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## Feasibility of a Peer Support Oriented Dialectical Behavior Therapy Skills Training Massive Open Online Course for Emotion Dysregulation

Rachel Gill  
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Feasibility of a Peer Support Oriented Dialectical Behavior Therapy Skills Training Massive

Open Online Course for Emotion Dysregulation

Rachel Gill

Linfield College

December 1, 2015

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Feasibility of a Peer Support Oriented Dialectical Behavior Therapy Skills Training Massive Open Online Course for Emotion Dysregulation

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### Abstract

Public interest in mental health care modernization has steadily gained momentum since ratifying *The United States Health Care Affordability Act*. ([U.S. Office of the Legislative Counsel, 2010](#)) Furthermore, with 1 in every 1000 people seeking online support for mental health issues, ([DeAndrea & Anthony, 2013](#)) research concerning the development of virtual mental health applications is critical to ensure science guides their innovation. To this end, this study explores the feasibility of a mental health intervention that unites the experiential, recovery-oriented, and self-determined values of mental health peer support ([Kaufman, et al, 2014](#)) with dialectical behavior therapy skills training (DBT-ST) ([Linehan, 1993b](#)) ([Linehan, 2014a](#)) ([Linehan, 2014b](#)), in a massive open online course (MOOC) format to create an adjunct, no-cost, DBT-ST resource for people with emotional difficulties. People stagnating on program waitlists, lacking access to comprehensive DBT, who want to brush up on prior DBT-ST, or who are simply curious and want to learn more about DBT-ST are most likely to benefit from this novel intervention. The pilot DBT-ST MOOC offers a robust user interface, ([See Appendix A for details.](#)) which increases flexibility in time and space and costs little to nothing compared to traditional brick and mortar learning environments. ([Hu, 2013](#)) The DBT-ST program teaches all four skill sets prescribed in standard DBT: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills, respectively ([Figure 1](#)) while presenting an introduction to the rapidly growing field of DBT oriented internet applications.

*Keywords:* dialectical behavior therapy, emotion regulation, peer support, massive open online course

Feasibility of a Peer Support Oriented Dialectical Behavior Therapy Skills Training Massive  
Open Online Course for Emotion Dysregulation

Dialectical behavior therapy skills training (DBT-ST) is a psychoeducational group component that, along with several other treatment components, defines the evidence-based standard of DBT. Initially developed to treat suicidal persons, particularly those with borderline personality disorder (BPD), DBT, delivered in its complete form, is a multi-faceted treatment that includes weekly, hour-long individual therapy sessions; one-on-one crisis phone coaching with on-call therapists; and weekly team consultation meetings (for therapists). These treatment features are all in addition to clients attending weekly DBT-ST groups, which is the sole component of DBT focused upon in this study. In traditional face-to-face DBT-ST groups, participation requires 2.5-hour long sessions that teach a variety of skills in four modules and which clients typically complete in 27 weeks. ([Linehan, 1993a](#)) ([Linehan, 1993b](#)) The overall goal of this study was to utilize communication and information technology to deliver a self-paced, recovery-oriented mode of DBT-ST to supplement overextended standard DBT programs and those with low or no income and/or health insurance.

Fidelity to DBT principles and presenting the entire scope of skills took precedent over fitting specific diagnostic populations, and with respect to adapting DBT-ST to the internet, the goal was not necessarily to create an alternative to standard DBT-ST but to enhance its functionality and offset some of the problems associated with accessibility. This fundamental dilemma of supply, demand, and socioeconomic strife is what made the MOOC model so appealing, it is an asynchronous learning environment that is removed from the restrictive qualities of time and space. As such, the DBT-ST MOOC likewise functions with minimal administrative oversight, relying instead upon static methods of teaching like YouTube videos and automated



methods of self-enrollment, quizzing, and giving participants the responsibility of overseeing peer support by encouraging them to maintain a compassionate, non-judgmental stance toward themselves and others in the course of group dialogues that are facilitated via the DBT-ST MOOC discussion forums.

### **Research Rationale**

DBT is arguably one of the most comprehensive and well-researched psychotherapies to date. Its evidence base includes over 60 published controlled, uncontrolled, and replicated studies. ([Linehan, et al, 2013](#)) However, the bulk of DBT research refers to comprehensive, face-to-face implementations. Comprehensive DBT as laid out in the definitive clinical manual ([Linehan, 1993a](#)) without doubt describes the gold standard of the treatment. However, with internet-based mental health applications (which were not feasible modes of delivery at DBT's conception) emerging at an exponential rate, ([Barak & Grohol, 2011](#)) DBT-ST continuing to prove its usefulness with populations who may not necessarily need the level of treatment intensity standard DBT entails, ([Wilks & Linehan, 2015](#)) and DBT research showing that DBT-ST may be a feasible stand-alone treatment for people with emotion regulation difficulties, ([Neacsiu, 2014](#)) research examining novel, internet-based DBT interventions, must be conducted in order to encourage evidence-based methods in their development and to ensure they produce equally favorable outcomes.

Therefore, in addition to promoting testing of mental health, web-based applications, the primary concerns driving this study include A) the high costs and low accessibility currently associated with standard DBT in particular and psychotherapy in general, B) the emergence of certified mental health peer support specialists (PSS) as supportive members on standard DBT teams. While as a treatment modality, this role has yet to be tested, the fact that therapists and clients

generally view the (PSS) role favorably, they may be less prone to burn out than therapists, ([Cawood, 2011](#)) and they represent a lower cost, easier to train, and therefore, easier to supply workforce, which appeals to insurance agencies, providers, and clients alike, the PSS not only appears to be a worthy addition to treatment teams, their growth and presence within the mental health system at large is inevitable. C) Mental health stigma, a tradition entrenched in American culture, ([Hinshaw, 2007](#)) is an important factor to consider in the research and development of mental health interventions because attitudes may dramatically affect people's willingness to learn and apply methods that refer specifically to stigmatized labels. For example, the stigma of homosexuality likely posed a barrier to expanding acquired immune deficiency syndrome (AIDS) research and prevented people from getting tested in its early phases because people did not want to be subject to the myriad of social consequences that exist for persons associated with behaviors labeled deviant.

From these primary concerns, the following trajectories evolved. A) Develop a no-cost, supplemental solution to standard DBT-ST for internet savvy individuals experiencing accessibility problems or wishing to increase learning. B) Create the DBT-ST program as an *adjunct* feature of standard DBT with peer mentors managing the program as observers and modelers of skills. C) Brand the DBT-ST program as being for emotion dysregulation to broaden its applicability and appeal to persons who might otherwise be put off by terms such as borderline personality disorder, depression, suicidal, etc.

Furthermore, by using diagnostically neutral terms the DBT-ST MOOC intentionally orients toward a biosocial understanding of dysfunctional behavior, which asserts that the cause of emotion dysregulation is a progressively escalating transaction of problematic responses occurring between a person's biologically-based emotion sensitivity and an invalidating rearing

environment, that is an environment which does not appropriately teach and/or acknowledge an emotionally sensitive child's need for additional support<sup>1</sup>.

This emphasis upon diagnostically neutral terms further challenges predominant sociopolitical views which explain the causes and nature of mental disorders mostly in narrow terms of *mental illness*. Whereas, this study proposes a more holistic model of dysfunctional behavior. In other words, traditional mental health treatments target a specific mental disorder, this program targets emotion dysregulation, a psychological quality thought to be a vulnerability precluding difficult-to-manage mental disorders of emotion regulation. ([Linehan, et al, 2007](#)) As such, the research orientation proposes that many problematic behaviors people want to change have roots in emotion dysregulation and do not necessarily demand explanation in terms of mental disorder diagnoses.

Likewise, with respect to clinical nomenclature, a recent study assessing the effects the diagnostic label borderline personality disorder (BPD) had upon therapist's optimistic or pessimistic beliefs and predictions regarding client outcomes recommends that, "efforts should be made to de-stigmatize diagnostic terms." ([Salkovskis & Hogg, 2015](#)) Apparently, when therapists associated a client with the BPD label, their beliefs and predictions were notably more pessimistic, demonstrating how language can critically affect treatment delivery. The implied effect on treatment outcomes presents a significant obstacle to the advancement of clinical psychology. Therefore, by mindfully branding treatment programs to be stigma aware, mental health language shifts toward describing extreme, emotionally-based behaviors as complex biosocial

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<sup>1</sup> Concerning the biosocial model for emotion dysregulation, just as a child with dyslexia needs additional teaching support to learn to read, so do emotionally sensitive children need additional emotional support to ensure healthy social/behavioral development. Without such support, just as the dyslexic child may not learn to read and/or may begin to think of himself as incompetent or incapable, so may the emotionally sensitive child develop problematic coping behaviors like rumination, social/professional withdrawal, drug/alcohol abuse, self-harm, binge-eating, restricting food intake, etc. and think she is mentally ill, damaged, socially inferior or otherwise unfixable. Untreated, otherwise preventable problematic behavior patterns may further regress into dysfunctional behaviors that eventually lead to mental disorder diagnoses.

processes that apply to all people rather than the current mental health model that views extreme, emotionally-based behaviors mostly as discrete phenomena applying only to those labeled *mentally ill*.

Marsha Linehan goes further in criticizing the language of mental health to challenge the medical implications of the widely used term, *mental illness* itself. In her definitive book, that outlines DBT, she explains. “In particular, many convey an idea that the individual's disordered behavior is caused by a ‘mental illness’ from which the individual must recover before real changes can be made. DBT is not based on a mental illness conception” ... “if it did accept one, it would suggest that making real changes is likely to cure it rather than vice versa.” ([Linehan, 1993a, p. 267](#)) In short, an illness model requires a person to change before healing may occur; whereas, DBT claims it is change itself that is the healer. As such, the medicine (in this case DBT skills) is not a concoction administered by an external force, (like pharmaceuticals) but a function of social learning that convalesces dysfunctional behaviors by learning and applying skills *in vivo*. Moreover, because the term *mental illness* implies a historically stigmatizing image of mental disorders, adopting behavioral perspectives formed outside of antiquated, medicalized nomenclature and cultural contexts that judge and/or devalue emotional expression and experience may inspire new perspectives that likewise lead to innovations in mental health.

The focus on functional mechanisms of distress over an illness model does not either exclude those bearing specific diagnostic labels because emotion dysregulation is apparently associated with about 85% of the mental disorders listed in the *Diagnostic Statistical Manual of Mental Disorders*<sup>2</sup> (DSM) ([Neacsiu, 2012](#)). As such, rather than attending to tedious DSM criteria

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<sup>2</sup> Now in its fifth edition, The DSM is the United States standard licensed mental health professionals use to diagnose *mental illness* for determination of potential treatments and health insurance reimbursement purposes. It has always been and continues to be a controversial gauge in the field of clinical psychology because of its lack of biological underpinnings and empirical measures for assessing diagnostic criteria.

that would narrow the proposed study's applicable treatment population and necessitate further clarification and imposed limitations, emotion dysregulation is the most reasonable variable to examine because it defines a general psychological quality that applies in some degree to most individuals experiencing emotional problems previously expressed exclusively in terms of symptomology.

