A DISSERTATION

By Wendy S. Bruton

AN ABSTRACT OF THE DISSERTATION OF

Wendy S. Bruton for the degree of Doctor of Philosophy in Counseling presented on May 3, 2013.
Title: The Impact of a DBT Training on the Counselor Self-Efficacy of Preservice Counselors Working with Borderline Personality Disordered Clients

Abstract approved:

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Amy E. Ford

As the demand for community mental health services grows, more and more counselors-in-training are being asked to face the challenge of working with high needs clients, including clients with Borderline Personality Disorder (BPD). Counselors-in-training are entering therapeutic relationships with high-risk clients without training specifically covering BPD client's unique needs. This lack of training has the potential to limit the counselor self-efficacy (CSE) of counselors-in-training. Researchers speculate that counselor self-efficacy (CSE) impacts the outcome of therapy. Larson (1998) believes that CSE is one of the major indicators of effective counseling. However, without specific training in how to work effectively with personality disorders such as BPD, many counselors-in-training are feeling ineffective and incompetent with regards to their work with this growing and needy population. Several empirical studies have emerged on different psychotherapies and practices which may benefit individuals with BPD. The most empirically based therapy for clients with BPD is Dialectical Behavior Therapy (DBT) (Linehan, Armstrong,

Suarez, Allmon, & Heard, 1991; Lynch, Chapman, Rosenthal, & Linehan, 2006; McMain & Korman, 2001; Neacsiu, Rizvi, & Linehan, 2010; Soler, et al., 2009). An understanding of the skills and interventions taught in DBT has been shown to be valuable not only to the client, but also therapists working with BPD individuals. One question that has not been addressed in the counseling literature is how training in DBT might impact the counselor self-efficacy of counselors-in-training with regards to their work with BPD clients.

The Impact of a DBT Training on the Counselor Self-Efficacy of Preservice
Counselors Working with Borderline Personality Disordered Clients

by
Wendy S. Bruton

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APPROVED:

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Major Professor, representing Counseling

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Dean of the College of Education

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Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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Wendy S. Bruton, Author

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CONTRIBUTION OF AUTHORS

Dr. Michelle Cox assisted in the interpretation of the data. Dr. Michelle Cox and Dr.

Amy Ford assisted in the formatting and editing of the dissertation final copy.

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CHAPTER I: GENERAL INTRODUCTION
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Chapter I: General Introduction

Overview

The purpose of this dissertation study is to demonstrate scholarly work by using the *manuscript document dissertation format* as outlined by the Oregon State University Graduate School. In following this format, chapter one provides explanation as to how two journal-formatted manuscripts found in chapters two and three are thematically tied and build toward research conclusions pertinent to counseling. Chapter two is a literature review titled, *A Review of the Literature on Counselor Self-Efficacy, Borderline Personality Disorder, and Dialectical Behavior Therapy*, and chapter three presents quantitative research in a manuscript entitled, *The Impact of a DBT Workshop on the Counselor Self-Efficacy of Counselors-in-Training: A Quantitative Study.* Both of these manuscripts focus on the construct of counselor self-efficacy. In short, the two manuscripts thematically converge on the application of a DBT workshop with counselors-in-training and its effect on their self-efficacy as related to their work with BPD clients. Counselor self-efficacy is the perception of competence to conduct counseling; it includes the beliefs and attitudes held by helping professionals or trainees that influence their capacity for the effective delivery of counseling or psychotherapy services (Larson & Daniels, 1998). It plays a vital part in the understanding of how counselor trainees subjectively construct their counseling and training experiences and develop into competent counselors (Barnes, 2004). Thus, counselor self-efficacy is generally accepted as being a vital precursor to competent practice and should be an important focus of clinical education. According to Bandura

(1986) people engage in activities in which they feel competent and effective. This fact leads to the assumption that self-efficacy is also a strong predictor of areas in which clinicians will practice and the types of clients with whom they will work.

The first scholarly manuscript is a literature review that provides background, definition, and theoretical underpinnings of both counselor self-efficacy and BPD. It also reviews research identifying the benefits of Dialectical Behavior Therapy (DBT). The second manuscript will present descriptive research on a pre- and post-assessment of self-efficacy given to counselors-in-training before and after a workshop on DBT. Chapter four will provide a general conclusion to this dissertation study, including results of the research, limitations, and suggestions for future research.

Thematic Introduction

Brief Introduction to Counselor Self-Efficacy

Theoretical as well as empirical literature suggests there is substantial interest in counselor self-efficacy within the fields of counseling and psychotherapy. Self-efficacy is a term first found in the writings of Albert Bandura (1977). This construct helps explain what motivates people to work toward growth, to take on challenges, and to learn new things. The construct of self-efficacy includes people's perceptions of their capabilities based on life events, trial and error, and exposure to a variety of experiences (Bandura, 1977; 1986; 1997).

The purpose of this dissertation study is to explore the construct of counselor self-efficacy in relation to working with BPD clients in counseling and psychotherapy.

Self-efficacy, as a construct, has found its way into the counseling research mainstream over the past several years. The need for counselors to feel effective while working with clients is vital to the success of the counseling experience. Many master's-level clinicians have graduated from counselor training programs feeling effective in their work with most clients, yet struggle with feelings of inadequacy and ineffectiveness when working with challenging, long term clients such as individuals with BPD. These individuals are high-end users of mental health services and notoriously difficult to work with in an ongoing therapeutic relationship.

Brief Introduction to Borderline Personality Disorder

BPD is a disorder statistically present in between .5% and 5.9% of the general population. Taking the median of these results, 1 out of 35 people in the United States meet the diagnostic criteria for BPD (Leichsenring, 2011). The literature often refers to four common traits of those diagnosed with BPD: (a) the inability to be in the here-and-now; (b) ineffective interpersonal relationships; (c) the inability to tolerate distress; and (d) the inability to regulate emotions. Individuals with borderline traits are prone to self-harm and have a suicide rate nine times higher than the general population (Leichsenring, 2011).

Brief Introduction to Dialectical Behavioral Therapy

There has been extensive research over the past two decades on the effectiveness of Dialectical Behavior Therapy (DBT) as a clinical modality for individuals diagnosed with BPD. The research indicates that using DBT interventions with clients

with BPD gives these clients concrete skills to improve the symptoms of their

disorder. Marsha Linehan developed DBT in the early 1990's. This therapy is a

comprehensive cognitive-behavioral treatment that also includes mindfulness and

some Buddhist meditative practices (Linehan, 1993a,b). It was originally developed

for chronically-suicidal individuals but has evolved into a treatment for individuals

with BPD as well as many other treatment resistant mental health disorders. Linehan

summarized DBT:

> As a comprehensive treatment, DBT addresses the following five
> areas: 1) enhances behavioral capabilities, 2) improves motivation
> to change by modifying inhibitions and reinforcement
> contingencies, 3) assures that new capabilities generalize to the
> natural environment, 4) structures the treatment environment in the
> ways essential to support client and therapist capabilities, and 5)
> enhances therapist capabilities and motivation to treat clients
> effectively. (Linehan, 2001, p. 10)

Rationale

Counselor self-efficacy (CSE) is relevant as an emerging construct in the

counseling and psychotherapy setting. Identifying ways by which to improve self-

efficacy in counselors-in-training is challenging. Counselors-in-training will receive

DBT training to enhance the development of CSE. This author developed this

perception as a result of experience in community counseling settings, working as a

clinical supervisor with graduate student interns in several counseling programs, and

through experiences in private practice. The topical relevance is substantiated in

counselor education literature as well as anecdotal information from practicing

clinicians who report feeling inadequately trained to help high-needs populations, such

as those with BPD. It is also important to note that this topic has much personal

interest and relevance to the author who uses DBT in private clinical practice and as a

master's-level counselor educator. Providing DBT-specific training for preservice

clinicians may better prepare them to work with high-needs clients, thus improving

clinician interest, motivation, and care for this population.

In addition to the need for improved counselor self-efficacy, it is also imperative

that counselors competently work with this specialized population. According to

Bandura (1986), competence breeds self-efficacy. This is true for CSE as well.

Research indicates that CSE increases when counselors-in-training practice specific

skills with real or analogue clients (Daniels & Larson, 2001; Larson et al., 1999).

However, these studies stipulate that for CSE to increase, the clinicians must

experience a feeling of success after the sessions.

It is also important for counselors to be competent in techniques that are effective

with the BPD population because it is an ethical expectation for clinicians to be

specially trained if they are going to work with a specific population (ACA, 2005,

C.2.b). The American Counseling Association (ACA) *Code of Ethics* (2005) states,

> Counselors must practice only within the boundaries of their competence,
> based on their education, training, supervised experience, state and national
> professional credentials, and appropriate professional experience (C.2.a.).

This idea of specific training is also found in the American Psychological

Association's (APA) *Ethical Principles*, (2002) which states:

> Psychologists provide services, teach, and conduct research with
> populations and in areas only within the boundaries of their

competence, based on their education, training, supervised experience, consultation, study, or professional experience. (Principle 2.01a).

It is productive and ethically responsible for all counselors-in-training to begin to develop a sense of professional competence working with BPD clients, which in turn develops an increased experience of counselor self-efficacy.

Research indicates that clinical work with BPD clients has potential to cause rapid burnout (Dimeff &Linehan, 2001; Fergusson & Tyrer, 1991; James & Cowman, 2007; Perseus, 2007; Rizq, 2012). In addition, the professional literature suggests that clinicians feel ineffective with this population and may even choose to avoid accepting them as clients. The literature also indicates that this client population is one of the highest service-seeking populations in mental health, thus creating a demand for services that is greater than resources allow (Bender et al., 2001; Zanarini, Frankenburg, Khera & Bleichmar, 2001).

Research implications extend far beyond the community of counselor educators. Research results described in these manuscripts are relevant for counseling and psychotherapy, and have broad implications for those whose professional degrees relate to counselor education. This research also has the potential to impact the fields of psychology, general medicine, social work, psychiatry, college counseling, and psychiatric nursing among others. It is relevant to all clinicians who encounter this population in a primary care setting and have a desire to work effectively with them.

The first manuscript, a literature review, examines the current professional literature on BPD and the impact this diagnosis can have on the counseling setting. It

looks at the research on DBT and its effectiveness with BPD clients. Finally, the first

manuscript addresses the construct of CSE and its importance in the therapeutic

relationship. The review of relevant literature in this first document contains

information regarding the history, the relevance in mental health practice, and

important definitions related to CSE, BPD, and DBT.

There are specific areas in which the literature seems to be lacking. To date, there

is no research published on the percentage of counselors and therapists who are

unwilling to work with BPD clients or why they may make their decisions. There is

also a lack of research connecting DBT training with the increase of counselor self-

efficacy. This specific concern motivated the author to move forward with the

following research question.

Statement of Research Questions

Research question #1: *What is the impact of DBT training on the counselor self-*

efficacy of counselors-in-training with regard to their work with BPD clients as

measured by the Counselor Self-Efficacy Inventory (COSE)?

DBT training is here defined as a didactic workshop covering basic DBT skills

and philosophy.

Research question #2: *To what extent does a DBT workshop impact the COSE*

subscales "challenging client behaviors"?

How Research Question Fills in a Critical Gap in the Research

Although literature supports the need for clinicians willing to work with high needs clients, there is limited training in counseling education programs on how to work with this population. This research will add to the body of knowledge on counselor self-efficacy and DBT, and help determine the effectiveness of diagnostic specific, Axis II training within counselor education programs.

<div align="center">Hypothesis</div>

The hypotheses are as follows:

Statement of Null Hypothesis (H_0) #1

There is no impact of DBT training on the counselor self-efficacy of counselors-in-training with regard to their work with BPD clients.

Statement of Alternative Hypothesis (H_1) #1

DBT training significantly increases the counselor self-efficacy of counselors-in -training with regard to their work with BPD clients.

Statement of Null Hypothesis (H_0) #2

COSE subscale "challenging client behaviors" will show no significant difference compared with the other COSE subscale means after a DBT training.

Statement of Alternative Hypothesis (H_1) #2

COSE subscale "challenging client behaviors" will show a significantly higher improvement compared with the other COSE subscale means after a DBT training.

Glossary of Terms

*Borderline Personality Disorder***-** BPD is a common and serious (even life-threatening) disorder. The DSM-IV-TR indicates that affirmation of five of nine possible criteria indicates BPD. These nine criteria include: (a) a frantic effort to avoid real or imagined abandonment; (b) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; (c) a markedly and persistently unstable sense of self; (d) impulsivity; (e) recurrent suicidal behavior; (f) affective instability due to a marked reactivity of mood; (g) chronic feelings of emptiness; (h) inappropriate intense anger, (i) transient, stress-related paranoid ideation or severe dissociative symptoms. (APA, p. 710)

*Counselor Self-Efficacy***- "**One's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future." (Larson, 1998, p. 180).

*Dialectical Behavior Therapy***-** Developed by Linehan (1993), DBT was the first method of psychotherapy shown in clinical trials to be effective for individuals with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991)

*Counselor-in-Training***-** Graduate in counseling students involved in their clinical internship experience.

Disclaimer

To the author's knowledge, empirical research on the effects of DBT training on the self-efficacy of counselors-in-training has not been conducted or proposed. It is

hoped that the second manuscript adds to current literature and helps in the process of

creating a perceived need for this kind of training within counselor education

programs. Results of this study add empirical research to the investigation of

counselor self-efficacy, dialectical behavior therapy, as well as clinical work with

borderline personality disordered individuals. The author wanted to conduct these

trainings and interact with students and professionals around these topics in order to

advance discussion, research, collaboration, and bring about change.

Chapter 2

A Review of the Literature on Counselor Self-Efficacy, Borderline Personality
Disorder, and Dialectical Behavior Therapy

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CHAPTER II: REVIEW OF THE RELATED LITERATURE
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Abstract

This literature review assesses counseling and psychotherapy literature on the relationship between preservice counselor self-efficacy (CSE), clinical work with clients presenting with BPD traits, and training in Dialectical Behavior Therapy (DBT). The manuscript will explore the literature related to effective work with clients who meet diagnostic criteria for BPD. Treatment history of this population is identified, along with a review of the literature about the effectiveness and implementation of DBT. The manuscript will then examine the construct of counselor self-efficacy and the development and impact of CSE in preservice clinicians. These constructs will converge with the legitimate assertion that DBT training can potentially have a positive impact on the counselor self-efficacy of preservice clinicians in their work with BPD clients.

