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A Dialectical Behavior Therapy Skills Group in a Psychoanalytic Community Service: A Pilot Study

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This exploratory study reports on the implementation and effectiveness of a 20-week Dialectical Behavior Therapy (DBT) skills group provided to 8 outpatients (7 women, average age 33 years old) within a psychoanalytic community clinic. We report on the practical implementation of this DBT skills group, and describe how the theoretical/ technical differences between DBT and psychoanalysis were negotiated by the two co-therapists. The effectiveness of the skills group was evaluated on standardized measures of borderline personality symptoms, depression, anxiety, interpersonal problems, quality of life, and mindfulness skills that patients completed before and after treatment. At post-treatment, patients evaluated the DBT skills group on a satisfaction questionnaire and therapists completed a countertransference measure. Pre–post outcome data indicated reduced symptom levels of anxiety, depression, and improved quality of life. Both therapists reported moderate therapist responses typically associated with borderline personality disorder psychopathology. Their therapist responses were not associated with symptom levels or change but were related to patient satisfaction. Accumulative pilot studies like these add to the practice-based evidence of DBT components offered within psychoanalytically-oriented community clinics. However, given the exploratory nature of this study, strong conclusions are precluded until further effectiveness research is conducted.

Keywords: dialectical behavior therapy (DBT); borderline personality disorder; low-fee community clinic; skills group; group therapy

Symptoms such as instability in affect and interpersonal relationships, impulsivity, and comorbid symptoms of depression Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Löffler-Stastka, Bartenstein, & Schlaff, 2011) are common in clinical populations, and associated with intensive use of mental health services, even in the absence of a full diagnosis of borderline personality disorder (BPD) (Cristea et al., 2017). Although these symptoms can be effectively addressed in a variety of longer term individual therapeutic approaches including

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psychoanalytic psychotherapy (e.g., Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013; Zanarini, 2009), mentalization-based treatment (e.g., Bateman & Fonagy, 2010), and transference-focused psychotherapy (e.g., Levy, Wasserman, Scott, & Yeomans, 2009), Dialectical Behavior Therapy (DBT) is one of the most popular, efficient, and effective treatments for these patients (for a recent meta-analysis, see Cristea et al., 2017). DBT is an evidence-based psychosocial treatment originally designed to target BPD symptoms (Linehan et al., 2006) and has been shown to reduce patients' emotional and interpersonal problems as well as associated mental healthcare costs (Amner, 2012).

The DBT model is a derivative of cognitive behavior therapy, which incorporates behaviorism (Koons, 2008), Zen principles of acceptance and mindfulness (Lynch, Trost, Salsman, & Linehan, 2007), and a dialectical mindset that allows the patient to find a balance between accepting oneself, while also urging for change to occur (Linehan, 1993). The full DBT protocol involves four treatment modalities: (a) weekly hour-long individual therapy, (b) weekly group skills training (typically 2–2.5 hours), (c) between-session telephone consultation as needed to coach the patient in the use of behavioral skills, and (d) and weekly therapist consultation team meetings designed to support, motivate, and enhance the skills of therapists (Linehan, 1993). The full DBT protocol with its four modalities offers a containing and supportive structure to therapists, particularly when dealing with potentially stressful issues such as risk (Bourke & Grenyer, 2013; Crawford et al., 2008; Hutton, Hodge, & Tighe, 2017).

While the full DBT protocol is effective in treating people with BPD in the community (e.g., Turner, 2000), the demand for it exceeds available resources (Carmel, Rose, & Fruzzetti, 2013). The length (often 12 months or longer) and resource-intensive nature of the full DBT protocol poses a barrier to its adoption in many community settings (McMain et al., 2018) and low-fee training clinics (Blackford & Love, 2011). Furthermore, private insurance often does not cover all components of the full DBT protocol (Swenson, Torrey, & Koerner, 2002). Therefore, the vast majority of individuals with BPD are left without access to this evidence-based treatment.

DBT Skills Group

Of the four DBT treatment modalities, the skills group has been shown to be the most essential component of the program for symptoms reduction (Linehan et al., 2015; Neacsiu, Rizvi, & Linehan, 2010). DBT skills groups can be effective as stand-alone treatment for Axis I mental health disorders, including major depressive disorder (see systematic review by Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015), and have shown to be effective in reducing BPD symptoms, such as self-harm, suicide attempts, emotion dysregulation, distress intolerance, and use of crisis services in a variety of community settings (Booth, Keogh, Doyle, & Owens, 2014; Harley, Baity, Blais, & Jacobo, 2007; Hunnicutt Hollenbaugh, & Lenz, 2018; Kramer, 2017; Lin et al., 2019; Linehan et al., 2015; Martin, Roos, Zalewski, & Cummins, 2017; McMain, Guimond, Barnhart, Habinski, & Streiner, 2017).

The skills group, as stand-alone intervention, is likely to be a feasible and cost-effective component to apply in a community training clinic for several reasons. Firstly, with a skills group, multiple patients with BPD-related symptoms can be treated at once. Many community clinics, including low-fee training clinics, experience a high demand for their psychotherapy services. The scarce resources mean that waitlists are common. One way to try to reduce these waitlists is to provide a targeted short-term group treatment (Sachdeva, Goldman, Mustata, Deranja, & Gregory, 2013). Secondly, since the skills group follows an explicit group-format protocol, and involves two co-therapists working together as facilitators, therapists in a training clinic may be able to provide these skills groups without the intensive training usually required for the full DBT protocol (Blackford & Love, 2011). By co-facilitating the skills group, they can observe each other's interventions, which allows them to ensure adherence to fundamental DBT principles and

to principles of behaviorism in managing group-interfering behavior. Moreover, it was thought that for the therapists, making the differences between a structured co-facilitated DBT group format and unstructured individual psychoanalytic therapy explicit, reduces the muddling of the waters, and further aids the adherence to each treatment modality. Thus, a DBT skills group, utilized as stand-alone intervention, may be an effective treatment option for people with BPD symptomatology in clinical training settings (e.g., Dimeff & Koerner, 2007). However, it currently remains unclear if the aforementioned studies within general community (training) clinics can be generalized to psychoanalytic settings. This exploratory study forms a partial replication and extension of the Blackford and Love (2011) pilot study that reported on the implementation of a DBT skills group for 12 outpatients (diverse in comorbid diagnoses, onset of illness, and education level) in a general community training setting. Our study is innovative in that it reports on the implementation and effectiveness of a DBT skills group as practiced in a psychoanalytic community training setting. Accumulating pilot studies like these can serve to add to their overall influence.

A Dialectical Behavioral Skills Group in a Psychoanalytic Context

Although the use of a "dissimilar" approach in a specific treatment environment is not so uncommon and has been shown to be effective in other countries/modalities (DiGiorgio, Glass, & Arnkoff, 2010; James, Winmill, Anderson, & Alfoadari, 2011; Kröger et al., 2010), the implementation of a DBT skills group into a psychoanalytic community setting, as reported in this study, has not yet been explored. It is important to note that this study does not represent the integration of DBT techniques into psychoanalytic therapy (e.g., described by Arlo, 2017), nor ways of integrating different approaches in the level of individual treatment, but instead focuses on the application of a DBT skills group within the setting of a psychoanalytic training clinic.

Running a DBT skills group in the clinic context of a fundamentally different theoretical model requires consideration of the commonalities and differences between these two therapeutic models. To begin, the two models differ with respect to how BPD is conceptualized (Swenson, 1989). In her DBT manual, Linehan (1993) describes BPD patients as suffering from biologically based deficits in emotion regulation, the effects of which are intensified by growing up in invalidating environments with insufficient emotional support. Linehan sees the dysfunctional behaviors as maladaptive problem-solving maneuvers that in the short-run predictably relieve intolerable affective states, but that in the long-term tend to become further emotionally dysregulated and self-destructive. In repeatedly relying on such methods, BPD patients fail to learn other more adaptive problem-solving strategies. DBT aims to expand the patient's repertoire of healthy problem-solving behaviors, which will eventually eliminate the need for self-destructive behaviors. In psychoanalysis, borderline pathology is seen as stemming from the initial years of life, where inadequate parenting resulted in an abundance of aggressive feelings and phantasies. These negative experiences are stored intra-psychically in the form of internalized object-relations. BPD symptomatology is viewed as derivative of the underlying self-object representations and of the pathological defense structure that the patient uses to manage these negative internal object-relations (Lyons, 2014).

