of the primary modes of the standard DBT model. In addition, while there is an interest in DBT out of need for effective treatment for students with challenging clinical presentations, at least 50% of each group (50% of those who offer/plan to offer DBT vs. 80% of those who do not offer DBT) endorsed “not enough team members/staff interest to form a DBT team” as a barrier to implementation. It is possible that because three of the four primary modes of DBT are anticipated or experienced as barriers to implementation, college counseling center clinicians may have lower interest in DBT because they do not view the model as generally feasible for implementation in their centers. This finding is concerning, given that effective treatments for college students presenting with a variety of severe psychological issues seem to be needed by respondents in this sample. More research is needed to understand whether interest in DBT might be lower among clinicians working in the college counseling context and if so, for what reasons.

**Implementation Solutions**

Given our findings, especially those related to the challenges that college counseling centers may have in implementing three of the four primary modes of DBT, we would like to offer some suggestions that we believe have the potential to enhance the feasibility of DBT programs in this practice setting. One way of assisting students in accessing DBT services without delivering all such services on campus is develop a university-community partnership by connecting with existing community providers who are interested in offering standard DBT.
Institutions may consider hosting DBT trainings on-campus, which can greatly reduce costs associated with training for local and campus providers. The college counseling center may consider offering a standard DBT skills training group for students, while community providers can offer DBT individual therapy and phone coaching. All clinicians (campus and community) can serve on a team together or alternately, campus DBT clinicians could join the community DBT team for consultation on a less frequent basis (in cases where time for team meetings represents a significant barrier to implementation).

There may be several advantages to this type of model. First, individual therapists in the community will be the primary therapists for severely distressed students and thus responsible for crisis management (see Linehan’s 2015 skills training manual for a contract to this effect between the skills group and individual therapy providers). Second, this model serves students in need by helping to subsidize their costs of treatment (offering a group that the student would otherwise need to pay for in the community), while continuing to offer a level of care that is practical for the college counseling setting. Finally, institutions that host DBT trainings on campus may do a tremendous service for their local communities by facilitating access to DBT training in areas where such services are not currently available for the public.

For college counseling centers in which low staff interest in DBT is a barrier to implementation, a potential solution may be for those clinicians who are interested to join a virtual DBT team with clinicians from other centers around the nation. In cases where only one staff member is interested in starting a DBT program, skills training groups (which traditionally require two group facilitators) can be delivered with the assistance of an intern. Virtual teams may enable clinicians who are motivated to begin offering DBT to participate in training, ongoing consultation, and program development without pressuring less interested staff members to
participate in the program. Another benefit of this model is that it may also reduce the challenges related to obtaining release time to learn a new treatment and/or for team consultation because in this model, the center may only need to grant these time releases to a much smaller group of staff (thus reducing the overall number of staff hours dedicated to a DBT program). Clinicians who are interested in developing virtual DBT teams be able to locate potential teammates via the International DBT Listserv (available to all intensively trained DBT clinicians) or the DBT-CCC listserv (free, open to any college counseling center clinician with interest in DBT, and managed by the first author).

With regard to obtaining administrative support, one method of obtaining funding for training and permission for release time to implement a DBT program may be to make use of the data the center is already collecting to demonstrate the need for such a program. For example, centers using electronic medical records (EMRs) can run reports detailing the frequency and/or increases in numbers of students presenting with mental health disorders for which DBT is an evidence-based treatment. Centers could also consider reporting other relevant data such as number of mental health related hospitalizations, suicides, and withdrawals from the university for psychological reasons over previous years. While current literature does seem to indicate that college counseling centers are dealing with increases in students presenting with challenging psychological issues, the case for funding and support may be more compelling if it is reinforced with data that documents the need on a specific campus.

Finally, while adapting an evidence-based treatment may not lead to the same clinical outcomes reported in the literature related to the original treatment, we acknowledge that some adaptation may be necessary and recent literature does offer initial support for this approach (e.g., Chugani, Ghali, & Brunner, 2013; Meaney-Tavares & Hasking, 2013; Rizvi & Steffel,
In these cases, we suggest that modifications are made strategically, only when absolutely required, and in a manner which adheres to the original functions of the treatment. Clinicians working on developing and implementing adapted DBT programs will likely benefit from education and training in the standard DBT model so that they have the necessary skills and knowledge to develop programs that are consistent with DBT principles and philosophy.

**Limitations**

There are several limitations to the present study. First, there is no available method to assess the true number of college counseling centers that offer DBT. This study used a variety of methods in order to reach as many potential DBT providers as possible and as such, it is not possible to report a response rate. Second, the sample was purposive and is likely to be indicative of the preferences of college counseling center employees who have at least some level of interest in DBT, rather than those of college counseling center employees in general. While these two issues make generalizability to the overall college counseling center population uncertain, we selected these sampling methods in order to attempt to best capture those centers with the greatest likelihood of offering DBT. Third, as the survey was quite lengthy, there was a high level of attrition, especially in longer sections of the survey such as the PETQ and BTI. Fourth, the findings reported here are entirely based on self-report data. Although participants offered feedback on what modes of DBT were offered in their centers, it is impossible to assess the level of adherence and fidelity to the DBT model with which these modes have been implemented. Assessment of DBT adherence at the therapist level requires access to tapes of therapy sessions and time intensive coding of each tape; this was beyond the scope of this project. Finally, psychometric data for the instruments used in the survey is not available and
thus, the scoring procedures employed in this study may not accurately reflect the information collected. Despite these limitations, we believe that the data reported here offers important insights into DBT implementation trends as well as barriers and facilitators to implementation on college campuses. This study is the first of its kind and provides information about a variety of issues relevant to DBT implementation in college counseling centers that are likely to be important in the design of future studies related to DBT interventions delivered in this practice setting.
CHAPTER FIVE
RECOVERED VOICES: EXPERIENCES OF BORDERLINE PERSONALITY DISORDER

Note to the Reader

This article has been accepted pending revisions by The Qualitative Report. In addition, this research project was supported by a donation from the Herman B. Lustigman Charitable Foundation.

Introduction

Borderline Personality Disorder (BPD) is a severe mental illness characterized by extreme dysregulation of emotions, behavior, interpersonal functioning, self (identity), and cognition (Linehan, 1993). Individuals with BPD often engage in a variety of risky behaviors (e.g., non-suicidal self injury, suicide attempts, substance abuse, risky sexual behaviors) that can be understood as both causes and perpetuators of the chaos typically associated with this disorder. An unfortunate consequence of these behaviors is that individuals with BPD are often labeled as manipulative, attention-seeking, or other similarly pejorative terms (see Nehls, 1998; Westwood & Baker, 2010 for reviews). Indeed, Rivera-Segarra and colleagues (2014) investigated stigmatization experiences of individuals living with BPD in Puerto Rico and found that the participants reported experiences related to social isolation, reduced support,
discrimination, and a great deal of personal responsibility (e.g., the idea that these individuals just need to try harder to be well) in their everyday lives, by their families, and by their intimate partners. The authors found that the experiences reported were consistent with stigmatization typically associated with severe mental illnesses (e.g., being out of control) as well as that which is associated with less severe forms of mental illness (e.g., over-reacting). These authors uncovered a powerful, dialectical dilemma that individuals with BPD may experience: they are simultaneously viewed as if they are both out of control and as if they can control their behavior. I propose that the continued stigmatization of individuals with BPD may be perpetuated, in part, by faulty assumptions about “borderline” behavior associated with failure to view such behavior within its context. For example, self-injurious behaviors may be interpreted as “attention-seeking” rather than as a maladaptive means of regulating emotions and/or a behavior that has been reinforced over time by an extremely dysfunctional and invalidating environment (i.e., biosocial theory; Linehan, 1993).

Recent literature supports the notion that individuals with BPD are viewed in a particularly negative light, even within the healthcare community. For example, Markham and Trower (2003) found that nurses were significantly more likely to rate examples of challenging patient behavior as within the control of the patient when the diagnostic label was BPD, as opposed to schizophrenia or depression. The authors investigated sympathy of nurses related to diagnostic label and found that, “staff were not only less sympathetic towards patients with a diagnosis of BPD, they were actually reporting being unsympathetic” (Markham & Trower, 2003, p. 251). The authors also found that nurses reported less optimism related to patient change and more negative personal experiences related to working with patients with the BPD diagnostic label. Similarly, Bourke and Grenyer (2010) found that therapists exhibited
significantly more negative emotional valence in their responses toward clients with BPD as compared with those diagnosed with Major Depressive Disorder. Finally, Bodner, Cohen-Fridel, and Iancu (2011) found that nurses, psychiatrists, and psychologists reported frustration and antagonistic judgments related to treatment of individuals with BPD; they note that these findings were mainly explained by the challenges of managing suicidal behavior.

