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## Finding the Middle Path Between Dependence and Autonomy: Recent Trainee Experiences in Dialectical Behavior Therapy Supervision

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Dialectical Behavior Therapy (DBT; Linehan, 1993; Linehan, 2014) is a principle-based, third-wave cognitive behavioral therapy originally designed to treat individuals with high levels of suicidality and shown to be efficacious with Borderline Personality Disorder (BPD) – a disorder of pervasive emotion dysregulation. Given the multi-modal nature of the treatment (Lungu & Linehan, 2016) and the acuteness of the clients for which it was designed, learning DBT as a psychology trainee can be a daunting task, as it requires trainees to learn a new treatment *and* also to manage one’s own emotional reactions to treating high-risk clients (Yang & Linehan, 2017). Importantly, recent research suggests that psychology trainees can effectively deliver DBT, with client outcomes that were comparable to study therapists in a large-scale randomized controlled trial (Rizvi, Hughes, Hittman, & Oliviera, 2017). High quality supervision is essential for psychology trainees to conduct effective DBT with a high-risk, complex client population. In fact, the very structure of DBT incorporates supervision for therapists of all experience levels through weekly therapist team consultation. Supervision is not an adjunct to DBT; rather, it is an essential component of the treatment itself (Fruzzetti, Waltz, & Linehan, 1997).

At the core of DBT lies the concept of dialectics – the idea that truth exists in opposite positions, and that growth occurs from honoring the truth in both positions in order to find a synthesis or

“middle path” between them (Linehan, 1993). Dialectics pervade all elements of the treatment, including supervision of trainees (Fruzzetti et al., 1997; Waltz, Fruzzetti, & Linehan, 1998). The central dialectic in DBT is balancing acceptance and change – accepting the client for who they<sup>1</sup> are currently, while simultaneously working to replace ineffective behaviors with new, skillful behaviors. Thus, a core dialectical assumption is that all clients are, at each moment, doing the best they can, *and* that they can do better. This dialectic is also present in DBT supervision (Waltz et al., 1998): DBT trainees need to feel validated, supported, and guided by their supervisors while simultaneously learning how to be more effective therapists.

As we, the authors, reflected on our own training experiences in DBT – as practicum students, interns, and postdoctoral fellows – we recognized another critical dialectic, embodied by our supervisors, that helped us to fully engage in learning DBT and to feel competent working with high-risk clients (Figure 1). This dialectic was based on how we believe our supervisors perceived us and behaved towards us as DBT trainees. At one extreme, supervisees may be treated as dependent on their supervisors, incapable of working with complex clients. Supervisors who view trainees from this pole may feel the need to “protect” trainees, treat

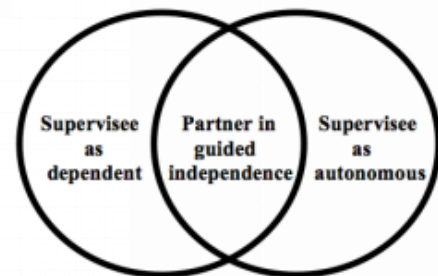


Figure 1. Dialectical View of Supervisee

them as fragile, and may micromanage their clinical decision-making. As a result, trainees may become increasingly insecure, question their treatment decisions, perhaps believing that they are fragile, and become fearful about making mistakes. At the opposite pole, supervisors may treat their

<sup>1</sup> For the purpose of gender inclusivity and maintaining client confidentiality in all case examples, we will refer to individual clients as “they”.

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trainees as wholly autonomous. From this position, supervisors may be too distant and trainees may feel anxious, lost, and unsure about how to make clinical progress, or simply not receive sufficient critical feedback to improve as needed. Likely, in either extreme, trainees are not learning the skills necessary to become competent, confident DBT therapists. The middle path, then, positions supervisees as partners in the process of guided independence; trainees are treated as fundamentally capable of effectively delivering DBT while simultaneously provided appropriate oversight and guidance in learning new therapeutic strategies and skills that are tailored to the client's clinical needs and trainee's developmental stage. While this dialectic may not be unique to supervision in DBT, we believe it is especially crucial given the emotional demands on both trainees and supervisors when treating high-risk, complex clients while learning a challenging, principle-based treatment.