Following from their theories of the etiology and maintenance of symptoms, the two models also differ in several technical ways. DBT, for example, focuses on sequences of measurable behavior and the contingencies that reinforce them, rather than exploration of unconscious intrapsychic and interpersonal processes. The treatment protocol is structured around the day-to-day planning of activities, concrete skills and specific targets, and goals that orient patients to the treatment (Linehan, 1993). It offers therapists structured session-by-session templates of teaching materials, exercises, and homework tasks.

Psychoanalysis is less pragmatic. For example, orientation about the treatment process and explicit discussion of the commitment to treatment goals are not usually part of psychoanalytic treatment (e.g., Joseph, 1979). The directive methods of DBT have often been viewed as antithetical to analytic reflection; impeding the necessary free associative processes necessary for the acquisition of insight and for change. Psychoanalysts often do not help patients implement new behaviors into their lives in systematic ways (Lyons, 2014). Instead, the purpose is to generate insight into unconscious meanings or motivations to better understand how the patients' symptoms previously developed and are currently maintained.

There is considerable theoretical overlap between DBT and psychoanalytic theory. For example, they share an emphasis on psychosocial factors in BPD etiology (Yeomans, Levy, & Caligor, 2013), in that both theories deem early-life relationships with primary caregivers to be important in patients' interpersonal difficulties later in life (Bliss & McCardle, 2014). Also, both theories make a link between the present-moment awareness and interpersonal relationships (Gabbard, 2000; Goodman, 2013) and emphasize the dialectic between affirmation and change (Wachtel, 2011), reflection on one's thoughts (Clarkin, Levy, & Schiavi, 2005; Linehan, 1993) and mindfulness (Lin & Seiden, 2015). Moreover, Lyons (2014) argues that DBT reimagines and operationalizes some relational psychoanalytic ideas. For example, what is referred to as "chain analysis" in DBT (and more generally in behavior therapy) has much in common with "detailed inquiry" (Sullivan, 1954), as well as with more open-ended exploration. Based on research done in other countries/-modalities (DiGiorgio et al., 2010; James et al., 2011; Kröger et al., 2010), we do not expect the psychoanalytic community setting to conflict with the pragmatic nature of DBT and its effectiveness, as long as these similarities and differences are acknowledged.

Therapist Responses to Patients

Regardless of treatment model, therapists historically had difficulty working with clients with diagnoses of BPD: "Many therapists are not prepared for the pain they will have to recognize in themselves while working with borderline patients, or the professional chance one must take, the personal doubts one must endure, and the traumatic moments that will come" (Linehan, 1993, pp. 516). The BPD population has been described as triggering antagonistic judgments from professionals (e.g., Bodner, Cohen-Fridel, & Iancu, 2011; Bourke & Grenyer, 2013) and eliciting particularly diverse and complicated therapist responses (e.g., Brown, 1980). Surveys have demonstrated professionals' reluctance to treat patients with BPD (Westwood & Baker, 2010), and reported on more feelings of anxiety and prejudice towards patients with BPD compared to other disorders (e.g., Jobst, Hörz, Birkhofer, Martius, & Rentrop, 2010). In fact, targeted trainings have been developed to improve professionals' attitudes toward and confidence in treating people with BPD (e.g., Krawitz, 2004; Shanks, Pfohl, Blum, & Black, 2001). More specifically, although treating patients with BPD is known to be weakly associated with feeling helpful (Thylstrup & Hesse, 2008), it is strongly associated with several complicated feelings, such as feeling less capable, less trustworthy and less attractive (Rosenberger & Hayes, 2002), feeling more anger or repulsion, rejection, being on guard, the desire to avoid the patient or end treatment (Rossberg, Karterud, Pedersen, & Friis, 2007), feeling overwhelmed/ disorganized (Betan, Heim, Conklin, & Westen, 2005), helpless/inadequate, or special/overinvolved (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014). If left unmanaged, these troublesome and problematic therapist responses to patients have shown to have a negative impact on the alliance (Ligiéro & Gelso, 2002) and treatment progress, leading to premature termination (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996) or subsequent reduced treatment outcome (Hayes, Gelso, & Hummel, 2011), in psychoanalytic treatments (e.g., Gabbard & Wilkinson, 2000) as well as in DBT (e.g., Cambanis, 2012). It is hypothesized that DBT might help to address these issues, for example, through emphasizing a non-judgmental stance as well as through principles that put the onus on the therapist rather than on the patientt, should

therapy not have the desired results. Therefore, identifying therapist responses to patients who present BPD-related symptoms might be relevant.

Aims

Our overall aim was twofold. We wanted to describe how the theoretical/technical differences between DBT and psychoanalysis were negotiated; how the therapists strived for adherence in facilitating a DBT skills group in the context of a psychoanalytic community clinic, and under psychoanalytic supervision. In addition, we aimed to evaluate whether this DBT skills group was satisfactory to the patients and explore its impact on psychiatric symptoms, quality of life, and mindfulness. Given the known challenges of working with this patient group, we also examined the potential impact of the therapists' responses on these treatment effects. This study can be viewed as a partial replication and extension of the Blackford and Love (2011) pilot study.

In light of the existing literature on DBT and the BPD population, we hypothesized that (a) patients will find the DBT skills group satisfactory, indicated by their attendance and treatment evaluation responses; (b) following the 20-week DBT skills group treatment, patients will show an overall reduction in borderline specific symptoms, symptoms of depression, anxiety, and interpersonal problems, and will show an increased quality of life and increased mindfulness; (c) in response to the patient group, the two therapists will show therapists responses typical of work with BPD patients (i.e., overwhelmed/ disorganized helpless/inadequate, or special/overinvolved); and these scores will be correlated with the level of pre-post patient change on the different outcome measures (i.e., more positive therapist feelings are expected to correlate with positive patient outcomes, whereas more negative therapist feelings are expected to correlated with negative patient outcomes).

Methods

Treatment Clinic

The current pilot study took place at a low-fee psychoanalytic training clinic. Fees were dependent on income and ranged from 35–110 dollars for individual sessions and 15–45 dollars for group sessions. In line with the standard practice, all clinic patients self-referred and were asked to participate in a 30 minutes phone intake interview before being allocated to an individual therapist or referred elsewhere for more appropriate treatment. The clinic typically offered long-term individual psychoanalytic treatment, facilitated by advanced doctoral level interns, once or twice a week for up to a period of 2 years. The current DBT skills group was initiated as a pilot to help reduce the waiting list and to offer a time-efficient alternative for patients who presented with emotion-regulation symptoms. Although alternative approaches, such as Mentalization-Based Treatment (e.g., Bateman & Fonagy, 2010) and Transference-Focused Psychotherapy (e.g., Levy et al., 2009) could have been implemented in this psychoanalytic training setting, the trainees had not received any kind of training in these treatments, and it was therefore not deemed a viable treatment option to be offered to patients in this clinic. In contrast to more formal DBT treatment settings for patients with severe level of symptoms associated with a BPD diagnosis, this DBT skills group was not complemented by individual DBT sessions, phone consultations, or a therapist consultation team. In line with the clinic's standard procedures, no formal diagnostic assessment was conducted prior to treatment, however, the symptoms reported by the patients as part of the initial interview were recorded in the notes.