Stigma related to BPD also has the potential to impact a therapist’s ability to provide effective treatment. Aviram, Brodsky, and Stanley (2006) note that stigma associated with BPD may interfere with treatment by setting up a self-fulfilling prophecy through which the therapist develops “a priori negative expectations about the course of treatment” (p. 252). Millar, Gillanders, and Saleem (2012) interviewed 16 clinical psychologists about their experiences and perceptions of working with clients with BPD and found both positive and negative themes. Negative themes included negative perceptions of the client (e.g., BPD clients are seen as different, manipulative, and as having limited capacity to change) and negative feelings within the psychologist (e.g., feeling overwhelmed, frustrated, and having a sense of low self-efficacy). Positive themes included positive perceptions of the client (e.g., seeing the client as likeable), desirable feelings in the psychologist (e.g., empathy), and having awareness of negativity and exploring the reasons for it. This research reflects a challenging dialectic experienced by many therapists working with individuals with BPD: Therapists are empathic and like their clients; they also become frustrated, overwhelmed, and confused about how to manage the multitude of issues and crises with which these individuals can present.

Dialectical behavior therapy (DBT; Linehan, 1993) was originally developed for the treatment of chronically suicidal and self-injuring individuals and it is considered to be a best practice for treatment of BPD (National Registry of Evidence-based Programs and Practices;
NREPP, 2006). The treatment includes many strategies for managing client and/or therapist behavior that can interfere with therapy. Team consultation, a core component of DBT, is one method of managing therapist reactions to client behavior. The DBT team serves many purposes, including helping therapists maintain adherence to treatment protocols and philosophies, as well as helping the therapist search for non-pejorative interpretations of client behavior (see Phenomenological Empathy Agreement, Linehan, 1993, p. 118). Linehan (1993) advocates for an understanding of BPD that is based on behavioral principles and the importance of “highlighting the basis of the disordered “borderline” behaviors in “normal” responses to dysfunctional biological, psychological, and environmental events” (p. 26).

Although DBT has a strong evidence base as an effective treatment for individuals with BPD as well as many other difficult to treat mental health issues which often present comorbidly with BPD (see Rizvi, Steffel, & Carson-Wong, 2013 for a review), it is unrealistic to propose that all professionals who may interact with individuals with BPD have training in DBT. However, I believe that it is important for healthcare providers who interact with individuals with BPD to have an understanding of “borderline” behavior that is grounded within context. That is, an understanding of the individual’s behavior that is based upon the experiences throughout his or her life that allowed the behavior to develop and be reinforced over time. Such understanding may facilitate generation of interventions that are more likely to be effective as well as validating of individual experiences. For example, suppose a client has recently ended a relationship and subsequently engages in a suicide attempt via overdose on an over-the-counter medication. If her therapist assumes that the client is engaging in this behavior to seek attention, social support, or to get her partner back (as opposed to other functions for this behavior, such as escaping overwhelming negative emotions), the clinician is less likely to select an intervention
that will effectively target the behavior and may actually end up inadvertently reinforcing the behavior. It may also be quite invalidating for the client to be labeled as “attention seeking” when she may be quite ashamed of the behavior, which serves a completely different function. Understanding the function of behavior is critically important in reducing dysfunctional behaviors associated with BPD and this can only be accomplished when behavior is viewed in context.

Borba and colleagues (2011) concur with the notion that understanding client experiences in context is important. These authors studied the experiences of women with severe mental illnesses and found that their participants’ reports included several interconnected themes, suggesting “a complex cycle of social disadvantage throughout their lifespan” (p. 288). Borba and colleagues (2011) found themes related to social isolation, fear of hospitalization, moving to different neighborhoods (i.e., having to move frequently to avoid being “found out,” p. 289), loss (e.g., of jobs, custody, relationships), and lack of control over life decisions. With regard to lack of control, the authors note that many of the participants linked their current circumstances to past abuse. For example, some participants became involved in drug or alcohol abuse as a way of trying to avoid abuse by a partner; another fled childhood molestation at home only to find that the man she moved in with also abused her. These findings illustrate the ways in which a variety of tragic circumstances that are beyond the individual’s control can lead to ongoing issues (including mental health, substance use, low social support, or unstable finances) that may restrict the individual’s ability to appear “in control” in the present. Borba and colleagues (2011) conclude that, “mental health care providers may unintentionally contribute to their diminished quality of life by not contextualizing their treatment (p. 290).
As is demonstrated by the studies cited above, viewing client behavior out of context can be damaging for a variety of reasons. Harboring negative attitudes about a client based on his or her diagnosis is likely to affect a clinician’s ability to connect and respond empathically with clients. Linehan (1993) issues this impassioned argument:

It is by making these individuals different in principle from ourselves that we can demean them. And perhaps, at times, we demean them to make them different. Once we see, however, that the principles of behavior influencing normal behavior (including our own) are the same principles influencing borderline behavior, we will more easily empathize and respond compassionately to the difficulties they present us with (p. 26).

The aim of this research is to present poetic accounts of experiences of BPD as authentically as possible, without separating out pieces (e.g. themes) of narratives that may de-contextualize them. Attending to the lived experiences of individuals with BPD may facilitate deeper understanding and compassion for those suffering with this disorder as well as reduced stigmatization. Additionally, while there is a small body of research attending to the experiences of individuals who are currently receiving treatment for BPD and authors have published powerful autobiographical accounts of their experiences and recoveries from BPD (e.g., Reiland, 2004; Van Gelder, 2010), there are no known studies that focus specifically on individuals who have recovered from BPD. Lack of research with regard to recovery from BPD is unfortunate as it is possible that this furthers the common stereotype that BPD is a chronic and incurable condition.

It is possible that recovered individuals often do not come forward to share their stories because they are now living happy, productive lives and do not wish to expose themselves by publicizing their previous struggles because doing so could open them up to judgment or
continued stigmatization. Coming forward as having been previously mentally ill may have real-world consequences such as increased scrutiny of one’s emotional state or decision-making as well as potential loss of employment. This study offers an opportunity for individuals who have recovered from BPD to share their experiences with the research community, without fear of continued stigmatization that might jeopardize their current success. In essence, the purpose of this study is to give individuals who have recovered from BPD the opportunity to share their lived experiences so that their voices can contribute to a richer and more authentic understanding of BPD.

Method

Reflexivity

I am a doctoral student and a licensed mental health counselor specializing in DBT for treatment of individuals with BPD and other difficult-to-treat mental illnesses. I have wondered about a research project including the stories of individuals who have recovered from BPD since I first began to learn about DBT. I believe that individuals with BPD can and do recover; understanding this process was the primary impetus for this research. In addition, I believe that DBT is the best treatment for BPD available at present. As such, the primary theoretical lens through which I approached this research was DBT (Linehan, 1993), which includes elements of cognitive, behavioral, and biosocial theory as well as dialectical philosophy and Zen practice. I present this information to the reader because I believe that it is important to acknowledge my own assumptions and influence on this research and data presented.
As I engaged with the participants and their experiences, I found it increasingly important to work toward setting aside my own objectives through reflexive journaling. I became aware that some of these objectives were to develop poems that present “triumphant” stories of recovery and to highlight the influence of DBT in these stories. In order to subvert these objectives, I decided that once I had completed each poem, I would send it back to the participant with an invitation to edit and to give final approval for the poem to be published as an accurate account of the experience. One technique that was particularly helpful during the interviewing process can be described as “mindfulness of assumptions.” I challenged myself to be mindful of times when, as a participant was describing an experience, I made an internal assumption about that experience. When I found myself assuming, I asked a follow-up question and allowed the participant to correct me. For example, one participant noted that her first hospitalization was a particularly significant part of her story. My internal assumption was that this was significant because the first psychiatric hospitalization can cement one’s “patient identity” (viewing oneself as a sick or disordered person) and I followed-up by asking what was significant about this event. The participant shared that it was significant for her because it was where she met her first therapist and that it, “got me on the track of healing myself.” Although objectivity was not a goal of this research, I have endeavored to be mindful of my own subjectivity and to subvert it where important and possible throughout the research process in order to allow the participants’ voices to come through as authentically and unmediated as possible.
**Participants**

A total of nine participants were originally recruited for this study. One participant was excluded because the treating therapist could not be reached to verify that she met the inclusion criteria, a second was excluded due to not meeting all of the inclusion criteria, and a third withdrew from the study prior to participating in the interviews. The participants in this study were six individuals (5 female, 1 male) ranging in age from 30 to 44 years old. Two participants were married, one was in a domestic partnership, one was in a relationship, one was divorced, and one was single. Four participants were employed, two were students, and one was a stay-at-home mother. All participants had been previously diagnosed with BPD. To the extent that it is known, participants also met criteria for the following diagnoses at the time they received DBT treatment (by report of the treatment provider): Mood Disorder (Not Otherwise Specified), Major Depressive Disorder, Post-Traumatic Stress Disorder, previous history of Cannabis Abuse, Panic Disorder with Agoraphobia, Dissociative Identity Disorder, Obsessive Compulsive Personality Disorder, Bipolar Disorder (Type I), Conversion Disorder, and Bulimia Nervosa.