In addition, because internet-based mental health interventions represent a relatively new field of study, the findings herein may not only be relevant to behavioral health, but also to web-based social researchers in general. In practice, social scientists, for the most part, appear to be embracing internet technology at a far slower rate than the public at large. ([Van Horn, et al, 2008](#)) This is surprising considering the apparent benefits to conducting online research, which, at first glance, appear to outweigh its apparent risks.

Lastly, there is promising evidence that web-based didactic strategies may be effective in the context of DBT. One recent study testing virtual learning environments for training therapists in DBT found that not only was it feasible to utilize online learning environments to attend to DBT training, data reflected higher participant satisfaction and increased knowledge in the web-based context compared to traditional in-person training contexts. ([Dimeff, et al, 2009](#)) Another study testing the feasibility of teaching DBT-ST through video was also promising ([Waltz, et al, 2009](#)).

In summary, the following research is relevant because it broadens DBT-ST's applicable population scope, helps redefine psychological treatments in terms of emotional function rather than focusing on specific illnesses or DSM labels, adds to the DBT evidence base and provides critical science to the rapidly growing and mostly uncharted fields of web-based and peer-delivered mental health applications.

## Methods

There was a 6-week dialectical behavior therapy skills training (DBT-ST) curriculum developed that utilized [youtube.com](https://www.youtube.com), a social media platform centered around video and [coursesites.com](https://www.coursesites.com), a free and robust MOOC platform powered by [blackboard.com](https://www.blackboard.com). The study design is a randomized controlled trial that uses a pretest–posttest, repeated measure applied to both an experimental and waitlist control group. (Barker, et al, 2002) Measures were taken immediately before and after the course of the experimental condition.

The randomization procedure consisted of alternating assignment of participants to each of the study conditions according to the order of receipt informed consents were returned. Upon such receipt and assignment, screened participations received a formal email invitation to participate in the study with a link to a customized, web-based, difficulties in emotion regulation scale (DERS) google form. All participants received a user ID to anonymize their form data. Those in the experimental group, additionally, received a pre-assigned password<sup>3</sup>. The DBT-ST MOOC login page URL is at [https://www.coursesites.com/s/\\_DBT0001](https://www.coursesites.com/s/_DBT0001)<sup>4</sup> the program curriculum consisted of a variety of learning materials including [integrated YouTube skills training videos](#)<sup>5</sup> peer discussion forums, and multiple-choice quizzes. Participants received the opportunity to learn all skills presented in standard DBT. However, this study focused on a 6-week timeline,

Peer mentors are persons who manage the experimental DBT-ST MOOC and who have gained a degree of DBT skills mastery through a combination of personal experience and focused training delivered by the primary researcher. The purpose for recruiting peer mentors to oversee

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<sup>3</sup> Those in the experimental condition needed passwords to log into the experimental DBT-ST MOOC. Those in the waitlist control condition only needed a user ID to submit the DERS anonymously.

<sup>4</sup> A public version of the pilot program is accessible online at [https://www.coursesites.com/webapps/Bb-sites-course-creation-BBLEARN/courseHomepage.htmlx?course\\_id=400442\\_1](https://www.coursesites.com/webapps/Bb-sites-course-creation-BBLEARN/courseHomepage.htmlx?course_id=400442_1)

<sup>5</sup> Chronological playlist of Youtube videos used in DBT-ST MOOC is at [http://www.youtube.com/playlist?list=PLb51Q732nMqeTJp05TQsE3YkCCY6p6\\_FS](http://www.youtube.com/playlist?list=PLb51Q732nMqeTJp05TQsE3YkCCY6p6_FS)

peer participant discussion forums is to reduce the risk of observer bias, which may weaken the validity of the research. ([Shaughnessy, et al, 2012](#)) As such, the primary researcher did not act as a peer mentor per se, having had no direct interaction with participants in the experimental condition, but acted as a peer mentor *trainer*. Within the DBT-ST MOOC, peer mentors operated mostly as observers who refrained from providing explicit direction to peer participants. Mainly, they used their skillful means to synthesize balance in discussion forums and if necessary redirect where there was a need to regain focus and/or re-orient ineffective communication. They also meant to provide a model of mindful participation within group discussions, and, generally, encouraged a middle path approach.

Peer mentors are not professionally qualified or certified mental health peer-support specialists, but self-identified mental health sufferers in recovery and who have learned DBT skills from a mixture of formal and informal trainings received from external sources prior to their engaging in the study. Peer participants are people who participate in either the experimental DBT-ST MOOC or the waitlist control group. Peer mentors assigned to the DBT-ST MOOC are mostly observers who may moderate user interactions when necessary.

The responsibility of training was the primary researcher's, Peer mentors were prepared over several months prior to the study in the course of co-managing an informal DBT skills support group on Facebook (See <https://www.facebook.com/groups/dbtskills/>) Training consisted of weekly, 2-hour, DBT-oriented consultation team meetings held online via chat. (See [Appendix B for consultation team agreements](#).) Meetings consisted of attending to problem behaviors according to the DBT hierarchy<sup>6</sup>. Therefore, the focus was upon strengthening one's own use of skills to increase

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<sup>6</sup> In DBT, a hierarchy, which outlines problem behavior targets, provides therapists a triage guide for managing sessions. First, suicidal and self-harming behaviors must be discussed/solved, then therapy interfering behaviors, quality of life interfering behaviors comprise the third level of targets, and the fourth and final level includes behaviors that inhibit self-respect, fulfillment, connectedness, purpose, etc.

adherence to DBT principles, prevent burnout, managing frustration, and non-dialectical thinking, sharing recovery stories, etc.

To provide further specification, *peer support oriented* refers to more than just the peer mentors. It also refers to the fact that the primary researcher whom developed the experimental program is also a person in recovery from borderline personality disorder and major depressive disorder, is an Oregon certified mental health peer support specialist, and has six years of experience as a DBT client in a comprehensive DBT standard program. What is more, peer support also refers to the research participants themselves, who necessarily provide each other peer-support through focused interactions in the DBT-ST MOOC.

### **Setting for Contact**

The study design utilizes innovations in web technology to orient an experimental DBT-ST MOOC to a virtual learning environment making it available and accessible to anyone with internet access. The pilot program as a whole initially aimed to fit within a 12-week timeline. However, due to study related time restrictions, the recommended completion timeline shortened from 12 to 6 weeks. Since the course is self-directed, those enrolled in the DBT-ST MOOC were aware that they might complete their learning as fast or slow as they chose, but for the purposes of meeting the timelines involved in completing this study, participants were encouraged to follow the recommended 6 week schedule.

The study took place entirely online through a closed web-based virtual learning environment hosted by <https://www.coursesites.com>. Peer participants logged into the site at [https://www.coursesites.com/s/\\_DBT0001](https://www.coursesites.com/s/_DBT0001) where they accessed all DBT-ST MOOC learning materials. The primary researcher pre-registered peer participants in the DBT-ST MOOC system, assigning each peer participant a numerical research ID. This served as the username that peer



participants used to log in. Peers had the option to attend to lessons at their convenience since they had access to the program twenty-four hours a day, seven days a week provided they had a connection to the internet. Each session, as prescribed for participants, ideally corresponds to one-week's worth of DBT-ST homework.

### **DBT-ST MOOC Structure**

The primary interest in the program's feasibility as a DBT-ST resource transpires from the perspective of its massive open online course (MOOC) utility. The six weekly DBT-ST sessions each contain written instructions, mindfulness tasks, training videos, ([See Appendix C for skills training video list.](#)) discussion forums, and multiple-choice quizzes. Videos mean to introduce skills; homework/discussions to reinforce skills application and increase comprehension, and quizzes to help retention of knowledge, as well as, highlight skills training areas needing further attention. The critical elements considered in program design are asynchronous learning, self-determination, low to no-cost DBT-ST, easy access, and, of course, aligning curriculum materials so that they emphasize fidelity to the DBT-ST model more than they prescribe a new mode of treatment.

Please note that peer-delivered service, is not a treatment variable designated for the purpose of this study. Rather, peer support serves mostly to provide a specific orientation to the experimental DBT-ST model. Considering DBT as the primary framework, peer support as an orientation comes from DBT's biosocial theory that views *dysfunctional behavior* as a transactional process synthesized by the individual interacting with the environment. In this case, the biosocial theory applies in the reverse. Meaning, *peer support* is a transactional process synthesized by the individual interacting with the environment, to produce functional behavior.

As such, unlike other mental health care relationships which impose an imbalanced relational

dynamic e.g., doctor and patient, therapist and client, etc., the peer support relationship depends upon a relationship that is dialectical by its nature, that is, it reinforces equality, self-disclosure, and mutual commitment within the natural framework of the peer support relationship because there is no pre-conceived relational imbalance imposed by role assignment. Therefore, this study proposes that peer support is a unique form of communication that exemplifies DBT's 6<sup>th</sup> level in the 6 levels of validation, *radical genuineness*, and that occurs between persons with similar lived experiences in the course of determining to improve one's mental health through daily practice of DBT skills and community cultivated through compassionate, non-judgmental acceptance. In this study, particularly, peer support takes place between participants in the course of focused discussion forums.

Discussion forums are a virtual space within the DBT-ST MOOC where participants respond to DBT-ST question prompts and engage in discussion with others. Everyone was required to post a minimum of one response to the discussion topic and at least one supportive, non-judgmental reply to a peer. By this process, peers were more responsible for ensuring peer-delivered support than peer mentors whose primary role was to observe group functions with minimal intervention. In short, a peer mentor's purpose was not to provide explicit coaching or skills training, but to use skillful means to provide a counterbalance for naturally occurring tensions, when needed, amongst peers in the course of learning, growing, and communicating. Additionally, since the primary researcher is also the curriculum developer, to further limit opportunity for observer bias, the primary researcher refrained from engaging in DBT-ST discussions and limited interactions with peer participants to questions related to working in the learning environment, technology and network connection issues, and other user interface problems. All DBT-ST related questions redirected to the recruited peer mentors.

