

Commentary on A Short-Term Training Clinic Model for Dialectical Behavior Therapy (DBT) in Treating Borderline Personality Disorder (BPD): The Case of “Jane”

Finding a Dialectical Balance Between Process and Procedure

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ABSTRACT

The case of “Jane” (Marks, 2022) provides a detailed examination of the evidenced-based treatment, Dialectical Behavior Therapy (DBT), in the treatment of a woman with complex and multifaceted psychiatric difficulties by Michael Marks, an advanced doctoral student clinician in a DBT training clinic. Marks’ presentation provides an excellent example of the challenges clinicians face when treating patients with borderline personality disorder (BPD) and many of the common and multiple co-morbidities that frequently accompany the BPD diagnosis. While DBT is sometimes dismissed as a treatment that just teaches skills, Marks demonstrates the technical demands and nuances that therapists must use to correctly and effectively treat suicidality, emotion dysregulation, mood dependent behaviors, and significant interpersonal deficits that often have destructive and painful consequences. The three authors bring a variety of perspectives in commenting on Marks’ case study. The first is a psychologist who is a senior DBT therapist and the Program Director and Director of Training at an established adolescent DBT Continuum of Care Program; the second is an internationally active psychiatrist who is the Medical Director of the same Continuum of Care Program and a Behavioral Tech DBT Trainer; and the third is a post-doctoral psychology fellow working with the first two authors. A major theme in our discussion will be the challenge, when delivering DBT, of how to balance between technical interventions, on the one hand, and emotional experiencing, on the other. In exploring this theme, we will answer the questions, what was left out and what does it feel like?

Key words: Dialectical Behavioral Therapy (DBT); Borderline Personality Disorder (BPD); countertransference; technical demands on a therapist; emotional demands on a therapist; case study; clinical case study

*“MISSING PIECES DO MORE THAN COMPLETE THE PUZZLE,
THEY FILL IN AN EMPTY SPACE” -Luanne Rice*

INTRODUCTION

DBT is an evidenced-based treatment based on a principle-driven manual. What this means is that unlike protocol-driven treatments that support the therapist by prescribing the procedures in each session, DBT demands that the therapist understand the principles of the treatment and the skills taught in the manual in order to synthesize the two in such a way that the therapist delivers a treatment with the many interventions required to be adherent to the model. As if this wasn't enough, the therapist must pay attention to their own experience. It is a lot to keep in mind while treating suicidal and self-destructive patients.

The case of “Jane” (Marks, 2022) provides a detailed examination of the evidenced-based treatment, Dialectical Behavior Therapy (DBT), in the treatment of a woman with complex and multifaceted psychiatric difficulties by Michael Marks, an advanced doctoral student clinician in a DBT training clinic. As can be seen in the case study, Marks does an excellent job describing the roller coaster ride of this treatment while he skillfully implemented one technical intervention after another to address symptoms of mood reactivity, interpersonal reactivity, body dysmorphia, impulsivity, and self-loathing. We see his use of case conceptualization, validation, metaphor, after-hours skills coaching, chain analysis, review of diary cards, skills teaching, use of his consultation team, addressing his and his patient's therapy interfering behaviors (TIBs), irreverence, problem solving, acceptance and change strategies, and more. So, what could be missing?

One of the hardest things for new DBT therapists to do is figure out how to manage all the aspects of the treatment and then remember to pay attention to their own emotional experience. Our awareness and ability to regulate our own emotions can be one way that we can support and allow space for the patient's own emotional experiencing. For new DBT therapists, this is not an idea that readily comes to mind, especially in the midst of an intensely emotional patient experience. Some models of clinical training and supervision may not even teach or particularly emphasize therapist self-regulation as part of treatment, making it difficult to attend to and target when needed. While Marks beautifully describes his procedures and interventions, he tells us little about the tool of using his own emotional experience and how he uses it specifically in the treatment. We do get a brief glimpse of his experience through a short vignette asking his consultation team for validation when feeling burned out. However, as we read through the sessions we wondered if without using that tool more systematically, Marks had a more difficult time allowing for pauses in the therapy to support the patient's own emotional experiencing in the sessions. Since the emotional intensity of a DBT treatment can be very charged, and even for some intimidating, it can be easy to duck behind technical interventions without realizing it.