All participants received standard DBT as part of their treatment. Standard DBT is defined as including the four primary components of DBT treatment: a) individual DBT therapy, b) group DBT skills training, c) as needed telephone coaching, and d) team consultation for the therapists (Linehan, 1993). Participants were also included if they attended a program that offered an adapted version of the standard DBT protocol, as long as the program’s elements met the functions of the primary components of DBT (e.g., some participants attended a DBT intensive outpatient program). DBT includes four main stages and the primary goals of these are as follows: 1) gaining behavioral control; 2) experiencing a range of emotions without suffering needlessly; 3) managing normal life problems; and 4) building capacity for freedom and joy.
I defined “recovery” as being in at least stage three of DBT, as stage four is not always completed in the context of therapy and often includes elements outside of treatment (e.g., developing an increased connection to oneself, others, or one’s sense of spirituality).

I distributed recruitment messages on two professional listservs for clinicians and researchers interested in DBT. Generally, participants were referred to the study by their former DBT therapists. The inclusion criteria for this study were as follows: a) minimum 18 years of age, b) willing to consent to up to four interviews lasting up to 90 minutes each, c) able to verify that he/she is able and willing to discuss experiences related to DBT and BPD, d) able to identify at least one personal and one professional source of support in the event that discussing these experiences is upsetting, and e) willing to authorize the principal investigator to contact the current or former therapist to verify that he/she has been diagnosed with BPD, treated by an intensively trained DBT therapist, and is in at least stage three of DBT. This article presents data that is part of a larger project on recovery from BPD through DBT and thus, inclusion criteria related to the type of treatment received and training level of the therapists involved was important.

Data Collection

Each participant engaged in three semi-structured interviews related to the following topics: experience of BPD, definitions of recovery from BPD, and experiences of the stages of DBT. I provided all participants with interview guides prior to each interview to ensure that they had time to consider the questions. Generally, the first interview lasted about 90 minutes, with the following two interviews lasting up to 60 minutes. Given the aims of this study, data from the first interview was analyzed and used to develop the poems. All but one of the participants
was located in a different state than the investigator and thus, the majority of the interviews were conducted via Skype. I recorded all of the interviews and submitted audio files for transcription. The institutional review board for the University of South Florida approved the procedures for this study; all participants gave informed consent to participate. In addition, all participants provided confirmation that the poem developed from their interview accurately represented their experiences and gave their consent for it to be published.

**Data Analysis**

I used poetic analysis because the aim of this data analysis is to offer evocative accounts that communicate lived experiences of BPD. This is consistent with Grbich’s (2013) definition of poetic analysis, in which she asserts that researchers must engage creatively with their data in order to “bring the reader as close as possible to the original researcher/participant experiences” (p. 130). In addition to communicating experiences, an advantage of poetic analysis that is it can “present subtle ideas that might be paradoxical or dialectic” (Furman, 2006, p. 561). As the participants in this study were all treated with DBT, which involves learning to think dialectically (e.g., learning to tolerate and accept that conflicting viewpoints can co-exist as individual truths), it was particularly important that any means used to report the results of the research allowed space for dialectics to exist. Lastly, Pelias (2011) notes that evocative methods of presenting qualitative research are used to “enrich or disrupt normative understanding” (p. 662) and these are the primary purposes for this work.

The data analysis process I used closely (but not exactly) mirrored Glesne’s (1997) description of poetic transcription or poetic narrative. During the early stages of data analysis, I began by coding each transcript for themes. I reflected on the transcripts as whole narratives,
trying to understand the “essence” of what each participant was communicating, and created found poetry using only the words of the participant (although these words/excerpts could be re-ordered as needed; Glesne, 1997, p. 206). I departed from Glesne’s (1997) approach in two main areas: I did not require myself to create poetry that mimicked the prosody of the participant and, I used some provisional codes (as defined by Miles, Huberman, & Saldaña, 2014) to guide my coding process.

I elected to use provisional codes because the transcripts were lengthy and I believed that it would be helpful to code them to highlight various sections (e.g., origins, experience of BPD, recovery, etc.) that could later be revisited for poetic transcription. Additionally, as part of the interview, I asked participants to identify what they believed to be the most significant parts of their stories. The aforementioned coding method was quite helpful in allowing me to return to the sections identified by the participants as the significant pieces to emphasize. As the data analysis proceeded and through discussions with my qualitative methods mentor, I came to realize that I viewed the creation of these poems more as (musical) composition than writing. This is not surprising, as I was previously trained as a classical musician. Upon this realization, I began to rely much more on listening to the data and I used the transcripts much less. I focused on participant-identified sections of significance, listening and re-listening (and/or watching video) to the sections several times over in order to tease out the pieces that were most emphasized by their manner of speech (e.g., volume, tone, word repetition) and physical gestures (e.g., facial expression, hand movements). I found this process to be more satisfying in terms of my desire to present authentic accounts based upon participant experiences and their views regarding the most significant parts of their stories. The iterative process of data analysis
described above resulted in the development of the following method for poetic transcription of participant experiences:

1. Listen to the recording of the interview without viewing the transcript.
2. Listen to the recording of the interview while coding the transcript.
3. List events or experiences identified as significant by the participants and begin to pull pieces representing these from the transcripts.
4. View and re-view to each specific section of the interview while arranging the participant’s words into poetic form (this step was repeated many times).
5. View the poem as a whole without listening to the recording or viewing the transcript; continue to arrange the words as needed to refine the poem into an evocative account of the participant’s experiences, as I understood it.
6. Obtain consent from the participant to send him/her a copy of the poem for review, any needed editing, and consent for publication.

Results

The results of this data analysis are poems representing each participant’s individual experience of BPD. It is important to keep in mind when viewing the poems that they were developed from a single interview with the main focus of understanding what the experience of BPD is. Poem titles are participant responses to the question, “if your experiences with BPD were written in a book, what would the title of the book be?”

I. BPD Transformation: From Hopelessness to Purpose

When I was a baby and I would cry, she would just not know what to do.
I was always trying to find my way,
Trying to find love,
Trying to find stability.
But there was a lot of crazy stuff going on,
They did all the stuff that you shouldn’t do.
I was at home all the time by myself.
Nobody was actually watching out for me.

You have to be the prettiest,
The smartest (I always got brilliant marks),
The most talented, hungry, driven.
And I was a wave of emotion.

I’m ashamed to tell you this but,
If I threatened suicide she would pay attention to me.

When I got my diagnosis, I felt completely exposed.
They told my mom that BPD was untreatable,
And I was not even allowed to be hospitalized there ever again.
You can’t get any validation when people think, “Well, there’s no hope for you.”
I felt like I had a terminal illness. Terminal hopelessness.

There’s no way I’m going to let this be my legacy.
They are completely wrong.
Nobody will ever understand this but,
It just feels really good to say that I got treatment and figured a way out.

I shouldn’t have gotten pregnant, but I did.
My mom told me to give her up for adoption,
there was no way I could keep her.
I’m a fighter, so I said no.

I got in the car, I moved, and,
Told no one.
I got a temp job, a train ticket,
And, I kept my daughter.

Food stamps.
Section 8 housing.
Wanting help but nowhere to go.
I broke down and accepted, but,
It got worse before it got better.

Once you start to get help, people use your diagnosis against you.
My husband had been out drinking for hours,
And I’m driving, frantically looking (I had my daughter in the car).
I called my therapist and I was venting.
I said, “I’m going to jump off the bridge.”

The state is taking custody of my daughter.

She said, “I will only work as hard as you work,”
And I took that as a challenge.
She validated her promise every time we met.
I saw how hard she worked for me,
So I wanted to give it to her in return.

DCF told me, “You will never get custody of your daughter back.”
I went head in to the situation, with all my skills and would not give up on either of us.
It was not easy, but,
I now have full, legal custody of my daughter.

Now that I no longer meet criteria for any diagnosis and haven’t taken anything but vitamins in three years,
I’m determining what I want out of life,
Where I am currently,
And where I see myself going in the future.

Sometimes I yell at God and sometimes, I’m like,

“I see what you did there.”

II. Growing and Changing in a Black and White World

My grandmother died in front of me,
I was 12 and, it messed me up.
There was sexual abuse by my grandfather,
Which went on for 10 years,
Some of it was on a daily basis.

I was depressed, and,
It just got worse and worse.
I was scheduled to go to college; I was enrolled,
And then I just wound up in the hospital.
I was really suicidal.

I started cutting,
I picked it up from another patient there,
It became a daily thing.
But, I met my first therapist,
We started talking about some of the abuse.
In the 5th hospitalization I met my soon to be husband.
He became abusive.
He was controlling and a sex addict.
I feel like I married my father.

I kicked him out.
The thing that got me was,
He was hitting my daughter.
I couldn’t stand for that.
The children are the only good that came out of that relationship.

We lived at my job on the sly for several months.
I would get them ready for daycare,
Go all the way back by bus to work; work a full day.
Go back to get them at daycare.
We would wander the street, find something to eat, and,
After the [job] closed we would go back.
I would bathe them and then put them to bed on the floor.

And we would do that every day,
Until we were found out.

We had no where to go and we were homeless,
There were literally roaches crawling down the walls,
I moved the bed into the middle of the room so that the roaches wouldn’t crawl on us.