### **DBT-ST MOOC 6-Week Schedule Overview**

**Week 1: Orientation to DBT Skills Training**

- Biosocial Model for Emotion Dysregulation, Wise Mind & TIP Crisis Survival Skills
- SMART Goals: Specific, Meaningful, Achievable, Recordable, Time-line Based
- VITALS to Success Skills: Validate Urges, Imagine, Take Small Steps, Applaud Yourself, Lighten Your Load, Sweeten the Pot
- DBT 6 Levels of Validation

**SESSION TASKS:**

1. Watch the Biosocial Model, Wise Mind & TIP Skills Training Video
2. Participate in Discussion 1a: Wise Mind
3. Complete the Biosocial Model & Wise Mind Quiz
4. Watch the SMART Goals & VITALS To Success Skills Training Video
5. Complete DBT Skills Training Discussion 1b: My SMART Goal
6. Complete the SMART Goals & VITALS to Success Quiz
7. Watch the DBT 6 Levels of Validation Training Video Discussion 1a: Mindfulness Skills

**INSTRUCTIONS:** Please post numbered responses to the following questions and one supportive, nonjudgmental response to a peer to receive full credit for the discussion

1. What are some body sensations you experience when you are in angry and in emotion mind?
2. What are some body sensations you experience when you are in anxious in emotion mind?
3. Describe a moment this week when you noticed being in wise mind?
4. In your own words, define dialectical thinking. Discussion 1b: My Smart Goal

**INSTRUCTIONS:** Now that you have learned about SMART goals, please answer the following questions. Please number your responses according to the prompts and post at least one

supportive, nonjudgmental response to a peer.

1. What goals do you want to accomplish with DBT skills?
2. Which goal is your priority?
3. What is a step to achieving this goal that you can do today?
4. What could get in the way of achieving your goal?
5. What can you do to make sure things do not get in the way of you achieving your goal?

### **Week 2: Mindfulness Skills**

- Mindfulness Skills: Observe, Describe, Participate, One-mindfully, Non-judgmentally, Effectively
- Reality Acceptance Skills: Radical Acceptance, Turn the Mind, Willingness, Loving Kindness

#### SESSION TASKS:

1. Watch the Core Mindfulness Skills Training Video
2. Complete DBT Skills Training Discussion 2a - Mindfulness Skills Review
3. Watch the Reality Acceptance Skills Training Video
4. Complete DBT Skills Training Discussion 2b- Loving Kindness
5. Complete the Mindfulness & Reality Acceptance Skills Quiz

#### Discussion 2a: Mindfulness Skills

INSTRUCTIONS: Now that you have learned about mindfulness skills, please answer the following questions and post at least one supportive, nonjudgmental response to a peer

1. What is mindfulness?
2. How do you practice mindfulness?
3. How often did you practice mindfully observing, describing, or participating this week?

4. What are your thoughts and feelings about the mindfulness practices you learned this session?

#### Discussion 2b: Loving Kindness

INSTRUCTIONS: After doing the loving kindness task, answer the following reflection questions. Please remember to number your responses accordingly and post at least one supportive, nonjudgmental response to a peer

1. What was your distress level on a scale from 1-100 before loving-kindness practice?
2. What was your distress level on a scale from 1-100 after loving-kindness practice?
3. What did you find or not find helpful about practicing loving kindness?
4. Will you practice loving-kindness again and if so how often?

#### Loving Kindness Task

Loving-kindness is a reality acceptance skill that we use to acknowledge reality while cultivating unconditional compassion. In practicing loving-kindness, we consciously and intentionally send warm wishes to ourselves and/or others using a personal chant, script, or dialogue that we say aloud or internally as we practice quiet mindful breathing. Practicing loving-kindness requires us to be in wise mind. As we focus on the target of our well wishes, we let go of judgments, expectations, and desires.

In the following mindfulness exercise, we will start with loving-kindness by sending it to ourselves. Once you become to feel more comfortable using the skill, you can add others to your loving kindness practice. The key is to start with people that you believe it will be easy to send well wishes to and work your way up to those that it may be harder to send well wishes. In addition, if you find it too difficult to start with yourself, you may begin with a pet, your child, or anyone else that your wise mind suggests.

*Before you start, on a scale from 1-100, please rate your distress level*

Preparing to Practice Loving Kindness

1. Get seated in a comfortable position with your feet planted flat on the floor
2. Place your right hand over your heart with the palm open, pressed gently on your chest
3. Find a single place to focus your gaze, usually looking forward and slightly downward
4. Take a few deep, slow, steady breaths in and out through your nose
5. Focus on your breath to bring you into wise mind.

Loving Kindness Script

NOTE: writing your own script is also an option and encouraged if you want to personalize your loving kindness practice to be more meaningful to your own DBT path or your spiritual/religious orientation. INSTRUCTIONS: Say the following script aloud or to yourself quietly as you breathe deeply and mindfully for 3-5 minutes or as long as your wind mind suggests.

*May I be happy - May I be healthy - May I have peace May I be loved - May I know kindness - May I love and be kind to myself*

After you finish, on a scale from 1-100, please rate your distress level

### **Week 3: Distress Tolerance Skills**

- STOP Skills: Stop, Take a Step Back, Observe the Situation, Proceed Effectively
- ACCEPTS Skills: Activities, Contributing, Comparisons, Emotion Opposites, Pushing Away, Thoughts, Sensations
- IMPROVE Skills: Imagery, Meaning, Prayer, Relaxation, One Thing at a Time, Vacation, Encouragement

SESSION TASKS:

1. Watch Distress Tolerance STOP Skills Training Video
2. Watch the Distress Tolerance ACCEPTS IMPROVE Skills Training Video
3. Complete DBT Skills Training Discussion 3: My Self-soothe Kit
4. Complete the STOP ACCEPTS IMPROVE Distress Tolerance Skills Quiz

#### Discussion 3: My Self-Soothe Kit

INSTRUCTIONS: Now that you have learned about Distress tolerance skills, please complete the self-soothe kit task below and answer the following questions. Number your responses accordingly and post at least one supportive, nonjudgmental response to a peer

1. What items did you put in your self-soothe kit?
2. What thoughts and feelings came up as you created your self-soothe kit?
3. What were you doing or what was happening when you decided to use your self-soothe kit?
4. What adjustments will you make (if any) to make your self-soothe kit more useful and/or easier to access when you need it the most?

#### Make a Self-Soothe Kit

Find a small basket, purse, box, etc. and within it place at least one soothing item per sense (sight, sound, Taste, Touch, and Smell). Keep it in a convenient place where you can quickly get to it in a crisis. Use your self-soothe kit whenever you feel emotionally dysregulated

#### **Week 4: Emotion Regulation Skills Introduction, Check the Facts & Opposite Action**

- Identify, Label and Functions of Emotions
- Check the Facts of Emotional Responses
- Opposite Action to Emotion Urges

#### SESSION TASKS

1. Watch Introduction to Emotion Regulation Skills Training Video

2. Complete DBT Skills Training Discussion 4: Emotion Regulation Introduction
  3. Watch Check the Facts of Emotional Responses Training Video
  4. Watch Opposite Action to Emotion Urges Training Video
  5. Complete the Introduction to Emotion Regulation, Check the Facts & Opposite Action Quiz
- Discussion 4: Introduction to Emotion Regulation

INSTRUCTIONS: Now that you are familiar with the basic concepts associated with emotion regulation skills, please answer the following questions. Please number your responses according to the prompts and post at least one supportive, nonjudgmental response to a peer

1. Why is it important to pay attention to emotions even if we do not like them?
2. Why is it important to identify and name the emotion we experience at any given time and especially while in distress?
3. What do you think the benefits of learning to love your emotions might be?
4. How can you practice loving your emotions today?

#### **Week 5: Emotion Regulation Problem Solving, Behavior Analysis & ABC PLEASE**

- Problem Solving Emotions & Behavior Chain Analysis
- ABC Skills: Accumulate Positive Experiences, Build Mastery, Cope Ahead
- PLEASE Skills: Treat Physical Illness, Eat Balanced Meals, Avoid Drugs, Sleep Balanced, Exercise

#### SESSION TASKS

1. Watch ABC PLEASE Emotion Regulation Skills Training Video=
2. Complete DBT Skills Training Discussion 5: Pleasant Activities
3. Watch the Behavior Chain Analysis Training Video
4. Complete the Problem Behavior Chain Analysis Assignment



5. Complete the Problem Solving, ABC PLEASE Skills

Quiz Discussion 5: My Pleasant Activities

INSTRUCTIONS: Now that you have learned ABC PLEASE Skills, please answer the following questions and number your responses accordingly. Post at least one supportive non-judgmental post to a peer.

1. What are the reasons DBT recommends committing to a pleasant activity a day?
2. What Pleasant Activities did you do this week?
3. How did doing the activity affect your mood after doing it?
4. What may get in the way of you committing to at least one pleasant activity a day?
5. What can you do to make sure that you do at least one pleasant activity a day?

### **Week 6: Interpersonal Effectiveness Skills**

- ✓ DEAR MAN Skills: Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate,
- ✓ GIVE FAST Skills: Gentle, Interested, Validate, Easy manner, Fair, No Apologies, Stick to Values, Truthfulness

SESSION TASKS:

1. Mindfulness Practice: Notice Judgments About Words
2. Watch the Interpersonal Effectiveness Skills Training Video
3. Complete the DBT Skills Training Discussion 6: My DBT Empowerment Plan
4. Complete the Interpersonal Effectiveness Skills

Quiz Discussion 6: My Peer Empowerment Plan

INSTRUCTIONS: Read through the following embedded handout and answer the following questions to help you build a clear DBT path for continuing daily skills practice after you

complete skills training. Read each item carefully and fill in your corresponding information. Number your answers accordingly and post at least one supportive, nonjudgmental response to a peer

## QUESTIONS

1. How will I build community connectedness once I finish DBT skills training?
2. What will I do to remind myself to practice skills daily?
3. What are signs that I am becoming emotionally dysregulated?
4. What can I do to help soothe myself when I become overwhelmed with distress?
5. What are the signs that I am at skills breakdown point?
6. Whom can I contact for emergency support when I reach skills breakdown point?
7. How will I cope ahead of time for emotional events?
8. What can I do daily to help reduce my emotional vulnerability?

## Measures

To determine the experimental DBT-MOOC's feasibility, the primary tool of measure employed was the *Difficulties in Emotion Regulation Scale* (DERS) (Gratz & Roemer, 2004) (See [Appendix D](#) for an image of the [DERS Google Form](#) created for web-based collection.). The DERS is a 36-item, self-reported survey that utilizes a 5-point Likert scale ranging from *almost never* to *almost always*. Before starting and at the completion of DBT-ST, participants from both the experimental and waitlist control groups filled out the DERS. Pre-test measures determined a baseline and post-test measures provided insight into DERS improvement. A control group accounted for potential shifts in emotion regulation that may occur naturally in the absence of DBT-ST. Therefore, in this study, the DERS applies to 2 groups (experimental and waitlist control) measured at 2 different intervals (prior to DBT-ST and after 6 weeks.) Scoring methods included

a DERS grand total that breaks down further into 6 subscales which each represent a scope of difficulties in emotion regulation, including non-acceptance, goals, impulsivity, awareness, strategies, and clarity. (Figure 2) Greater scores indicate greater difficulties with emotion regulation. The DERS grand total ranges from as low as 36 to as high as 180. Subscale scores range from as low as 5 to as high as 40 depending upon the scale.