Dr. Marsha Linehan, the creator of DBT, often borrows a quote from James Audubon who says, “When the bird and the book disagree, always follow the bird.” While DBT gives us a phenomenal book to learn from, it is the use of our own experience as an intervention that takes longer to develop. To follow the “bird,” you must pay attention and open yourself up to your own emotions and briefly let go of the technical guide. Our hope is to discuss the challenges that DBT therapists face around using their own emotional experience as part of the therapeutic intervention.

THERAPIST EMOTIONAL EXPERIENCING WHEN TREATING BPD

Historically, long-term psychodynamic therapeutic work was seen as a process of meaning-making in which both the patient and the therapist represented their inner worlds in mental state terms and in this process, therapists needed to recognize their own internal experiences in relation to the external manifestations of their patient’s experience. There is a concept in traditional psychodynamic therapies known as *countertransference*, which is defined as a therapist’s reactions to a patient’s behavior. In psychodynamic theory, these therapist responses are considered to be out of their awareness, or unconscious, and are considered to be based on the therapist’s own psychological makeup and their past experiences. DBT practice does not consider countertransference in its model, and yet there is no question that DBT patient behaviors can elicit powerful reactions in the therapist, as all behaviors have consequences. One of the reasons we have a consultation team in DBT is to help validate and/or problem-solve when such reactions interfere with treatment. Being mindful of our own emotions and urges is a critical part of being an effective DBT therapist.

The research literature notes that therapist reactions are particularly notable when working with patients with borderline personality disorder (BPD). The late Harvard Professor and McLean Hospital psychiatrist Dr. John Gunderson, considered by many to be the person who defined BPD, used to say: “No other condition (than BPD) more frequently makes a therapist feel as if they have personally failed.” In the context of their own strong emotional reactions and fearing failure, any therapist may find themselves vacillating between two poles. At one extreme, the therapist is drawn into an over reliance on technical interventions and therapeutic jargon as a way to avoid their own emotional experience. At the other extreme, the therapist is drawn into becoming thoroughly engrossed in the treatment relationship, extending their efforts and feeling excessively responsible for their patient to the point that they become over-involved and even at times lured into violating their professional code of conduct. Understandably, therapists who may be still be in training or new to DBT may be particularly susceptible to this pattern of vacillation, and part of training is to be mindful of which extreme they may be leaning towards at any moment, and to recalibrate when effective.

DBT does not have a mechanism for specifically looking at these relational reactions in the way that psychodynamic therapies have. Although the idea of countertransference has its

roots in psychodynamic theory, it is now seen as a pan-theoretical construct, relevant across many conceptual orientations. The contemporary and expanded view of countertransference is one that includes a therapists conscious and unconscious reactions to a patient's actions, including sensory, affective, cognitive, and behavioral responses. Indeed, there is an emerging conversation in the literature about the role of countertransference and related constructs in different types of treatment for BPD, including DBT (Cambanis, 2012; Chapman, Turner & Dixon-Gordon, 2011; Ellis, Schwartz & Rufino, 2018; Liebman & Burnette, 2013).

Patients with borderline personality disorder have intense emotional reactions and intense and unstable relationships. When this intensity is directed at the therapist, the therapist can experience intense and complicated emotional reactions themselves. When asked about their work, therapists including DBT therapists have reported feeling: anxiety, guilt, rage, helplessness, worthlessness, rescue fantasies, and even terror, when working with patients with borderline personality disorder (Gabbard & Wilkinson, 2000). This is commonly described as the experience of “walking on eggshells” among therapists and can be one of the leading drivers of a therapist's treatment interfering behaviors (TIBs). It stands to reason that these kinds of emotional reactions can become therapeutically counterproductive, particularly when they are neither recognized nor explored. This is where the role of the consultation team is both critical and essential.