SEARCH PARAMETERS FOR REVIEW:

Counselor Self-Efficacy (CSE); Self-Efficacy of Counselor's in Training; Borderline Personality Disorder (BPD); Dialectical Behavior Therapy (DBT); Training of Counselor-in-Training.

MAIN RESULTS:

Findings throughout the literature indicate clients with BPD are challenging to work with in any mental health setting. Dialectical Behavior Therapy is an evidence-based therapy showing significant results when treating individuals with BPD. This therapy has also been shown to decrease counselor stress and burnout among those

working with this client base. In addition, the literature asserts training can impact the self-efficacy of counselors-in-training.

IMPLICATIONS FOR PRACTICE AND RESEARCH:

Throughout the literature it is clear that counselor self-efficacy impacts outcomes for clients. If training in DBT can increase the self-efficacy of preservice clinicians working with BPD clients, service to clients will increase, resulting in individuals with productive and healthy lives. This study will add to the body of literature and research on both counselor self-efficacy and DBT.

Chapter II: A Review of the Related Literature

Introduction

Counselor Self-Efficacy (CSE) is defined as a counselor's self-judgment about the ability to effectively counsel others (Daniels & Larson, 2001). CSE gained popularity in the psychological and counseling literature over the past decade. The importance of counselor self-efficacy and its impact on both clinicians and clients is well documented (Barnes, 2004; Halverson et al., 2006; Johnson, Baker, Kopala, Kiselica, & Thompson, 1989; Kozina et al., 2011; Larson et al., 1997; Larson, 1998). Bandura (1986) asserted that people engage in activities in which they feel competent and effective. Counselors want to feel effective in their work, and thus include in their practice people with whom they can feel successful. This is of great concern when reflecting upon the lack of counselors who are willing to work with clients with Borderline Personality Disorder (BPD). Counselors lacking competence, motivation, and a sense of effectiveness tend to shy away from these clients (Dimeff & Linehan, 2001). Across the United States, as well as other parts of the world, individuals with BPD are frequent and consistent users of mental health services (Leichsenring, 2011). Finding counselors who feel effective working with this population is challenging. There is little, if any, training in counselor education programs intended to specifically focus on working with these individuals. Historically, many counselors-in-training have been discouraged from working with this population because of client treatment inconsistencies and client tendencies toward self-harm. Throughout this literature review, one question that seems to surface is whether a lack of preservice training in

effective work with BPD creates a lack of self-efficacy in counselors, and therefore a lack of counselors in the field who are willing to work with this high-needs population.

In recent years there have been several different interventions and types of therapy focused on helping individuals with BPD. Dialectical Behavior Therapy (DBT) is the most researched therapy for this population demonstrating high levels of validity and reliability (Grant et al., 2008). First published in 1993 by Dr. Marsha Linehan, this method of working with clients with BPD has shown itself to be useful for client success. Yet treating clients with BPD continues to be a challenge for therapists. Over the past two decades DBT has been well researched and found effective with BPD clients. However, to date, no published research has asked how a DBT training might impact the self-efficacy of counselors-in-training in regard to their work with BPD clients.

In this review of the literature, the research on BPD and its treatments, the implementation and effectiveness of DBT, and the construct and importance of CSE are discussed.

Borderline Personality Disorder

Defining Borderline Personality Disorder

Stern (1938) is most often acknowledged as being the first to identify the symptom cluster now attributed to BPD. Criteria evolved to the list currently available in the DSM-IV-TR (APA. 2000). BPD is a common and serious, even life threatening

personality disorder. The DSM-IV-TR indicates that affirmation of five of nine

possible criteria indicates BPD. These nine criteria include:

> (a) a frantic effort to avoid real or imagined abandonment, (b) a
> pattern of unstable and intense interpersonal relationships
> characterized by alternating between extremes of idealization and
> devaluation, (c) a markedly and persistently unstable sense of self,
> (d) impulsivity, (e) recurrent suicidal behavior, (f) affective
> instability due to a marked reactivity of mood, (g) chronic feelings
> of emptiness, (h) inappropriate intense anger, (i) transient, stress-
> related paranoid ideation or severe dissociative symptoms. (p. 710)

The variety of possible combinations produces more than 250 ways to fulfill a BPD

diagnosis (Critchfiled, Levy & Clarkin, 2007; Kendler, 2011). With this many

different ways to diagnose the same disorder, the personality characteristics may be

significantly different from one correctly-diagnosed individual to the next. However,

research indicates moderate to strong levels of interrater reliability using these criteria

(Critchfiled, Levy & Clarkin, 2007).

BPD is found to be comorbid with several different Axis I disorders such as

drug and alcohol abuse and dependence; major depressive disorder (MDD); attention

deficit (hyperactivity) disorder (ADHD); post-traumatic stress disorder (PTSD);

bipolar disorders, and a variety of anxiety disorders (Cheavens, J. & Heiy J., 2011;

Critchfiled, Levy, & Clarkin, 2007; Skodol et al., 1999; Zimmerman & Mattia, 1999).

Discrepancies in the literature exist regarding the percentage of individuals

seeking therapy who meet criteria for BPD. One study stated 24% of the sample taken

in primary care settings met criteria for BPD when using an informant sample (Moran

et al., 2000). In another study, 50% of clients at a primary care counseling agency met

the criteria for a personality disorder on a self-report measure (Howey & Ormerod, 2002). Yet in a different study, individuals with BPD accounted for only 10-20% of all outpatient clients treated in mental health settings (Bjorklund, 2006; Gunderson & Links, 2007; Widiger & Weissman, 1991). In a national epidemiologic survey (Grant, 2008) prevalence of BPD was suggested to be between .5% and 5.9% in the general population. Although there is a discrepancy in the actual numbers reported by these studies, all confirm BPD as a prevalent and significant diagnosis within the mental health profession. Taking the median of the national epidemiologic survey, 1 out of 35 people in the United States meet the diagnostic criteria for BPD (Leichsenring, 2011).

It is important to note that published research on BPD is predominantly focused on women. Some research indicates that women are diagnosed with this disorder 3:1 over men (APA, 2000; Swartz, Blazer, George, & Winfield, 1990; Widiger & Weissman, 1991). In the same way, men are more commonly diagnosed with antisocial personality disorder (APA, 2000). Although there are many overlapping behaviors and symptoms, the acting out of these behaviors often leads to different diagnoses among genders (APA, 2000; Bjorklund, 2006). Bjorklund (2006) addressed this gender bias in the diagnosis of BPD. This author concluded that sociocultural factors play a role in the "expression of disease conditions" (p. 3). It is also indicated that BPD, along with all other personality disorders, has cultural history impacting diagnosis (Bjorklund, 2006). For example, gendered expectations around emotionality and relationship behaviors often occur in BPD. Women are expected to be more emotional, as opposed to men who are seen to be more aggressive (Block,

1983; Crick & Grotpeter, 1995; Taylor et al., 2000; Verona & Curtin, 2006). These

assumptions naturally influence diagnosis. It is evident that gender stereotypes impact

women and men in expression of, and perceptions about mental illness, specifically as

it relates to BPD (Bjorklund, 2006; Wright & Owen, 2001).

Although BPD was thought to develop through trauma in childhood, recent

studies suggested that its development also has genetic components (Foti et al., 2010;

Kendler, Myers & Reichborn-Kjennerud, 2010). Linehan (1993) referred to this as the

biosocial development of BPD. The neuropsychological aspect of BPD is emerging in

the literature including research showing newfound clinical disturbances in cognition

and perception (Dell'Osso, Berlin, Serati, & Altamura, 2010). This includes

difficulties with memory, attention, language, and frontal lobe functions (Dell'Osso,

Berlin, Serati, & Altamura, 2010; Kernberg, Dulz, & Sachsse, 2000; Sternbach, et al.,

1992: Zanarini, Gunderson, & Frankenburg, 1990). One aspect of memory

disturbance among this population proven to be challenging for clinicians is the

individual's difficulty with autobiographical memory specificity (Reid & Startup,

2010). One study indicated there is also a relationship between these individuals'

autobiographical memory and their social problem-solving skills (Maurex et al.,

2010). Autobiographical memory refers to the ability to recall personally meaningful

events. These memories help to create a structure upon which individuals build a

history of life. These memories impact the ability to problem solve in social situations

because they create a database of possible solutions to social dilemmas (Williams &

Broadbent, 1986). Although autobiographical memory specificity is lacking in the

overall BPD population, researchers warn this challenge may be better explained by differences in IQ and education (Reid & Startup, 2010).

The Prevalence of BPD and its Impact on the Community

On any given day in inpatient and outpatient clinical settings up to 20% of patients meet the criteria for BPD (Gunderson & Links, 2007). This population uses a disproportionately large percentage of the available community mental health services (Bender et al., 2001; Zanarini, Frankenburg, Khera & Bleichmar, 2001). However, this condition is dramatically underdiagnosed. One study suggested that because clinicians are hesitant to diagnosis BPD only two out of 61 patients who met BPD criteria were actually assigned the diagnosis (Zimmerman, 1999). Because of their inability to regulate emotions, and history of mood instability, many of these individuals were diagnosed with a bipolar disorder. Over 40% of patients diagnosed with BPD were previously diagnosed with a bipolar disorder (Zimmernam, 2010). When BPD is undiagnosed and untreated it has the potential to cost individuals, families, and the community a significant amount of money. One study reported treatment as usual (TAU) for people with undiagnosed BPD or undertreated BPD is approximately $17,682 a year (Foti et al., 2010). This is a conservative estimate includes emergency room visits at an average daily cost of $569 and inpatient stays at an average cost of $12,079 per visit.

Fortunately, the ability to screen for this diagnosis is becoming easier. The development of the McLean Screening Instrument for BPD (MSI-BPD) has been

helpful with this task. In one study the MSI-BPD was found to be an effective way to screen clients for this disorder in both inpatient and outpatient settings (Melartin, Hakkinen, Koivisto, Suominen, & Isometsa, 2009). An accurate diagnosis is essential to the effective work with this clientele for several reasons, especially because of the potential for self-harm.

The Self-Harm Component of BPD

Individuals with this disorder are chronically suicidal and prone to self-harm. The majority of clients are tormented with a constant invasion of suicidal thoughts and desires. Between 70% and 75% of people who have been diagnosed with this disorder have made at least one life-threatening act of self-harm (Black et al., 2004; Lieb et al., 2004; Perseius et al, 2007). These individuals often attempt suicide or self-harm to gain the attention of the people around them. They are desperate to feel connected, cared about, and avoid abandonment. The tragedy is that many times the attempts to take their own life are successful. In long-term studies the data reveals that over 10% of individuals who are diagnosed and have received some kind of treatment for BPD actually die from suicide (McGlashan 1986; Paris 2002; Stone, 1993). Brooks and Horn (2010) looked at the meaning of self-injury and parasuicidal gestures among women with BPD. They discovered that there were three themes that ran through their conversations. First, the context of the women's distress included distant factors (e.g. childhood abuse) and current factors (e.g. interpersonal conflict) (Brooke & Horn, 2010). The second theme was the progressive management of distress (Brooke &

Horn, 2010). The suicidal gesture was seen as a last resort after all other forms of self-harm no longer were effective in managing the pain (Brooke & Horn, 2010). The third theme was client ambivalence in their reactions to death. These suicidal gestures were talked about in the context of *wanting to die,* but appeared to be simply attempts to resolve strong feelings of pain and as "cries for help" (Brooke & Horn, 2010, p. 113).

Characteristics of BPD Individuals

One important study evaluated shame as a prospective predictor of self-inflicted injury among individuals with BPD (Brown, Linehan, Comtois, Murray & Chapman, 2009). Higher levels of shame were found to be a predictor of self-inflicted injury and shorter periods between self-inflicted injurious behaviors (Brown et al., 2009). Another recent study found identity disturbance, emptiness, and fear of abandonment may be at the core of the development of BPD and self-harm symptomology (Meares, Gerull, Stevenson, & Koner, 2011). These researchers found that although two people, both diagnosed with BPD, may not have most criterion in common, the vast majority of patients have the symptom of self or identity disturbance and emptiness (Meares et al., 2011).

Lachkar (2011) wrote the main dynamic of individuals with BPD is abandonment anxiety. In a similar way as people who are codependent, individuals with BPD do whatever they can to prevent both real and imagined abandonment by those with whom they perceive are the closest. They exhibit a sense of panic in their relationships, holding tightly to whatever they experience as connection (Lachkar,

2011). This intense attachment is accompanied by idealization, and then a fast and

unrelenting rejection of the person they are connected with at the time (Vaknin, 2007).

These individuals continually strive to achieve and maintain a sense of self or self-

worth.

> To get a sense of self or of self-worth, or to offset a chaotic self-
> image they will do anything (steal, gamble, take drugs, shop, abuse
> alcohol, engage in promiscuous behavior) to assuage the emptiness.
> (Lachkar, 2011, p. 1)

Impulse control is another characteristic of individuals with BPD identified

throughout the literature (Brooke, 2010; Critchfield, 2007; Lachkar, 2011;

Leichsenring, 2011; Linehan, 1993). This characteristic is played out with a multitude

of self-destructive and self-defeating behaviors. Suicidal gestures, high-risk behavior,

and self-mutilation are common in this population. One study indicated that

individuals diagnosed with BPD are 16 times more likely to engage in suicidal

behaviors than people diagnosed with major depressive disorder (Kelly, Soloff, Lynch,

Haas, & Mann, 2001). Individuals with this disorder are often unable to control their

desires to eliminate pain, and are unable to self-sooth (Brooke, 2010; Linehan, 1993).

Because of their inability to regulate emotions, their emotional pain is perceived as

never-ending.

Impact on Clinicians

Although emotional regulation plays a part in the inability to control impulses,

impulsiveness may also be impacted by psychotic reactivity in the borderline patient

(Glaser, 2010). These symptoms can prove to be a challenge for therapists treating

BPD clients (Rizq, 2012). In her recent study, Rizq (2012) interviewed clinicians

working with this population. Clinicians in this study describe how they can feel "on

the verge" of something dangerous.

> They latch on to you and it's like suck suck suck suck……I feel that
> we're like in this kind of quicksand, and I might be on the edge, but
> they're in there, and I'm holding their hands, but I feel… urghhh
> (gestures)… pulled in, no firm foothold. (Rizq, 2012, p. 40)

It is clear that clients with BPD leave clinicians nervous and confused due to their

impulsivity.