In this paper, we share three illustrations of this dialectic in action and specific supervisory interactions in which we believe supervisors found this middle path. We describe three supervisory experiences in the four different modes of DBT – skills group, individual therapy, phone coaching, and consultation team – and how they made a significant impact on our development as clinical psychology trainees, as well as broader lessons that can be taken away from these formative supervisory experiences.

**Skills Group Supervision.** As I (Elizabeth Nelson) entered my fourth year of graduate school, I was anxious as I began leading a skills group for adults in a full-model outpatient DBT clinic. I was worried I would not effectively teach the material and I would not skillfully draw out effective behaviors from clients and manage ineffective behaviors as they arose within the group. My supervisor was aware of my anxiety in this new role, and she exemplified guided independence by providing support without fragilizing me. While she arrived at all of my supervision appointments having prepared detailed notes on the video recording of my last skills group, she

set the expectation that I create the agenda for our supervision. She asked me to reflect upon my own adherence to DBT in the previous group, to ask questions before receiving feedback, and to take the lead in planning for the next group. Research has found that trainees find it helpful to critique their own session tapes before receiving feedback from their supervisors, as this allows them to provide suggestions for their own clinical skill development and to more openly and non-defensively receive corrective feedback (Sobell, Manor, Sobell, & Dum, 2008). Thus, while I always felt that my supervisor had a wealth of DBT knowledge, she trusted that I could self-identify areas of growth and development to effectively teach DBT skills.

This approach was exemplified when navigating a particularly challenging situation with one DBT skills group member. For several weeks, a member of our skills group made regular statements to my co-leader and me that they intended to engage in self-harm behaviors following group. They also refused to engage in skills coaching, including a refusal to reach out to their individual DBT therapist. We were unsure how to respond to the client's self-harm statements. In supervision, rather than immediately providing an answer and assuaging our anxieties, the supervisor asked me and the other leader what DBT principles we should consider. We discussed the principles we believed to be relevant, namely consultation to the client versus an environmental intervention, our conceptualization of the function of the client's behavior, and ideas on how to respond. Our supervisor responded with praise regarding our conceptualization, highlighting that it did not fragilize the client and clarified the lead role of the client's individual therapist and our role as skills group leaders to increase effective behavior. Our supervisor reinforced that the client was capable of being reoriented regarding whom to contact for coaching and that we were capable of providing an environment conducive to the client learning new skills while simultaneously setting limits around addressing self-harm. Rather than treat me as too novice to address this serious problem or too anxious or fragile to come up with solutions, my

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supervisor, consistent with guided independence, encouraged me to apply what I learned and provided me with additional feedback she thought would help. This was very helpful in responding to the client, whose behavior radically changed once we implemented our plan. This interaction instilled in me the principle that DBT does not treat either its therapists or clients as fragile or incompetent to solve high-risk problems. Rather, both clients and trainees, with therapists and supervisors serving as touchstones and guides, can make more progress than they believe they can.

**Individual Therapy and Phone Coaching Supervision.** My (Joyce Yang) DBT supervisor impressed upon me that there didn't need to be, and indeed wasn't, anything fragile about me, even though I was a trainee. She conveyed that each individual, from graduate student to treatment founder, was a critical member of our DBT Consultation Team, which emphasized supporting one another as people and therapists. One way we demonstrated support was to provide phone coaching as back-up therapists for team members who were out of town, not only to provide clinical coverage but also to validate their need for relief from 24-hr phone coaching.