Recruitment

During the 3-month period of recruitment for this pilot study, all people who reported emotion-dysregulation (e.g., manifestations of angry outbursts or acting out behavior such as destroying objects or self-harm, interpersonal conflicts, and threats to kill oneself) during their intake interview, were also informed about the DBT skills group and, if they were interested, were asked to meet for an informational meeting with the two therapists. During this period of recruitment, 14 of the 45 people who participated in the phone intake procedures of the clinic, were informed about the new DBT skills group. From these 14 people, 10 said they would be willing and able to participate in the group for the given 20-week period and were invited to attend an introductory meeting with the two therapists. Of these 10 people, one person no longer reported difficulties with emotion-regulation and/or interpersonal problems and another person reported extremely negative experiences with previous mindfulness training and chose to take up individual psychoanalytic treatment instead. A total of eight people started the DBT skills group.[1]

Patient Sample

The study sample comprised of a heterogeneous group of 8 adults, most of whom (87.5%) were female with an average age of 33 years (SD = 12.8). One patient was a homemaker, the other seven patients were in full-time employment or education (salary range $1,000–$4,000 per month), reflected in a session-fee range from $15 to $45 per session. As common in psychotherapy clinics (Quintana, 1993), all patients had previously been seen by a psychiatrist or psychologist. In order to enhance the clinical validity of the findings, this naturalistic sample was not restricted by psychiatric diagnosis or level of functioning. The patients were assessed as mildly to moderately impaired, with and average GAF score of 62 with scores ranging from 50 to 70 (M = 61.9; SD = 6.8). Although the patients were not formally diagnosed with BPD, they reported long-lasting emotion dysregulation, impulsivity, interpersonal problems, and depressive symptoms (all commonly associated with BPD; see Leichsenring et al., 2011; Löffler-Stastka et al., 2011) during the intake interview as well as during the introductory meeting with the two therapists, which was also reflected on the standardized pretreatment self-report measures. According to the pretreatment measures described below several patients reported symptoms above the clinical cut-off; n = 2 on the BSI, n = 5 on the BDI, n = 1 on the BAI and n = 3 on the IIP-32). In addition to the standard intake procedures at the clinic, and the standardized measures that included items on suicidal ideation and self-harm, the two therapists also asked the patients about their suicidal ideation or non-suicidal self-injury during the introductory meeting and provided patients with local resources in advance of the group. Although the patients reported some level of suicidal ideation and self-harming behavior in the past, no current disturbances were reported. All patients identified better emotion regulation skills and improvement of interpersonal relationships as their main treatment goals.

Therapists

The DBT skills group was conducted by two therapists during their advanced internship in the psychoanalytic training clinic, as part of their final year of doctoral training in Clinical Psychology. Both therapists had over 8 years of clinical experience and had received formal training in DBT in a previous doctoral internship. They had both received 10–12 hours of didactic training in DBT via their university and had completed a previous 6-month doctoral internship in which they had worked as part of the larger DBT protocol. Therapist 1 was a 33 years old European female who had received training in DBT in the United Kingdom. Therapist 2 was a 28 years old Asian American female who had received DBT training in the USA. Due to their experience in DBT they had been asked to facilitate this DBT skills group in the psychoanalytic community clinic.

Both therapists received bi-weekly supervision on the running of the DBT group by the clinic's training director. The training director was a psychoanalyst, experienced in psychoanalytic individual and group therapy. The training director was not trained in DBT. In addition to this bi-weekly supervision for the DBT group, the two therapists received regular twice a week psychoanalytic supervision for their individual cases.

DBT Skills Group

In total, the patients received 20 sessions of weekly 2-hour DBT group skills-training. Patients completed standardized self-report measures at two time points: prior to the initial session and at the end of the last session. The 20 weekly group sessions followed the structure described in the skills training manual for BPD (Linehan, 1993). This manual provided the main resources for the teaching materials on modules of mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills. Each module, followed the overall session-by-session treatment outlines for skills training, starting with a session of orientation to skills training, a session on core-mindfulness skills, specific module skills (three or four sessions), and a last session.

In the most recent manual based on Linehan's research and the idea that "some DBT is better than none," there is flexibility in how to run DBT skills groups (Linehan et al., 2015, p. 25). Although the overall length, structure, and content of the skills-based DBT group treatment followed the exact guidelines described in the DBT manual (Linehan, 1993), the format of the group sessions was adapted to the psychoanalytic setting in three ways: (a) the last 15 minutes of each group session were unstructured to allow for processing of the patients' subjective experience of the group session; (b) immediately after each group session, the two therapists wrote notes on their experience of the treatment process and their responses to patients; (c) the two therapists were supervised by a psychoanalytic psychotherapist, rather than a DBT therapist.

Adherence to DBT Principles

The patients were solely exposed to DBT principles (e.g., none of the materials included references to psycho-analytic jargon). Given the evening time-slot of the DBT skills group, there was no contact with individual psychoanalytic patients and or therapists, which means that the patients may not have been aware of the psychoanalytic orientation of the clinic.

The therapists, however, discussed and negotiated practical and philosophical differences between DBT and psychoanalysis extensively in advance. The importance of strict adherence to DBT principles and skills group treatment manual was agreed upon. For example, despite not working behaviorally in this current training setting, the therapists agreed to use solely behavioral principles in running the skills group (e.g., ensured and reinforced homework completion, modeled skills use themselves, exercised effective contingency management in response to group-interfering behaviors). For example, the co-therapists prepared several role plays illustrating unhelpful interpersonal responses as well as more adaptive interactions. And they also modeled genuine disagreement with each other on what exact interpersonal approach would be most adaptive in what situation, in line with DBT principles. Similarly, different from the standard approach in individual psychoanalytic treatment, attendance and lateness policies were strictly upheld. Although skills application and generalization could not be handled through neither coaching nor individual therapy outside of the skills group, time was allocated to discuss with the group members how skills could be readily practiced individually in between sessions.

Moreover, in line with the DBT principles, therapists held themselves equally accountable for the patients' behavioral change. Unlike their individual psychoanalytic work, in the DBT skills

group the therapists used self-involving self-disclosure and/or radical genuineness to share their own feelings about patient behaviors.

They also openly shared difficulties they experienced when practicing mindfulness skills themselves, and were honest in their imperfect attempts. Patient behaviors that merited chain analysis (e.g., quality of life interfering behaviors, such as an episode of drug or alcohol use, a serious fight with a colleague), were conceptualized in individualized homework tasks according to data collected over chain analyses. The therapists actively practiced framing patient and their own experiences in nonjudgmental, nonevaluative language. Above and beyond the standard clinic practices, the therapists also actively prepared for possible suicidal ideation or nonsuicidal self-injury by providing patients with local resources in advance, by discussing suicidal thoughts and self-harming behaviors in the group more broadly as examples of self-regulation attempts, and by requesting on-demand contact with their supervisor if/when needed.

Measures

Pre–Post Measurements

Patient progress was analyzed using standardized outcome measures of borderline symptoms, depression, anxiety, interpersonal problems, quality of life, and mindfulness pre- and post-treatment. Following treatment, the therapists agreed on the level of general functioning of each patient and each completed two measures of therapist responses to patients. Patients satisfaction with the treatment as a whole was assessed by a brief group evaluation post-treatment. In order to limit response bias and maintain confidentiality, the patients were asked to return the completed outcome measures and satisfaction questionnaire to the clinic secretary who was not involved in the DBT skills group.

Borderline Symptoms and Behavior. The Borderline Symptom List-23 (BSL-23; Bohus et al., 2009) is a 23-item self-report measure of borderline-typical symptomatology, including emotion dysregulation and instability. This shortened version of the original 95-item instrument was used to limit patient burden and assessment time. Responses are scored on a 5-point Likert scale (0 = "not at all" to 4 = "very much"), with higher scores indicating more borderline symptomatology. The BSL-23 assesses emotion dysregulation through various items (e.g., "My mood rapidly cycled in terms of anxiety, anger, and depression" and "I was afraid of losing control"). The BSL-23 has strong test-retest reliability and favorable convergent and discriminant validity (Bohus et al., 2009). A mean score >2 suggests a level of symptom severity indicative of diagnosis of BPD, and a mean between 1.5 and <2.0 represents sub-clinical symptoms of BPD (Glenn, Weinberg, & Klonsky, 2009).