The other mothers told me right off the bat,
that my children would eventually be taken from me.
I didn’t believe them, but it came to be true.
I don’t know their reasoning,
They just felt like I wasn’t in control.

It seemed like every time I would try to get my kids back,
Something would keep them from giving them back to me.
So I was hospitalized over 50 times.

She wrote me a letter that said she wanted to be adopted by her foster parents.
I didn’t want to go against her wishes, but,
I wanted to fight for her; I wanted her back.
The CPS worker was like, “Well, you’ll never get her back, so you shouldn’t even try.”
One of the worst days of my life was giving up my rights to her.

I met my soul mate.
I meant something to someone.
I was really pushing and pulling,
And it was so difficult we almost didn’t make it.
Miraculously, I realized what I was doing, and, I realized I didn’t want to lose him. I did some major changing, [he] did some changing, and, We’ve really got a strong relationship now.

I got a new CPS worker. As soon as I got a new worker, He was like, “why are you not reunified?” I got my son back.

It’s so ingrained in me now, the DBT stuff. Even in the times when it felt like I wasn’t, There was at least a little bit of growth.

III. Misunderstood

I’m adopted. That primal wound of abandonment, I’ve carried with me the sense that there’s something wrong with me.

They didn’t want me to be seen as a black person, Even before I was old enough to feel the problems, I was clearly being invalidated. I’m looking at myself in the mirror and I’m seeing, And everybody’s telling me, “Oh, but that’s not really what you’re seeing.”

I just remember feeling like I hated myself, There wasn’t anything I could do to fix, There was something really terrible about me. It was inherent.

There was this need for me to hurt myself. I would break my bones. Fingers were easier to break than wrists, I learned, So I would take a hammer to my fingers. I was eight years old.

The man who raped me was the only other black person I ever knew. I figured he picked me because I was black, But I probably looked like a good victim, Vulnerable and lost; an easy target.

I started living with my boyfriend. After my daughter was born, I felt like all my insides were on fire and bouncing around,
Burning me.
And then I would down a bunch of pills.
I didn’t value myself as a mother,
So it never occurred to me that my life mattered to her.

I remember one night calling my dad and begging him.
Do anything!
Put me in a straightjacket and ship me overseas.
Help me! I desperately need something.
I went to an outpatient DBT program.
I was trying to use my skills but the pieces weren’t falling together.

“I’m not going to take my medicine anymore,
Then maybe I’ll be brave enough to jump off of a building.”
My mind was telling me that was the right thing to do,
I didn’t talk to my doctors – I just stopped.
And coincidentally, it changed everything.
I was actually doing better!

She explained to me that this behavior I have,
Of taking a whole bunch of pills,
Is just a behavior.
All my skills – everything started falling into place.
I still had lots of feelings to work through,
But they were my feelings.

I ended up getting strong enough to divorce my husband.
Regardless of how much I loved him,
I knew I couldn’t let her see me set this example.
But shortly after that, he died.

I could survive something that terrible and still live through it.
That’s when I realized I was gonna be fine.

I understand how to live within these special feelings,
There’s something about this that makes me even more powerful.

IV. Out is Through

I was tortured when I was a small child.

Growing up I remember feeling different from everyone else,
My emotions weren’t allowed.
I would whip my legs with tree branches,
And pull my eyelashes out.
I did everything I could to be accepted, still I felt so empty,
I was acting my way through life so no one would see me.
I don’t know what I was hiding,
But something was very dark.

I had episodes,
Running down the hall terrified,
In the fetal position, screaming.
I decided to go to therapy.

The first therapist I saw abused me.
Unknown to me at the time,
I switched into an alternate personality when he abused me.
I still remember very little.
See, I am DID.

I began having flashes and images of a little girl being tortured and abused.
You can see the movie, but it’s jumbled.
Like taking a VHS tape, playing it,
And then pushing fast forward.

I continued with my life,
Not making the connection,
That those images of that little girl were images of me.

I was very successful,
Again, I had to be the best.
It was becoming harder, and it was right there,
Under the surface.

The realization that the movie that played in my head was me.
I would suddenly act like a child or become another person.
I had my psychotic break.

Usually after episodes I could put it away in my box.
My box was too full. Couldn’t shake it off.
I went home and told my husband: I quit my job and I’m going into a mental hospital.
He gave me a hug.
I made it a point that I would do everything I could to get better for my [family].

I had to take an eight-hour psychological evaluation.
Borderline Personality Disorder was added to my diagnosis.
Treatment was one year long.
This program saved my life.

I have nine alters that I know of and have met.
I still get triggered, I still struggle.  
With hard work, determination, good medication, and,  
my [family] to fight for,  
I now live a normal life.  

The most important part of my story is the ending.  

I have accomplished a lot.  
I bring a face to mental illness,  
Put awareness out there,  
Fight the stigma,  
And most importantly,  
To be an inspiration to others.  

V.  Sex, Fashion, and Mental Illness  

I came from a background of instability.  
Fighting, getting arrested for drugs and alcohol, food stamps.  
My mom tried to commit suicide several times.  
I didn’t feel safe.  

The first time I ever got aggressive with a girl was in high school.  
My sense of identity was so lost in her,  
I was so angry that she had abandoned me.  
Things were so uncomfortable at my house,  
My only salvation would be through this relationship.  

The next relationship was five years,  
Of fighting and arguing.  
She left me, and I felt that same fear.  
Primal fear of the mother leaving a child.  

That was the first time that I did any kind of suicide attempt.  
It was staged, a cry for help.  
But the pain-killers started to feel good.  
I almost killed myself on accident.  

I can get my needs met by doing this thing!  
It was this euphoric moment that turned dark.  
This was the first time that I understood,  
Something had to change.  

The court ordered me to anger management courses.  
It wasn’t life changing, but,  
It felt a little bit more peaceful.  
It felt good to have some kind of way to express something.
He planted a lot of the seeds of DBT.
He: “Everything is exactly the way it’s supposed to be.”
And I: “I don’t fucking understand what the fuck you’re saying.”
He was doing the best he could, but I was still raging.
I started cutting during that time.

Every time something bad happened I would research,
Trying to figure out how I could fix myself.
That’s when I came across something about BPD.
Shit. This is who I am? Great.
It wasn’t very validating for me at the time,
But there’s truth to it.

And then I got into a dark place again.
I didn’t eat for a couple weeks.
All this trauma started coming out,
It was the lowest point.

I found [my DBT therapist].
She was really compassionate, and,
She told me to eat a sandwich.
It was clear that [she] was the teacher.

I was very open-minded going in.
I made progress,
I started feeling like nothing was really happening anymore…
And then [my current girlfriend] enters the picture.
[She] has been an amazing mirror for me.

I would write down the triggers,
Trying to figure out what was causing these rage episodes.
I studied myself like a lab rat, and eventually,
There’s a list! There’s a pattern.
It feels conquerable!

Exposure therapy helped, but there were still these things.
That’s when I started experimenting with psychedelics.
It takes you to a place of pure stillness.
No being, no non-being.
It wasn’t a magic bullet, I was still using skills.

I remember one time,
I realized I was sexually abused,
But I moved through it.
I remember the teaching, “Face the demon and sit with it.”
And I remember going, “Here I am.”

[My DBT therapist] took me up to where she could, but there was another journey I had to walk, with a different teacher. With the Universe.

VI. The Dinner Party

My parents weren’t really equipped to be parents. My mom was incredibly volatile. She would go in the bathroom, and narrate the fact that she was killing herself.

I got picked on a lot. I think I used to cut myself a lot. And then I would not eat for a while.

In high school, I started expressing myself more. They would have that suicide checklist, all of a sudden, the tone would change. I was pretty good at knowing how far to go with what I was saying.

Initially, I was okay in college. And I started going to see a therapist there. I was so anxious all the time, I think it came off as jittery and happy, like I couldn’t stay in my skin. I wanted to get out of the situation.

Things started getting really out of control. I wasn’t sleeping; my emotions would flip really rapidly. I used to think about suicide a lot, and it would just completely short-circuit all of that emotion. I would feel fine afterwards.

I accepted that I was going to kill myself at some point, and I have never felt so much ecstasy in my entire life. It was incredibly hard to hear, “I don’t know how I can help you.” So I ended up going to the hospital. It made things a lot worse. The therapy was incredibly condescending. No one listens to you if you’re crazy.

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1 This title is a reference to the 1962 surrealist film, “The Exterminating Angel,” in which several wealthy guests become unable to leave a dinner party at the end of the evening, resulting in increasingly bizarre occurrences.
Initially [DBT] was kind of rough. I honestly couldn’t conceive of going to therapy for that long. I’m desperate and you’re giving me homework?

I was just a mess. I was getting hospitalized all the time, Yet I was still excelling in my classes. I still had that illusion that everything was going well.

We talked about the life worth living. It was beyond my comprehension, Because my brain had been so inundated with the thought - I just really want to die. I just really don’t want to feel.

So I finished DBT, And I was actually more of a mess. And then I decided, I’m going to volunteer for six months.