Glaser (2010) investigated the transient, stress-related paranoid ideation or

severe dissociative symptoms that have been seen as a core feature of BPD. In a recent

study Glaser (2010) found stress-related psychosis may be a more accurate way to

define the stress-related reality disturbances experienced by individuals with BPD than

the way the psychotic symptoms are defined currently in the DSM-IV-TR criterion as

transient, stress-related paranoid ideation. The study found that people with a BPD

diagnosis exhibited the strongest psychotic reactivity to daily life stress (Glaser, 2010).

This is an important finding when considering the impact that psychosis can have on

relationships with family and friends, as well as relationships with clinicians.

Counselors who work with this population can feel a sense of risk from the time of

their first encounter (Rizq, 2012). The counselor must continually assess whether the

client will be able to emotionally manage what might come up in session (Rizq, 2012).

This is challenging and risky in the eyes of counselors working with these clients.

The impulsivity and psychotic reactivity experienced by this population can create much difficulty in their ability to maintain connection and relationship with their mental health clinicians. Individuals with BPD characteristically are difficult to retain in treatment (Dimeff & Linehan, 2001). They often fail to respond to the emotional demands that come with therapeutic efforts (Perseus, 2007). These individuals are also emotionally and mentally draining on the clinicians with whom they work (Dimeff &Linehan, 2001; Perseus, 2007). When these clients are involved in TAU they often view their treatment as invalidating and tend to withdraw from therapy, turning their anger and frustration toward the clinician. Many times these clients vacillate between two extremes: withdrawing from the therapeutic alliance and over-engaging with angry outbursts (Dimeff & Linehan, 2001).

Treatments of BPD

Individuals with BPD are most vulnerable when they are not in treatment (Bergman & Eckerdal, 2000). Suicide among BPD clients is predominantly seen in the first five years after treatment ends (Mehlum et al., 1991). Because of this fact, treatment is part of life for most of these individuals. Over their lifetime 97% of these individuals receive outpatient psychiatric treatment from an average of six therapists (Lieb et al., 2004; Skodol, Buckley & Charles, 1983). Many different modalities are used in the treatment of BPD as well. These treatments include individual counseling, group therapy, couple and family psychotherapy, day treatment, psychiatric hospitalizations, and half-way houses in the community (Lieb, et al., 2004).

The American Psychiatric Association believes that the best treatment for this disorder is psychotherapy. Practice guidelines (APA, 2001) state that psychotherapy is best used in conjunction with pharmacotherapy for this population. The use of pharmacotherapy may be most effective during periods of significant decompensating or for specific trait vulnerabilities. Useful types of psychotherapies are strongly debated in the literature. A recently published overview of treatment for BPD (Leichsenring et al., 2011) assessed 24 different randomized controlled trials (RCTs) comparing treatments and their effectiveness with this population. These RCT's looked at TAU compared to different kinds of cognitive behavior therapy such as Dialectical Behavior Therapy. They also evaluated the effectiveness of transference-focused therapy, community treatment by experts, interpersonal group therapy, and many others (Lieb et al., 2004). This meta-analysis determined that cognitive behavior therapy including specific therapies such as Dialectical Behavior Therapy was more effective than other treatments in impacting most characteristics of BPD (Lieb et al., 2004). It is important to note that although other cognitive behavior therapies have been helpful with this population, research strongly indicates that Dialectical Behavior Therapy is the most effective therapeutic intervention with individuals with BPD to date (Davenport, 2010; Linehan, 2006; Perseus, 2007; Solar, 2009).

Dialectical Behavior Therapy

Van Gelder (2010), in a personal memoir about her journey of recovery from BPD, addressed the value of DBT from a client's perspective.

> What makes DBT therapy so critical to BPD is not just the
> presentation of skills, it is the approach to the borderline tension
> between needing to be accepted and validated, versus needing to be
> pushed into making changes. (p. 103)

This tension or *dialectic* is the characteristic that challenges counselors when working

with the BPD population.

History

Developed by Linehan (1993), DBT was the first method of psychotherapy

shown in clinical trials to be effective for individuals with BPD (Linehan, Armstrong,

Suarez, Allmon, & Heard, 1991). Trial and error over two decades of work with

difficult and extremely challenging BPD clients led to DBT's development (Linehan,

1993). Linehan reported that DBT was created out of a multitude of failed attempts to

apply standard treatment to chronically-suicidal clients (Dimeff & Linehan, 2001).

Similar to many clinicians who work with this population, Linehan reported her

experience as a counselor for these individuals was filled with frustration, challenge,

fear, and a feeling of inadequacy because of the ineffective TAU. Linehan also noticed

that these clients experienced invalidation, which created animosity and emotional or

verbal attacks toward the clinician (Dimeff & Linehan, 2001).

The first DBT clinical trial in 1991 brought new hope for therapists in their

work with individuals with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard,

1991). This study showed a significant drop in parasuicidal actions during the

treatment year. Parasuicidal actions include actions that mimic the act of suicide, but

do not end in suicide. These actions include behaviors such as overdosing or cutting.

Linehan's study (1991) also reported that DBT was significantly more effective than TAU in decreasing the dropout rate among DBT clients. These and many other findings (Lynch, Chapman, Rosenthal, & Linehan, 2006; McMain & Korman, 2001; Neacsiu, Rizvi, & Linehan, 2010; Soler et al., 2009) encouraged therapists to begin a thorough investigation into the impact that this approach could have on clients who have been traditionally considered hopeless and helpless.

The DBT World View

A dialectical perspective, as used in this therapy, is defined by three major characteristics (Linehan, 1993). The first characteristic is the interrelatedness and wholeness of reality. Reality, Linehan purported, comes with good and bad, right and wrong, dark and light. BPD clients struggle to accept multiple realities or understand reality as the sum of parts (e.g. good and bad) (Linehan, 1993). DBT promotes this characteristic as a skill that both client and clinician must learn. Further, the clinician is burdened to manage the client skills deficits.

> The therapist must take into account the interrelatedness of skills deficits. Learning one new set of skills is extremely difficult without learning other related skills simultaneously- a task that in itself is even more difficult. (Linehan, 1993, pp. 1-2)

Fundamentally, clinicians must understand the incongruent nature of what is being asked of the client; a client must learn new skills to manage emotional reaction and response, *and* the client needs the skill set they lack in order to learn the new skill set. This is the crux of dialectic tension.

Dialectic's second characteristic addresses the dynamic nature of reality. Reality is not static, but rather made up of opposing forces that, when synthesized, create more opposing forces (Linehan, 1993). BPD clients experience dichotomous thoughts, feelings, or behaviors as dialectical failures. This extreme and one-sided emotive reaction characterizes BPD client experiences. When counselors work with this population, three polarities (dialectics) can interfere with DBT skills training. The clinician's task includes the synthesis of these polarities (Linehan, 1993).

- The first dialectic is the need for clients to accept their realities in the moment while accepting their need for change.

- The second polarity addresses the tension clients experience trying to meet their needs and the willingness to potentially lose what they have prioritized as important if they improve.

- The third polarity challenges clients to validate their experiences and views while developing an awareness of the need to learn new skills, or the negative impact of their current unhealthy behaviors (Linehan, 1993).

The third dialectic characteristic focuses on the reality of change, and the value of process, rather than on content or structure (Linehan, 1993). Client and clinician must accept that individuals and environments are continually in a state of transition. The goal of the therapist is not to stabilize the client's environment, but to empower the client to function effectively through change. The therapist also must maintain

awareness of how they are changing over time. This change in both attitude and action can impact the way in which they interact with clients.

In addition to the three characteristics of dialectics, another of DBT's central philosophies is the idea that all people do the best they can with the skills they have (Moonshine, 2008). However, with this understanding also comes the acknowledgement that people's best efforts are often ineffective for creating healthy relationships and improving life circumstances.

DBT Structure and Components

Linehan's (1991) original work introduced the structure and components for implementing a DBT treatment program. These four components included skills group training, individual counseling, phone consultation, and clinician consultation groups. These components were originally intended to work together as a system to help both the client and the counselor. For the purposes of this literature review, only the skills training group component is discussed.

Skills group training. The skills training group is one of the unique components of DBT. Skills training groups (DBT-ST) differ from standard group therapy (SGT) in that DBT-ST has a strong psycho-educational component and focuses less on therapeutic process. These groups emphasize education and implementation of skills that help lead clients into more effective lifestyles. This group component of DBT includes between 2 and 2.5 hours of group skills coaching per

week. The goal is to increase the clients' abilities to behave effectively in the

environments in which they live (Soler, 2009).

Compared to SGT, skills training groups are considerably more effective when

working with clients with BPD (Soler, 2009). Clients who implemented DBT skills

demonstrated improved dropout rates, mood regulation, and general psychiatric

symptom reduction at greater rates than those in SGT (Soler, 2009). This is important

for therapists to consider when recommending concurrent therapy for their individual

clients. Interestingly, Linehan (1993) asserted that the skills training component of

DBT does not need to be done in groups. Although group interventions are cost

effective and provide unique benefits (Soler, 2009), Linehan asserted that the

effectiveness is not diminished when taught individually to clients (Linehan, 1993).

The skills training group experience was originally intended to be a part of a

larger program for individauls with BPD that incorporated all of the four components

Linehan developed (Linehan, 1991). However, studies indicate that clients

participating in the DBT Skills Training component alone can see notable

improvement, even when it is not combined with the other components of DBT

(Koons et al., 2001; Neacsiu, 2010). This group experience seems to be the component

of DBT that increases perceived efficacy in clients (Miller, Wyman, Huppert,

Glassman, & Rathus, 2000).

DBT-ST increases the client's ability to implement coping skills (Neacsiu,

2010). Researchers in one study adapted the Revised Ways of Coping Checklist

(RWCCL; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985) for use with DBT clients (Neacsiu, 2010). This DBT-WCCL is a self-report questionnaire measuring the frequency of DBT skills use. The use of these skills, which leads to significant improvement in symptoms, was substantially higher in individuals who were merely involved in DBT skills training, than clients in TAU (Neacsiu, 2010).

DBT-ST is comprised of four different modules that teach all DBT skills over a four to six month period. These modules include core mindfulness, emotional regulation, interpersonal effectiveness, and distress tolerance (Linehan, 1993).

Core mindfulness module. The Core Mindfulness module is essential to the understanding and implementation of DBT. The skills learned in this module include what Linehan (1993) refers to as mindfulness *what* skills and mindfulness *how* skills.

Mindfulness *what* skills help clients become aware of their circumstances and environments. This includes teaching clients to observe, describe, and participate in their surroundings (Linehan, 1993; Moonshine, 2008). In this module *observing* is the skill which allows individuals to cultivate awareness and connection to events, behaviors, or feelings without needing to either stop these experiences, or make them last longer (Linehan, 1993; Moonshine, 2008). The mindfulness skill of *describing* allows clients to put words to their emotions and circumstances without including judgment in their language. It includes the ability to take a non-judgmental stance toward people, emotions, events, and circumstances, which is a vital part of the success of DBT. Individuals with BPD are inclined to confuse emotions and thoughts

with facts. This leads to dysfunctional thinking and behaving (Linehan, 1993; Moonshine, 2008). The core mindfulness skill of *describing* requires individuals to leave out judgmental or subjective language and focus on the actual event of the moment.

The third core mindfulness skill called *participate* allows clients to enter into their here-and-now moment without judging themselves or experiencing self-consciousness (Moonshine, 2008). It is a skill that enables clients to see themselves in their circumstances, and act effectively in those circumstances. For example, people walk through their homes without participating when they get into a room and wonder why or how they got there. To *participate* is to fully enter into their current moment and activity without concerning themselves about past or future events (Linehan, 1993; Moonshine, 2008).

The next mindfulness skill set includes the *how* skills. Skills training facilitators teach individuals *how* to observe, describe, and participate. This is comprised of three specific skills including taking a nonjudgmental stance, focusing on one thing in the moment, and being effective in interactions (Linehan, 1993; Moonshine, 2008).

Nonjudgmental stance requires participants to maintain a non-evaluative attitude to all things around them. The tendency for the BPD population is to adopt either an extreme negative judgment of themselves, others, or events, or an extreme positive judgment of the same things. Nonjudgmental stance allows for the

observation of consequences for behaviors, but does not allow anything to be labeled good or bad (Linehan, 1993; Moonshine, 2008).

The next mindfulness *how* skill is the skill of focusing one's mind on the task at hand rather than allowing the mind to wander to past or future activities. This requires participants to pay attention and control their minds and thoughts (Linehan, 1993; Moonshine, 2008). This is a task that most BPD clients find almost impossible. Many times these individuals cannot comprehend that they have the ability to control their thoughts. They often report feeling out of control of their thought process. This is most often a new concept to many clients in DBT skills groups.

The final *how* skill is the concept of effectiveness. This is a core skill in DBT and is used throughout all other modules. Linehan stated:

> Effectiveness is the opposite of 'cutting off your nose to spite your face'. As our clients often say it is "playing the game" or "doing what works". From an Eastern mediation perspective, focusing on effectiveness is "using skillful means". The inability to let go of being right in favor of achieving goals is, of course, related to borderline individuals' experiences with invalidating environments. A central issue for many clients is whether they can indeed trust their own perceptions, judgments and decisions- that is, whether they can expect their own actions to be correct or "right." (Linehan, 1993, p. 64)

Although core mindfulness is a separate module, the additional three modules taught in DBT-ST are interrelated (Linehan, 1993; Moonshine, 2008). The skills overlap and are built upon one another. The order in which the modules are taught is not important, however the skills are best understood after the participant has completed the entire sequence.

Emotional regulation module. Another Module that is part of DBT-ST is emotional regulation. DBT postulates BPD clients' inability to regulate painful emotions plays an integral part in their inability to behave effectively. Disregulated emotions are closely linked to the BPD's biosocial component and are a fundamental part of this diagnosis (Linehan, 1993a; Linehan, Bohus, & Lynch, 2007; Lynch, 2006). One study suggested the reduction of ineffective behavior tendencies linked to disregulated emotions is the main mechanism of change in DBT and impacts the success of the client greater than other skill acquisition (Lynch, 2006). This module allows the skills training participant to learn skills that teach them to participate in useful, edifying behaviors, even while experiencing strong emotions. These skills must be taught within a "context of emotional self-validation" (Linehan, 1993, p. 84). Many BPD clients initially reject the idea that they can change their emotions because there has been little validation or acknowledgment of the need for these emotions in the environments in which they have developed (Linehan, Bohus, & Lynch, 2007). However, studies indicate that individuals who complete DBT skills training have substantially improved emotional regulation skills (Axelrod, Perepletchikova, Holtzman, & Sinha, 2010; Linehan, 1993; McMain, Korman, & Dimeff, 2001). The client's regulated emotional state decreases self-harm behaviors, including substance use, as well as decreased dangerous impulsivity (Axelrod, Perepletchikova, Holtzman, & Sinha, 2010; Linehan, 1993; McMain, Korman, & Dimeff, 2001).