Statistical analysis consisted of ANOVA single factor analysis on each of the 4 conditions measured. That is, pre-test measures for both the experimental group (group A,  $n=14$ ) and the waitlist control group (group B,  $n=14$ ) and post-test measures for both groups. The average pre-test DERS totals for both groups were then comparatively matched to each respective group's post-test DERS scores to determine feasibility. A reduced DERS average indicates overall reduced difficulties with emotion regulation within a group and vice versa.

### **Participant Selection**

The primary researcher created an automated waitlist form for persons interested in participating in the experimental DBT-ST MOOC. The digitally managed interest form provided basic contact info and demographic data that synchronized in real-time to a cloud-based spreadsheet. Distribution of the live form was through embedding and standard linking in various social networking sites, particularly those organized around mental health recovery and peer support. Exclusion criteria included all prospective participants who expressed recent suicidal thoughts/actions and/or who reported having no access to an individual therapist on a regular basis. The resultant sample consisted of persons over the age of 18 with variable experience in DBT-ST, mental health statuses, and receiving any variety of treatments while participating in the study. Approximately 30 percent of the participants identified as men (9 of 28) and the remainder as women.

Those who signed up on the interest form were not participants and contact did not commence until after a) receiving confirmation that the IRB approved the proposal b) individuals received a formal invitation to participate in the study, c) thorough review and a digital signature acknowledging informed consent form returned via email.

Furthermore, those who received a formal invitation to participate in the study were English speaking and had consistent access to and experience in communicating through the internet. Such persons also self-reported as having problems with emotion regulation, expressed interest in DBT self-help and/or peer support resources, had adjunct therapist support, and did not admit to suicide ideation, urges, or action. Nearly 300 people signed up on the web-based interest waitlist. After screening and collecting informed consent, the sample was  $N=28$ . Research participants assigned to the wait-list control group  $n=14$  were measured at the similar intervals of time as those assigned to the experimental condition  $n=14$ .

### **Data Collection**

Upon receiving a signed informed consent and assigning participants to either the experimental or waitlist condition, gathering of pre-test DERS data commenced. 3 email notices sent over the course of 1 week provided participants with an anonymized google form link for the DERS. Participants used their assigned usernames to record their data, as well as, indicated whether they were providing data pre or post-test. All information submitted immediately and stored on a web-based google spreadsheet via the primary researchers private google drive. This procedure was repeated a second time beginning approximately 1 week prior to the closing date for the experimental group. Participants were allowed 1 week past the closing date for the experimental condition to submit their post-test data. Participants who returned their post-test data in a timely fashion (within 7 days) received a free digital copy of the primary researcher's

unpublished DBT skills training workbook titled *DBT Peer Connections Dialectical Behavior Therapy Skills Training Workbook*.

All participants for both study conditions completed the pre-test measure within 5 days of each other. For those within the experimental condition, additional data, including forum posts, homework assignments, quizzes, and weekly DBT skills diary cards collected also. However, for the purpose of this study, only the DERS pre and post-test data for both groups was subject to analysis. On the first day of the last week of the study, all participants received individualized emails to remind them that the study would be closing and to fill out the post-test measure at the end of the week. Upon the final day of the study, a second round of reminder via email provided participants with the live link to the DERS post-test survey. The web-based DERS remained open for one week after the DBT-ST MOOC to allow for final submission of post-test data. Upon closing the DERS form, the raw spreadsheet data imported into Microsoft Excel for statistical analysis.

### **Risks & Safeguards**

Persons were informed that their participation may cause added emotional distress while doing homework or interacting with peer participants via group discussions. Therefore, along with the informed consent packet, participants received 2 pages of contacts for various crisis resources. Those in the experimental group also learned T.I.P crisis skills (Temperature, Intense physical sensations, and paced breathing) in their first training session to help offset potential distress.

Furthermore, during the informed consent process, there was emphasis on participants' right to discontinue participation at any point without consequence or need for explanation. A licensed psychologist and DBT expert, whom advised the research was also available for brief consultation in the event participants experienced a crisis and to ensure the study curriculum

adhered to DBT principles. Additionally, peer mentors experienced with online DBT peer support moderated forum discussions. Finally, excluded from the study were those who expressed suicidal actions, urges and whom admitted not having adjunct therapist support. As such, to counteract added risk of emotional distress participants were subject to, safeguards consisted of a list of contact information and crisis resources for all participants, critical distress tolerance skills training in the first DBT-ST MOOC session for those in the experimental group, added DBT-specific clinical oversight for the entire study, and requisite, adjunct therapist support for those in the experimental group.

### Results

To review, the study hypothesis postulated that participants in the experimental DBT-ST program would show an overall reduced score in difficulties in emotion regulation compared those in the control group. The sample was  $N=28$ . The experimental group was  $n=14$  and the waitlist control group was  $n=14$ . Upon analysis, the overall findings suggest that peer support oriented DBT-ST MOOC is a feasible mode of delivery. DERS score totals could range between a minimum of 36 and a maximum of 180. The six subscales that comprise the DERS total include the *non-accept subscale* with a minimum score of 6 and a maximum score of 30, the *goals subscale* with a minimum score of 5 and a maximum score of 25, the *impulsivity subscale* with a minimum score of 6 and a maximum score of 30, the *awareness subscale* with a minimum score of 6 and a maximum score of 30, the *strategies subscale* with a minimum score of 8 and a maximum score of 40, and finally, the *clarity subscale* with a minimum score of 5 and a maximum score of 25.

The average DERS pre-test total for the experimental condition (Group A) was 152. The *non-accept* pre-test average for the experimental condition was 22, *goals* average score was 20,

*impulsivity* was 19, *awareness* was 19, *strategies* was 29, and the average score for *clarity* was 15.

([Table 1](#)) pre-test

The average DERS pre-test total for the waitlist control group (Group B) was an average of 161. The no-accept pre-test average for the waitlist control condition was 24, *goals* was 22, *impulsivity* was 21, *awareness* was 19, *strategies* was 31, and clarity score was 16. ([Table 2](#)) This means the waitlist control group had an overall average DERS total that was 9 points higher than the experimental group. This could be to elevated distress related to being assigned to the waitlist control, which prevented immediate access to the DBT-ST MOOC. However, this is purely speculation. All subscales from the experimental condition were on the average less than the subscale scores of the waitlist control with the exception of the awareness scale in which both group's pre-test average score was 19.

The average DERS total post-test score for the experimental condition (Group A) was 137. The subscale average scores for each of the six subscales were, non-accept=18, goals=17, impulsivity=16, awareness=14, strategies=22, and clarity=12. ([Table 3](#)). The average DERS post-test total for the waitlist control condition was 155 with the 6 subscale average scores as follows: non-accept=22, goals=21, impulsivity=19, awareness=17, strategies=29, and clarity=15. ([Table 4](#)) As such, both the experimental and waitlist control groups showed a reduction in average DERS scores when comparing pre-test to post-test data. However, the experimental group showed a modestly greater reduction in DERS scores compared to the waitlist control group. Specifically, there is a 15-point reduction in the average DERS total for the experimental group and a 6-point reduction in the average DERS total for the waitlist control group. Thus, implying that the DBT-ST MOOC is a feasible mode of DBT-ST delivery.

### Discussion

The fact that the experimental group's average DERS score showed a greater reduction compared to the waitlist control group suggests that the DBT-ST MOOC is a feasible *adjunct* DBT-ST method. However, because these reductions are modest, it is unlikely that such reductions are comparable to standard face-to-face DBT-ST groups. However modest the findings may be with respect to the DBT-ST MOOC's feasibility, considerable insight into web-based social research was gained.

The most notable benefits to web-based approaches appear to be the ability to recruit, with relative ease and speed, large numbers of research participants that represent a targeted population sample; the ability to automate the gathering, organizing, analyzing and visual output of large amounts of data; the ability to collaborate with fellow researchers across the globe and streamline communications; and finally the ability to disseminate research exponentially thanks to the advent of digital publishing.

Despite these apparently impressive benefits to web-based, scientific inquiry, there are also notable risks to consider. Currently, the most critical problems with social research in internet environments appear to be a reduced ability to protect the privacy of research participants' information, less ability to confirm the source or quality of gathered data, and reduced accessibility to social research topics concerning populations that do not have internet access or necessary computer skills.

While, at present, the previously mentioned risks remain obstacles to ethics, validity, and reliability, there is little doubt future researchers will develop innovative solutions that will open wide the possibilities for the advancing field of internet-based social science. Furthermore, social researchers with particular skills in or collaboratively working with colleagues specializing in



software development will be critical to innovating such solutions. Most notably, future research poses the possibility of capturing statistically powered samples. The promise of strengthening research validity by accessing more diverse and a greater number of participants through the internet are significant. Therefore, in addition to assessing the feasibility of a novel, web-based DBT intervention, the study as a whole likewise provides an introduction to online methods for conducting social and behavioral experiments.

### **Study Limitations**

There are several factors to consider in assessing the limitations to this study. Most notably, is the small sample size. A larger sample would be needed for the study to be statistically powered. This brings us to the discussion concerning participant inclusion/exclusion criteria. Over one-third of the initial participants considered for this study could not participate due to self-harming/suicidal thoughts, urges, or behaviors. Particularly, it was considerably difficult attempting to gain approval to work with potentially suicidal persons from the overseeing institutional review board (IRB). The IRB requested exclusion of suicidal persons to approve the study. While, on the surface, this appears to be reasonable, perhaps, even necessary for the protection of participants, a recent podcast hosted by DBT expert Linda Dimeff, suggested, in reference to the issue of long waitlists for DBT and an experimental pre-commitment group, that it is better for people in crisis to have some support than none at all. ([Dimeff & Koerner, 2015](#)) However, the reluctance to include suicidal persons in studies appears to be consistent across the field of psychotherapeutic research. ([Lakeman & FitzGerald, 2009](#)) With the continued growing public concern calling for evidence-based methods to aid in the prevention and resolution of self-harming and suicidal behaviors, institutional review boards and researchers/clinicians need to look closer to understand what is reinforcing the reluctance to work with self-harming/suicidal persons. Is the trend due to the need

to protect participants or due to a stigma-based fear of working with suicidal people?

Protection of participants is certainly important and, yet, there seems to be an overpowering assumption that not supporting suicidal people at all is less harmful than providing experimental support. Furthermore, “the paucity of studies and risk aversive exclusion criteria for research on suicidality create an odd situation in medical practice in which few empirical studies are conducted to investigate treatments for conditions or disorders with fatal outcomes.” ([Fisher, et al, 2002](#)) It may be that fear and anxiety at the thought of working with self-harming/suicidal persons could be just as if not more important to participant exclusion trends. Whatever the details may amount to, it seems the nature, and causes of this reluctance appear to have culturally laden implications. However, this is purely speculation that needs to be more thorough scrutinized by future research.