I remember feeling really lonely and just dealing – It made me deal with my stuff on my own. I actually used DBT quite a bit.

Eventually, therapy became this crutch. I was too scared to do it on my own. What I did was not recommendable, But for me, it was necessary. If not, I was always going to act up to get back the support.

I had a clear point of view. This is what I want to do, And I’m going to do it no matter what. Hopefully, to get my self back.

If you were to tape a scene, And then put two different types of music to it. One is happy-go-lucky, And one from a terror film. That was my experience over all those years. I would be living in an experience, But the music to what I was seeing was very different.
Discussion

The poems presented here offer deeply personal, moving accounts of the life experiences of individuals who have recovered from BPD. Although I had originally set out to understand what the experience of BPD was, what I found was that these experiences are described in a wholly different manner from that which I had become accustomed to using in my clinical work. Specifically, what I was expecting was a great deal more discussion and description of experiences that corresponded relatively closely with the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) criteria for BPD. Although there were certainly references to symptoms, there was also significant attention to early childhood experiences, abuse, trauma, and self-hatred. It appears that dialectical tension exists between the utility of viewing a disorder as a collection of symptoms (which facilitates referral for appropriate treatment) and the potential for harm (decontextualization, stigmatization) that may come to a person when her experience is reduced to a collection of problems. In addition, the particular problems associated with BPD can make balancing this dialectic very difficult. For example, Aviram, Brodsky, and Stanley (2006) suggest that “because of the unpredictability of behavior and the intense range of emotion associated with BPD, it may be challenging for clinicians to maintain a view of the problems that emerge as reflecting “nature of the pathology” and not the “nature of the individual” (p. 249).

A metaphor may be useful in further illustrating the importance and process of developing contextualized understanding. In the field of classical music, teachers sometimes have the habit of assigning a very advanced student a classic, but not extremely technically challenging piece of music that the student learned at an earlier point in his or her education. The point of such an exercise is to move beyond the technical capacity to play the notes, in order
to develop artistry. Similarly, Faye-Ellen Silverman (a contemporary composer and professor at Mannes College, The New School for Music, NY, NY) uses the technique of introducing very difficult pieces of music to freshman conservatory students and again, when the students reach their junior year. In discussing this method, she notes that, “some of them hated the work as freshman but understood it as juniors, so going back creates a new level of understanding” (F.-E. Silverman, personal communication, April 6, 2015). She explains that her own perspective of these pieces is also constantly evolving and that each encounter with a piece helps her to further her understanding of the piece, its details, and the composer’s intentions. In the field of counseling, understanding the client’s subjective experience is regarded as one of the very first and most central tenants of the profession. Returning our focus to understanding client experiences and responding with phenomenological empathy is both beginning and end. It is the primary foundation on which everything else is built, and it is a means through which we continuously develop our understanding and the artistry of helping.

As academics in the helping professions, we plant the seeds of this artistry for future generations of counselors, social workers, psychologists, nurses, physicians, and many other professionals. The experiences detailed in these poems give important insight into the differing ways that BPD and treatment via a variety of interventions (e.g., hospitalization) can be experienced (sometimes quite negatively) by the individual client. It is critical that we help students develop the skills to intervene when clients are having harmful or ineffective treatment experiences. Doing so requires the ability to look beyond stereotypes, assumptions, biases, and one’s own reactions to client behavior that can be quite aversive, anxiety-provoking, and frustrating at times. It is important to encourage students to accept that we are all fallible human beings and thus, prone to moments of less compassion, less positive regard, and of lowered
energy and tolerance and, to push past these moments to see individuals as they really are rather than as a diagnosis or a collection of problems to be solved. Seeing clients as they are, with all of the unique experiences that have lead them to a particular moment, facilitates not only more compassion and understanding (Linehan, 1993), but a more contextualized view of client difficulties that may reduce the negative biases and stigmatization that have been documented to occur among healthcare workers and clinicians (e.g., Millar, Gillanders, & Saleem, 2012; Markham & Trower, 2003).

It is my hope that these poems will serve, in part, as a call to mindfulness. The purpose of mindfulness is not to reach a point where we can do something perfectly – we will never understand and respond perfectly to our clients. Rather, there is great value in our moments of non-understanding because these give us the opportunity to develop awareness of those times when we are off track and have become unmindful. These poems may be used as a way for students and professionals to continue to work on the ability to become mindful of times when their compassion for BPD clients is lowered. They may also be useful as a method of assisting students and professionals in learning the value of viewing individuals and their behavior within context. Ultimately, I hope that the poems presented here will promote more awareness of the seemingly insurmountable challenges and suffering faced by those with BPD and, the incredible strength, resilience, and humanity that these individuals possess. Even when things seem hopeless, there is hope.
CHAPTER SIX

DISCUSSION

Introduction

The purpose of this dissertation was to offer research that would advance the field of DBT in college counseling centers both in terms of practical and theoretical issues and I have presented four papers with the aim of achieving this goal. Specifically, I first presented a review of the literature related to DBT in college counseling centers to date. I also offered a detailed overview of a DBT program development and implementation in a college counseling center. Next, I presented findings from two research studies. The first study was focused on gathering information related to current trends and barriers to implementation of DBT programs in college counseling centers. The second study was a qualitative investigation of the experience of BPD as told by individuals who have been successfully treated with DBT. Before I discuss what can be gleaned from these papers when they are considered as a body of work, I will begin by briefly summarizing the major findings from each of the four pieces. Next, I offer my conclusions based upon the four papers when considered together. I conclude this chapter with a discussion of the collective limitations of the papers presented here and my recommendations for further research related to DBT in college counseling centers. Lastly, I offer a final comment to the reader that includes my personal reflections about the process of producing these works.
Summary of Findings

Literature Review

I began my investigation of DBT in college counseling centers with a review of the literature. While relatively few papers have been published on the topic at hand, those that are in print do offer some important insights. First, all of the authors reported data from programs in which the clinicians had professional training in DBT. This training level was variable and included having read Linehan’s (1993a, 1993b) treatment manuals, participating in an online skills training program, and having a two-day consultation and training in DBT (Chugani, Ghali, and Brunner, 2013), “formal” training in DBT (not further specified; Meaney-Tavares & Hasking, 2013), treatment delivered by interns who had received a week-long training and ongoing supervision by a DBT expert (Pistorello, et al., 2012), and intensive training and consultation with an expert in in DBT regarding program development (Engle, et al., 2013). As these studies all have differing designs and offer different interventions, it is not possible to compare their outcomes by training level. However, I believe it is important to note that there has not been a study published to date in which the clinicians implemented a DBT program in their college counseling centers after reading the treatment manuals without any follow-up training activities. DBT is a complex treatment and even in implementing only one mode (for example, a skills training group), there are numerous strategies and techniques (in addition to a voluminous amount of content related to the skills themselves) that one must learn. It is likely that successful program implementation includes a level of DBT training commensurate with the type of program desired, with higher levels of training likely required for comprehensive programs. However, it is important to note that there is no data currently available to suggest what particular types of training activities (e.g., structured training event vs. ongoing
consultation/supervision, in-vivo vs. online, 2-day vs. 5-day vs. 10-day) are best suited for clinicians wishing to implement DBT programs in college counseling centers.

In addition to training issues, all the programs reviewed engaged in on-going outcome measurement of some type. This may not be surprising since these were research studies for which clinical outcomes were the variables of interest. However, it is somewhat unusual to see clinicians conducting research in a college counseling center, as this activity can be time consuming and take away from direct service provision (which is the main part of the position for most clinicians in this practice setting). In addition, since the majority of literature related to DBT in college counseling centers reported adapted DBT programs, it makes good sense to measure outcomes to ensure that the program is achieving the desired results. There are several free and easy to administer and score instruments that are widely used by other authors in the field of DBT research (e.g., Difficulties in Emotion Regulation Scale, Gratz & Roemer, 2004). Such assessment is likely to be an important part of securing continued support for DBT programs housed in college counseling centers. Not only is regular outcome assessment clinically advisable, it is also helpful in demonstrating the need for DBT programs on specific campuses.

Lastly, all of the DBT programs in college counseling centers reported in the literature (including those that offered the standard DBT model) had made some type of adaptation to the model based on the student and institution characteristics. Examples of these adaptations include shortening DBT skills training groups so that they can be delivered within a single semester (Meaney-Tavares & Hasking, 2012), broadening inclusion criteria (e.g., personality disorder “traits” vs. meeting full criteria for BPD; Chugani, Ghali, & Brunner, 2013), and waiving the “4-miss rule” in cases where a student leaves campus for winter or summer vacations (Pistorello et
al., 2012). I argue that while some adaptation may be necessary for some centers, it is important that adaptations to the model are strategic. In other words, adaptations should be made out of necessity or to facilitate treatment delivery and in a manner that strives to be consistent with DBT principles, practices, and philosophy.