Linehan (1993) created a set of emotional regulation skills that help the group participants. These skills include:

- identifying and labeling emotions;

- identifying obstacles to changing emotions:

- reducing vulnerability to "emotion mind";

- increasing positive emotional events;

- increasing mindfulness to current emotions;

- taking opposite action; and

- applying distress tolerance techniques (Linehan, 1993).

These skills are heavily reliant on *observe and describe* skills from the mindfulness module. Individuals must be able to look at their own emotional responses and describe the context in which the emotion took place. Then the participant must take intentional actions aimed at regulating emotions.

In the emotional regulation module of DBT-ST, clients not only learn a set of skills, they are also introduced to the DBT diary card which helps the client track emotion lability (Linehan, 1993; Moonshine, 2008). Clients track and measure emotional intensity throughout the week and record both emotion fluctuation and skills used. Linehan (1993) instituted the diary card concept as a visual that allowed clients to evaluate their changing emotions over time. This tool has also been used in tracking client skill development (Stepp, 2008). Diary cards are helpful to both client and clinician in evaluating therapy effectiveness and implementation of skills. The diary card helps clients understand that emotions do not last forever - a concept difficult for individuals with BPD to comprehend. They often experience emotions as

if they are unchangeable (Linehan, 1993; Moonshine, 2008). The concept of changing

emotions gives clients hope and the ability to tolerate strong negative emotions.

    Distress tolerance module. A recent review of the literature on distress

tolerance (Leyro, 2010) found the inability to tolerate distress is a central component

seen in individuals with psychological disorders, including personality disorders such

as BPD. Distress intolerance has also been established as a risk factor for these same

disorders (Leyro, 2010).

    Linehan (1993) included distress tolerance as a core concept in DBT based on

the idea that pain is a human experience and impossible to avoid. DBT also

acknowledges that no desired change can occur without short-term distress. Distress

tolerance skills give clients the ability to stifle impulsive actions and move toward

desired change. Linehan (1993) is quick to point out that accepting the reality of

distress does not equal approval of a difficult reality. Accepting one's reality is the

starting point of changing reality. In order to tolerate distress, clients must learn to

admit and accept their circumstances, both past and present.

    DBT-ST group facilitators teach clients to distract themselves from negative

emotions during crisis and in day-to-day living. Instruction is given on how clients can

self-sooth in healthy ways. In addition, the participants learn to *improve the moment* so

that they can handle their emotion from an improved state (Linehan, 1993;

Moonshine, 2008). The final skill in this module is the skill of *pros* and *cons*. Clients

learn to evaluate their circumstances, taking into consideration both the positive and

negative aspects of any situation (Linehan, 1993; Moonshine, 2008). These skills are

foreign concepts to most clients with BPD and are vital for the clinician to understand

as they work with this population. Whereas distress tolerance has been shown to be a

mechanism of change for various pathologies, clinicians have misunderstood the value

of incorporating these skills into therapeutic process (Leyro, 2010). DBT allows

clinicians to have a concrete way to introduce this concept to clients.

Linehan (1993), and later Cathy Moonshine (2008), also emphasized the

contrast between *willingness* and *willfulness*.

> The notion of *willingness versus willfulness* is taken from Gerald
> May's (1982) book on the topic.
> 1. *Willingness* is accepting what is, together with responding to
>   what is, in an effective or appropriate way. It is doing what
>   works. It is doing just what is needed in the current situation
>   or moment.
> 2. *Willfulness* is imposing one's will on reality – trying to fix
>   everything, or refusing to do what is needed. It is the
>   opposite of doing what works. (Linehan, 1993, p. 103)

Empirical evidence suggested that when DBT-ST facilitators can understand and

incorporate willingness versus willfulness into their interventions, clients are more

open to distress tolerance concepts (Leyro, 2010).

Interpersonal effectiveness module. Because of the BPD clients' inability to

tolerate distress and regulate emotions these individuals inevitably struggle with

maintaining effective relationships (Linehan, 1993; Pederson, 2012). DBT

incorporates a separate module to address the application of relationship skills in order

to help BPD clients manage their lives in community (Linehan, 1993; Moonshine,

2008). There is limited research done on this module of DBT in comparison to the

other three modules.

Interpersonal effectiveness includes three different skill sets. DBT asserts that

all interactions have three different goals; obtaining your objective, maintaining

relationship, and self-respect (Linehan, 1993). When teaching these skills, it is vital

for clinicians to incorporate role-play into the group process in order for clients to see

these skills in action (Moonshine, 2008). Despite the importance of in-session

practice, new counselors tend to shy away because of lack of confidence (Linehan,

1993). As the clinician feels more confident, the clients get more exposure to skills

practice where they are able to begin incorporating learned behavior into their

relationships.

DBT's Impact on Clients

Since the publication of Linehan's (1993) book almost two decades ago

researchers have empirically studied this therapeutic model. The effectiveness of this

therapy as a whole, as well as most of its individual components have been well

researched (Davenport, 2010a; Leyro, 2010; Linehan, 2006; Perseus, 2007; Solar,

2009). DBT correlates with better client outcomes as compared with treatment as

usual (TAU) (Linehan, 2006; Lynch, 2006; Neacsiu, 2010; Soler, 2009). Clients who

completed DBT were half as likely to attempt suicide or engage in parasuicidal

activity, and had lower risk of all self-injurious behaviors over a two-year follow-up

study (Linehan, 2006). The 2006 study, along with several others, discovered that

individuals who were involved in DBT were less likely to drop out of therapy and had

a significantly reduced amount of psychiatric hospitalizations and emergency room

visits (Linehan, 2006; Neacsiu, 2010; Soler, 2009). Another benefit is that, because of

the decreased need for high-end services, the average cost of treatment is significantly

lower for clients who are involved in a DBT treatment plan than for those who receive

TAU (Pasieczny & Conner, 2011).

In their qualitative study, Hodgetts, Wright, and Gough (2007) explored the

client's experience of DBT. Overall, clients who finished DBT reported emotional and

behavior change, and a great satisfaction with their experience. One aspects of DBT

valued by clients was its highly-organized structure. When one client compared DBT

to other treatments she stated, "this (DBT) was the only one that I could get my teeth

into that meant anything" (Hodgetts et al., 2007, p. 174). Other clients in this study

expressed challenges in DBT, however all participants described their relationship

with their DBT therapist as very valuable. These study participants indicated that their

DBT experience impacts the therapeutic relationship because of the therapy's

effectiveness (Hodgetts et al., 2007; Pasieczny & Conner, 2011). The DBT therapist

makes significant impact on clients in their groups and individual practice (Hodgetts et

al., 2007). This collection of research indicates that the effectiveness of DBT is not

simply due to "factors associated with expert psychotherapy," but that DBT is

"uniquely effective" when used with this difficult population (Pasieczny & Conner,

2011, p. 5)

DBT's Impact on Clinicians

Not only do clients benefit from DBT, recent research indicated clinicians are finding help when learning DBT skills as well (Miller et al., 2011; Pasieczny & Conner, 2011). Therapists who receive face-to-face training in DBT see significantly greater improvement in their clients, compared to what is seen from therapists who receive only minimal training (Pasieczny & Conner, 2011). A recent study showed counselors who received DBT training experienced decreased stress when working with clients with borderline traits (Miller et al., 2011). In this study the researchers measured the cortical levels in counselor trainees working with clients exhibiting borderline traits. Over the course of 12 months counselors who received DBT training had a decrease in cortical levels, whereas the comparison group's levels increased. This ground breaking study points to the effectiveness of DBT training for decreasing counselor stress and anxiety while working with difficult clients (Miller et al., 2011).

When combining the knowledge that counselors-in-training have increased exposure to BPD clients, with the information presented in these two studies, it is interesting to postulate that there would be a significant benefit to exposing counselors-in-training to DBT skill sets and offering DBT training to preservice counselors.

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Counselor Self-Efficacy

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"Beliefs in personal efficacy constitute the key factor of human
agency. If people believe they have no power to produce results, they
will not attempt to make things happen" (Bandura, 1997, p. 3).

Definition

Self-Efficacy became a topic of interest in the world of psychology in the early twentieth century (Irwin & Mintzer, 1942). However, Bandura (1977, 1986) was the first to define and measure this construct, giving it a scientific foundation. Self-efficacy is defined as the "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3). Bandura's early research indicated that when self-efficacy beliefs are low individuals are less likely to put effort into an activity, spend time attempting to succeed, and feel a greater level of anxiety about failing at activities than when self-efficacy beliefs are higher (Bandura, 1986).

The application of this construct to the field of counseling has helped in the understanding of how counselors construct their counseling environments as well as how they implement counseling activities (Bandura, 1997; Larson, 1998). Counselor self-efficacy (CSE) is defined as "one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson, 1998, p. 180). Although Bandura did not comment specifically on CSE, his ideas about how self-efficacy impacts functioning have been easily applied to the counseling field (Larson, 1998). CSE has been conceptualized into three domains: performing basic helping skills, managing session tasks, and negotiating challenging counseling situations and presenting issues (Lent, Hill, & Hoffman, 2003). As CSE increases so does the counselor's likelihood of accepting and approaching clients, putting more effort into

the therapeutic relationship, and persisting in counseling behaviors (Larson, 1992). Individuals with higher CSE are more likely to demonstrate the following skills: (a) advanced empathy, (b) advanced ability to assess client's concerns, (c) process with clients, (d) advanced ability to manage dichotomy, and (e) discern which therapeutic technique to use in session (Halverson, 2006).

Predicting & Building Counselor Self-Efficacy

Much of the CSE research is focused on counselors-in-training because building CSE begins while clinicians are in the initial phases of their career development. Throughout the literature there are several factors that have been suggested to help build CSE in counselors-in-training.

In one study looking at the effects of emotional intelligence on CSE, researchers found a significant correlation between CSE and the ability of the counselors-in-training to identify their own emotions and the emotions of others (Easton, Martin, & Wilson, 2008). In this study, there was a positive correlation between graduate counseling student's scores on the Emotional Judgment Inventory (EJI) and the Counseling Self-Efficacy Inventory (COSE). These areas of CSE included attending to process and dealing with difficult clients (Easton et al., 2008).

Mindfulness has also been suggested to be a predictor of CSE (Breason & Cashwell, 2009). In this study the researchers evaluated the predictive relationship between mindfulness and CSE. The study also focused on the potential mediating effects of both attention and empathy, on the relationship between mindfulness and

CSE. The study indicated that when counseling interns and doctoral counseling students demonstrated high levels of mindfulness, they also score high on CSE inventories (Greason & Cashwell, 2009). In this same study attention and empathy were shown to be strong mediators between mindfulness and CSE.

> Students who can be mindful in everyday life are more likely to
> strategically control their attention in the counseling session and to
> be empathic. They can sustain nonjudgmental attention on the
> client's narrative as well as divide attention to observe such things as
> client non-verbals without getting lost in their own inner dialogue.
> (Greason & Cashwell, 2009, p. 14)

The student's ability to maintain attention and be mindful in session was strongly correlated with CSE scores.

In their longitudinal study, Halverson and colleagues (2006) found that moral reasoning and conceptual development may both be predictors and builders of CSE. Moral reasoning, as a construct, is defined as the way in which one conceptualizes *self-other* quandaries lending to the ability to create an action plan (Kohlberg, 1976). Conceptual development, a domain in cognitive development theory, includes critical thinking skills used by the individual to conceptualize and make meaning out of their relationships and other experiences (Halverson, Miars, Livneh, 2006; Morgan, 1998). The study indicated that these three constructs developed together. When one increased so did the other (Halverson et al., 2006).

Research points out that counselor education, training, and supervision positively impacts and builds CSE (Barnes, 2004; Halverson et al., 2006; Johnson, Baker, Kopala, Kiselica, & Thompson, 1989; Kozina et al., 2011; Larson, 1998). The

positive relationship is also found through practical counseling experience (Larson et al., 1997). Counselors-in-training consistently demonstrated a growth in CSE over the first year in a counseling education program consisting of only classroom experience (Halverson et al., 2006; Kozina, 2011). However, CSE appears to dramatically increase during the subsequent two years of a counselor education program which adds practicum and field experience to class work (Barbee et al., 2003; Ladany, Ellis, & Friedlander, 1999; Larson et al., 1992). When counselors are able to put into practice and experience themselves as counselor they have a sense of mastery and competence in their use of counseling skills.

CSE and Performance

Although it is beneficial to note the increase in CSE through counselor training and practice, the question that is perhaps more important is if CSE can impact clinical skills and outcomes. One study showed that graduate training played an important role in the client's efficacy expectation of their clinician (Sipps, Sugden, & Faiver, 1988). Additionally, there has been research that suggested that trainees who measured higher in CSE were confident in the implementation of basic therapeutic skills and handling difficult situations with their clients (Lent, Hill, & Hoffman, 2004). This same study also stated that clinicians with higher CSE were also more likely to demonstrate confidence in other basic aspects of counseling. Larson (1998) wrote counselors-in-training who score high in CSE are better able to accept and apply feedback from instructors and supervisors into their learning experience. The application of leaned

skills and knowledge translates into more effective work with clients (Larson, 1998). However, with the exception of these three studies this writer is unaware of further research focused on the correlation between CSE and counseling outcomes. This area requires further research.

CSE as a Predictor of Career Choice

Lent and Hackett (1987) discovered that individuals chose career paths, and subsequently specific paths within a career, based in part on perceived self-efficacy. People generally will gravitate toward areas of comfort and competence, and in turn, gravitate away from career paths where they feel they would not be successful (Lent & Hackett, 1987; Kozina, Grabovari, De Stefano, & Drapeau, 2011). It is interesting to postulate, because of the impact of self-efficacy on career, counselors would move toward clients with whom they feel effective, and with whom the clinician feels they can have impact.

Hindrances to CSE

Counselor anxiety.