A pivotal moment in my development as a DBT clinician occurred the first time I served as back-up therapist for my supervisor's client with chronic suicidality. The day she left the client called me in anticipatory distress that their therapist had left them in my hands for several days. They experienced a feeling of abandonment, compounded by their partner's work-related absence. They feared being home alone at night and reported a significant increase in their suicidal thoughts and self-harm urges. They insisted upon either being hospitalized or for my supervisor to return to their assistance. Although I knew the client in my capacity as their skills group leader and had reviewed the client's case conceptualization and treatment plan with my supervisor before she left, I was not yet familiar with their interpersonal style on the phone or while acutely distressed. As my own anxiety ramped

up, I considered a) the client's physical safety (perhaps pointing me towards agreeing to initiate hospitalization), b) what was clinically indicated (knowing this client's perception of themselves as fragile, their history of using hospitalization as an escape, and research that completed suicide is highest immediately post-discharge from inpatient hospitalization) and c) my own internal pressure to do a "good job" in the eyes of my supervisor, which meant, at the very least, keeping her client alive while she was away. As I attempted to sort through these thoughts, I fumbled my coaching on the phone and the client hung up on me.

Based on my supervisor's previous encouragement, I did not hesitate to reach out to her for guidance. Prior to her departure, she had instructed me to call her as needed, explicitly telling me not to worry about disturbing her. While developing procedures for emergency situations is an important element of orientation to supervision, particularly in a supervision contract (APA, 2015), I believe encouragement to call her for additional supervision was essential, given the high-risk nature of the client. It reassured me that the client's safety was the top priority and she was committed to providing me necessary support. On the phone with her, when I stated doubt about my risk assessment skills, my supervisor began first by acknowledging the validity in my concerns (Linehan, 1993): not even the most seasoned clinician can assess risk in a way that predicts the future 100%. My anxiety and worry served a clear purpose of letting me know that I care about my clients, and reminded me of the real levels of danger associated with their suicidal ideation and attempts. This acknowledgement reminded me to find the validity in the client's emotions: they felt alone because people they cared about were away and feeling alone is often scary. After validating, my supervisor encouraged me to share my impressions based on my assessment prior to giving her own impressions, thereby communicating trust in my clinical abilities. She also guided me to undertake a functional assessment in addition to the topographical assessment of the client's behavior, which allowed me to conceptualize the function of the

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client's suicidal and self-harm thoughts as serving an escape from a situation they believed they couldn't tolerate. This conceptualization allowed me to generate and successfully coach the patient to choose more adaptive escapes behaviors (such as distraction through watching an engaging movie) as well as increasing distress tolerance to survive being alone for the night. Importantly, this plan did not involve extensive suicide risk assessment, which we conceptualized as further reinforcing the escape function in thinking about and planning for suicide and self-harm.

Rather than bypassing me to call the client herself and coach them directly, my supervisor's willingness to spend the extra time to supervise me through assessment and coaching of her client and encouraging me to continue to call her with questions and updates, communicated both belief in my ability as a clinician and that I was not alone in delivering the treatment, holding the middle path of guided independence. By allowing me to coach her client while also not leaving me to autonomously make treatment decisions, my supervisor allowed me to demonstrate to the client that they were able to stay safe on their own (without a hospital) and that they actually were not alone, with me a phone call away. In this way, my supervisor modeled for me the power in not treating someone as fragile, and in the same way, I learned to not treat my clients as fragile.

**Therapist Team Consultation.** I remember anxiously observing the team dynamics during my (Jennifer Staples) first DBT consultation team meeting, gathering clues to understand my role as a trainee team member and trying to formulate an articulate and insightful contribution. These team experiences often provoke that familiar "imposter syndrome" and increase awareness of unavoidable power dynamics which leave trainees – and particularly young women trainees – feeling silenced. Fortunately, I did not encounter the competitive pecking order that I anticipated. I was impressed by the genuine respect and consideration afforded to trainees' ideas and suggestions.