**Adapting DBT for College Counseling**

With regard to program development and implementation, I presented a detailed overview of the manner in which the DBT program for the students of FGCU originated, was developed, and consequently expanded into an adapted-comprehensive program. The years I spent with this program included many challenges to be resolved and successes to celebrate. I also learned many lessons that may be helpful to other clinicians in college counseling centers that wish to implement DBT programs. First, I address specific issues in program development that I believe are critically important in resolving early to avoid later challenges. These include many suggestions related to discussions that must occur between staff and administration such as examining how this program may change the balance in services provided to some students, asking each potential team member to assess how much time he or she can commit to program-related activities as well as which components of the program they can participate in (to ensure sustainability), and realistically assessing the required resources (including time, funding, materials, etc.) required to deliver the program and engaging in an honest discussion about these with key administrators. My experience has been that a systematic assessment of the resources needed and the resources available is extremely helpful in determining what type of program will be realistic for implementation. Similarly, I offer suggestions related to program adaptation that
are based on an assessment of what level of treatment is needed by the student body, what the center’s scope of services is, and what will be realistic given the available resources.

Lastly, I offer several suggestions for the development of the DBT team. DBT team meetings include professional consultation, but they are also conceptualized as “therapy for the therapists.” Linehan (1993a) notes that therapists working with high-risk, suicidal clients need support and thus, DBT team meetings often include a level of personal vulnerability not typically observed in the average case consultation meeting. As such, it is important to prepare potential DBT team members for the unique commitments they will be expected to make as part of the team. These include reviewing Linehan’s (1993a) team agreements, discussing willingness to learn and practice DBT skills in one’s personal life, examining and discussing each clinician’s limits around the practice of DBT, and ensuring that team members make informed and voluntary decisions about joining the team. While it is likely that some team members will decide that they do not wish to continue to practice DBT as they grow to learn more about it, examining these issues early in the process can be helpful in assembling a team of clinicians that is more likely to be successful in implementing a program on their college campus.

**Research Findings**

**Trends and Barriers to Implementation**

In order to gather more information that might inform future research related to DBT in college counseling, my coauthor and I used an electronic survey with 107 college counseling clinicians in order to explore two questions: 1) What are the current trends in DBT implementation in college counseling centers, and 2) What are the barriers and facilitators to implementation of such programs? With regard to current trends, the most commonly reported
reasons for interested in DBT were related to students who were presenting with a variety of serious psychological concerns (e.g., self-injury, BPD, suicidality, and multiple diagnoses). Profession and size of student body were the only two factors found to be differentially associated with having a current or planned DBT program. In the case of profession, counselors were less likely to report having a current or planned program than psychologists or social workers and the reasons for this finding are unclear. In addition, larger institutions (especially those with 15,000 students or more) were more likely to have current or planned DBT programs. I assert that while larger institutions may have better resources with which to implement DBT, institutions of all sizes can benefit from DBT programs although the type and scope of the program may vary depending on the specific needs of the student body and the availability of treatment in the local community.

Overall, 35 participants indicated that their centers had a planned or current DBT program. In addition, 22 participants provided characteristics of 20 different DBT programs housed in their college counseling centers. The most common primary mode of treatment offered was DBT group skills training and many programs indicated that they were running or planning to run an adapted program. Formal training in DBT was relatively low, with the most frequently endorsed training activities being reading related to DBT (e.g., reading Linehan’s treatment manuals or journal articles about DBT). Among the participants who reported current or planned programs, only 26% had completed a DBT intensive training (Landes & Linehan, 2012).

With regard to barriers to implementation, we gathered data from participants who offered or planned to offer DBT programs as well as those who did not have any plans for a DBT program in order to collect information related to anticipated barriers to implementation in the
college counseling practice setting. In terms of the most highly endorsed barriers to implementation, there was good agreement between both groups (those who have a current/planned DBT program vs. those who do not have a program). Specifically, the most highly endorsed barriers by domain (of the BTI measure; Behavioral Tech, LLC, n.d.) for both groups were productivity demands, not willing to take phone calls, lack of individual therapists, and no time for team meetings. This finding is particularly interesting because three of these four barriers represent three of the four primary modes of the standard DBT treatment model. These findings suggest that college counseling clinicians may view many critical pieces of the DBT model as challenging to implement in their setting. Lastly, the most frequently endorsed facilitators to implementation included staff interest in DBT, staff expertise in DBT, DBT programs designed for college counseling centers, staff experience with DBT, DBT training programs designed for college counseling centers, and funding for DBT training.

**Experiences of BPD**

This study used poetic inquiry as a method of presenting accounts of the lived experience of BPD as told by individuals who had recovered from BPD and had been treated with DBT. I offer these poems to the reader as a method of examining the importance of viewing behavior within context. I argue that viewing behavior and experiences in context, which is a key component of DBT theory and practice, may be important in achieving a number of goals associated with the effective and compassionate treatment of clients with BPD. First, viewing client behavior or experience within context is a method of developing phenomenological understanding and empathy. Second, contextualized understanding of client problems enables accurate assessment of the functions of behavior. Accurate assessment of the function of client
behavior is necessary in selecting interventions that are more likely to address the actual problem at hand. Third, these poems may serve as training tools for both professionals and students in learning the importance of viewing individuals with BPD with compassion and developing the skill of becoming aware of those times when compassion and empathy might be lowered. I argue that as helping professionals are human, these moments of lowered compassion (i.e., times when biases or judgmental thoughts about clients occur) are natural. Rather than endeavoring to eliminate these moments, a more realistic solution is to work toward developing the skill of becoming mindful of these moments so that we as helping professionals do not perpetuate the cycle of stigmatization and invalidation of individuals with BPD.

**Conclusion**

The overarching aim of this dissertation was to answer the question of how college counseling centers can address the varied practical issues associated with implementing DBT programs while still adhering to the spirit of the DBT treatment model. I have presented four separate but related papers that collectively attempt to answer this question. When one considers these four pieces together, several issues are revealed. The practical aspects of implementing DBT programs are diverse and may be particularly challenging for the college counseling practice setting, which traditionally does not emphasize offering comprehensive mental health care services for students with difficult-to-treat and complex clinical presentations (Gilbert, 1992). In addition, the students whom such programs would serve can be challenging to treat. The diagnosis of BPD has been associated with higher levels of stigmatization than other mental health disorders (e.g., Markham & Trower, 2003). Further, the behaviors associated with BPD may provoke continued stigmatization from helping professionals in part, because such
behaviors can be quite scary, stressful and frustrating to manage (Aviram, Brodsky, & Stanley, 2006). Put plainly, implementing DBT is difficult and working with individuals with BPD is also difficult. Thus, it is easy to understand why more college counseling centers have not yet implemented DBT programs.

On the other hand, recent literature also reflects that more students are presenting for treatment to their college counseling centers with difficult-to-treat mental health issues (Gallagher, 2014). Therefore, despite the difficulties associated with modifying existing practice structures to accommodate more comprehensive services, it may be important for more centers to begin considering the reality that while some students may have the means to access treatment off campus, others may be relying on on-campus services. If college counseling centers are going to continue to treat students with suicidal and self-injuring behaviors, I argue that the most responsible way to proceed in offering such treatment is by implementing evidence-based practices known to be effective in reducing these behaviors. While other treatment models have been developed specifically for the treatment of BPD (e.g., Mentalization-Based Therapy; see Bateman & Fonagy, 2010), there is no single treatment approach that has as much efficacy data specifically related to the management of suicidal and self-injurious behavior as DBT. At present, I believe that DBT is a logical choice for implementation in college counseling centers that wish to provide evidence-based treatment to students with a variety of challenging psychological disorders.

However, simply providing a treatment that has been labeled as “evidence-based” is a deceptively challenging task because what can be achieved in a research laboratory that has access to grant funding and expert supervision is not necessarily achievable in real-world practice settings. This task is especially challenging in the case of DBT implementation, which
is a particularly complex treatment model that represents a higher level of care than treatment as usual (e.g., in a college counseling center, this might be weekly individual therapy or group therapy). In order for college counseling centers to implement and sustain DBT programs that provide effective and compassionate care, both practical and theoretical issues must be considered. More specifically, consideration of practical issues in implementation includes but is not limited to examining methods of program and team development, strategic DBT adaptation, required training in DBT, resources available (staff, funding, materials, space, etc.), and the specific needs of the student body served by the center.

On the other hand, consideration of theoretical issues in implementation requires that clinicians consider their own biases and judgments about students with BPD, their feelings about being professionally responsible for the care of suicidal and self-injuring individuals, their willingness to take on this task, and perhaps most importantly, their willingness to acknowledge those times when they are being judgmental and to try to search for the non-pejorative interpretation of the student’s behavior. While Linehan’s (1993a) treatment manual addresses many of these issues, the purpose of the book is to outline, with exceptional detail, the practice, principles, and philosophy of the standard DBT model. Linehan’s (1993a) text is an essential element of learning and implementing a DBT program, however, it is not written with the special needs of college counseling centers in mind.