Research indicates that counselor anxiety negatively affects CSE (Barbee et al., 2003; Barnes, 2004; Larson et al., 1992). Not only did increasing CSE in counselors-in-training help decrease anxiety, but counselors-in-training experiencing an higher amounts of anxiety reported CSE scores lower than their less anxious counterpart (Barbee et al., 2003).

Difficult Clients.

A recent qualitative study explored the experience of counselors working with clients with high needs, such as those with BPD (Rizq, 2012). The results of this study suggest that working with high needs clients creates a sense of failure and ineffectiveness for counselors (Rizq, 2012). The counselors who were interviewed for this study discussed the fact that although many of them felt they were skilled clinicians, they were going to be unable to be effective with these specific clients. One clinician stated:

> I feel an expectation on me, a pressure somehow to do more than maybe the service could offer, than the relationship is going to offer… my kind of reaction is: 'this is never going to be enough'.
> (Rizq, 2012, p. 39)

The clinicians interviewed for this study collectively acknowledged a pervasive sense of failure when working with this population. No matter how good these clinicians believed they were, they believed that their efforts with this population were not effective to bring about change (Razq, 2012)

Summary

Developing counselor self-efficacy in counselors-in-training is important to both the success of the student, as well as to their future clients. Factors such as emotional intelligence, anxiety level, training, and experience impact the development of CSE. Elevated levels of anxiety have been shown to decrease CSE scores. It is also true that working with difficult clients, such as clients with BPD, can decrease CSE.

Borderline personality disorder is a pervasive disorder that, among other symptoms, limits people's ability to regulate emotions, tolerated distress, and be effective in relationships (Linehan, 1993). Individuals with BPD do not have a defined sense of self and tend to self-harm significantly more than other clients. These individuals are at increased risk of suicidal ideation as well as suicidal gestures. This population uses a disproportionately large percentage of the available mental health services provided in our communities (Bender et al., 2001; Zanarini, Frankenburg, Khera, & Bleichmar, 2001). Due to the symptoms of this disorder, it is often challenging for counselors to work with these clients (Raz, 2012). In general, treatment as usual for this population of clients is ineffective. The BPD populations traditionally have a high drop-out rate in counseling settings. Although there have been several treatments studied with this population, Dialectical Behavior Therapy (DBT) has proven to be one of the most widely researched and effective therapies for this population of clients (Lynch, Chapman, Rosenthal, & Linehan, 2006; McMain & Korman, 2001; Neacsiu, Rizvi, & Linehan, 2010; Soler, et al., 2009).

Linehan introduced DBT in 1993. It was the first method of psychotherapy shown in clinical trials to be effective for individuals with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). DBT has both an individual counseling component, as well as a skills training group component to the therapy (Linehan, 1993). In skills training, clients focus on skills that help them regulate emotions, become more effective in their interpersonal relationships, tolerate stress in their lives, and live more

mindfully in the moment. DBT gives counselors tools to use to work with this specific population with more effectiveness and compassion.

In this review of the literature there is an indication of the need for further research to assess whether training in DBT could increase the CSE of counselors-in-training as they work with clients with BPD.

Chapter 3

The Impact of a DBT Workshop on the Counselor Self-Efficacy of Counselors-in-
Training: A Quantitative Study.

by

Wendy S. Bruton

CHAPTER III: METHODS & RESULTS
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Abstract

The aim of this study was to build upon the presented literature review and provide information into the employed research procedures and design. This quantitative study used a nonequivalent groups, quasi-experimental design to investigate how a workshop in dialectical behavior therapy (DBT) impacted the counselor self-efficacy (CSE) of graduate counseling students ($n = 21$), as measured by the Counselor Self-Estimate Inventory (COSE), with regard to their work with borderline personality disordered clients. Participants were recruited out of clinical internship classes from a northwest university graduate counseling department. Study participants were divided into two groups by classroom. The first group, the treatment group ($n=12$), took the pretest and then attended a DBT workshop. Upon completion of the workshop the treatment group was given a posttest. The other group, the comparison group ($n = 9$), had no additional intervention between the pretest and posttest. The data analysis was done using an ANCOVA along with repeated measures t-tests. The results indicated that the use of specific training in DBT has the potential to increase the self-efficacy of counselors-in-training.

Chapter III: Methods & Results

Introduction

Borderline Personality Disorder

Borderline personality disorder (BPD) is a severe psychiatric disorder often associated with patterns of emotional disregulation, impulsivity, and increased self-harm risk (APA, 2000). Individuals with this disorder are chronically suicidal, prone to self-harm, and are characterized by a lack of a sense of self (APA, 2000). The vast majority of individuals with BPD have made at least one significant suicide attempt (Black et al., 2004; Lieb et al., 2004; Perseius et al., 2007). Community mental health facilities struggle to serve the growing number of BPD clients: Up to 20% of clients meet the criteria for BPD (Gunderson & Links, 2007). This population uses a disproportionately large percentage of available community mental health services (Bender et al., 2001; Zanarini, Frankenburg, Khera & Bleichmar, 2001).

Counselors working with BPD clients reported feeling overwhelmed and underprepared to interact effectively with these clients (Rizq, 2012). Historically, BPD clients have been non-response to treatment as usual (TAU), and are frequently emotionally draining to their clinicians (Howey & Ormerod, 2002; Perseus et al., 2007; Rizq, 2012). Working with clients who exhibit symptoms of BPD increased the risk of both counselor stress and counselor burnout (Loughrey et al., 1997; Melchior et al., 1997, Perseus et al., 2007). The continuous concern for the safety and wellbeing of chronically suicidal and self-harming clients stresses even experienced clinicians (Perseus et al., 2007). High stress levels from working with this population have

potential to impact counselor self-efficacy.

Therefore, reduction of stress and improved counselor self-efficacy is key when working with BPD clients. The purpose of this study was to investigate the self-efficacy of counselors-in-training with regards to their work with clients who exhibit BPD symptoms. The study examined the impact of DBT training on the experience of effectiveness of counselors-in-training (measured as counselor self-efficacy) with BPD clientele.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) was the first method of psychotherapy shown in clinical trials to be effective for individuals with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The first DBT clinical trial in 1991 brought new hope for therapists working with individuals with BPD (Linehan et al., 1991). Linehan's study showed a significant drop in parasuicidal actions during the treatment year. It also reported that DBT was more effective than TAU in decreasing the dropout rate among BPD clients.

Not only is DBT beneficial to the clients, it also was designed to be helpful to clinicians working with this population. The structure of DBT has been set up to include teamwork, mindfulness training, and structured interventions that are preventative measures against counselor burnout and stress (Linehan, 1993; Pereius, 2007). When counselors can incorporate the DBT skills they teach their clients into their own personal and professional life, they are more easily able to deal effectively with BPD clients (Miller et al., 2011; Pasieczny & Conner, 2011).

Counselor Self-Efficacy

The importance and relevance of counselor self-efficacy continues to be a source of interest for both clinicians and researchers in the counseling field (Larson, 1998; Lent, Hill, & Hoffman, 2003). Counselor self-efficacy (CSE) is defined as "one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson, 1998, p. 180).

As CSE increases, so does a counselor's likelihood of accepting and approaching clients, putting more effort into the therapeutic relationship, and persisting in counseling behaviors (Larson, 1992). Clinicians with higher CSE are more likely to show advanced empathy, advanced ability to assess client's concerns, process with clients, advanced ability to manage dichotomy, and discern which therapeutic technique to use in session (Halverson, 2006). Counselors-in-training with higher scores in CSE proved confident in the implementation of not only the basic therapeutic skills, but also in handling difficult situations with their clients (Lent, Hill, & Hoffman, 2004). The same study also suggests that clinicians with higher CSE are more likely to demonstrate confidence in other basic aspects of counseling (Lent et al., 2004). Research indicates counselors-in-training scoring high in CSE are better able to accept and apply feedback from instructors and supervisors (Larson, 1998; Lent et al, 2004; Lent, Hill, & Hoffman, 2004). The application of learned skills and knowledge translates into more effective work with all clients, including challenging individuals (Larson, 1998).

Purpose and Research Question

This study examined changes in the self-efficacy (CSE) of counselors-in-training following a DBT training. Two research questions were established in order to determine the effects of the DBT training on CSE.

Research Question #1: *What is the impact of DBT training on the counselor self-efficacy of counselors-in-training with regard to their work with BPD clients as measured by the Counselor Self-Estimate Inventory (COSE)?*

DBT training is here defined as a four hour didactic workshop covering basic DBT skills and philosophy.

Hypothesis #1:

H_0: *There is no impact of DBT training on the counselor self-efficacy of counselors-in-training with regard to their work with BPD clients.*

H_1: *DBT training significantly increases the counselor self-efficacy of counselors-in -training with regard to their work with BPD clients.*

Research Question #2: *To what extent does a DBT workshop impact each of the COSE subscales "challenging client behaviors"?*

Hypothesis #2:

H_0 *COSE subscale "challenging client behaviors" will show no significant difference compared with the other COSE subscale means after a DBT training.*

H₁   COSE subscale "challenging client behaviors" will show a significantly higher improvement compared with the other COSE subscale means after a DBT training.

Study Purpose

The purpose of this study was to observe the impact of a DBT training on counselor education students' counselor self-efficacy using the Counselor Self-Estimate Inventory (COSE). Self-doubt is a significant barrier in preservice and new professional development. We purpose to understand the way in which training related to working with difficult diagnoses may help counselor educators and supervisors train preservice clinicians, as well as enhance the skill development of professionals.

Dependent variable. The dependent variable is defined as the participant's counselor self-efficacy as evidenced by a change of score on the COSE.

Independent variable. The independent variable is defined as a workshop-style training on DBT.

Methods

Design

This study employed a quantitative, nonequivalent groups design (NEGD), using a pre- and posttest (Trochim, 2005). This design was chosen in order to examine the impact of a workshop in DBT on the CSE of counselors-in-training with regards to their work with BPD clients. The intervention in this study is defined as a training workshop on basic DBT skills (see appendix C). This design was chosen because NEGD allows data to be evaluated for how a specific treatment affects the dependent

variable by comparing results from a comparison group using non-equivalent pre-existing groups. NEGD is also employed when there is an inability to randomly assign participants to groups (e.g.: a convenience sample) (Sheperis, 2010). The participants in this study could not be randomly assigned because both the treatment group and the comparison group were established by course enrollment, and pre-assigned course sections. In this study, a treatment group received the intervention (DBT training provided over two class sessions). A second group of counselors-in-training did not receive the DBT training. Differences in their pre- and post-scores on the COSE were compared (Sheperis, 2010; Trochim, 2005).

Design Strengths. The non-equivalent group pretest – posttest design is a commonly used research design used to establish the impact of a program or intervention on a specific group (Shadish, Cook, & Campble, 2008; Trochim, 2005). This design enables the researcher to measure outcomes for a treatment group and a comparison group that are similar, or have matching characteristics that are important to the study, and will allow the researcher the ability to measure a significant change between a treatment group and a comparison group. Non-equivalent group pretest and posttest design allows researchers to simply and effectively measure the impact of their intervention (Shadish et al., 2008; Trochim, 2005). In this study an ANCOVA was employed to determine results, along with repeated measures t-tests.

Any design must be evaluated on the ability to strengthen internal validity. The use of this design significantly decreases the *maturation* threat to internal validity (Trochim, 2005). When measuring the impact of the DBT workshop on CSE of

counselors-in-training, it was important to attempt to eliminate any outside events that may impact the students learning and therefore impact the outcome of the study. The intervention is implemented over only a one week period (two sequential Monday classes). This time line significantly decreases the likelihood that the counselor's maturation over time will impact the study.

The *mortality* threat to internal validity was limited with this design and participant selection (Trochim, 2005). There were no students who dropped out of the study because this study was conducted as part of the curriculum presented in a required class.

All of these threats were also diminished due to the use of a comparison group. The use of a comparison group brings strength to the internal validity of this study.

Design Weaknesses. A threat to internal validity is possible: "The groups are not comparable before the study" (Trochim, 2005, p. 141). Placement of participants within the treatment or comparison groups was not random. As such, there may have been alternate explanations to the outcomes of the treatment due to differences between the groups prior to the intervention such as demographics, career experiences, prior work with BPD clients, or previous instruction given by different clinical supervisors or instructors. These differences are a threat to internal validity because they may limit the ability to identify whether the outcomes of the intervention are solely attributable to the intervention itself. Convenience samples can create statistically unequal groups which impacts the results. An ANCOVA was used to help decrease this concern.

History threat to the internal validity (prior exposure to the instrument) was a concern as well. In NEGD studies the participants take both a pretest and a posttest (Trochim, 2005). After the participants completed the pretest instrument there was a possibility that the exposure to the instrument impacted the posttest scores. However, the pre- and posttest design provides a statistically stronger result, outweighing the limited risk to internal validity.

Another weakness of this design is the *social interaction* threat to internal validity (Trochim, 2005). When participants from the comparison group and the treatment group interact in social settings, or other classes, information about the intervention can be shared and the results may be impacted. The time duration of this study decreases the likelihood of this occurring, yet the threat is still substantial.

Treatment Participants

The sample groups were comprised of 21 total students from two sections of clinical internship at a private liberal arts university in northwest Oregon. The inclusion criteria for this study required that all participants were in their final semester of study, and enrolled in a clinical internship supervision class. Participants were recruited by a research assistant who is a current first year student at GFU. All participants completed a demographic questionnaire and COSE, during weeks 8 and 9 of the last semester of their graduate program.

Treatment group participants. The participants in the treatment group participated in a workshop style training on DBT (see appendix C) as part of their course activities. Before the workshop, the participants completed a pretest, which

included a demographic questionnaire and a counselor self-estimate inventory

(COSE). Participants were also instructed to answer the questions on the COSE with

regard to their work with BPD clients (See appendix A). After the inventory was

completed, the DBT workshop was taught during the following two class periods. The

group was then given the posttest, including the questionnaire and COSE.

Comparison group participants. The participants in this group were asked to

complete the demographic questionnaire and COSE. One week later, the comparison

group participants completed the posttest. No further intervention or contact occurred.

The DBT workshop was offered to this group of students at no cost after the results of

the study was determined.

Sampling Procedures

Following the approval from the OSU Institutional Review Board (IRB),

participants were recruited from a graduate counselor education program at a private

liberal arts university in Oregon. All participants were students who were currently in

the second semester of clinical internship and in their last semester of graduate school.

All students enrolled in these clinical internship classes were invited to participate in

the study, though participation was optional.