As it stands, current methods seem to present a significant limitation to all psychotherapy research, generally. Particularly, trends in IRB policies and federal and state laws that limit use of human subjects based on deviant behaviors associated with self-harm and suicide need critical assessment at an infrastructural level before reasonable consideration to the development of treatments targeting suicide can gain momentum. Otherwise, the trend of excluding research participants based on expressed suicidal and/or self-harming behaviors will likely continue to limit opportunities for researchers, participants, as well as the scope of suicide related research. Finally, and, perhaps, most significantly, current participant screening trends may negatively reinforce the historical taboo regarding disclosure and discussion of suicidal/self-harming behaviors that is prominent in Western European oriented cultures.

### **Conclusions and Future Study**

The present study demonstrates that dialectical behavior therapy skills training provided in

an online; peer support oriented environment is a feasible approach to DBT-ST. Furthermore, it presents several advantages, particularly as an adjunct, cost-effective, behavioral health care support. To build upon research findings, future studies implementing DBT-ST as a stand-alone treatment should utilize weekly DBT skills diary cards ([See Appendix E for a DBT diary card example](#)) in addition to measures like the difficulties in emotion regulation scale to assess whether increased use of skills may correlate with reduced emotional difficulties and to examine treatment efficacy and/or outcomes. Furthermore, peer support and DBT-ST oriented research will benefit from comparative studies that examine how and what effects different web-based contexts may have upon peer support dynamics and DBT-ST outcomes. Certainly, the need for research in the area of web-based, DBT-ST shall grow. As such, studies assessing and comparing multiple modes of online DBT programs with comprehensive DBT may be the most revealing as to their applicability, the potential benefits, and the consequences they may present.

To illustrate the multiple, web-based modes concept, an informal DBT-ST support group on Facebook likely poses different risks and benefits than a small weekly skills training group that utilizes webcams and webinar oriented software to communicate. For example, since most people are on Facebook these days, users may be more likely to participate and engage in Facebook oriented peer support groups. On the other hand, since Facebook groups do not have many administration features like forums, blogs, group chat, integrated webinar and document organization tools, facilitating an adherent DBT-ST group, with weekly meetings, that include teaching new skills, completing homework and review in live discussions, is not necessarily feasible.

In the case of using learning management systems (LMS) like [coursesites.com](#), they offer a wealth of administration tools that complement the structured nature of proper DBT-ST, however,

it seems that users have variable ability to utilize or willingness to learn to use LMS interfaces. Furthermore, because the MOOC format is an online learning environment constructed to maximize public accessibility to learning with minimum oversight, important relational dynamics that occur in comprehensive, face-to-face DBT-ST groups may lose or diminish in large online group contexts.

In conclusion, DBT-ST, as a stand-alone treatment continues to show promising results with populations exhibiting difficulties with emotion regulation. However, as a web-based solution, it remains, at best, a supplement to comprehensive DBT. Furthermore, there is no evidence supporting DBT-ST alone is a feasible alternative to comprehensive DBT for those with severely dysfunctional behavior or co-morbid diagnoses. The burgeoning field of web-based mental health, however, provides an interesting route for solving current problems with DBT accessibility that may become more reasonable as research emerges and findings lead to more fine-tuned and compelling applications.

## References

- Barak, A., & Grohol, J. M. (2011). Current and future trends in Internet-supported mental health interventions. *Journal Of Technology In Human Services, 29(3), 155-196*.  
doi:10.1080/15228835.2011.616939
- Barker, C., Pistrang, N., & Elliott, R. (2002). Research methods in clinical psychology: an introduction for students and practitioners, second edition. *John Wiley & Sons, Ltd.* West Sussex, England.
- Cawood, C. Moving to the other side of the desk: An examination of the practice of including peer support specialists as treatment providers within the dialectical behavior therapy paradigm. (2011). *Eastern Michigan University Master's Theses and Doctoral Dissertations DigitalCommons@EMU*. Paper 467. <http://commons.emich.edu/theses>
- DeAndrea, D. C., & Anthony, J. C. (2013). Online peer support for mental health problems in the United States: 2004–2010. *Psychological Medicine, 43*, pp 2277-2288. Doi: 10.1017/S0033291713000172.
- Dimeff, L. & Koerner, K. (2015). *Just how important are DBT skills? 1-hour DBT skills Q&A and research updates* [.mp3] Retrieved from Practice Ground at <https://app.box.com/s/9ejdckysg3bnryg2e3uodrckukjd9loz>
- Dimeff, L., Koerner, K., Woodcock, E. A., Beadnell, B., Brown, M.Z., Skutch, J.M., Paves, A.P., Bazinet, A., & Harned, M.S. (2009). Which training method works best? A randomized controlled trial comparing three methods of training clinicians in dialectical behavior therapy skills. *Behaviour Research and Therapy*. Vol.47 (11), pp.921-930.
- Fisher, C. B., Pearson, J. L., Kim, S., & Reynolds, C. F. (2002). Ethical Issues in including Suicidal Individuals in Clinical Research. *IRB: Ethics and Human Research, 24 (5), 9– 14*.

<http://doi.org/10.2307/3563804>

- Gratz, K. L. & Roemer, E., (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of psychology and behavioral assessment*. Vol. 26 no. (Doctoral dissertation). University of Massachusetts Boston, Boston, MA.
- Hinshaw, S. P. (2007). *The mark of shame: Stigma of mental illness and an agenda for change*. Oxford University Press. Oxford, UK.
- Hu, H. MOOC migration: massive open online courses are changing the way we think about higher education. *Diverse Issues in Higher Education* 28 March 2013. *Academic OneFile*.
- Kaufman, L., Brooks, W., Bellinger, J., Steinley-Bumgarner, M., & Stevens-Manser, S. (2014). Peer specialist training and certification programs: A national overview. *Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin*.
- Lakeman, R., & FitzGerald, M. (2009). The ethics of suicide research: The views of ethics committee members. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 30(1), 13-19. doi:10.1027/0227-5910.30.1.13
- Linehan, M.M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press, NY.
- Linehan, M. M., Bohus, M., & Lynch, T. R. (2007). Dialectical Behavior Therapy for Pervasive Emotion Dysregulation: Theoretical and Practical Underpinnings. In J. J. Gross, J. J. Gross (Eds.), *Handbook of emotion regulation* (pp. 581-605). New York, NY, US: Guilford Press.
- Linehan, M.M. (1993b). *Skills training manual for treating borderline personality disorder*. Guilford Press, NY.

- Linehan, M.M., Dimeff, L., Koerner, K., Miga, E.M. (2013). Research on dialectical behavior therapy: Summary of the data to date. *Behavioral Tech, LLC*, WA.
- Linehan, M. M. (2014a). Client handouts and worksheets for dbt skills training. *Guilford Press*, NY.
- Linehan, M. M. (2014b). DBT skills training manual second edition. *Guilford Press*, NY.
- Neacsiu, A.D. (2012) A treatment mechanism for emotion dysregulation across mood and anxiety disorders. (Doctoral dissertation). Retrieved from [worldcat.org](http://worldcat.org). *University of Washington*. Seattle, Washington. 8 November 2014.
- Neacsiu, A.D., Eberle, J., Kramer, R., Wiesmann, T., Linehan, M.M. (2014). Dialectical behavior therapy skills for transdiagnostic emotion dysregulation: a pilot randomized controlled trial, *Behaviour Research and Therapy*. doi: 10.1016/j.brat.2014.05.00
- Salkovskis, P. and Hogg, L., (2015). An experimental investigation of the impact of personality disorder diagnosis on clinicians: can we see past the borderline? *British Association for Behavioural and Cognitive Psychotherapies*. DOI: <http://dx.doi.org/10.1017/S1352465815000351>
- Shaughnessy, J. J., Zechmeister, E. B., & Zechmeister, J. S. (2012). Research methods in psychology (Ninth ed.). New York, NY: McGraw-Hill.
- United States Office of the Legislative Counsel. (2010) *Compilation of patient protection and affordable care act*. U.S. House of Representatives. <http://housedocs.house.gov/energycommerce/ppacacon.pdf>
- Valentine, S.E., Bankoff, S.M., Poulin, R.M., Reidler, E.B., Pantalone, D.W. (2015) The use of dialectical behavior therapy skills training as stand-alone treatment: A systematic review of the treatment outcome literature. *Journal of Clinical Psychology*. 10.1002/jclp.22114. <http://onlinelibrary.wiley.com/doi/10.1002/jclp.22114/pdf>

VanHorn, P. S., Green, K. E., & Monica Martinussen. (2008) Survey response rates and survey administration in counseling and clinical psychology: A meta-analysis. *Educational and Psychological Measurement*. 69: 389-403. doi: 10.1177/0013164408324462

Waltz, J., Dimeff, L. A., Koerner, K., Linehan, M. M., Taylor, L., & Miller, C. (2009). Feasibility of using video to teach a dialectical behavior therapy skill to clients with borderline personality disorder. *Cognitive and Behavioral Practice*, 16, 2, 214-222

Wilks, C., Linehan, M. (2015). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy Vol. 69, No. 2, 97-110*



## Tables

Table 1  
Group A Pre-test

SUMMARY					
<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>	
DERS TOTAL (36-180)	14	2134	152.42857	579.03297	
Nonaccept Score (6-30)	14	308	22	60.769231	
Goals (5-25)	14	274	19.571429	15.494505	
Impulse Score (6-30)	14	268	19.142857	32.747253	
Awareness Score (6-30)	14	272	19.428571	32.725275	
Strategies (8-40)	14	400	28.571429	66.10989	
Clarity (5-25)	14	210	15	21.230769	
1st assement or 2nd assement?	14	14	1	0	

ANOVA						
<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	228014.29	7	32573.469	322.46574	1.732E-67	2.098871
Within Groups	10505.429	104	101.01374			
Total	238519.71	111				

Table 2  
Group B Pretest

SUMMARY					
<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>	
DERS TOTAL (36-180)	14	2259	161.35714	121.47802	
Nonaccept Score (6-30)	14	330	23.571429	38.417582	
Goals (5-25)	14	307	21.928571	9.3021978	
Impulse Score (6-30)	14	291	20.785714	19.104396	
Awareness Score (6-30)	14	263	18.785714	30.027473	
Strategies (8-40)	14	435	31.071429	17.148352	
Clarity (5-25)	14	228	16.285714	12.681319	
1st assement or 2nd assement?	14	14	1	0	

ANOVA						
<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	255176.35	7	36453.764	1175.1728	6.346E-96	2.098871
Within Groups	3226.0714	104	31.019918			
Total	258402.42	111				