The BSL-Supplement: Assessing Behavior (Bohus et al., 2007) is a 10-item self-report scale that assesses the frequency of specific behaviors over the previous week. Specifically, the supplement examines self-harming behaviors, suicidal intent and attempts, binge and purge behaviors, impulsivity, substance use, hostile outbursts, and sexual promiscuity. The items are rated on a 5-point frequency scale, with 0 (not at all) to 4 (daily or more often).

Anxiety. The Beck Anxiety Inventory (BAI; Beck & Steer, 1990) is a self-report measure of anxiety symptoms often used in psychiatric outpatient services. The BAI comprises of 21 questions, on a 4-point Likert scale (0 = "Not at all" to 3 = "Severely - it bothered me a lot") regarding how the individual has been feeling in terms of common symptoms of anxiety in the past week. The BAI demonstrates high internal reliability and good factorial and discriminant validity (Kabacoff, Segal, Hersen, & Van Hasselt, 1997).

Depression. The Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item self-report measure that assesses common depressive symptoms, such as

depressed mood, hopelessness, suicidal ideation, sleep disturbance, and appetite change. The BDI-II uses a 4-point Likert scale (0 = "Not at all" to 3 = "Severely"), is commonly used in psychiatric outpatient services and has well-established internal consistency and validity (Beck et al., 1996; Richter, Werner, Heerlein, Kraus, & Sauer, 1998).

Interpersonal. The Inventory of Interpersonal Problems (IIP-32; Barkham, Hardy, & Startup, 1996) is a 32-item self-report instrument with eight subscales reflecting difficulties people have in their interpersonal relationships. Responses for each of the items are made on a 5-point scale ranging from 0 ("not at all") to 4 ("extremely"). A high score may indicate the existence of interpersonal problems, reflective of poor understanding of the progression of feelings in relationships (Barkham et al., 1996). The IIP-32 has demonstrated adequate internal consistency in outpatient and nonclinical samples (Barkham et al., 1996).

Quality of Life. The Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q; Endicott, Nee, Harrison, & Blumenthal, 1993) is a 93-item self-report measure of the degree of enjoyment and satisfaction experienced in various areas of daily functioning (physical health, subjective feelings, work, household duties, school, leisure activities, social relationships, and general activities). Responses are scored on a 5-point scale (1 = *very poor* to 5 = *very good*), with higher scores indicating better quality of life, resulting in a global quality of life (QOL) index and dimension scores with good psychometric properties (Endicott et al., 1993).

Mindfulness. The Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) is a 15-item self-report measure of a receptive state of mindful attention to what is taking place in the present. The MAAS used a 6-point Likert scale (1 = *almost always*, to 6 = *almost never*). The MAAS has strong psychometric properties and has shown to be related to, and predictive of, a variety of self-regulation and well-being constructs (Brown & Ryan, 2003).

The study's BSI, BAI, BDI, IIP-32, Q-LES-Q and MAAS had good internal consistency (Cronbach's α = .94, .72, .82, .90, .96, and .81, respectively).

Post-treatment Measures

Functioning. The observer-rated Global Assessment of Functioning (GAF) provides a composite score of psychosocial functioning on a 0–100 scale (American Psychiatric Association, 2013; Pedersen & Karterud, 2012). The score reflects the overall level of functioning, considering possible impairments in psychological, social, and occupational/school functioning. A level of 60 is often used as a cut-off level between mild/no impairment and moderate/severe impairment. In this study, the GAF score for each patient was determined at the end of the 6-month treatment by consensus between the two therapists.

Therapist Responses to Patients. The Countertransference Questionnaire (CTQ; Conklin & Westen, 2003) contains 79 self-report items, which therapists are asked to rate on a 5-point scale (ranging from 1 = *Not True* to 5 = *Very True*) and provides a psychometrically valid instrument for assessing therapist responses to patients (regardless of therapist's specific theoretical orientation) within the therapeutic process (Conklin & Westen, 2003). The CTQ measures a wide range of thoughts, feelings, and behaviors expressed by therapists toward their patients, describing the therapist's emotional response toward the patient: (overwhelmed/disorganized, helpless/inadequate,) representing the quality of the working alliance between therapist and patient (positive/satisfying), and the behavioral patterns present during treatment (special/overinvolved, sexualized, disengaged, parental/protective, and criticized/mistreated) (Betan et al., 2005; Löffler-Stastka et al., 2011). The eight factors of levels of physical and/or emotional therapist responses may be interpreted as high (>4), moderate (2–4), or low (<2) (e.g., Gorman-Ezell, 2010).

Satisfaction Questionnaire. A brief nine-item evaluation form (see Appendix) was designed to gain feedback from the patients about the DBT skills group. The evaluation was handed out at the end of the last session. Nine items, on a 7-point Likert scale (1 = "not true at all," 4 = "somewhat

true," 7 = "very true") focused on the experience working with the therapists in the group as well as on how helpful the group was for meeting therapy goals. In addition to these 9 specific questions, the 10th item was an open field, in which patients were asked to provide additional comments on their experiences, concerns, and perceived benefits of the group.

Although positive patient feedback on DBT skills groups have been reported in previous studies, the authors felt it was worthwhile including a patient satisfaction questionnaire given the unique nature of the psychoanalytic clinic context. Moreover, adding a measure of satisfaction was desirable, because within the clinic this skills group was seen as a pilot. In order to ensure that future DBT skills groups might be offered within this training clinic, "proof" of its outcomes was deemed helpful.

Statistical Analyses

Parametric tests were used in the analyses.[2] Treatment change was assessed by comparing pre- and post-scores on all outcome measures using paired samples *t*-tests. One-tailed tests were used because of the directional nature of the hypotheses. Effect sizes were calculated by examining the magnitude of pre–post change correcting for the pooled standard deviation and the correlation of the outcome at both time points (Cohen, 1992; Dunlap, Cortina, Vaslow, & Burke, 1996). The within-group effect sizes for all outcome variables were evaluated using Cohen's *d* according to standard criteria: small (d = .20), medium (d = .50), and large (d =.80).

The Reliable Change Index (RCI; Jacobson & Truax, 1991) was calculated as 1.96, standard deviation (*SD*) of pre-score in our sample * 2 * (1- Cronbach's α in our sample). The clinical cut-off scores for the BSL-23 (46; Glenn et al., 2009), BDI (24; Beck et al., 1996), BAI (24; Beck, Epstein, Brown, & Steer, 1988), and IIP-32 (39; Barkham et al., 1996) were used; no clinical cut-off scores for the Q-LES-Q and MAAS have been published. Spearman's correlations were used to test for a relationship between number of group sessions attended and symptom change as well as the relationship between therapist response to patients and treatment outcome. Differences in therapist response levels between the two therapists were analyzed by two-tailed t-tests. Analyses were performed using SPSS software, version 24.0.

Results

Hypothesis 1. Satisfaction

The first hypothesis predicted that the DBT skills group would be satisfactory for patients within this psychoanalytic community setting based on attendance and patient feedback.

Attendance. Attendance was 80%, with an average of 16 sessions (*SD* = 4.60), ranging from 9 to 20 sessions attended. Two patients attended all 20 sessions, two patients attended 19 sessions, one patient attended 18 sessions. One patient attended 13 sessions, and moved out of state for a new job near the end of the group treatment and therefore completed the post-outcome measures at week 18 instead of week 20. One other patient attended intermittently (10 out of 20 sessions) due to reported physical illness and requested to be included in the next DBT skills group facilitated within the clinic in order to continue her skills training. One other patient dropped out prematurely (after having attended nine sessions) because of reported difficulties with childcare arrangements and regrettably was not asked to complete the post-treatment measures.[3] Guidelines in Linehan's manual were followed with respect to attendance policies. Homework completion was assessed; homework was reviewed at the beginning of each session and patients were engaged in reminders of the rationale for homework tasks when these were not fully completed. Although one can never be sure that patients indeed practiced their skills in between sessions (i.e., adherence to the DBT skills practice itself) patients appeared to be engaged in the homework tasks

as they frequently reported their experience of practicing emotion-regulation skills in between sessions. Seven out of eight patients completed post-treatment measures.