Treatment group. Students in this group were told that a special guest

lecturer would be giving a presentation on DBT for their clinical internship class over

two class periods. The students were obligated, as part of their course requirements, to

attend the workshop, however they were not required to participate in the study. At the

beginning of class, before the initial intervention, the researcher informed the students

about the general purpose of the study and its voluntary nature, and collected consent

forms. Participants then completed a brief demographic form, which also included

statistics of their counseling experiences (i.e.: number of client contact hours, hours of

supervision, experience with BPD clients, clinical internship site type, current number

of direct client contact hours) (see appendix A). The COSE inventory was included

with the questionnaire. These same participants also completed the posttest, which

consisted of the questionnaire/COSE (see appendix B) at the end of the DBT training

intervention. To ensure confidentiality, the questionnaires were coded and separated

from the consent forms. In order to match pre- and posttests, students created their

personal random numbers by using their initials and date of birth. The master

participant list, along with the pretest documents, was stored in a locked box in the

office of the researcher.

       Comparison group. A second group of clinical internship students from the

same institution was used as a comparison group. These students were also given a

brief introduction to the purpose of the study and given the questionnaire/COSE with

the same instructions as the treatment group. This group completed the both the pretest

and the posttest, including the demographic questionnaire and COSE two different

times, one week apart, during the same weeks in the semester as the treatment group.

This group did not receive any further training or interaction.

Participants

    The sample consisted of 21 (treatment group: $n = 12$; comparison group: $n = 9$)

graduate students enrolled in a clinical internship course. The treatment group

participants were 92% female (n = 11), and 8% transgender (n = 1), and ranged in age

between 23 and 52 (m = 33.66, sd = 9.38). There were no male participants in this

group. Among the treatment group participants, 75% (n = 9) were White/Non-

Hispanic, and 17% (n = 2) were Hispanic/Latino, 8% (n = 1) were other/unknown.

This treatment group reported their religious affiliation as 50% (n = 6) Protestant, 8%

(n = 1) Jewish, 25% (n = 3) other, and 17% (n = 2) no preference.

The comparison group participants were 89% female (n = 8), and 11% male (n =

1), and ranged in age between 23 and 55 (m = 39.33, sd = 11.05). Among the

treatment group participants, 89% (n = 8) were White/Non-Hispanic, and 11% (n = 1)

were other/unknown. Their religious affiliation was 67% (n = 6) Protestant, 11% (n =

1) Catholic, 11% (n = 1) LDS, and 11% (n = 1) other.

Instrumentation

Handling and Reporting Data

Participant's responses were coded to ensure anonymity and confidentiality.

Data was securely stored on a password-encrypted computer in a locked office.

Findings were reported without disclosing individual participant names. This

identifying information is not significant to the results of this study. All paper forms

were disposed of after the findings were coded. The data has been made available for

additional research as per the consent form agreement.

Participant Demographic Questionnaire

Participants' demographic information was collected to describe sample

characteristics. Along with demographic information, this instrument included items

regarding clinical experience with BPD. These additional questions (Appendix A) are considered covariates in the literature. Participants were asked to provide previous work experience in the counseling or social work field. Additionally, participants indicated which core curriculum classes they had completed. The COSE inventory was attached to the demographic questionnaire when handed to participants.

Counselor Self-Estimate Inventory (COSE)

In a review of the literature Larson and Daniels (1998) found that there were ten counseling self-efficacy measurements in published studies. Four of the ten focused on individual counseling microskills. When comparing the psychometric properties of the other inventories to the COSE, this inventory stands out as the strongest, most well researched measurement of counselor self-efficacy (Larson & Daniels, 1998). For this reason, the Self-Estimate Inventory (COSE) was used in this study to assess the counselor self-efficacy beliefs of the counselors-in-training and was used with author permission (Larson et al., 1992).

The COSE was developed to be a self-assessment measurement of counseling effectiveness (Larson et al., 1992). This inventory is based on Bandura's (1982) self-efficacy theory, which postulates that individuals are more likely to engage in behaviors in which they feel effective. The theory also suggests that individual's beliefs about their abilities to be effective will impact their performance. The COSE is not intended to measure actual counseling performance; rather, it was created to measure perceived confidence in one's ability to counsel (Larson et al., 1992). It has,

however, been shown to moderately relate to counseling performance (Larson et al., 1992; White, 1996).

The COSE is a self-report inventory and has 37 items with a 6-point, Likert type scale ranging from 1 (*Strongly Disagree*) to 6 (*Strongly Agree*). Nineteen of the items (2, 6, 7, 9, 16, 18, 19, 21, 22, 23, 24, 26, 27, 28, 31, 33, 35, 36, & 37) were reverse coded. A total score could range from 37-222. There is no research to date indicating a standard score that would show positive CSE or negative CSE. The research has simply measured changes in CSE over time, or correlated COSE scores with other inventories (Alvarez, 1995; Cruchfiled & Borders, 1997; Daniels & Larson, 2001; De Graaf, 1996; Easton, Martin, & Wilson, 2008; Larson et al., 1992; Larson et al., 1996; Yuen et al., 2004). However, higher scores do indicate higher self-efficacy beliefs (Larson et al., 1992).

This inventory includes five factors, which more specifically measure self-efficacy. These subscales measure the participants' perceived ability to (a) perform counseling micro skills, (b) handle client process in counseling, (c) manage difficult client behaviors, (d) demonstrate cultural competence in a counseling setting, and (e) be aware of personal values. This study includes all items in the COSE. Although the subscale *awareness of values* is less psychometrically sound than the other four subscales, it was included in order to compute a global score. This data may also be relevant for further study.

Example COSE items. Example COSE items include:

- "I feel competent regarding my abilities to deal with crisis situations that may arise during the counseling sessions—e.g., suicide, alcoholism, abuse, etc."

- "My assessment of client problems may not be as accurate as I would like them to be."

- "I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals."

COSE reliability and validity. Five studies (*N = 213)* have tested internal consistency, convergent and discriminate validity, criterion validity, test-re-test reliability, and additional factors that impact the strength of this instrument (Alvarez, 1995; Cruchfiled & Borders, 1997; Daniels & Larson, 2001; De Graaf, 1996; Larson et al., 1992).

Larson and her colleagues found the COSE to be internally consistent (*a = .93*). Internal consistency ratings by subscale were as follows: Microskills (.88), counseling Process (.87), Difficult Client (.80), Cultural Competence (.78), Awareness of Values (.62). A 3-week test-retest reliability was reported as $r = .87$ (Larson et al., 1992). Indications that the COSE has strong convergent validity have been discussed in more than one study (Cruchfiled & Borders, 1997; Larson, et al., 1992). Validity estimates for the COSE indicate that: (a) the COSE and anxiety significantly predicted counselor performance; (b) trainees' COSE scores increased about one standard deviation over practicum; (c) counselors and psychologists reported higher COSE scores than pre-practicum trainees; (d) people with at least one semester of supervision or more report higher COSE scores than people with no supervision; (e) the COSE

was positively related to self-esteem, self-evaluation, positive affect, and outcome expectations (Daniels & Larson, 2001; Larson et al., 1992; Larson et al., 1996); (f) the COSE was negatively related to anxiety and negative affect (Alvarez, 1995, Daniels & Larson, 2001; De Graaf, 1996; Larson et al., 1992; 1996); (g) the COSE minimally correlated with defensiveness, aptitude, achievement, age, personality type, and time spent as a client, and does not appear to differ across sex or theoretical orientation (Alvarez, 1995, Larson et al., 1992).

Treatment

Description of the Treatment

Following the pretest, each participant in the treatment group received handouts from Linehan's (1993) *Skills Training Manual for Treating Borderline Personality Disorder* and Cathy Moonshine's (2008) book, *Acquiring Competency & Achieving Proficiency with Dialectical Behavior Therapy Volume II.* The collective information from these two books created a well-rounded introduction to DBT as well as important resources. Information gained from Pederson's (2012) workbook *The Expanded Dialectical Behavior Therapy skills Training Manual* was also incorporated in the training. The workshop was broken into six segments:

1. Overview of Borderline Personality Disorder

2. Overview of Dialectical Behavior Therapy

3. Mindfulness Skills and Interventions

4. Distress Tolerance Skills and Interventions

5. Emotional Regulation Skills and Interventions

6.   Interpersonal Effectiveness Skills and Interventions

The first three segments were covered during the initial meeting, and the last three

segments were taught the following class session (Appendix C).

Overview of Borderline Personality Disorder. This segment covered the

development and possible causes of BPD. Other constructs covered in this section

were symptomology, diagnostic errors, therapeutic alliance, and the potential impact

on clinicians.

Overview of Dialectical Behavior Therapy. This segment of the workshop

covered the history, development, and research base of this therapy. The concept of

dialectics and the generalizability of DBT as a therapeutic intervention was discussed.

Additionally, the differences between *what* and *how* skills were taught. Specific

teaching strategies and skills to overcome barriers to therapy were covered in this

section as well.

Another concept that was discussed with the students during this segment of

the workshop was the impact of DBT on both the counselor's personal and

professional life.

Mindfulness skills and interventions. During this section of the training the

concept of *wise mind* was introduced. Other skills and interventions covered were:

focus on nonjudgmental stance, focus on one-mindfulness, being in the moment (here

and now vs. there and then), and mindfulness practice and application.

Distress tolerance skills and interventions. In this section of the workshop

the students learned how and when to teach clients to use distress tolerance skills. The

importance of combining mindfulness skills with distress tolerance skills was

discussed. The students also learned how to partner with clients to create a Distress

Tolerance Crisis and Safety Plan (Pederson, 2012). Additionally, the following

distress tolerance skills were covered during the workshop: ACCEPTS, self-soothe

with senses, urge surfing, IMPROVE the moment, radical acceptance, willingness.

Emotional regulation skills and interventions. At the beginning of this

section of the workshop, students were introduced to the idea of *Well-Being*

(Pederson, 2012). This concept connects the mind and body, explaining the difficulty

of having a sense of well-being without balance in both the physical and mental health

realms. The following skills and interventions were discussed in this segment:

PLEASED, build mastery, feelings model, basic feelings and their opposites, mood

momentum, and opposite to emotion action.

Interpersonal effectiveness skills and interventions. In this section of the

student participants were taught the value of teaching boundaries to clients. The

definitions and types of boundaries were discussed. Boundaries are included in this

section because they are vital to the effectiveness of relationships. Interpersonal

effectiveness skills allow individuals to make and maintain relationships, get needs

met, and resolve conflict in appropriate ways. The three main skill sets that were

taught during this section were: FAST, GIVE, and DEAR MAN (Linehan, 1993;

Moonshine, 2008; Pederson, 2012).

Treatment Fidelity

Treatment fidelity is the methodological strategy that is put into place in

research to monitor and enhance the reliability and validity of psychological interventions (Berg, 2007; Resnick, 2004). The focus on treatment fidelity in this study was divided into five key areas including design, training, treatment delivery, treatment receipt, and enactment of treatment (Alverez, 2008).

The focus on fidelity in *study design* of this project began with the development of the hypothesis. As the research question was developed, the question of provability and replication were taken into consideration. Both hypothesis #1 and #2 are able to be supported given the design and research methods listed above. This study is also able to be easily replicated by counselor educators in their own classroom setting.

When looking at the fidelity of *training*, the focus is on training the trainer. The design of this study lent itself to strong fidelity in this area. One trainer conducted the entire workshop. The trainer had a strong background in DBT and extensive clinical and teaching experience. This experience is important to note because of the importance of the trainer's ability to ensure that the intervention was implemented consistently, and that the instructor understood the intention of the interventions as well as possessing the skills needed to train students in the subject matter.

When looking at the fidelity of *treatment delivery* in this study, the researcher attempted to insure that the treatment was delivered consistently between subjects. All participants were in the same workshop and received the same training. The intervention was outlined and specifically developed to be replicated by other researchers in the future. Handouts were created by permission of published authors.

Each participant engaged in the entire workshop, thus receiving the complete intervention.

An additional way in which the fidelity of *treatment delivery* was ensured was by using a written script when handing out the questionnaire and COSE. The script was written by the author of the COSE and added to by the researcher. These scripts were read verbatim to both the treatment group and the comparison group.

Fidelity of *treatment receipt* in this study is the area that focuses on the experience of the participants. For strong validity it was important to understand whether the participants comprehended and integrated the knowledge gained in the workshop. Throughout the workshop the participants were given check-in evaluations. These evaluations tested the knowledge comprehension of the participants so that the trainer could determine if the learning objectives had been understood by the participant.

The last key area of treatment fidelity according to Alverez (2008) is *treatment enactment*. In this study strong treatment fidelity was shown in this area as participants did role plays throughout the workshop to demonstrate their understanding in integration of their newly learned skills. There was some threat to treatment fidelity in this area because of the limited time for the interventions as well as the limited duration of the study. A follow-up study would be beneficial to determine if the participants incorporated the knowledge from the workshop into their clinical practice. A follow-up study could also determine if the newly gained level of CSE remained as they incorporated the DBT skills into practice.

Data Analysis Plan and Procedures

Repeated measures t-tests were conducted to determine the change in mean from pretest to posttest. An analysis of covariance (ANCOVA) was also used to examine posttest scores of the COSE after removing the effects of several covariates (Trochim, 2005). The covariates in this study included; amount of logged face-to-face clinical hours, number of clients with BPD, exposure to DBT, and previous work experience. Because the effects of these factors were of major concern, the ANCOVA was used to adjust posttest scores for variability of the covariates in the pretest. Also, due to the nonequivalent groups design (NEGD) there is a bias in ANCOVA treatment effects. This bias was solved by using a *reliability correlation* that adjusted the pretest for measurement error. This adjustment was done separately for both the treatment and comparison groups.

Results

The first hypothesis posited there would be an improvement in the COSE scores of counselors-in-training after attending a workshop on DBT. Using a multiple repeated measures *t*-tests to compare the outcome variables of pretest and posttest COSE scores, the alternative hypothesis was supported. Results indicated a statistically significant improvement in the posttest scores of the treatment group ($m = 4.67$, $sd = .63$) over the pretest scores ($m = 4.45$, $sd = .14$), $t = -2.34$, $p < .05$. Additionally, the difference between the treatment group and the comparison group was significant. In the comparison group, the posttest scores ($m = 4.66$, $sd = .58$) actually decreased from the pretest scores ($m = 4.75$, $sd = .58$), $t = 1.16$, $p > .05$. The

ANCOVA results showed no significant outcomes for any of the tested covariates which included the amount of logged face-to-face clinical hours, number of clients with BPD, exposure to DBT, and previous work experience. The ANCOVA results indicate that the evaluated covariates are not responsible for the mean differences in the dependent variable (Trochim, 2005). Although it is possible that there may be covariates that were not analyzed which could explain the variances, the covariates analyzed in this study do not. This finding contributes to the evidence that the hypothesis was supported and the DBT intervention made the difference in the mean from pretest to posttest.