Table 3  
Group A Post-test

SUMMARY					
<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>	
DERS TOTAL (36-180)	14	1915	136.78571	704.64286	
Nonaccept Score (6-30)	14	246	17.571429	44.879121	
Goals (5-25)	14	244	17.428571	32.10989	
Impulse Score (6-30)	14	222	15.857143	48.593407	
Awareness Score (6-30)	14	202	14.428571	29.956044	
Strategies (8-40)	14	311	22.214286	78.950549	
Clarity (5-25)	14	169	12.071429	12.994505	
1st or 2nd assessment?	14	28	2	0	

ANOVA						
<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	186534.63	7	26647.805	223.90141	1.054E-59	2.098871
Within Groups	12377.643	104	119.0158			
Total	198912.28	111				

Table 4  
Group B Post-test

SUMMARY					
<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>	
DERS TOTAL (36-180)	14	2172	155.14286	256.43956	
Nonaccept Score (6-30)	14	314	22.428571	26.417582	
Goals (5-25)	14	289	20.642857	10.554945	
Impulse Score (6-30)	14	260	18.571429	35.956044	
Awareness Score (6-30)	14	239	17.071429	18.225275	
Strategies (8-40)	14	412	29.428571	36.10989	
Clarity (5-25)	14	209	14.928571	8.3791209	
1st assement or 2nd assement?	14	28	2	0	

ANOVA						
<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	236777.85	7	33825.407	690.16932	4.126E-84	2.098871
Within Groups	5097.0714	104	49.010302			
Total	241874.92	111				

Figures

Figure 1. DBT Skills. This figure illustrates the four-module array of skills taught in dialectical behavior therapy group skills training

**Dialectical Behavior Therapy Life Enhancement Skills At A Glance**

<p><b>Skills Training AAA Model</b></p> <p>Awareness Acceptance Action</p> <p><b>Core Mindfulness Skills</b></p> <p><b>What Skills    How Skills</b> Observe    One-mindfully Describe    Effectively Participate    Non-judgmentally</p> <p><b>Reality Acceptance Skills</b> <b>Pain + Non-acceptance = Suffering</b></p> <ul style="list-style-type: none"> <li>• Radical Acceptance</li> <li>• Turn the Mind</li> <li>• Practice Willingness</li> <li>• Notice Willfulness</li> <li>• Loving Kindness</li> </ul>	<p><b>Create SMART Goals</b></p> <p>Specific Meaningful Achievable Recordable Timeline plan</p> <p><b>VITALS to Success</b></p> <p>Validate Imagine Take small steps Applaud yourself Lighten your load Sweeten the pot</p>	<p><b>4 options 4 problems</b></p> <ol style="list-style-type: none"> <li>1 Tolerate the problem</li> <li>2 Change your beliefs</li> <li>3 Solve the problem</li> <li>4 Stay miserable</li> </ol> <p><b>Behavior Analysis</b></p> <ol style="list-style-type: none"> <li>1. Name the behavior</li> <li>2. Prompting event</li> <li>3. Rate intensity Level</li> <li>4. Note duration</li> <li>5. List vulnerabilities</li> <li>6. Behavior links: actions, body sensations, thoughts, events, feelings</li> <li>7. Short term positive effects</li> <li>8. Long term negative effects</li> <li>9. Replace problematic links with skills</li> <li>10. Apply skills until you find what works for you</li> </ol>
<p><b>Distress Tolerance Skills</b></p> <p>Temperature Intense physical sensations Paced breathing Paired Muscle Relaxation</p> <p>Stop what you are doing Take some deep breaths Observe the situation Proceed effectively</p> <p>Activities Contributing Comparisons Emotion opposites Pushing away Thoughts Self-soothe with the senses</p> <p>Imagery Meaning Prayer Relaxation One thing at a time Vacation Encouragement</p>	<p><b>Emotion Regulation Goals</b></p> <ul style="list-style-type: none"> <li>• Identify, label, understand emotions</li> <li>• Decrease unwanted emotion responses</li> <li>• Decrease emotional vulnerability</li> </ul> <p><b>Emotion Regulation Skills</b></p> <ul style="list-style-type: none"> <li>• Identify, label, functions of emotions</li> <li>• Mindful to emotions</li> <li>• Check the facts of emotion responses</li> <li>• Behavior chain analysis</li> <li>• Problem solving</li> <li>• Pros and cons</li> <li>• Opposite action to emotion urges</li> <li>• Respecting emotions</li> <li>• Managing extreme emotions</li> </ul> <p>Accumulate positive emotions Build skills mastery Cope ahead for emotional events</p> <p>treat Physical iLness Eat balanced meals Avoid drug use Sleep balanced Exercise regularly</p>	<p><b>Interpersonal Effectiveness Skills</b></p> <p>Describe Express Assert Reinforce</p> <p>Mindful Appear confident Negotiate</p> <p>Gentle Interested Validate Easy manner</p> <p>Fair Apology free Stick to values Truthfulness</p>

*Figure 2* DERS Scoring Key. This image depicts the scoring scheme for the Difficulties in Emotion Regulation Scale

**DERS Scoring Key:**

Greater scores indicate greater difficulties in emotion regulation

***DERS 6 Subscale Totals:***

**6-30 NONACCEPT:** tendency to judge, deny, invalidate emotional experience: 11, 12, 21, 23, 25, 29

**5-25 GOALS:** Tendency to engage in goal-directed behavior 13, 18, 20R, 26, 33

**6-30 IMPULSE:** Impulsive patterns of coping by engaging in problem behaviors 3, 14, 19, 24R, 27, 32

**6-30 AWARENESS:** Observe, label & describe emotional experience 2R, 6R, 8R, 10R, 17R, 34R

**8-40 STRATEGIES:** Limited access to emotion regulation strategies 15, 16, 22R, 28, 30, 31, 35, 36

**5-25 CLARITY:** Lack of emotional clarity 1R, 4, 5, 7R, 9

***DERS Grand Total:***

**36 -180** (Sum of all 6 subscales)



Appendix A

# Coursesites.com: Get The Most Powerful Tools For Your Classroom

## Interactive, Free Online Learning Platform

CourseSites is a free, hosted online course creation and facilitation service that empowers individual K–12 teachers, college and university instructors and community educators to add a web-based component to their courses, or even host an entire course on the Internet. You even choose your own URL, so students can find your page easily.

## Engage Your Students Anywhere, Anytime

Imagine having your own interactive elearning platform, that allows you to post and update course material, interact with students, promote collaboration, as well as assess and improve performance -- anytime, anywhere, 24/7. All the online teaching tools you need in one place!

## Powered By Blackboard's Latest Technology

CourseSites is powered by the latest and greatest technology from Blackboard, including Blackboard Learn™, Release 9.1, Blackboard Collaborate™, Blackboard Mobile™, and Blackboard Connect™.

Want the tools to engage and assess learners—at no cost? Click on ["Get Started"](#) to learn how to build your course website today.

Still have questions?  
[Read the FAQ »](#)

**Quick Setup Guide**

1. Set Up Your Course
2. Choose a Course Structure
  - Existing Menu
    - By Subject
    - By Topic
    - By Unit
    - Science-Focused**
    - Traditional
    - Focus on Systems
  - ANGEL

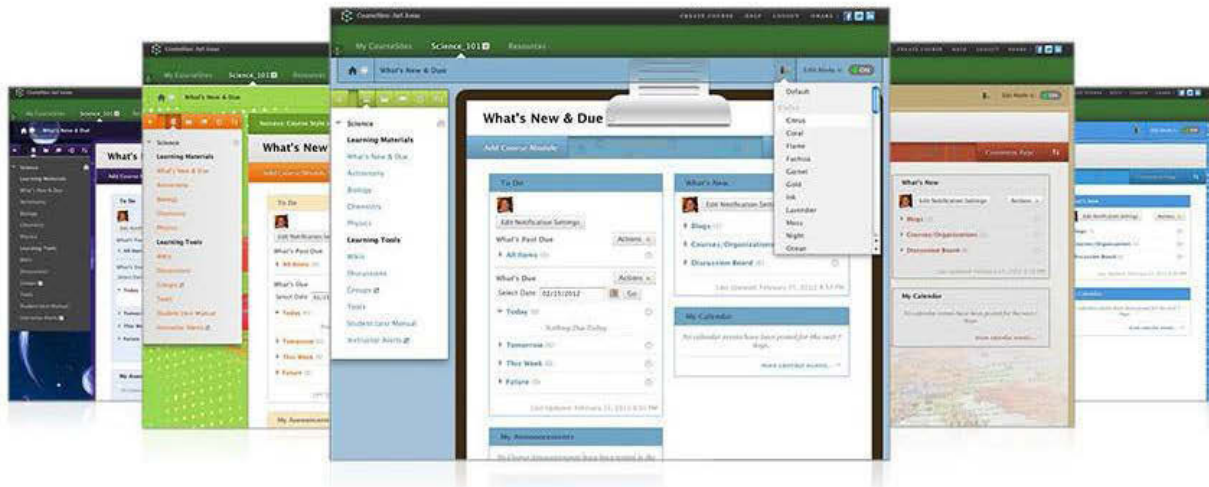
**Science-Focused**

The Units area organizes your s project, or lecture, encouraging Students can record their ideas Journal, discuss their findings i Lab Wiki.

[Learn more about course struct](#)

**Course Structures**

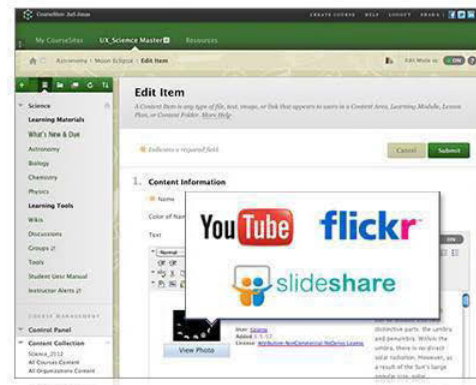
See how quick it is to set up courses and how to get a jump-start with a structure that supports your primary teaching method, such as lecture, guided discussion, or social learning.



Course Themes  
 Choose a course style that matches your subject matter or mood.



**Open Educational Resources (OER)**  
With CourseSites, you now have the ability to publish and share your courses as OER under a Creative Commons Attribution license (CC BY).



**Mash-ups**  
Engage learners with multi-media! Mash-ups integrate Web 2.0 resources from youtube.com, slideshare.com and flickr.com. The YouTube player has built-in accessible controls.