Patient Feedback. Treatment satisfaction scores on the post-treatment evaluation also suggested that patients experienced the DBT skills group as beneficial. The average rating was 6 (*SD* = 1.09; ranging from 3.90 to 7). Most patients reported feeling understood, accepted, and encouraged by the therapists, and reported an increased understanding of emotional experiences, perceived utility of the DBT skills, and ability to be assertive in relationship with others. However, most ratings for these items were not in the extreme positive category (6 out of 7-point Likert scale).

Feedback from the qualitative section of the feedback form provided a more personal perspective on the perceived benefits of the intervention. Although some indicated being part of a group was "stressful" (*n* = 2), six patients reported enjoying the social aspects of being in a group, including "feeling supported," "encouraged," and "less alone." All patients indicated that the group had helped them, either by stating this explicitly "I learnt a lot that was helpful" or by asking for continued or longer sessions ("Can you sign me up for the next DBT group that you run here?" and "I liked it a lot, the only thing is that I wish we had longer meetings"). Four patients found the DBT group treatment sufficient at this time and three patients indicated to want to seek further psychotherapy following the end of this treatment to continue the work.

Hypothesis 2. Effectiveness

The second hypothesis predicted that following treatment the patients would report a reduction of borderline symptoms and behavior, depressive and anxiety symptoms, interpersonal problems, and an increased quality of life and mindfulness skills. For the patient group as a whole, change reached significance on the BDI, BAI, and Q-LES-Q, and not on the BSI-23, IIP-32, and MAAS (see Table 1). The effect sizes for change on the BSI-23 supplement, and MAAS were small to moderate (.02–.11) and large on the BSI-23, BAI, BDI, IIP-32, and Q-LES-Q (.71–1.36; Cohen, 1992). Six patients (86 %) recovered (reached both clinical significance and reliable change) on the BSI-23, BDI, or IIP-32. Out of the seven patients who completed post-treatment measures, those who previously reported symptom levels in the clinical range on the BSI-23 (*n* = 1; 29%), BDI (*n* = 4; 59%) no longer met clinical diagnostic criteria. For the IIP-32, one out of the three patients previously in the clinical range, now reported symptoms below the clinical cut-off. As indicated in Table 2, most patients showed reliable improvement on the BDI (*n* = 5; 71%). Three patients showed reliable improvement on the BAI, the BSL- supplement, or the Q-LES-Q (43%), and two patients showed reliable improvement on the BSL or the MAAS (29%). Some patients reported a reliable deterioration (reliable change in negative direction) of borderline behaviors (*n* = 2; 29%), depression (*n* = 1; 14%), quality of life (*n* = 1; 14%), or mindfulness (*n* = 2; 29%).

BSL-23. For the seven patients, no significant pre–post change was found on the BSL-23 or BSL supplement (*p*'s > .16). Borderline symptoms of a majority of the patients' improved: two patients (29%) reached reliable change and one patient (14%) reached clinical significant change on the BSL-23, and borderline behaviors of three patients (43%) improved reliably on the BSL supplement.

BDI. Change on the BDI showed a significant reduction in overall depressive symptoms from moderate/severe levels of depression (*M* = 1.01, *SD* = .40) to low moderate scores post-therapy (*M* = .49, *SD* = .36; $t(6) = 2.24$, $p = .03$). The effect size of this change was large (1.36; Cohen's $d = 1.36$). Five out of seven patients showed reliable improvement (71%).

BAI. There was also a significant decrease in anxiety on the BAI scores from pre (*M* = .56, *SD* = .18) to post-therapy (*M* = .41, *SD* = .24); $t(6) = 2.09$, $p = .04$), with a large effect size (Cohen's $d = 0.71$). Three patients' anxiety scores reliably decreased.

TABLE 1. Means and Standard Deviations of Outcome Measures, Change Scores, and Paired t-test Scores

		Mean (*SD*)				
Outcome Measure	Pre-treatment	Post-treatment	Change Score	*t(6)*	*p*	Cohen's *d*
BSL-23	1.14 (.78)	.70 (.39)	−0.44 (1.06)	1.10	.16	0.71
BSL-23 suppl.	.23 (.18)	.21 (.19)	−0.03 (.16)	.42	.34	0.11
BDI-II	1.01 (.40)	.49 (.36)	−.52 (.61)	2.24	.03*	1.36
BAI	.56 (.18)	.41 (.24)	−.16 (.20)	2.09	.04*	0.71
IIP-32	1.40 (.63)	.97 (.42)	−.43 (.63)	1.82	.06	0.80
Q-LES-Q	3.33 (.61)	3.78 (.61)	.45 (.62)	−1.91	.05*	0.74
MAAS	3.68 (.68)	3.69 (.98)	.02 (.94)	−.05	.48	0.02

Note. $N = 7$; BSL-23 = Borderline Symptom List 23; BSL-23 suppl = Borderline Symptom List 23 supplement; BDI-II = Beck's Depression Inventory-II; BAI = Beck's Anxiety Inventory; IIP-32 = Inventory of Interpersonal Problems-32; Q-LES-Q = Quality of Life Satisfaction and Enjoyment Questionnaire; MAAS = Mindful Attention Awareness Scale.
*$p < .05$.

TABLE 2. Change Following the DBT Skills Group in Different Change Categories

	Percentages and Frequencies of Patients					
Outcome Measure	Improved % (*n*)	No Change % (*n*)	Deteriorated % (*n*)	Reliably Improved % (*n*)	Reliably Deteriorated % (*n*)	Clinically Improved % (*n*)
BSL-23	71 (5)	0 (0)	14 (2)	29 (2)	0 (0)	14 (1)
BSL-23 suppl	43 (3)	29 (2)	29 (2)	43 (3)	29 (2)	n/a
BDI-II	86 (6)	0 (0)	14 (1)	71 (5)	14 (1)	57 (4)
BAI	71 (5)	14 (1)	14 (1)	43 (3)	0 (0)	0 (0)
IIP-32	57 (5)	0 (0)	29 (2)	14 (1)	0 (0)	29 (2)
Q-LES-Q	71 (5)	0 (0)	14 (2)	43 (3)	14 (1)	n/a
MAAS	57 (4)	0 (0)	43 (3)	29 (2)	29 (2)	n/a

Note. n/a = No clinical norms/cut-off points have been published for this outcome measure; $N = 7$; BSL-23 = Borderline Symptom List 23; BSL-23 suppl = Borderline Symptom List 23 supplement; BDI-II = Beck's Depression Inventory-II; BAI = Beck's Anxiety Inventory; IIP-32 = Inventory of Interpersonal Problems-32; Q-LES-Q = Quality of Life Satisfaction and Enjoyment Questionnaire; MAAS = Mindful Attention Awareness Scale.
*indicates statistically significant change $p < .05$

IIP-32. The IIP-32 showed a trend toward significant change on the overall score from pre- ($M = 1.40$, $SD = .63$) to post-scores ($M = .97$, $SD = .42$; $t(6) = 1.82$, $p = .06$), with a large effect size (Cohen's $d = .80$). Two of the seven patients no longer met the clinical cut-off and another patient showed reliable improvement on the IIP-32. More specifically, the seven patients showed a significant improvement for the subscale "too aggressive," from pre- ($M = 1.21$, $SD = 1.13$) to post-therapy ($M = .50$, $SD = .56$; $t(6) = 2.17$, $p = .04$). The changes on the other subscales were not significant.

Q-LES-Q. Overall quality of life on the Q-LES-Q improved significantly from pre- ($M = 3.33$, $SD = .61$) to post-treatment ($M = 3.78$, $SD = .61$; $t(6) = -1.91$, $p = .05$). More specifically, the patients improved significantly on the subscale "social" from pre- ($M = 3.49$, $SD = .39$) to post-treatment

(M = 4.08, SD =.89); $t(6) = -2.03$, $p = .04$) and the subscale "activities," from pre- (M = 3.24, SD = .77) to post-treatment (M = 3.81, SD = 1.06; $t(6) = -2.62$, $p = .02$). The change on the other subscales was not significant. Three patients (42.3%) indicated a reliable improvement and one patient (14%) a reliable deterioration in quality of life following treatment.