The second hypothesis proposed that the posttest of the treatment group would show significant improvement in the scores of the COSE subscale "challenging client behaviors". There was a change in the average score of this subscale in the pre- to posttest that indicated improvement, but the change was not statistically significant. The null hypothesis for hypothesis #2 was not rejected. Although there was no significant change in the posttest scores for the subscale "challenging client behaviors", the subscale "cultural competence" did show a significant change. The posttest of the treatment group ($m = 5.21$, $sd = .62$) was significantly higher than the pretest ($m = 4.83$, $sd = .39$), ($t = -2.91$, $p > .05$) in the posttest scores.

Effect size also was calculated for both the treatment ($d = .15$) and control ($d = .14$) groups. Cohen's d, showed low to moderate effect sizes for both hypotheses (Acock, 2005).

Discussion

Borderline Personality Disorder is a mental health concern that is prevalent in all mental health settings, both in-patient and community based settings (Bender et al., 2001; Zanarini, Frankenburg, Khera & Bleichmar, 2001). BPD has historically been reputed with poor clinical outcomes, and continues to pose a significant concern to clients, their families, and mental health clinicians (Dimeff &Linehan, 2001; Perseus, 2007; Rizq, 2012; Vaknin, 2007). Counselors in the community have struggled to feel effective and competent in their work with this population. Many have chosen not to work with BPD clients because of their fears and feelings of inadequacy (Perseus, 2007; Rizq, 2012). The research on BPD suggests that incorporating DBT into clinical work with BPD clients increases the perceived success of both the client and clinician (Pasinczy, 2011; Miller, et al., 2011). This current study demonstrated that attending training in DBT has the potential to increase CSE in counselors-in-training in regards to their work with BPD clients.

Although the results are statistically significant, it was more important to this researcher see a change in the willingness of counselors-in-training to work with this difficult and disadvantaged population. It is interesting to note that workshop participants indicated throughout the workshop that they feel more comfortable working with this population after they had gained understanding of skills and interventions. Several participants also indicated that the specific information about BPD diagnosis changed the way in which they conceptualize these clients. It is hopeful that this study might help lead to stronger standards for counselor educators

which encourage them to add diagnostic specific training, including DBT, to program

curriculum. Increased training will help masters level clinicians deal with these

difficult clients that they will inevitably encounters in practice.

Although the failure to support the alternative hypothesis of Hypothesis #2 was

surprising, it is interesting to consider that the results may have been affected by the

length of the training. It is important to consider the long-term impact that short-term

trainings have on preservice counselors. The standard that exists in many counselor

education programs of limited training on many subjects should be revisited. Intense,

diagnostic specific training may be more beneficial. Further research on focused

training is needed.

Additionally, the result for the COSE subscale "cultural competence" is

noteworthy. The data indicates a significant positive change in this lone subscale for

the treatment group only. This increase in CSE may be a result of a conversation

discussing socio-economic and cultural differences with regard to the impact they can

have on the presentation of BPD. Also, during the training there was conversation with

the participants about the thinking strategies of clients with BPD with regard to the

creation of autobiographical memory in the brain (Maurex et al., 2010; Reid &

Startup, 2010; Williams & Broadbent, 1986). This topic of discussion may have

impacted the results for this sub-scale. The outcome of the change in CSE in this area

has potential to be impactful to both the clinicians and their clients. If clinicians feel

more comfortable working with clients from different socio-economic and other

cultural experiences, they will be more likely to work through difficult situations in a

counseling setting with clients from different cultural backgrounds (Lent, Hill, & Hoffman, 2004). In addition, because of the connection between BPD and challenges with autobiographical memory social problem-solving skills, counselors often have difficulty connecting or relating to their narratives (Maurex et al., 2010). If the counselor has higher CSE in working with people from different cultures they may be able to work more effectively with this population as well.

The need for effective training to help counselors work with high needs clients is substantiated in both counselor education literature as well as anecdotal experience. Both counselors-in-training and practicing clinicians reported feeling inadequately trained to help high-needs populations, such as those with BPD. Due to this lack of confidence in their ability to impact these clients, many counselors will not take BPD clients into their practice. This lack of self-efficacy begins in their graduate training experience. However, because of the prevalence and frequency in which individuals with BPD seek care, it is inevitable that counselors will work with several clients with borderline traits. This training has the potential to impact the competency of counselors and their effectiveness with these individuals.

As CSE increases, counselors-in-training will feel more effective in their work with BPD clients in both practicum and clinical internship settings. The increase in self-efficacy with this clientele has the potential to also increase their CSE with all other clients. The skills learned in the DBT training are applicable to the majority of clients entering a counseling setting. DBT has been shown to be effective with clients with addiction concerns as well as a variety of anxiety and mood disorders (e.g.:

post-traumatic stress disorder, generalized anxiety disorder, depression, and bipolar) (Gratz, Tull, & Wagner, 2005; Harley et al., 2008). Because of the skills taught in DBT training, it is reasonable to imagine that this training would also impact clients with relationship concerns. If DBT training can increase CSE for counselors-in-training as they work with clients in their practicum and internship sites, the generalizability of DBT will help them work with not only BPD clients, but all clients they encounter. These skills and self-efficacy go with them into the community when they graduate. If more therapists are able to effectively work with this population, BPD clients will be able to more readily access services.

When clients with BPD can access and engage in mental health services they are less likely to utilize hospital emergency rooms or inpatient settings (Bergman & Eckerdal, 2000; Lieb et al., 2004; Skodol, Buckley & Charles, 1983). This preventative approach of training counselors to feel effective in working with BPD clients will financially benefit both the clients and the community. This also has the potential to free up the limited resources available to severely and persistently mentally ill individuals.

Limitations

Participating in a DBT workshop has resulted in an increase in the overall CSE of counselors-in-training, particularly with BPD clients, as measured by the COSE. Although this study contributes to the knowledge base in regards to the treatment of BPD clients, CSE of counselors-in-training, and the importance of DBT, this study is not without limitations. The sample in this study was composed of participants from

only one university. Other university training programs may have incorporated

additional training on BPD, or DBT earlier in the counselor-training program, which

may have significantly altered the results of the study. These students were also

required to participate in the training as part of their class work, which may have

impacted the way in which they answered questions.

It is also interesting to note that the participants in this study were asked,

verbally and in writing, to answer each of the questions on the COSE with regards to

their ability to work with clients with BPD, or BPD traits (see Appendix A). These

instructions were added to the original instructions given by the author of the

inventory. This addition was an attempt to acquire an accurate picture of the

participant's CSE specifically around BPD diagnosis. Adding to original instructions

of any instrument can impact the results of the data. Although this addition was

intended to increase the likelihood of gathering diagnostic specific CSE information, it

still may have limited the reliability and validity of the results.

Because of the structure of the study, and that the participants were required as

part of their class to participate in the training, the Hawthorne Effect could have

impacted the results. The Hawthorne Effect refers to the tendency of research

participants to work harder and perform better when they are participating in a

research study (Parsons, 1974). The participants in this study may have answered

differently in the inventory because of the attention they received from the researcher

or their instructor, rather than because of any change in the independent variables. The

use of a comparison group, recruited by a graduate assistant, may have limited the

impact of the Hawthorne Effect, however, it still exists. In the future the Hawthorne

Effect could be further mediated by the addition of a third group of students who

participate in an alternative exercise.

This study had a small number of participants ($n = 21$). Because of the small

sample size it is potentially difficult to generalize to the larger population of graduate

counseling students. This was a pioneer study regarding the connection between DBT

and CSE. This sample size indicates a need for further research.

Another limitation was the time constraint on the training. Although the

scheduled time for the training was 3 hours each class (total of 6 hours). The actual

time that was spent on the training was approximately 2 hours per class session (total

of 4 hours). It was challenging for the trainer to cover all of the materials. Because of

this time constraint, the participants did not engage in as many role-plays or practice

interventions. This may have limited the outcomes, and be a significant part in why

the COSE subscale *challenging client behavior* did not show a statistically significant

result.

The limited time between the pre- and posttest could also be a limitation of this

study. Because of the limited duration of the study, the participants did not have

opportunity to implement the learned skills with clients before they completed the

posttest. This creates the chance for a type I error. However, this time limitation also

created a chance for a type II error as well. Participants could have evaluated their

skills low before they got a chance to use the gained skills with their clients. Because

the alternative hypothesis was supported, the type II error did not occur.

Implications for Practitioners and Counselor Educators

The results suggest some potential modifications in practice for both practitioners and counselor educators. This study demonstrated that there are valid and reliable tools to help counselors gain knowledge, competence, and self-efficacy in their work with clients who exhibit BPD traits. This may encourage clinicians to consider engaging in training around DBT skills and interventions. It may begin to grow a sense of optimism and hope for a population that has historically been disregarded.

Counselor educators may be challenged to embrace the reality that the students they are teaching will be treating this difficult population, regardless of the setting within which they choose to work. These results may also encourage counselor educators to include training on this important subject into Diagnosis & Appraisal classes, or into clinical supervision training opportunities.

Suggestions for Future Research

Given the strength of the findings after only a week long intervention, a 90 day follow-up study would strengthen the findings and be able to explore the effects of the intervention for a longer period. It would also be interesting to conduct this study at the beginning of the student's internship experience and use a time series design measuring CSE over the duration of clinical internship.

Incorporating this training with supervision for a long term study may also be interesting. The combination of an initial DBT training along with continued exposure to DBT skills in supervision throughout the internship process may change the results

of the COSE subscale *challenging client behavior* strong enough for the results to be at a significant level.

Additionally, it would be interesting to conduct this study using a different methodology. A qualitative, phenomenological study on the experience of counselors-in-training and with regard to their work with BPD clients would deepen the understanding of this experience.

Additional information gathered

In addition to the COSE, the participants in this study also answered 18 additional questions regarding their counselor self-efficacy. These questions were written specifically about the clinicians work with BPD clients. They were diagnostic specific, including wording around diagnostic criteria (see appendix D). These questions were scored on the same 6 point Likert type scale as the COSE. The intention around these questions was to use them in a future study, linking the results from these questions to the results of the COSE. Although there was no original hypothesis proposed regarding these 18 questions, it is interesting to note that the treatment group posttest results ($m = 4.82$, $sd = .21$) were significantly higher than the pretest ($m = 4.02$, $sd = 1.11$), $t = -3.52$,, $p < .01$. The Future research on these 18 diagnostic specific questions may be directed at the connection between these questions and the COSE subscale *challenging client behavior*. The results of the second hypothesis of this study may be impacted by the results of this future study.

Conclusion

This study used a nonequivalent group design with a pre- and posttest to measure the impact of a DBT workshop style training on the counselor self-efficacy of counselors-in-training in regards to their work with BPD clients. Repeated measures t-tests were done, along with an ANCOVA. The results suggested that there was a positive and significant difference between the COSE scores of the pre- and posttests for the treatment group. Prior to this study no research has been done on the connection between CSE, BPD, and DBT training. The results of this study have established a need for a discussion about further research to add to the body of knowledge on these topics.

Chapter 4

Dialectical Behavior Therapy Workshop as an Intervention for the Improvement of the
Counselor Self-Efficacy of Counselors-in-Training: A Non-Equivalent Group Design

by

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CHAPTER IV: GENERAL CONCLUSION
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Chapter IV: General Conclusion

Two manuscripts thematically linked in examination of Borderline Personality Disorder (BPD), Dialectical Behavior Therapy (DBT), and Counselor Self-Efficacy (CSE) were included in this dissertation. Review of the literature asserted that the primary instrument of interest in this dissertation, the Counselor Self-Estimate Inventory (COSE), is a valid and reliable instrument that can accurately measure counselor self-efficacy (Alvarez, 1995; Cruchfiled & Borders, 1997; Daniels & Larson, 2001; De Graaf, 1996; Larson et al., 1992;). The review of the literature also indicated that Dialectical Behavior Therapy is a strong, evidence based therapy, which can be effective for use with BPD individuals (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

The study presented above provides empirical evidence for the use of a DBT workshop to improve the CSE of counselors-in-training in regards to their work with BPD clients. Due to the history of poor outcomes for BPD clientele when clinicians use treatment as usual (TAU) (Howey & Ormerod, 2002; Perseus et al., 2007; Rizq, 2012), and the high cost of mental health treatment that is incurred by both the individuals with BPD and the community (Foti et al., 2010)., it is prudent to improve the clinician's skills and effectiveness with this population. In addition, including specific training on working with Axis II, particularly BPD clients, in CACREP requirements for counselor education programs is recommended.

Recommendations for Further Research

Research to further understand the impact of counselor-self-efficacy on the

selection of clients by practicing clinicians is imperative. Recommendations for future studies incorporating the theme of increasing CSE using DBT training include utilizing a larger sample size, longer training interventions with increased skills practice, and measuring CSE longitudinally. An additional recommendation with regard to the non-equivalent group design (NEGD) includes a random sampling of students from several different universities who are enrolled in clinical supervision groups while in internship. It would also be interesting to conduct the DBT intervention toward the beginning of student's internship experience in order to impact the ability for the inexperienced counselor-in-training to diagnose and treat clients with borderline traits.

Using a non-equivalent group design with repeated measures t-tests, along with an ANCOVA, this study focused on the counselor self-efficacy of graduate counseling students in the last term of their clinical internship (treatment group: n = 12; comparison group: n = 9), with females comprising 98% of the treatment group and 89% of the comparison group. The hypothesis stating there would be a positive change in the CSE of counselors-in-training with regard to their work with BPD clients, as measured by the COSE was supported. Considering covariates, the intervention increased CSE among treatment group participants.