[Back to top](#) ↑



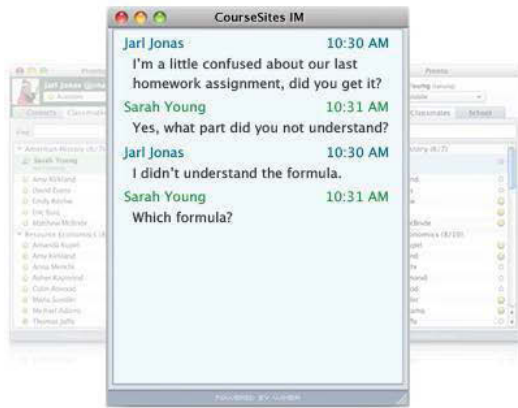
**Wikis**  
Promote active collaboration around course content and group projects, as well as support social learning with course wikis.



**Tests and Quizzes**  
Create tests and quizzes quicker and easier. With powerful search functionality, you'll be able to link to questions for quick and easy updates.



**Grade Center**  
Centrally and efficiently manage your grading using in-line grading forms and rubrics, as well as smart filters which help you view only those activities that need to be graded.



**Instant Messaging**  
 Connect with your students instantly through the instant messaging solution designed for education while enriching collaboration amongst students.

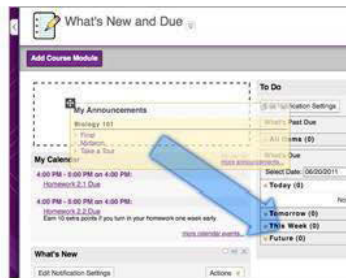


**Live Classroom**  
 Collaborate with students in a live, online classroom featuring text chat, two-way audio, video, interactive whiteboard, application and desktop sharing and breakout rooms.

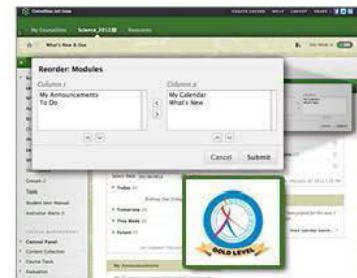
[Back to top](#) ↑



**Mobile Learning**  
 Blackboard Mobile Learn enables interactive teaching and learning on the go. Now students and teachers can access their courses, content and communities on CourseSites from a variety of devices, including iOS™, Android™, Palm@ webOS™ and BlackBerry®.



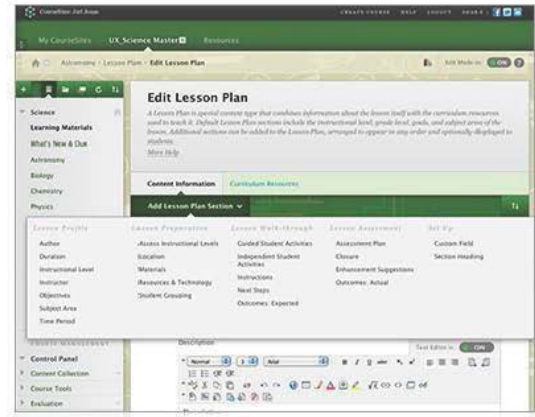
**Web 2.0 User Experience**  
 A modern and intuitive design enables instructors and students to easily navigate the system, and provides opportunities to personalize the user experience through drag and drop technology.



**Accessibility**  
 Ensure that your CourseSites are accessible to all students with a platform that has been Gold Level certified by the National Federation of the Blind for Non-Visual Accessibility.



**Central Course File Management**  
Efficiently manage course files and simplify content updates with everything in one place.

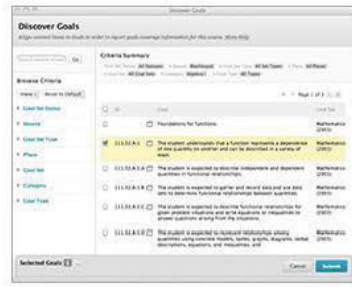


**Lesson Plans**  
Build personalized and integrated Lesson Plans that align to K-12 state standards.

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**Learning Modules**  
Present content with a Table of Contents to better guide students through a structured learning experience.



**K-12 State Standards Alignment**  
Use K-12 State Standards Alignment and coverage reports to deliver standards-based instruction.



**Instructor Homepage**  
Create your own webpage, with a personalized public URL, so students and guests can quickly access your courses, links, and blog posts.



## Appendix B

# DBT Peer Mentor Consultation Team Agreements

from <<https://dbt-lbc.org/index.php?page=101147>>

## 1. Orientation and Commitment

Being a member of a DBT CT means assuming certain responsibilities, agreeing to interact in particular ways, and accepting certain foundational assumptions about one's self as a DBT peer mentor, as well as peers, and consultation teammates. An orientation and commitment process helps new members understand these expectations in advance so that they can make an informed choice about team participation.

## 2. Behavioral Agreements

Members agree to do the following:

- remain compassionate, non-judgmental, mindful and dialectical,
- be engaged in team and not be silent observers or only focused on their own work,
- treat the meeting as vital to the DBT process and to avoid distractions or cancellations,
- do homework and come prepared,
- give advice even to those with more DBT experience,
- have humility to admit mistakes,
- assess problems before giving solutions,
- call out the “elephant in the room”,
- be willing to undergo chain analysis for one’s own problem behaviors,
- ask for permission, prepare for and repair after, when missing team,
- speak up when concerned or frustrated by the process,
- carry on even when feeling burnt out, frustrated, tired, overworked, under-appreciated, hopeless, ineffective...

## 3. Consultation Team Agreements

Team members accept these fundamental perspectives as a shared foundation for thinking about themselves, their mentees, and each other.

- Dialectical Agreement (to follow a dialectical philosophy);
- Consultation to the client agreement (to empower and not fragilize peers served);
- Consistency Agreement (to not insist on consistency, but accept diversity and change);
- Phenomenological empathy agreement (to find empathic, non-pejorative interpretations of ours and others' behaviors);
- Fallibility agreement (to admit to mistakes, humanness and to recognize and let go of defensiveness).

## 4. Roles during DBT CT Meetings

Members agree to assume any one of these roles (as needed) at each meeting. A detailed description of each role is available [here: Team Roles.doc]

- **Meeting Leader** – manages the agenda and how time is spent. Although teams may have a member who is considered a leader based on DBT experience, the role of meeting leader is rotated.
- **Observer** – is mindful of deviations from Team Agreements and other ineffective behaviors during the meeting. Brings the team's attention to those as they arise.
- **Note Taker** – takes notes on the content of the meeting, including issues brought for consultation and advice given by the team.
- **Member** – Actively participates in assessment of issues brought for consultation, including defining the problem behaviorally and helping to formulate solution strategies.

## 5. Structure of DBT CT Meeting

Meetings happen weekly and for at least 60 minutes – ideally for 90 minutes. Generally, meeting activities occur in this order:

- Mindfulness practice;
- Agenda Setting
- Case Consultation (based on hierarchy of targets and urgency rating)
- Teaching

## DBT Consultation Team Commitment for New Members

All new DBT team members should meet with the team leader, a team member, or, in some cases, the entire team, for a commitment session before they join the team. The following items are reviewed during the commitment session with the emphasis on assuring that the potential new consultation team member understands:

1. What a DBT consultation team is and how the team functions.
2. What the obligations of team members are.
3. The ramifications of each commitment that is made (i.e.; the upside and downside of each commitment).
4. That participation in a DBT team must be voluntary, but that once a commitment is made, there will be every expectation that the member abides by the commitments made.

The strategies used in this meeting are identical to those used in commitment sessions with new clients in DBT, including, for example, orienting to DBT team, all of the commitment strategies, troubleshooting, etc.

## Fundamental commitments required to be on the team:

1. The primary function of a DBT team is to increase the peer mentor's motivation and capability in applying DBT with peer mentees. Thus, when joining a team, members agree to participate in team consultation meetings and make every effort to increase their own and other team members' effectiveness as DBT peer mentors and adherence to DBT principles.
2. DBT Peer Connections is a peer support community. When joining a team, members agree to be responsible for the outcomes of ALL peers the team works with. It is not a minor responsibility to worry about others, be on the team, and to agree to be a full-fledged member of the community of peer mentors and providing leadership to the broader peer support community.

### Commitments that must be initialed & signed when joining a DBT consultation team:

#### DBT Consultation Team Agreements

1. **Dialectical Agreement:** We agree to accept a dialectical philosophy: There is no absolute truth (nor is truth relative). When caught between two conflicting opinions, we agree to look for the truth in both \_\_\_\_\_ positions and to search for a synthesis by asking such questions as, "What is being left out?"
2. **Consultation to the Client Agreement:** We agree that the primary goal of this team is to improve our own skills as DBT peer mentors, and not serve as a go-between for mentees to each other. We agree \_\_\_\_\_ to not treat mentees or each other as fragile. We agree to treat other team members with the belief that others can speak on their own behalf.
3. **Consistency Agreement:** Because change is a natural life occurrence, we agree to accept diversity and change as they naturally come about. This means that we do not have to agree with each other's \_\_\_\_\_ positions about how to respond to specific mentees, nor do we have to tailor our own behavior to be consistent with everyone else's.
4. **Observing Limits Agreement:** we agree to observe our own limits. As peer mentors and team \_\_\_\_\_ members, we agree to not judge or criticize other members for having different limits from our own (e.g.: too broad, too narrow, "just right").
5. **Phenomenological Empathy Agreement:** All things being equal, we agree to search for non-pejorative \_\_\_\_\_ or phenomenologically empathic interpretations of our peer's, our own, and other members' behavior. We agree to assume we and our peers are trying our best, and want to improve. We agree to strive to see the world through our peers' eyes and through one another's eyes. We agree to practice a nonjudgmental stance with our peer mentees and one another.
6. **Fallibility Agreement:** We agree ahead of time that we are each fallible and make mistakes. We agree \_\_\_\_\_ that we have probably either done whatever problematic things we're being accused of, or some part of it, so that we can let go of assuming a defensive stance to prove our virtue or competence. Because we are fallible, it is agreed that we will inevitably violate all of these agreements, and when this is done, we will rely on each other to point out the polarity and move to a synthesis

---

 Signature

---

 Date

## DBT Consultation Team Member Tasks - examples

### **Meeting Leader (same as mindfulness leader):**

1. Develops agenda with team members
2. Determines the order of the agenda
3. Manages time
4. Reads one of the Dialectical Agreements

### **Observer (leader from previous week) observes and rings bell lightly when:**

1. A dialectic is unresolved
2. Anyone (cpeer mentor or mentee) is treated as fragile (is an elephant in the room?)
3. A judgmental/non-compassionate comment is made
4. Defensiveness arises, forgetting that we are all fallible
5. Non-mindfulness, doing two things at once appears
6. Solutions given before the problem is assessed
7. Treatment recommendations/comments violate DBT principles
8. Consultant-to-the-team/DBT team leader intervening, doing rather than teaching

### **Note Taker (next up as meeting leader) takes notes during the meeting of:**

1. Peer mentor-mentee dyads discussed
2. Problems brought up
3. Advice given
4. Topics unaddressed due to time
5. Issues/agreements for follow-up at next meeting

### **Consultation Members:**

1. Participate, remembering that peer mentors always have something to say, i.e.: staying silent throughout an entire consultation meeting is not participating
2. Consult with members who want consultation
  - a. First, get agreement on problem presented and get it defined behaviorally (peer behavior is problem; peer mentor behavior is problem; peer mentor wants to summarize and get validation/cheerleading/sympathy)
  - b. Second, assess problem behaviorally:
    - i. Look for reinforcers
    - ii. Look for aversive consequences
    - iii. Look for inadequate or inappropriate stimulus control
    - iv. Consider skills deficits
    - v. Ask about secondary targets that might be contributing
  - c. Third, suggest strategies based on assessment/formulation
  - d. Fourth, check if more help is needed
3. Give feedback to and coach team members who fall out of DBT in their therapy or during the meeting
4. Highlight “elephants in the room” and topic avoidance when they arise
5. Listen to and validate (when appropriate) members who wish to share or process experiences with peers or other team members.