There are several reasons why the standard methods of beginning to learn about DBT (i.e., reading Linehan’s 1993a and 2015 manuals) may not translate well to college counseling centers. As I have previously noted, college counseling centers traditionally offer brief services and remediation for normal developmental issues or low-severity psychological issues (Mowbray et al., 2006). Plainly, college counseling centers are not intended to function as comprehensive
mental health agencies equipped to manage every type of psychological crisis, just as campus health clinics are not intended to function as hospitals. The difference between the college counseling center and the campus health clinic is that even small towns have doctors and hospital services available off-campus. For many cities around the country DBT is still not widely available and even where it is available, it is not always affordable. An issue in DBT implementation for college counseling centers that may not be as problematic for other types of agencies (e.g., community mental health and crisis stabilization units) is that program implementation may require the center to radically change or expand its scope of practice.

A related issue is that of how the scope of practice of the professionals employed by the college counseling center must change. Just as a center’s scope of practice affects the types of services it provides, it likely affects the staff hired to provide those services. Although there is no data that specifically elucidates clinical specialization among college counseling professionals currently available, it stands to reason that typically, college counseling centers do not have a focus on hiring individuals who are specifically interested in suicidal behavior. It is more likely that such individuals would seek employment in other types of practice settings where the care of such individuals typically takes place (e.g., inpatient psychiatric hospitals, intensive out-patient programs, community mental health crisis centers). Thus, an additional challenge in DBT implementation on a college campus is that it is likely that some of the center’s employees will not be interested in the practice of DBT or the idea of dedicating significant time and energy to working with suicidal and self-injuring students.

While practical issues in implementation are relatively easy to communicate, theoretical issues are sometimes more complicated to convey. Although my work using poetic inquiry to present lived experiences of BPD is not specific to the college counseling setting, the purpose of
including it here was to have a method of discussing some of the issues that ultimately interfere with the development of DBT programs that applies to the broader healthcare community, regardless of the professional’s interest in learning DBT. While Linehan’s (1993a) text discusses assumptions about borderline patients and the consultation team agreements as a way of helping therapists who are committed to the practice of DBT achieve a nonjudgmental and non-pejorative stance towards individuals with BPD, my research makes no assumptions regarding the commitment of any therapist or other helping professional to DBT as a model. I do not make these assumptions because the experience of having implemented my own program has taught me, among other things, that DBT simply is not for everyone. Thus, the purpose of this dissertation is not to suggest that all college counseling center clinicians should become DBT therapists. Rather, my purpose is to assist centers that are interested in implementing programs in achieving their goals by: 1) Offering practical solutions to known issues in program and team development and implementation, including some solutions that can be applied by clinicians with relatively little training in the DBT model, and 2) Offering a method for understanding and viewing borderline experiences and behavior that may increase compassion for this population and consequently, perhaps increase motivation and willingness to alter existing practice structures and professional beliefs. The purpose of synthesizing these two strands of research and promoting DBT as a solution to some of the challenges currently faced by college counseling centers is ultimately to increase access to good quality, evidence-based, comprehensive mental health care to young people who are suffering.
Limitations

There are several limitations to the body of work presented in this dissertation. First, the literature related to DBT in college counseling centers is quite limited and to date, there has only been one randomized controlled trial conducted with DBT in this practice setting (see Pistorello et al., 2012). As such, the implications for practice, methods on which I based adaptations to DBT for my own program, and barriers to implementation investigated may not accurately reflect the needs of college counseling centers across the nation. In addition, those centers that have implemented DBT and taken the additional step of conducting a research study for publication may be outliers rather than representative of what a typical college counseling center might be interested in delivering to students. This issue seems to be reflected further if one considers the number of respondents from the survey study that indicated that their center had a planned or current DBT program ($n=35$). Based on the data collected, it appears that college counseling centers may be adopting DBT at a relatively low rate. However, the methods used in this dissertation were not sufficient to determine the full extent to which DBT is currently being implemented in college counseling centers around the country and thus, it is unclear how well this data is representative of the larger college counseling center population. Although I have offered a variety of practical solutions and suggestions for college counseling centers that wish to implement DBT (including a step by step overview of an actual program development and implementation process), it is unclear to what extent my suggestions will be realistic for the average college counseling center.

Another major limitation to the body of work presented here is that my qualitative research is not specifically focused on college counseling centers. I chose to broaden the scope of my research for this project in part because the aim my research related to the experience of
having BPD (or any other mental health disorder) seemed to transcend practice settings. In addition, it would also have been quite challenging to locate participants who met my study criteria who had been treated in their college counseling centers because my criteria included requirements that the individual had received standard DBT delivered by an intensively trained therapist. To the extent that it is known, very few college counseling centers currently offer standard DBT services (Chugani & Landes, under revision; Sauers, Mattei, & Paull, 2013).

Although the treatment setting may affect one’s report of the experiences encountered during the treatment period, this research was intended to assist helping professionals in recognizing their own biases and the ways in which these might reduce effective treatment (rather than to be generalized to the college counseling professionals in particular). The challenge of maintaining a nonjudgmental stance is one that diverse helping professionals working with individuals with BPD may struggle with and thus, I elected to pursue the experiences of individuals who had recovered from BPD, who had received good quality DBT treatment (to the extent that this could be verified retrospectively) regardless of practice setting.

Although I had reasonable justification for conducting my qualitative research outside of the college counseling practice setting, other qualitative studies focused on this setting may have also been quite informative. For example, given the finding that some of the most highly endorsed barriers to DBT implementation among both college counseling clinicians who did and did not have a current or planned DBT program were closely tied to three of the four primary modes of the standard DBT model (see Chapter Four), it may have been useful to follow up on this (and other quantitative findings) with a qualitative study investigating college counseling center clinicians’ perspectives about DBT. Similarly, it may have been interesting to examine college counseling center clinicians’ views about working with students with BPD. Such an
investigation may have the potential to address both practical (e.g., low interest or motivation levels, views that this is not the role of the center, etc.) and theoretical challenges (e.g., professional theoretical beliefs that are discrepant with the DBT model, fears about working with suicidal students, personal biases) in the implementation of DBT programs on college campuses.

**Future Research**

The research presented in this dissertation suggests several important issues for further inquiry. A major issue that requires further investigation is that of what type of DBT treatment programs will be most efficacious when delivered in a college counseling center. For centers that wish to implement standard DBT programs (include all four primary modes of treatment), there is reasonable evidence to suggest that such an endeavor would be effective as this model has been rigorously tested (see Rizvi, Steffel, & Carson-Wong, 2013 for an overview). However, my findings indicate that many college counseling centers may be making significant adaptations to the DBT model (e.g., only implementing some of the four primary modes of DBT) and, that it may be useful to develop a less complex treatment model for this practice setting.

More research should focus on clarifying the ways in which college counseling centers are adapting DBT via qualitative and/or mixed methods research that would provide more richly detailed data related to how programs have been developed, what they actually do while delivering the DBT-related interventions, and the extent to which clinician training and activities are comparable to the standards associated with fidelity to the standard DBT model. Further, it would be helpful to have a standardized method for collecting outcome data from these programs that might permit some examination of the ways in which outcomes may vary by level of implementation and/or fidelity to the model. The type of center may be an additional variable of
interest and future research should explore the variations in and effectiveness of college
counseling center DBT programs housed in a variety of types of centers (e.g., large vs. small
centers, publicly vs. privately funded institutions, institutions with access to DBT experts on
campus vs. those without access to expert consultation, etc.).

The data collected by all of the aforementioned projects would be useful in working to
clarify how DBT can be adapted in a manner that adheres to DBT principles and philosophy
while also increasing feasibility for implementation in this practice setting. Once derived, the
adapted DBT program model designed for college counseling centers will need to be rigorously
evaluated. Ideally, such an evaluation would consist of a multi-site randomized controlled trial
with active, time-matched comparison conditions to ensure that DBT treatment is truly superior
to other modes of treatment that are either already offered by the center or are more easily
offered. It is particularly important to be able to demonstrate the superiority of DBT in adapted
form because the implementation data from the survey study (see chapter four) suggests that the
standard model may not be feasible for implementation in many centers.

As college counseling centers begin to implement DBT programs at an increased rate,
there will be opportunities to conduct more research with the aim of continuing to improve the
experience of DBT on campus. In this case, future research should explore both student and
clinician experiences of the campus DBT program. Whether the focus is on student or therapist
experiences, future research should include both quantitative and qualitative methods. When
examining student experiences, future research should include investigation of clinical outcomes,
treatment acceptability, and reports of how the treatment received has impacted their lives.
When examining therapist experience, future research should include investigations of therapist
experiences of training and the impact of such training on their interest in and attitudes toward
working with students with BPD as well as their confidence in doing so. I believe that the data presented in this dissertation suggests that while further implementation research related to DBT in college counseling centers is warranted (because so few programs appear to exist at this time and more data will need to be collected as this field grows in order to accurately capture trends from the field), it will also be important to address some of the issues that likely interfere with successful implementation. For example, the implementation data presented in chapter four suggests that there may be significant challenges associated with obtaining release time to hold team meetings and having a sufficient number of individual therapists to deliver individual DBT treatment. These issues represent two of the four primary modes of DBT. One method of resolving these types of barriers to implementation may be to conduct research that demonstrates the utility and effectiveness of DBT in a manner that appeals to institutional administrators who are responsible for granting funds that would facilitate these activities (e.g., time releases, additional staff members, focused hiring and development plans that include interest/experience with DBT has part of position descriptions) as well as funds for training.