MAAS. No significant pre–post change was found for the group as a whole on the MAAS ($p = .48$). Four patients (57%) showed improvement in mindfulness skills. Mindfulness skills of two patients improved reliably (29%) and of two other patients (29%) deteriorated reliably according to the MAAS. Since patients had different attendance rates, the correlation between the amount of sessions attended and each change score was tested. Session attendance was not associated with changes in any of the outcomes from pre- to post intervention (all ps >.40).

Hypothesis 3. Therapist Response to Patients

The third hypothesis predicted that the two therapists would report responses to patients associated with BPD and that this would be correlated with treatment change.

CTQ. Therapists' scores on the eight factors of the CTQ are summarized in Table 3. Neither of the therapists reported high levels of responses (>4) on the different subscales. Both therapists' emotional responses toward the patients were moderately helpless/inadequate, with low levels of feeling overwhelmed/disorganized. Their moderate levels on the positive/satisfying subscale indicate a relatively good quality of the working alliance between the two therapists and patient-group. For the subscales representing behavioral patterns in treatment, both therapists reported moderate levels on the parental/protective, criticized/mistreated, and disengaged subscales compared to low levels on the special/overinvolved or sexualized subscales. For the overall levels of therapist responses toward the group, there was a difference between the two therapists in that Therapist 1 scored lower (M = 12.38, SD = 1.40) than Therapist 2 (M = 16.33, SD = 3.66; $t(7) = -3.32$, $p = .01$). Therapist 1 showed relatively little variety in her scores for the different patients (ranging from 10.74 to 14.83), whereas the scores of Therapist 2 for each patient varied more widely (ranging from 13.47 to 23.09). For the CTQ subscales, no significant differences between the two therapists were found (all ps >.6). When examining the two therapist's responses to patients in relation to pre–post-treatment change, the CTQ score of Therapist 1 and 2 were not significantly correlated to any of the change scores on the outcome measures (all ps >.22). The CTQ scores of Therapists 1 and

TABLE 3. Countertransference Feelings Toward the Patient Group

CTQ	Mean (SD)		
	Therapist 1	Therapist 2	Therapists 1 and 2
Total Score	12.38 (1.39)	16.33 (3.66)	14.35 (2.20)
Emotional response subscales			
Overwhelmed/disorganized	1.39 (.66)	1.54 (.97)	1.47 (.80)
Helpless/inadequate	1.93 (.83)	2.28 (1.23)	2.10 (.98)
Working alliance subscale			
Positive/satisfying	2.89 (1.21)	2.57 (1.28)	2.73 (1.22)
Behavioral patterns subscales			
Parental/protective	2.17 (.83)	2.75 (1.15)	2.46 (.93)
Criticized/mistreated	1.99 (1.17)	2.42 (1.26)	2.21 (1.14)
Special/overinvolved	1 (0)	1.18(.42)	1.09 (.21)
Sexualized	1 (0)	1 (0)	1(0)
Disengaged	2 (.92)	2.59 (1.3)	2.30 (.99)

Note. N = 8; CTQ = Countertransference Questionnaire (Likert scale 1–5).

2 were not significantly related to the patients' pre- or post-treatment measurements, however, CTQ scores of Therapist 1 and Therapist 2 were negatively correlated with mean satisfaction scores reported by patients post-treatment, $r(6) = -.829$, $p = .011$ and $r(6) = -.703$, $p = .039$, respectively.

Discussion

This exploratory study reports on the implementation and effectiveness of a 20-week DBT skills group provided within a psychoanalytic community training clinic. This study forms a partial extension and replication of the Blackford and Love (2011) pilot study on the implementation of a DBT skills group for a sample of 12 outpatients in a community training setting. In line with this previous pilot study, our naturalistic sample was not restricted by psychiatric diagnosis or level of functioning, enhancing the clinical validity of the findings. Eight patients who presented with BPD associated symptoms of emotion dysregulation and interpersonal problems participated in the DBT skills group. Different from this previous pilot study, we examined the satisfaction with and effectiveness of a DBT skills group within a psychoanalytic community setting and explored not only the change in psychiatric symptoms, quality of life and gained skills, but also the potential impact of the responses from the two therapists on treatment effects. After treatment, patients indicated that they were satisfied with the DBT skills group and reported reduced symptom levels of anxiety, depression, and improved quality of life. Borderline symptomology and mindfulness did not significantly improve in the patient sample. Both therapists reported moderate therapist responses typically associated with BPD psychopathology. Their responses were not associated with patient symptom levels or change but were related to patient satisfaction.

Implementation

Despite the lack of knowledge and interest in DBT within the staff team in the psychoanalytic training clinic, the director of the training clinic, who supervised the DBT skills group, was supportive of the implementation of the DBT skills group within the psychoanalytic training clinic. However, the fact that the supervisor was a psychoanalyst, not trained in DBT, had several implications. First, during supervision the two therapists were asked to share their responses to patients in a way that is typical for a psychoanalysis (i.e., openly exploring subjective experiences of feelings of hate, disgust, hopelessness, and mistrust triggered in the therapist, regardless of objective facts), but not typical for DBT (which would have encouraged to be nonjudgmental, non-evaluative, fact-based, and dialectical). Moreover, the two therapists had to integrate different conceptualizations of the patients' behavioral presentations, and translate psychoanalytic formulations into DBT therapeutic techniques. By explaining DBT terms to the supervising psychoanalyst, unfamiliar with the DBT principles, the therapists became more aware of the commonalities in theoretical understandings of the etiology of symptoms (e.g., attachment, trauma history, and dialectics), as well as the mechanisms of change in treatment (e.g., present moment focus, transference, and therapist responses to patients). In this respect, this dual perspective offered a valuable learning experience to the therapists.

An implication of this dual perspective is that the therapists needed to be aware of different theoretical and practical concepts in order to be effective in their communication to patients and their supervisor. On reflection, both therapists made sense of this translation of theories in terms of their bilingual language skills. They felt they had to switch gears and translate the DBT process into language that was understood by the psychoanalytic supervisor and clinic staff (e.g., therapist emotional reactions are not termed 'countertransference' within DBT). The language of DBT was only spoken by the two therapists, and not well understood by the other therapists in the clinic. On a few occasions, where interpersonal difficulties in the group were reflected on in supervision but not concretely problem solved, the two therapists ended up consulting with each other and

with their DBT handbooks to decide on the most appropriate behavioral way to deal with interactions in the DBT skills group. The lack of a DBT consultation team, an integral component in the full DBT protocol, likely contributed to this sense of isolation, and consultation with a therapist familiar with both DBT and psychoanalytic principles would have been particularly valuable to the two therapists.

Rather than an attempt to integrate or "fit" DBT into psychoanalytic jargon, the therapists viewed the two therapy modalities as two independent approaches that had to be kept in mind separately. From the therapists' experience in this DBT skills group, it was important to follow one model of thought during the treatment, using the theoretical foundations of DBT as guiding principles with which to steer the ship, and to not be distracted my other models of thought during the skills groups. As the therapists felt anxious about facilitating this treatment approach within the psychoanalytic setting, they tried to adhere very strictly to a theoretical DBT perspective to help provide an organizing principle to address the difficulties faced by the patients. Rather than adapting the content of the group skills sessions, they choose to adapt the format by adding an additional 15 minutes of process time to the standard DBT protocol. These unstructured 15 minutes gave the participants an opportunity to practice many of the skills they learned throughout the group. For example, participants would give voice to the various feelings that arose in them during the group, which indicated that they were increasing their ability to track and identify their feeling states. While this may have been a helpful addition to the traditional DBT group format for some patients, it is possible that it felt overstimulating for others. However, this unstructured time to process at the end of each session may have helped the therapists with their own emotional reactions toward the group dynamics, explaining the relatively modest level of responses to patients of the two therapists. Also, these unstructured 15 minutes allowed the therapists to commit to their DBT conceptualization throughout the structured part of the session. This conscious effort to keep a consistent perspective within the skills group, especially given the lack of DBT supervision, was helpful for the therapist to guide what they would talk about, and how they would approach the patient's problems. The therapists did not integrate the two perspectives but used the psychoanalytic clinic context and supervision as a complementary perspective, an alternative viewpoint worthy of contemplation in between sessions. Future research will need to elucidate how this psychoanalytic adaptation to the DBT skills group format, differs from other structured group formats that incorporate some relatively unstructured process work (not necessarily called psychoanalytic).