## CONSULTATION TEAM MEETING CHECKLIST

### Part A: Structure of the Consultation Team Meeting

The Team designated:

- A Team Leader (TL)
- An Observer
- A Note Taker (NT)
- The TL led a mindfulness practice
- The TL read one of the Consultation Team Agreements
- The NT read the notes from last team meeting
- The TL Identified a Dyad of the Week to discuss
- The TL checked if anyone was going out of town
- The Team identified back-up coverage
- No peer mentor expressed plans to go out of town
- The TL asked for updates to the emergency contact sheet

The TL checked if anyone interacted with peers with:

- Life-Threatening Behavior (including imminent risk)
- Therapy Interfering Behavior (including approaching 4 misses)
- Serious Quality of Life Interfering Behavior

The TL checked if any peer mentors were engaging in:

- Unethical, severely irresponsible behavior
- Team interfering behavior
- Therapy Interfering Behavior

The TL checked if any peer mentors were approaching burnout

The TL rang the bell to end the meeting

### General Team Process

- The team discussions focused on primarily PEER MENTOR behavior vs. PEER MENTEE behavior
- Highlighting, targeting, and problem-solving conducted with easy manner
- A strong position was expressed about a clinical or related issue
  - Someone on the team brought up an opposing issue
  - The dialectic or tension was highlighted
  - The team worked to achieve synthesis
- The team meeting involved a balance of acceptance and change-based styles

### Part B: Behaviors During the Consultation Team Meeting

- A peer mentor was doing 2 things at once (i.e.: reading and listening, talking on the telephone, chatting out of turn with other members)
  - The Observer rang the bell
  - The behavior was highlighted and blocked by the team
- A peer mentor was treated as fragile. An obvious issue came up that needed to be targeted (i.e.: defensiveness, judgmental talking, lateness) that was not highlighted or discussed by the team. Or, feedback clearly was needed, but was not provided.


- The Observer range the bell
- The behavior was highlighted
- The team discussed the avoided issue or provided the needed feedback
- A peer mentor displayed defensiveness in response to feedback
  - The Observer range the bell
  - The behavior was highlighted
  - The peer mentor was asked to rephrase the statement
- A peer mentor offered solutions before the problem was defined
  - The Observer range the bell
  - The behavior was highlighted
  - The problem was clarified
- A peer mentor engaged in self-invalidation (denigrating self, judgmental toward self, presenting as incompetent)
  - The Observer range the bell
  - The behavior was highlighted
  - The peer mentor was asked to rephrase the invalidating statement
- A peer mentor spoke in a judgmental or derogatory manner about his or her peer mentees
  - The Observer range the bell
  - The behavior was highlighted
  - The peer mentor was asked to rephrase the judgmental statement
- A peer mentor was late for the meeting
  - The behavior was highlighted
  - A chain analysis was conducted
  - Solutions were agreed upon
  - A commitment to implement a solution was elicited
- A peer mentor was obviously unprepared
  - The behavior was highlighted
  - A chain analysis was conducted
  - Solutions were agreed upon
  - A commitment to implement a solution was elicited
- A peer mentor did not speak during the meeting
  - The behavior was highlighted
  - A chain analysis was conducted
  - Solutions were agreed upon
  - A commitment to implement a solution was elicited

## Appendix C

## DBT Peer Connections YouTube Channel

Order	Video Title	Duration
1	<a href="#">Introduction to DBT Skills Training</a>	25:47
2	<a href="#">Biosocial Model, Wise Mind &amp; TIP Skills</a>	20:36
3	<a href="#">DBT Skills 6 Levels of Validation</a>	39:11
4	<a href="#">SMART Goals &amp; VITALS to Success Skills</a>	20:44
5	<a href="#">Core Mindfulness Skills</a>	52:31
6	<a href="#">Reality Acceptance Skills</a>	31:06
7	<a href="#">Distress Tolerance STOP Skills</a>	4:39
8	<a href="#">Distress Tolerance ACCEPTS IMPROVE Skills</a>	1:04:38
9	<a href="#">Emotion Regulation: Identify, Label &amp; Function of Emotions</a>	37:17
10	<a href="#">Emotion Regulation Skills - Check the Facts</a>	9:55
11	<a href="#">Emotion Regulation Skills - Opposite to Emotion Action</a>	52:47
12	<a href="#">Problem Solving Emotion Regulation Skills</a>	1:49:38
13	<a href="#">Emotion Regulation Skills - Behavior Chain Analysis</a>	34:25
14	<a href="#">Emotion Regulation Skills - ABC PLEASE Skills</a>	39:42
15	<a href="#">Interpersonal Effectiveness DEAR MAN GIVE FAST Skills</a>	24:0

Appendix D

 Edit this form

## Difficulties in Emotion Regulation Scale

DERS (abbr.) Please fill in the date you filled the form, your research participant information and then indicate how often the following statements apply to you. The collected information shall be used for research purposes only. No personally identifying information shall be collected, published, or distributed through this form.

\* Required

**Today's Date \***

**Research ID \***

	1 almost never (0-10%)	2 sometimes (11-35%)	3 about half the time (36-65%)	4 most of the time (66-90%)	5 almost always (91-100%)
	1	2	3	4	5
1. I am clear about my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I pay attention to how I feel.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I experience my emotions as overwhelming and out of control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have no idea how I am feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I have difficulty making sense out of my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I am attentive to my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I know exactly how I am feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I care about what I am feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I am confused about how I feel.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. When I am upset, I acknowledge my emotions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. When I am upset, I become angry with myself for feeling that way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. When I am upset, I become					



embarrassed for feeling that way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. When I am upset, I have difficulty getting work done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. When I am upset, I become out of control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. When I am upset, I believe that I will remain that way for a long time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. When I am upset, I believe that I will end up feeling very depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. When I am upset, I believe that my feelings are valid and important.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. When I am upset, I have difficulty focusing on other things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. When I am upset, I feel out of control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. When I am upset, I can still get things done.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. When I am upset, I feel ashamed at myself for feeling that way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. When I am upset, I know that I can find a way to eventually feel better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. When I am upset, I feel like I am weak.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. When I am upset, I feel like I can remain in control of my behaviors.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. When I am upset, I feel guilty for feeling that way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. When I am upset, I have difficulty concentrating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. When I am upset, I have difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

controlling my behaviors.					
28. When I am upset, I believe there is nothing I can do to make myself feel better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. When I am upset, I become irritated at myself for feeling that way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. When I am upset, I start to feel very bad about myself.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. When I am upset, I believe that wallowing in it is all I can do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. When I am upset, I lose control over my behavior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. When I am upset, I have difficulty thinking about anything else.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. When I am upset I take time to figure out what I am really feeling.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. When I am upset, it takes me a long time to feel better.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. When I am upset, my emotions feel overwhelming.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Is this your 1st assessment or 2nd assessment? \***

The 1st assessment or pre-test is taken before study. The 2nd Assessment or post-test is taken after the study

**Reference**

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41-54.  
<http://depts.washington.edu/uwcscs/sites/default/files//FAP%20Measures%20Library%20Index.pdf>

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Appendix E  
Dialectical Behavior Therapy Weekly Diary Card (Filled Example)

Name: <b>Jane Doe</b>								Date: <b>04/26/2015</b>		How many days did U fill card? 1-7		<b>1</b>
Mood	Happy	Sadness	Anger	Fear	Guilt	Self Harm	Suicide Ideation	* Other Target Behaviors UA/1-5	Skillfulness	Notes:		
Date	0-10	0-10	0-10	0-10	0-10	UA/1-5	UA/1-5	<b>Avoidance</b>	0-5			
Sun. 26	<b>3</b>	<b>4</b>	<b>3</b>	<b>7</b>	<b>3</b>	-	-	<b>U/3</b>	<b>4</b>	<b>Went to individual session today</b>		
Mon. 27												
Tues. 28												
Wed. 29												
Thurs. 30												
Fri. 31												
Sat. 1												
*Enter a U for Urge or an A for Action. Then enter the Intensity level as 1=Minimal 2=Mild 3=Moderate 4=Strong 5=Intense Example U1												
Skillfulness Rating for the Day:										Rate urges intensity from 0-5		
0 =Didn't think about using skills					3 = Used skills, but they didn't help					Urge to quit Individual Therapy		<b>0</b>
1 =Thought about skills, didn't want to					4 = Used skills & they helped					Urge to quit Group Therapy		<b>0</b>
2 =Thought about/wanted to use skills but didn't					5 = Did not need skills, but practiced					Urge to quit Medication		<b>0</b>

DBT Skills Tracking Table

1. Beneath Week day fill in Day of Month 2. mark an X in column A and/or B for day skill practiced			Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
	Column A	Column B	A	B	A	B	A	B	A	B	A	B	A	B	A	B
Mindfulness	Observe	One-mindfully	X													
	Describe	Non-Judgmentally	X													
	Participate	Effectively	X	X												
	Radical Acceptance	Loving Kindness	X													
Distress Tolerance	Activities	Imagery														
	Contributing	Meaning	X	X												
	Comparisons	Prayer														
	Pushing Away	Relaxation														
	Thoughts	One Thing at a Time														
	Self-Soothe w/ Senses	Vacation														
	STOP Skills	Encouragement	X													
Emotion Regulation	Temperature	Eat Balanced Meals														
	Intense Physical Activity	Avoid Drug Misuse														
	Paced Breathing	Sleep Balanced														
	Accumulate Positives	Exercise Regularly														
	Build Master	Check the Facts														
	Cope Ahead of Time	Opposite Action														
	Treat Physical Illness	Behavior Chain Analysis														
Interpersonal Effectiveness	Describe	Gentle														
	Express	Interessted		X												
	Assert	Validate														
	Reinforce	Easy Manner														
	Mindful	Fair														
	Appear Confident	Apology Free														
	Negotiate	Stick 2 Values														
Exposure	Truthfulness	X														