I argue that since college campuses are essentially a community within a broader (local) community, it may be helpful to explore the extent to which DBT programs on college campuses impact the campus community or the student’s educational experience. One issue that has been particularly salient during the last few years due to recent changes in the definition of direct threat in the ADA (Americans with Disabilities Act of 1990, 2011) is that of having students who are suicidal withdraw from the university. Engle and colleagues (2013) found that their DBT program decreased such withdrawals; this type of outcome arguably does support a student’s educational experience and successful pursuit of higher education. Future research should also explore the extent to which students who learn DBT skills can generalize those skills
into their campus or academic lives. One method for collecting such information may be to modify the DBT Ways of Coping Checklist (Neasciu, Rizvi, Vitaliano, Lynch, & Linehan, 2010), which includes subscale for both DBT skills use as well as maladaptive coping skills use, so that it measures the extent to which students use DBT and maladaptive skills while on campus and/or during campus-related activities (e.g., in residence halls, Greek life, during interaction with professors, etc.).

Further, since BPD is associated with a variety of behaviors that would likely be disruptive on a college campus (because they are disruptive in most contexts), it may also be useful to explore the extent to which the campus community could benefit from reductions in such behaviors. This research could be conducted using data that the institution already has the capacity to collect fairly easily (e.g., number of times a student misses class, number of assignments turned in on time, grades, and number of disruptive incidents occurring during class, during campus related activities, and on-campus in general. If research demonstrates that offering students treatment with DBT can not only produce reductions in clinically concerning behaviors (including but not limited to suicidal and self-injuring behaviors), but also reduce behaviors that are 1) disruptive to the other students and staff on campus, and 2) disruptive to the student’s own educational experience and ability to be successful, it would provide very good justification for the investment of institutional resources to implement such treatment programs.

Finally, it appears that a dialectic exists between the need for the DBT model to be adapted to better fit into the scope of a college counseling center practice and the need for the standard college counseling center model to adapt to accommodate the provision of a higher level of care. Specifically, college counseling centers are traditionally viewed as brief treatment centers focused on normative issues and/or lower level pathology (Gilbert, 1992). If these
centers wish to begin (or continue) to address the needs of suicidal, self-injuring, and/or diagnostically complex students, it is likely that the brief treatment model will not be sufficient. Thus, an overarching aim of future research related to DBT in college counseling should be focused on balancing changes to the DBT model of treatment with changes that the center may need to make as the level or scope of service provision necessarily evolves to accommodate the changing needs of the students who present to these centers for services.

**Unanswered Questions**

In addition to the suggested areas for inquiry noted above, there are some questions that remain unanswered or unaddressed by this dissertation that I believe are important to note. First, it is unclear how institutional factors (e.g., size of student body, type of institution, etc.) might impact the implementation process. Second, it is unclear why the likelihood of having a planned or current DBT program in a college counseling center differed by profession of the respondent. In order to address this question, one might consider conducting a survey study that samples each of the major professions (psychology, social work, and counseling) through their national organizations to collect data in areas such as attitudes toward evidence-based practices, attitudes and interest level in DBT, and level of exposure/training in content areas necessary to the competent practice of DBT (e.g., behavioral theory, mindfulness, etc.). Although it is unclear how these professions differ on these variables at present, my hypothesis is that psychologists typically will have more exposure to content required for the practice of DBT and consequently, may have more interest or confidence in using DBT.

An area for consideration that may be supported by the study suggested above (in the case that my hypothesis is correct) is how to increase the level of exposure to DBT among
master’s level clinicians (i.e., counselors and social workers). Increasing exposure at the master’s level is important because although some clients have the means to receive treatment through private practice, many individuals with BPD and other challenging mental health issues (including college students, who often lack the means to pay out of pocket for treatment) will be seen in community mental health centers that are mainly staffed by master’s level therapists. At present, there is only one social work training program (Colombia University, New York, NY) that offers an optional DBT training track with practicum experience for students. I am not aware of any such program that exists in counselor education. In contrast, doctoral level psychology students are often able to access in-depth training in DBT via their mentors or internships, although these students must purposefully seek out DBT training opportunities.

A final area that remains somewhat unclear is how to best contribute to social justice issues and the need for changing the narrative related to individuals with BPD. I address this issue here because while my qualitative research does advance this aim, I believe that ultimately it will require that we as counselor educators change the way we train our students. DBT training programs at the master’s level can communicate the importance of using evidence-based practices, especially when working with acute cases, and provide interested students with a valuable and highly marketable skill set. They can also support both the institutional community (by offering a DBT focused practicum experience in the college counseling center, thus reducing the burden the center must carry in training staff and providing DBT services), and the broader community (by graduating more students who are better equipped to effectively interact with and treat individuals with BPD and other complex mental health issues). The ultimate impact of working to change the way helping professionals view individuals with BPD remains to be seen.
Final Comment

It is important to note that at present, the field of DBT in college counseling centers has not evolved to the point where some of the aforementioned suggestions for research can realistically be investigated. However, I hope that I will have the opportunity to answer many of these questions over the course of my career. It may be that the end result of the studies suggested here is that DBT is truly not suitable for implementation in the average college counseling center or, that a more parsimonious treatment could be developed that would be better suited for this practice setting. In this case, while the result would be disappointing for me personally, it would be extremely valuable and important information in terms of addressing college student mental health needs. In the final analysis, one must accept that one’s goals cannot always be willed into reality. As such, it is very important that I never lose sight of the purpose for my goals related to DBT research and college counseling centers.

Throughout this dissertation, I have argued for the importance of rising to the challenge of treating students who present to their college counseling centers with suicidal and self-injurious behavior. I have argued that effective, evidence-based treatments such as DBT are sorely needed to assist young people who are suffering and that the implementation of DBT programs on college campuses may be suitable for addressing a variety of serious psychological issues with which college students present. These are very academically oriented arguments. On the other hand, it always gives me pause to think about the ways in which DBT programs might radically change the lives of the students who are in need of this treatment. I question what it will mean if just one life can be improved or spared; this is a more emotionally based way of thinking.
One of the first lessons in the DBT skills training mindfulness module (Linehan, 1993b, 2015) is the three states of mind: reasonable mind, emotion mind, and wise mind. I have spent years teaching my clients the following (paraphrased from Linehan, 1993b): “You cannot reason your way out of your emotions, nor can you create reason from your emotions, you must find the synthesis between the two; this synthesis represents a deeper way of knowing. Wise mind is knowing with your heart and with your head.” It is only fitting that my research would parallel this most fundamental lesson in the practice of DBT. While my work with quantitative methods appeals to my reasonable mind, my work with qualitative methods represents my emotional mind. It is only by bringing them together in a synthesis that they begin to inform one another and a deeper understanding is achieved.
REFERENCES


Appendix A: Copyright Permission

From: "Muller, Mary Ann" <MaryAnn.Muller@taylorandfrancis.com>
Subject: RE: Copyright permission
Date: February 9, 2016 at 3:53:02 PM EST
To: Carla Chugani <cchugani@mail.usf.edu>
Cc: Academic UK Non Rightslink <permissionrequest@tandf.co.uk>

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“This dissertation is derived in part from an article published in the Journal of College Student Psychotherapy on April 15, 2015, available online: http://www.tandfonline.com/doi/full/10.1080/87568225.2015.1008368.

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Appendix B: IRB Approval Letters

June 26, 2014

Carla Chugani
L-CACHE - Leadership, Counseling, Adult, Career & Higher Education
Tampa, FL 33612

RE: Expedited Approval for Initial Review
IRB#: Pro00017610
Title: Dialectical Behavior Therapy in College Counseling Centers: Current Trends and Barriers to Implementation

Study Approval Period: 6/26/2014 to 6/26/2015

Dear Ms. Chugani:

On 6/26/2014, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):

DBTBarriersIRBProtocol_Chugani_Revision.docx

Consent/Assent Document(s)*:
DBTImplementation_InformedConsent_Revision.docx (**granted a waiver)

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s). **Waivers are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review
category:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

John Schinka, Ph.D., Chairperson
USF Institutional Review Board
10/13/2014

Carla Chugani, M.A., LMHC
L-CACHE - Leadership, Counseling, Adult, Career & Higher Education
4202 E. Fowler Avenue
Tampa, FL 33620

RE: Full Board Approval for Initial Review
IRB#: Pro00017992
Title: Building a Life Worth Living:
       Recovery from Borderline Personality Disorder through Dialectical Behavior Therapy

Study Approval Period: 9/19/2014 to 9/19/2015

Dear Ms. Chugani:

On 9/19/2014, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
IRB_Chugani_QualProtocol.docx

Consent/Assent Document(s)*:
IRB_InformedConsent_QualStudy17992_Revision2_CleanCopy.docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.
We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John A. Schinka, Ph.D.

John Schinka, Ph.D., Chairperson
USF Institutional Review Board