In an article about the emotional reactions of therapists to their patients with BPD, Bhola and Mehrotra (2021) found that one of the considerations about the magnitude of impact has to do with the level of therapist experience, that is, the less experience the therapist has the greater the emotional demands and challenges of working with patients with borderline personality disorder. It may seem obvious as to why a relative lack of experience could play a role in the negative reactions that trainees or early career practitioners experience. They often have had a limited exposure to patients with BPD; may have had incomplete training in BPD treatment; may not have full awareness of their own vulnerabilities and in this context have trouble managing their own anxiety; worry about their technical skills; and worry about how they are perceived by their colleagues. It is therefore not surprising that Bhola and Mehrotra empirically discovered that a therapists' accumulation of therapeutic experience over their career trajectory—and particularly seeing more patients with BPD—made the therapists less vulnerable to difficult countertransference reactions, which in turn made them more effective therapists. Interestingly, although much of the literature focuses on the negative reactions of therapists in treating BPD, Bhola and Mehrotra also found that there were many interactions that were positive and satisfying.

One way for DBT supervisors to address a therapist's emotional reactions to their patients is to ensure ongoing training, supervision, and consultation team participation, including encouraging trainees and early career practitioners to monitor and track their thoughts, feelings, and behaviors. These supervisory and didactic encounters are made more salient through two types of active modeling by the supervisor. First the supervisor can share their own reactions,

both non-judgmental and judgmental, and transparently elucidate the ways in which such reactions might arise in each of the four modes of DBT therapy: the individual psychotherapy, DBT Skills Training Groups, in-the-moment phone coaching, and DBT Consultation Teams for therapists. In addition, the supervisor can illustrate their own use of DBT practice and the consultation team, showing how their own personal feelings and reactions can be addressed. All of this is fundamental as a core tenet of DBT in that clinicians are also expected to practice the very DBT skills that they teach; most importantly, in order to build awareness of their moment-to-moment experience, and then to regulate their emotions, to tolerate distress, and to be effective in therapy.

I CAN IMAGINE WHAT IT FELT LIKE: REFLECTIONS FROM A DBT POST-DOC

As a recent DBT student therapist myself (J.W.T.), I was particularly impressed with Michael Marks' (2022) intentional and systematic approach to his treatment with Jane. His mindful implementation of change versus acceptance strategies showed his clear grasp of treatment skills and the effective "dance" of the dialectic between these two strategies. I also couldn't help but wonder how Michael, as a student therapist, was feeling throughout working with a very complex and at times very challenging patient. In the following paragraphs, I will extend beyond the technical steps described in Michael's case by highlighting common emotional experiences from DBT student trainees and by considering the potential impact of these experiences on Michael's work with Jane. My hope is that this commentary is ultimately validating for DBT student clinicians (and perhaps seasoned clinicians, too), and may prompt further discussion about DBT training in the consultation team, in supervision, and in research.

To begin, throughout the case I was reminded of the common emotions that many student clinicians experience when providing therapy while simultaneously being evaluated by a supervisor. As Michael describes, in addition to the DBT consultation team, as a training clinic, DBT-RU includes individual and group supervision by the clinic director and recording of individual sessions. Even with the most supportive of supervisors, it is natural to worry about our competencies, effectiveness, and perception by others. In Michael's work with Jane, there were several instances where I was curious what he was feeling, given this added layer of supervision/evaluation. For instance, towards the end of treatment, when Michael requested help with problem-solving Jane's increases in risk for suicide, he expressed

my feelings of frustration, inadequacy as a therapist, disappointment that we had "not accomplished anything," and stress about the limited time...left in treatment. I became noticeably emotional (p. 59).

While not stated outright, I wonder if being a relatively new DBT therapist and a student played into his feelings of inadequacy. Furthermore, if his anxiety was at least in part a result of his trainee role, did that impact how he discussed the case in supervision or in consultation team? Most trainees would have the urge to prove that they are skilled and competent in treatment

delivery. This is an important consideration in clinical training broadly, but particularly interesting in DBT given that one of the DBT assumptions is that everyone, including clinicians, are doing their best, *and* they can do better. There is also the assumption that we are all fallible and make mistakes. DBT assumptions that require one to be reminded of one's fallibility and that they can do better, while ultimately helpful, can be a challenging shift in mindset for student clinicians.