When a supportive-exploratory continuum is used to structure a course of treatment, the common sequence is to move from a supportive and highly structured (e.g., DBT) therapy to an exploratory one (e.g., psychoanalysis) (Rockland, 1989). The therapists therefore conceptualized this DBT skills group as an initial phase of potentially long-term psychological treatment available to the patients. They hoped that as therapy progressed, these patients would improve to the point where more exploratory psychoanalytic interventions could be used safely and effectively. Notably, patients were oriented to DBT (in line with DBT principles) but not to the psychoanalytic orientation of the clinic (in line with psychoanalytic principles), which means that this long-term goal was not explicitly communicated to the patients. The use of the skills group in longer-term psychoanalytic interventions would be interesting to further explore in future empirical research.

Treatment Effectiveness

Based on treatment attendance and patient feedback post-treatment, the patients appeared to be satisfied with this skills group, thus confirming the first hypothesis. Although only two patients attended all 20 sessions, only one patient dropped out prematurely. Attendance rates and engagement in skills practice during treatment were high but were not associated with outcome changes

from pre- to post-treatment. This differs from some previous studies on DBT as practiced in community mental health services, such as the naturalistic study on the full DBT protocol for patients with BPD (Harley et al., 2007) and the Blackford and Love (2011) pilot study, where more than half of the patients stopped coming after the first month and where greater attendance was positively associated with both reductions in symptoms and improvements in functioning. It is possible that the overall high attendance rates across participants in our sample, left little variability to account for differences in outcomes.

On the group evaluation, most patients indicated that they felt supported by the group and enjoyed being in a group, which may be an important factor given the positive relationship between group alliance and attendance rate (Johnson, Penn, Bauer, Meyer, & Evans, 2008). All patients indicated that the group had helped them. Although an expressed wish for more therapy could be interpreted as a failed treatment in terms of efficiency, it is also possible that it reflects an appropriate wish to take better care of themselves, and to make use of available resources and support. Taken together, treatment attendance rates and patient feedback indicated that the DBT skills group was satisfactory and that they were motivated to attend. This is promising, especially given the long-term nature of the symptoms and their interpersonal implications in daily functioning.

Our second hypothesis was partially confirmed. In line with the expectations, this study found a significant reduction in depression and anxiety symptoms, quality of life, and a trend of a reduction in interpersonal problems following treatment. Although Blackford and Love (2011) also reported significant improvements in depression, their patients did not report significant changes on their other outcomes of symptom severity, community functioning, quality of life, and recovery. Their nonsignificant findings might have been explained by their high drop-out rates early in treatment. Looking at the rate of recovery, we found that several patients recovered on some of the outcome measures using the traditional clinical change or RCI method. Previous researchers found similar improvements in social and global adjustments and in depression symptoms among patients following DBT treatment, compared to community-based treatment-as-usual (Koons et al., 2001; Linehan et al., 1999).

However, contrary to expectations, the reported reduction of borderline symptoms and behaviors was not significant. Given that 71% of patients did show improvement on the BSI-23, it is possible that our sample, with widely varying and mostly subclinical levels of borderline symptoms pretreatment was too high functioning (also reflected by a relatively high mean GAF score of 62) to show significant change on this measure (i.e., the scope for change was minimal). It could also be the case that a more comprehensive DBT approach, including individual treatment and skills coaching, would be necessary to achieve a reduction of BPD symptoms specifically. The fact that with our very small sample, we still found significant improvement on the BDI, BAI, and Q-LES-Q and a trend for the IIP-32 (even though it is difficult to improve interpersonal problems with short-term treatments; e.g., Vinnars, Thormählen, Gallop, Norén, & Barber, 2009) could be partly due to the chosen statistical analyses (directional hypotheses and parametric tests), but might also be indicative of a large treatment effect. Although the recovery rates and clinical significant changes might be most impressive to researchers, the improvement in quality of life and to some extent the reduced interpersonal problems seem clinically most relevant, given that all patients aimed to improve their interpersonal functioning.

Our nonsignificant results on the MAAS suggest that patients did not change in their level of awareness of the present moment. Arguably, change in mindfulness is harder to measure than other more explicit outcomes, because it reflects a change in awareness of thought, rather than a change in thoughts and images. However, other studies reported patient improvement in several mindfulness-based self-efficacy scales after attending DBT treatment (Van Dijk, Jeffrey, & Katz, 2013) and increased self-reported awareness of the present moment, after attending a mindfulness group (York, 2007). It is possible that the therapists in this study were less skilled in mindfulness

themselves, than other therapists who might be more experienced in DBT or who are under the supervision of a senior DBT therapist. Another explanation for this difference in findings may be that reinforcement of mindfulness skills application in individual therapy, and skill generalization through coaching, would have been necessary for greater skills acquisition. If the study had included measurement of acquisition of other skills, these possible explanations could have been empirically parsed out.

Furthermore, it is important to note that several patients reliably deteriorated on some of the outcome measures. Due to the limited measurement points and small sample size, it is unclear if this reflected a temporary increase in borderline symptoms and a momentary reduction of quality of life/mindfulness. It is possible that these patients experienced the group treatment (group-format or the skills-based practice) as overwhelming, especially without the support of individual sessions and team consultations, standard in most DBT treatment centers.

The third hypothesis was also partially supported, in that therapist responses to patients resembled those previously reported in work with BPD patients, but this was not related to treatment outcome. Both therapists reported moderate levels of responses towards the group as a whole. Arguably, these findings are lower than expected, given that therapists in training tend to display more affective reactions and are more likely to be influenced by their responses to patients than their more experienced colleagues (Hayes et al., 2011) and given that the reported BPD symptomatology of the patients is associated with intense therapist responses (Betan et al., 2005). It is possible that the mindfulness skills practice in DBT may have provided the therapists with a helpful sense of calm, facilitative conversation, and slowed pace of the session (Horst, Newsom, & Stith, 2013). Alternatively, the more diffused group-format instead of intense individual therapy, and the support of the co-therapist may have been helped the therapists manage their triggered feelings. Also, other factors unique to this adapted DBT skills group could potentially have contributed to these lower levels of therapist responses to this patient group: the regular exploration of therapist responses (countertransference) in psychoanalytic supervision, the experience of writing process notes after each group session, as well as the 15 minutes of group processing time at the end of each session.

Congruent with previous research, the treatment of these patients seemed to evoke moderate levels of helplessness and inadequacy, as well as a mixture of protective and criticized behavioral patterns. However, the therapists only reported mild feelings of being overwhelmed/disorganized, and only mild special/overinvolved behavioral patterns, which is often associated with BPD (Betan et al., 2005; Colli et al., 2014). Despite the fact that the relational instability and poor executive attention that characterize BPD, are associated with challenges in building a positive working alliance (Hirsh, Quilty, Bagby, & McMain, 2012; Levy, Beeney, Wasserman, & Clarkin, 2010), the therapists reported relatively high levels of positive/satisfying experience. These findings could possibly be explained by the naturalistic sample of patients, without formal BPD diagnosis and with comorbid depressive symptoms, who self-selected to treatment and therefore may have been more reinforcing for therapists to work with. Also, upholding DBT principles and adherence to its principles and core dialectic, might have allowed for increased feelings of acceptance and compassion on behalf of the two therapists (Hutton et al., 2017).