Implications of this study can be extended beyond counselor education. The literature review presented in these manuscripts is not only applicable to counseling, but it also has broad use for counselor education, psychology, social work, nursing, and other professionals who work with individuals with borderline personality

disorder. The findings of this study support the use of a DBT training as a means to increase counselor self-efficacy in counselors-in-training. Counselors with DBT training have improved self-efficacy. The more counselors with strong CSE and knowledge of Dialectical Behavior Therapy, the more efficiently and effectively these clients will be served. Counselor Educators can impact this growing concern by incorporating training that will increase counselor self-efficacy around working with BPD and other difficult clients. This training can be incorporated into both diagnosis and assessment classes, as well as clinical supervision of practicum and internship students. Clinical supervisors in the community can also use this information to positively impact their supervisee's CSE by recommending DBT training.

Mental health professionals, as well as educators, must work to advocate for vulnerable populations such as clients diagnosed with BPD. This is part of the ethical standard of the profession. There must be a strong and steady challenge to the historical assumption of some professionals that BPD clients have no hope. The counseling profession, as a whole, needs to become more prepared and empowered to treat these individuals and feel effective in their work.

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Appendices

Appendix A

Pretest Questionnaire: Demographics and COSE:

Number: _____

Gender: _____ Male _____ Female

Age: _____ Date of Birth: ____/____/_____

Would you describe yourself as…

- o American Indian / Native American
- o Asian
- o Black / African American
- o Hispanic / Latino
- o White / Caucasian
- o Pacific Islander
- o Other

What, if any, is your religious preference?

- o Protestant
- o Catholic
- o LDS / Mormon
- o Jewish
- o Other
- o No Preference / No religious affiliation
- o Prefer not to say

How active do you consider yourself in the practice of your religious preference?

- o Very active
- o Somewhat active
- o Not very active
- o Does not apply / Prefer not to say

How many face to face clinical hours do you currently have?

- o 0-50
- o 50-100
- o 100-150
- o 150-200
- o 200+

Type of internship site:

- o Community Counseling
- o University Setting
- o Work Only with Children
- o Other: Please describe

_____

_____

_____

What core curriculum classes do you still need to complete in order to graduate from this program?

- o I have completed all classes
- o I still need…

_____

_____

_____

How many (number of) clients have you seen at your internship site to date?

- o 0-10
- o 10-20
- o 20-30
- o 30-50
- o 50+

How many clients have you seen during your clinical internship that you believe exhibit borderline personality disorder traits?

- o 0-1
- o 2-5
- o 5-10
- o 10-20
- o More than 20… please help me!!!

How would you describe your exposure to Dialectical Behavior Therapy (DBT) during your internship experience?

- o What is Dialectical Behavior Therapy??
- o I am somewhat familiar with DBT
- o I am fairly familiar with DBT
- o I completely understand the concepts of DBT
- o I facilitate DBT groups at my internship site

Please indicate if you have had previous work experience in the social work or counseling field prior to or during your graduate school experience.

- o No, I have no prior work experience in social work or the counseling field.
- o Yes, I have some experience. Please briefly list your experience:

_____

This is not a test. There are no right or wrong answers. Rather—it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. **In this case, we want you to respond to these questions with regards to your ability working with clients with Borderline Personality Disorder, or Borderline traits**. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor to clients **with BPD or Borderline traits**. Do not respond with how you wish you could perform each item—rather answer in a way that reflects your actual estimate of how you will perform as a counselor **to BPD clients** at the present time.

Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

PLEASE — Put your responses on this inventory by marking your answer to the left of each statement.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____ 1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.

_____ 2. I am likely to impose my values on the client during the interview.

_____ 3. When I initiate the end of a session I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.

_____ 4. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).

_____ 5. I am certain that my interpretation and confrontation responses will be concise and to the point.

_____ 6. I am worried that the wording of my responses (e.g., reflection of feeling, clarification, and probing) may be confusing and hard to understand.

_____ 7. I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client's values, beliefs, etc.

_____ 8. I feel I will respond to the client in an appropriate length of time (neither interrupting the client nor waiting too long to respond).

_____ 9. I am worried that the type of response I use at a particular time, i.e., reflection of feeling, interpretation, etc., may not be the appropriate response.

_____ 10. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.

_____ 11. I feel confident that I will appear competent and earn the respect of my client.

_____ 12. I am confident that my interpretation and confrontation responses will be effective in that they will be validated by the client's immediate response.

_____ 13. I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.

_____ 14. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.

_____ 15. I feel that I have enough fundamental knowledge to do effective counseling.

_____ 16. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.

_____ 17. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.

_____ 18. I am not sure that in a counseling relationship I will express myself in a way that is natural without deliberating over every response or action.

_____ 19. I am afraid that I may not understand and properly determine probable meanings of the client's nonverbal behaviors.

_____ 20. I am confident that I will know when to use open or closed-ended probes and that these probes will reflect the concerns of the client and not be trivial.
1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____ 21. My assessments of client problems may not be as accurate as I would like them to be.

_____ 22. I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy.

_____ 23. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I'm afraid that they may not be effective in that they won't be validated by the client's immediate response.

_____ 24. I do not feel that I possess a large enough repertoire of techniques to deal with the different problems my clients may present.

_____ 25. I feel competent regarding my abilities to deal with crisis situations that may arise during the counseling sessions—e.g., suicide, alcoholism, abuse, etc.

_____ 26. I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals.

_____ 27. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.

_____ 28. I am unsure as to how to deal with clients who appear noncommittal and indecisive.

_____ 29. When working with ethnic minorities clients I am confident that I will be able to bridge cultural differences in the counseling process.

_____ 30. I will be an effective counselor with clients of a different social class.

_____ 31. I am worried that my interpretation and confrontation responses may not over time assist the client to be more specific in defining and clarifying their problem.

_____ 32. I am confident that I will be able to conceptualize my client's problems.

_____ 33. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work towards.

_____ 34. I am confident that I can assess my client's readiness and commitment to change.

_____ 35. I feel I may give advice.
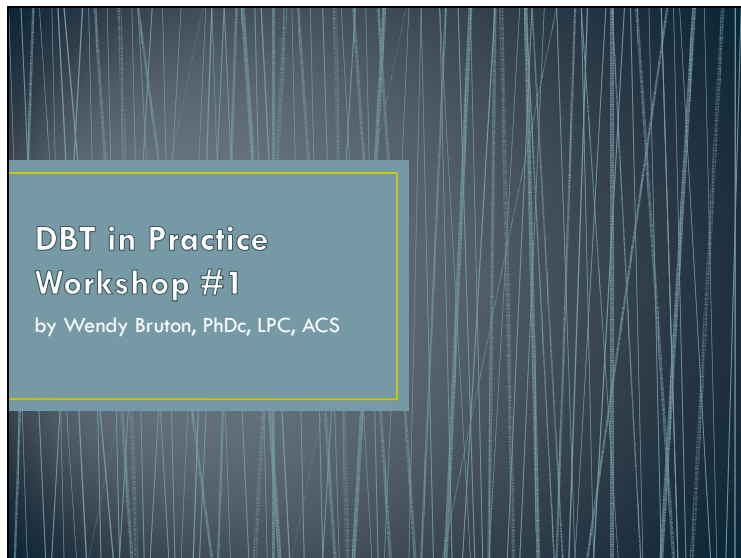
_____ 36. In working with culturally different clients I may have a difficult time viewing situations from their perspective.

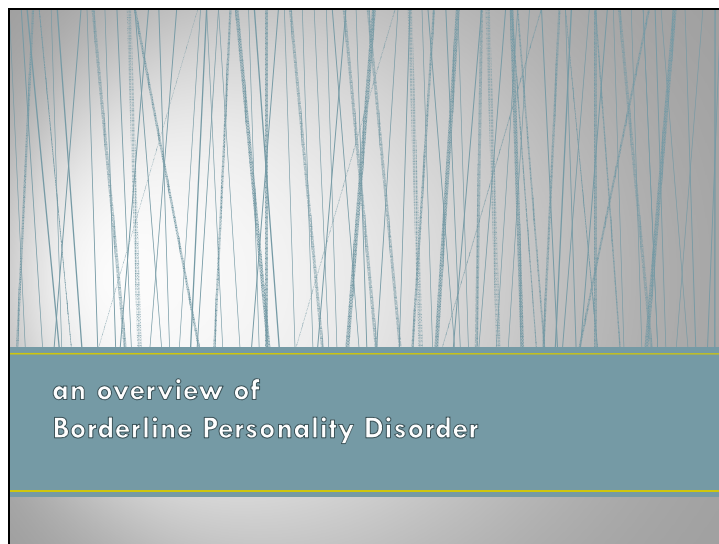_____ 37. I am afraid that I may not be able to effectively relate to someone of lower socioeconomic status than me.

Appendix B

Posttest Questionnaire: Demographics and COSE:

Number: _____

Gender: _____ Male _____ Female

Age: _____ Date of Birth: ____/____/_____

How many face to face clinical hours do you currently have?

- o 0-50
- o 50-100
- o 100-150
- o 150-200
- o 200+

Type of internship site:

- o Community Counseling
- o University Setting
- o Work Only with Children
- o Other: Please describe

_____
_____
_____
_____

What core curriculum classes do you still need to complete in order to graduate from this program?

- o I have completed all classes
- o I still need…
  _____
  _____
  _____

How many (number of) clients have you seen at your internship site to date?

- o 0-10
- o 10-20
- o 20-30
- o 30-50
- o 50+

How many clients have you seen during your clinical internship that you believe exhibit borderline personality disorder traits?

- o 0-1
- o 2-5
- o 5-10
- o 10-20
- o More than 20… please help me!!!

How many clients did you see this week that you believe exhibit borderline personality disorder traits?

- o 0-1
- o 2-5
- o 5-10

How would you describe your exposure to Dialectical Behavior Therapy (DBT) during your internship experience?

- o What is Dialectical Behavioral Therapy??
- o I am somewhat familiar with DBT
- o I am fairly familiar with DBT
- o I completely understand the concepts of DBT
- o I facilitate DBT groups at my internship site

Please indicate if you have had previous work experience in the social work or counseling field prior to or during your graduate school experience.

- o No, I have no prior work experience in social work or the counseling field.
- o Yes, I have some experience. Please briefly list your experience:
  _____
  _____
  _____
  _____
  _____

This is not a test. There are no right or wrong answers. Rather—it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. **In this case, we want you to respond to these questions with regards to your ability working with clients with Borderline Personality Disorder, or Borderline traits**. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor to clients **with BPD or Borderline traits**. Do not respond with how you wish you could perform each item—rather answer in a way that reflects your actual estimate of how you will perform as a counselor **to BPD clients** at the present time.
Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

PLEASE — Put your responses on this inventory by marking your answer to the left of each statement.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____ 1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.

_____ 2. I am likely to impose my values on the client during the interview.

_____ 3. When I initiate the end of a session I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.

_____ 4. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).

_____ 5. I am certain that my interpretation and confrontation responses will be concise and to the point.

_____ 6. I am worried that the wording of my responses (e.g., reflection of feeling, clarification, and probing) may be confusing and hard to understand.

_____ 7. I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client's values, beliefs, etc.

_____ 8. I feel I will respond to the client in an appropriate length of time (neither interrupting the client nor waiting too long to respond).

_____ 9. I am worried that the type of response I use at a particular time, i.e., reflection of feeling, interpretation, etc., may not be the appropriate response.

_____ 10. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.

_____ 11. I feel confident that I will appear competent and earn the respect of my client.

_____ 12. I am confident that my interpretation and confrontation responses will be effective in that they will be validated by the client's immediate response.

_____ 13. I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.

_____ 14. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.

_____ 15. I feel that I have enough fundamental knowledge to do effective counseling.

_____ 16. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.
_____ 17. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.

_____ 18. I am not sure that in a counseling relationship I will express myself in a way that is natural without deliberating over every response or action.

_____ 19. I am afraid that I may not understand and properly determine probable meanings of the client's nonverbal behaviors.

_____ 20. I am confident that I will know when to use open or closed-ended probes and that these probes will reflect the concerns of the client and not be trivial.

_____ 21. My assessments of client problems may not be as accurate as I would like them to be.

_____ 22. I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy.

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____ 23. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I'm afraid that they may not be effective in that they won't be validated by the client's immediate response.

_____ 24. I do not feel that I possess a large enough repertoire of techniques to deal with the different problems my clients may present.

_____ 25. I feel competent regarding my abilities to deal with crisis situations that may arise during the counseling sessions—e.g., suicide, alcoholism, abuse, etc.

_____ 26. I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals.

_____ 27. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.

_____ 28. I am unsure as to how to deal with clients who appear noncommittal and indecisive.

_____ 29. When working with ethnic minorities clients I am confident that I will be able to bridge cultural differences in the counseling process.

_____ 30. I will be an effective counselor with clients of a different social class.

_____ 31. I am worried that my interpretation and confrontation responses may not over time assist the client to be more specific in defining and clarifying their problem.

_____ 32. I am confident that I will be able to conceptualize my client's problems.
_____ 33. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work towards.

_____ 34. I am confident that I can assess my client's readiness and commitment to change.

_____ 35. I feel I may give advice.

_____ 36. In working with culturally different clients I may have a difficult time viewing situations from their perspective.

_____ 37. I am afraid that I may not be able to effectively relate to someone of lower socioeconomic status than me.

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Appendix C

Power-Point Presentation for DBT Workshop

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THE IMPACT OF DBT ON COUNSELOR SELF-EFFICACY

Appendix D

Diagnostic Specific: 18 BPD questions:

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

_____ 38. My knowledge of personality disorders is adequate for counseling clients with BPD effectively.

_____ 39. I am able to accurately diagnose clients with BPD to professional standards.

_____ 40. I am able to effectively develop healthy therapeutic relationships with clients with BPD.

_____ 41. I can effectively help BPD clients learn and practice mindfulness.

_____ 42. I understand the unique relationship challenges that BPD clients face.

_____ 43. I do not feel confident in my ability to assist BPD clients integrate emotional regulation skills into their life.

_____ 44. I am able to effectively teach skills that will increase BPD clients' capacity to tolerate the distress experienced in their life.

_____ 45. I feel competent working with clients with self-harm tendencies

_____ 46. I am able to accurately and consciously identify my own emotional response to clients with borderline traits.

_____ 47. I am not able to conceptualize the needs of BPD clients well enough to form an effective treatment plan.

_____ 48. I am able to keep my personal thoughts and feelings about my clients with BPD from negatively affecting my counseling.

_____ 49. I am familiar with the advantages and disadvantages of Dialectical Behavioral Therapy in working with clients with BPD

_____ 50. My knowledge of the principles of DBT is adequate to use it effectively with BPD clients.

_____ 51. I can function effectively as a DBT group facilitator.