In Michael's case, it would be interesting to know how his feelings of anxiety and frustration, not only for Jane's safety and treatment goals, but also for evaluation and judgments from others in supervisory roles influenced his clinical decisions and his relationship with Jane. For instance, in the hour-long phone coaching call between session 8 and 9, Michael described trying to "convince" Jane to engage in interpersonal effectiveness skills, and that he "was overly focused on resolving the crisis" because of his care for Jane (p. 52). Michael didn't comment on his emotions following the phone call, but I wonder how he felt going into the next session with Jane. I could imagine feeling burnt out after an hour long coaching call, frustrated that she did not follow through on the plan, worried about interpretations about his own effectiveness from his supervisor, all contributing to further feelings of anxiety, anger, and inadequacy as a therapist.

Similarly, I wonder about the emotions that factored into Michael's decision to schedule a telehealth session while Michael was away on a family vacation. Certainly, every therapist has their own limits, and holding a session while on vacation may make sense in some situations. At the same time, I know that as a student clinician, there is often worry about being a "good" therapist, student, and colleague who is always available. As with the hour-long phone coaching call, it would be curious to know how Michael felt when agreeing to this particular session and the session following his vacation. Did this contribute to burnout and frustration with the case? If so, was it discussed in supervision or consultation team? If not, why not?

Furthermore, throughout the course of treatment, Michael worked with Jane to target effective emotional expression, which ultimately played a key role in her progress in treatment. Interestingly, as treatment progressed, Michael also appeared to express more of his emotions as well, at least as described in his retrospective case study. For a myriad of reasons—such as clinical experience, beliefs about what it means to be professional, therapeutic orientation, cultural norms, and rapport with the patient—emotional expression can be challenging and may not come naturally. However, as one becomes more comfortable and confident in their role as a therapist, emotional expression often becomes easier. It is also consistent with DBT's use of radical genuineness (level 6 validation) as a therapeutic tool, which encourages the therapist to be their authentic selves, including having emotional reactions as any human does. It makes sense that following session 19, Michael's sharing of his frustration and anxiety about Jane's treatment progress in the consultation team led to his team helping him with validation and problem-solving, which in turn increased Michael's emotional expression in-session with Jane.

Specifically, he self-disclosed about how Jane’s behaviors made him feel, both to Jane directly, and in self-reflection. For example, in the case study he wrote:

I shared that I was feeling pulled to do so [to challenge her thoughts] (p. 60). ...

[To Jane I said,] “I’ve always felt [like I am kept] at an arms distance from you” (p. 64). ...

“I felt frustrated since Jane had now missed three of four ...groups (p. 65) ...

My heart sank p .66).

It would be illuminating to know if Jane noticed more emotional expression and self-disclosures from Michael, if she felt more validated, and if this helped to model effective emotional expression for her to learn and apply in her own life. As a reader, these sorts of descriptions certainly helped me better understand the therapeutic relationship between Michael and Jane and shed more light on the rationale for the specific clinical decisions made.

As we work as a field to increase dissemination and implementation of DBT, a natural (and I believe, positive) consequence is that more trainees and young clinicians have the opportunity to learn and provide this treatment through growing DBT-specific practicum opportunities and fellowships. It is worthwhile to consider how to most effectively support this new generation of DBT providers, who may be providing DBT as their first clinical experience. For example, as a consultation team member, are there specific ways we can model incorporation of validation and problem-solving strategies for our fellow team members who are trainees? For the supervisor, can it become routine to discuss how the supervisor-supervisee relationship may affect treatment? For my fellow trainees, what may be most helpful for us and our patients is to practice mindfulness of our own emotions, and practice “opposite action” to anxiety or shame. And for researchers, there is value in empirically evaluating DBT training. Indeed, some studies have found promising clinical outcomes in DBT training clinics (Kerr, Muehlenkamp, & Larsen, 2009; Rizvi et al., 2017), including at DBT-RU, where results were similar to that of large randomized controlled trials (Rizvi et al., 2017). As highlighted in Michael’s case study of “Jane,” in addition to outcomes and treatment adherence, future directions may include evaluation of the therapeutic relationship, process, and qualitative experience of DBT student therapists and trainees.

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