One particular interaction exemplifies the concept of guided independence during my experience of DBT supervision within a team context. In my internship year, during one weekly consultation team meeting that was part of an outpatient, full-model DBT program, two of the staff psychologists – one of whom served as my direct supervisor – became locked in a struggle about how to accurately conceptualize a client's recent suicidal behavior. They continued to fervently express their differing positions, and there was noticeable tension in the room. In an attempt to address other items on our agenda, and perhaps to dispel the tension, the group changed topics without resolution. I remembered the DBT team agreement to accept a dialectical philosophy that caught between two conflicting opinions, to look for the truth in both positions and to search for a synthesis. Debating whether or not it was my place as a trainee to highlight tension between two supervisors, I decided to name the "elephant in the room" and requested that the team revisit the dialectic between the two team members and attempt to find a synthesis. Immediately, I was behaviorally reinforced when my supervisor expressed appreciation, confirmed that he was still feeling frustration related to the client's conceptualization, and the team proceeded to work toward a synthesis.

Following team, my supervisor approached me individually and praised me for addressing the dialectical tension in the room. He asked about what that experience was like for me as a trainee and, when I expressed my uncertainty and nervousness, expressed genuine appreciation for the chance to resolve the situation and highlighted my adherence to the DBT team agreements and consultative role.

I was grateful for my supervisor's support in the moment, further appreciative that he checked in with me afterward and allowed for the opportunity to debrief, and proud that I took a risk to uphold my consultative role and grow as a trainee. Indeed, research suggests that supervisors' skills in applying different roles (e.g., teacher, consultant, counselor, and evaluator), forming a strong working relationship with the supervisee,

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and expressing appropriate affective responses is predictive of trainees' reports of their needs being met (Eisenhard & Muse-Burke, 2015). In this interaction, my supervisor allowed me to serve as consultant to him on a difficult clinical issue. He also strengthened our supervisory relationship by showing his genuine appreciation for my intervention. This example is just one of many experiences in DBT where I felt that my supervisors successfully attained a synthesis of guided independence, promoting competence while providing a foundation of support.

### Discussion

In this paper, we provided three examples of our supervision experiences in DBT, in which our supervisors took a dialectical approach to supervision, and we as trainees felt empowered to work with high-risk, complex clients while still being able (and required) to ask for and receive guidance when needed. In other words, our supervisors allowed us to become partners with them in a process of guided independence.

Importantly, the dialectical balance between dependence and autonomy may differ based on trainees' developmental level. More novice trainees may require more didactic, "hands-on" supervision to develop their competence in delivering a treatment, whereas more advanced trainees may need a more "hands-off" supervisor who takes on a consultant-like role and actively encourages the trainee to function more independently. A thorough assessment of a trainee's skill level in the beginning stages of supervision is important for determining the appropriate balance (APA, 2004). However, we believe that a spirit of support and belief in the trainee's capability to become a skilled therapist must still pervade the supervisory relationship, no matter the trainee's current stage of development.

While research on psychological supervision is increasing, there remains a need to understand which specific supervisory behaviors enhance supervisee confidence and skill acquisition. Supervision in DBT is no exception. While we pro-

vide anecdotal evidence for supervisory behaviors we found helpful for our development as DBT therapists, research on DBT-specific supervision (e.g., use of dialectical strategies with supervisees) and their impact on both therapist and client outcomes is lacking.

In conclusion, we believe it is important for DBT supervisors to have confidence that their supervisees can effectively deliver the treatment; fortunately, evidence suggests this is the case (Rizvi et al., 2017). Equally important is for DBT supervisors to communicate this belief through their supervisory behaviors, while simultaneously providing the appropriate oversight and guidance necessary for supervisees to continue their clinical skill development. In turn, we believe that trainees will begin to trust in their own capacity to work with high-risk, complex clients, providing effective treatment to those in need.

[Find References Here](#)