In line with the previously reported variety in therapist responses toward patients with BPD symptoms (e.g., Rossberg et al., 2007), the two therapists in this pilot study showed a different pattern of therapist responses toward the patient group, with one therapist experiencing a higher level of emotional reaction toward the group than the other. The therapists' reported levels of responses to patients could possibly be explained by their difference in cultural background, attachment, or personality (e.g., Ligiéro & Gelso, 2002). Unlike previous literature, which suggests that complicated therapist responses to patients are associated with poorer alliance and treatment outcome (e.g., Betan et al., 2005; Ligiéro & Gelso, 2002), the relationship between therapist responses and

patient change following treatment was not significant for either therapist. Although level of therapist responses to patients was not related to the standardized pre-and post-outcome measurements, patients who reported to be more satisfied with the treatment, triggered lower levels of responses in both therapists. Future replication studies will have to elucidate if these limited findings were a result of the methodological limitations of this pilot study or a unique finding for therapist responses to patients in a DBT skills group in naturalistic community settings.

Clinical Implications

This exploratory pilot study complements several previous small-scale practice-based studies that showed DBT skills groups to be effective in community clinics (e.g., Koons et al., 2001; Linehan, Heard, & Armstrong, 1993). Although our patients did not have a formal BPD diagnosis and were not offered the total DBT treatment package (i.e., additional phone support, team consultations, and individual therapy), this study was comparable with regard to group size, manualized treatment, and patient demographics such as gender, age, and presenting symptoms (Blackford & Love, 2011; Linehan et al., 1993, 1999). Accumulating pilot studies like these can serve to add to their overall influence and a pre–post naturalistic design is a recommended first step in determining the acceptability of an intervention in a new treatment setting and in accordance with treatment development procedures (e.g., Drake, Merrens, & Lynde, 2005).

As the evidence accumulates for the efficacy of DBT for BPD and related problems (Harned & Linehan, 2008), and as research continues to highlight and clarify the mechanisms of change associated with this treatment (Lynch, Rosenthal, & Smoski, 2008), the awareness and use of DBT skills groups in a variety of clinical settings will likely continue to increase. However, it is important for therapists practicing DBT to adhere to the behavioral and dialectical theoretical foundations of the approach, in order to provide a skills group that is effective, coherent, and consistent (Chapman, Turner, & Dixon-Gordon, 2011).

Although we argue that therapists should generally avoid attempts at the integration of alternative theoretical frameworks into DBT, eclecticism, and flexibility in terms of technique can be effective in DBT. The techniques and principles of DBT have some overlap with other systems of thought, such as Zen practice, humanistic or Gestalt traditions, and even psychoanalysis. Sufficient training in DBT principles, supervision by a trained DBT therapist, as well as retention of a DBT consultation team, are likely a requisite for effectively integrating and translating different techniques within DBT.

Limitations

Our pilot study has obvious methodological limitations. First, the statistical analyses of this practice-based intervention study were restrained by a very small diverse patient sample. A small sample size is associated with low statistical power, inflated false discovery rate, inflated effect size estimation, and low reproducibility. For example, this means that the nonsignificant findings could be interpreted as a true lack of relationship between variables, but might also have been the result of the small power of the study. A further limitation is the lack of a comparison group of similar patients in individual psychoanalytic or DBT treatment. In future studies, comparison to a treatment-as-usual control group could test whether the skills group improves symptoms relative to standard care. Also, comparison to another type of group therapy could test for specific effects due to the DBT skills training controlling for other nonspecific therapeutic group factors such as universality and cohesion. Moreover, the absence of formal measurement regarding adherence to the treatment manual leaves it unclear if treatment integrity to DBT was adequately maintained. It

is, for example, possible that the lack of supervision by a DBT trained therapist, an important part of BPD treatments (Shearin & Linehan, 1994), might have affected the adherence of the treatment manual.

In addition to a control group, and adherence check, follow-up data could have provided more information on the maintenance of the gains achieved post-treatment. Also, session-by-session outcome data could have given a more complete overview of therapeutic progress throughout treatment. Moreover, formal diagnostic assessments could have offered valuable information about the patient's specific symptoms, and increased its comparability to other publications on the effectiveness of DBT skills groups. The effectiveness of DBT skills groups in clinical populations, other than BPD might be addressed in future research. For example, based on the frequent comorbidity of depressive disorder (Cristea et al., 2017) and the reliable and clinically significant change achieved on the BDI in this pilot sample, we can hypothesize that a DBT skills group might be effective for people with depressive disorders. Patient differences other than psychopathology in the level of outcome change and therapist responses to patients should also be considered in future studies (e.g., gender differences in evoked levels of therapist responses reported by Armelius & Holmqvist, 2003). Future research should include patient-self report measures of alliance, especially given that interpersonal difficulties related to BPD symptoms often make the process of entering a working alliance critical, painful, and extended (Bordin, 1994).

Besides the study design, the limited validity of the operationalization of therapist responses to patients might have also impacted the findings. First, the CTQ is a therapist self-report measure, which implies that unconscious therapist responses were not identified. Future research should include observer-rated measures of therapist responses to patients (see Colli et al., 2014). Second, the CTQ was developed for therapeutic dyads, instructing therapists to complete the instrument while thinking about one particular patient, and scores are not typically averaged for a therapist responses score of groups of patients as a whole. Therefore, individual relationships might have disappeared when examining the group as a whole. The assessment of the hypothesis regarding therapist responses might have been improved with a method to study the difference between the two therapists' CT reactions toward individual patients rather than the group as a whole. For example, Greene, Rosenkrantz, and Muth (1986) found that the more that the borderline group patients polarized, or split, the co-therapists, the more the group co-therapists had polarized reactions toward the individual patient in the group. Furthermore, the reported therapist responses toward the group members were likely influenced by the co-therapist and by discussion with the psychoanalytic supervisor. In future research, it would be interesting to assess whether the co-therapists' responses toward individual patients (or differential responses) relate to the patients' symptoms.

Even though therapist response to patients is a common concept, in theories of group psychotherapy, empirical research has been almost nonexistent (Hayes, 1995). The field would benefit from the development of a counter transference measure designed to assess the therapists' reactions toward the patient group as a whole. In order to increase comparability of results, future research could include the Feeling Word Checklist (FWC; Røssberg, Hoffart, & Friis, 2003), the most commonly used measure to assess therapist response in psychotherapy (de Bitencourt Machado et al., 2014). However, the FWC focuses on feelings only, whereas the CTQ also assesses thoughts and behaviors and thus gives a well-rounded view of the therapists' responses to patients. The CTQ might therefore be better suited to discover differences in responses to patients between the two therapists. Also, both the FWC and CTQ are based on a totalistic conception of therapist responses to patients, which means that other measures assessing therapist response that view these responses as the therapist's reactions based on the therapist unresolved conflicts and vulnerabilities (e.g., Inventory of Countertransference Behavior by Friedman & Gelso, 2000) might have illustrated different aspects of the therapists' responses. Furthermore, larger samples of more diverse therapists would be able to examine previously reported differences in therapist response

levels between more experienced and less experienced therapists as well as between female and male therapists (De Vogel & Louppen, 2016).

In sum, this practice-based pilot study adds to accumulating evidence for the clinical benefits of implementing a DBT skills group into a community setting. It is the first study to explore the implementation and effectiveness of a DBT skills group specifically within a psychoanalytic setting. However, given our very small sample size, statistical inferences should be made with great caution and strong conclusion are precluded until further research is conducted. The challenges of a community training clinic setting and supervision within a very different treatment approach are important to consider for further implementation of evidence-based DBT skills groups into routine practice.

Notes

1. To protect patients' confidentiality personal information was de-identified. Number codes were used to identify patients and all identifiable information (name of partner/workplace) was removed from the satisfaction questionnaire by the clinic administration before analyses of the data. All individual patients, the supervisor and the training clinic director provided verbal informed consent for the write-up of the study findings prior to commencement of the group.
2. Because nonparametric tests have less power than parametric tests, which is especially noticeable with very small samples, we chose to conduct parametric tests in this pre-post analyses. The limited sample size does not contain enough information to make reliable inferences about the shape of the distribution in the entire population. Normality tests have little power to detect whether or not a sample comes from a Gaussian population when n <12 (Skene & Kenward, 2010). Given our very small sample size (n = 7), statistical inferences should be made with great caution.
3. Pre-treatment, this patient had reported symptom levels within the clinical range on the BSI-23, BDI, BAI and IIP-32.

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