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Therapists' Use of DBT: A Survey Study of Clinical Practice

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The purpose of this study was to examine how therapists conduct Dialectical Behavior Therapy (DBT) individual psychotherapy with clients, focusing on clinical factors that could account for decisions regarding modifications of DBT (e.g., client diagnosis, therapist theoretical orientation, and intensity of DBT training). Additionally, the study investigated how therapists integrate DBT into their primary approach to therapy. Greater adherence to the DBT protocol was reported by therapists who described using DBT with a client with a diagnosis of borderline personality disorder. More frequent use of DBT components (i.e., group skills training, consultation teams, and telephone consultation) was reported by therapists who viewed their therapy as being guided by an applied behavior analysis/radical behavioral theoretical orientation and by therapists who had received intensive DBT training. Most therapists reported using DBT skills in their non-DBT work, with non-cognitive-behavioral therapists more likely to introduce mindfulness skills.

Survey studies have found that practicing psychologists are increasingly favoring the use of eclectic therapeutic approaches that combine aspects from different theoretical orientations (Norcross, Alford, & DeMichele, 1992; Norcross, Karpiak, & Lister, 2005). Dialectical behavior therapy (DBT; Linehan, 1993) is an example of a primarily behavioral therapy that integrates techniques and theory from Zen philosophy and genuineness from client-centered therapy (M. Linehan, personal communication, August 27, 2007). Its interventions also overlap with, but were not drawn from, theoretical approaches such as cognitive-behavioral, gestalt, client-centered, psychodynamic, paradoxical, and strategic (Robins & Chapman, 2004; Wolpow, 2000). DBT consists of both individual psychotherapy and group skills training, in addition to offering telephone consultations between sessions. Therapists are also required to participate on consultation teams that provide them with both emotional and technical support.

To date, due to its proven efficacy with clients with borderline personality disorder (BPD) (Linehan et al., 2006), therapists from differing theoretical orientations have begun modifying DBT to better fit the populations they are treating (see Dimeff & Koerner, 2007). For example, DBT has been adapted for use with suicidal adolescents (Katz, Cox, Gunasekara, & Miller, 2004; Rathus & Miller, 2002), criminal offenders (Nee & Farman, 2007), depressed elders (Lynch & Cheavens, 2007), clients with eating disorders (McCabe, LaVia, & Marcus, 2004; Safer, Telch, & Agras, 2001; Wisniewski, Safer, & Chen, 2007), clients suffering from PTSD (Bradley & Follingstad, 2003), and personality disordered inpatients (Swenson, Witterholt, & Bohus, 2007).

In addition to modifying DBT, many therapists who use DBT report that they assimilate it into the therapeutic techniques they normally practice. Assimilative integration, the process by which therapists incorporate techniques from other approaches into their primary theoretical structure, draws on differing therapy approaches, but is guided by a unitary theoretical understanding (Messer, 2000; Stricker, 1994). For example, therapists have reported using DBT in combination with psychodynamic techniques designed to facilitate the conceptualization of clients' emotions and cognitions (Barley et al., 1993; Turner, 2000). Other therapists have incorporated DBT within a family systems theoretical framework that focuses on the role of family relationships in the development and maintenance of pathology (Fruzzetti, Santisteban, & Hoffman, 2007; Rathus & Miller, 2002).

Street, Niederehe, and Lebowitz (2000) called for examination of how treatments typically are used in practice settings, recommending more research to better understand the methods commonly used in clinical practice and to explore efficacious treatments used in community settings. In a survey study of assimilative integration, Lyhus, Glass, and Arnkoff (2009) examined how therapists from different training backgrounds integrated Eye Movement Desensitization

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and Reprocessing (EMDR; Shapiro, 1995) into their primary theoretical orientations. Lyhus et al. (2009) found that therapists often conceptualize EMDR according to their own theoretical orientation and also integrate EMDR into their usual approach to therapy.

Although such survey studies have begun to examine how therapists use manualized treatments such as EMDR, the practice research on how DBT is actually used with clients and how therapists are integrating DBT into their typical therapy approaches is nonexistent. Consequently, the present study sought to further research that examines real-world integration, as well as clinical factors that influence modifications of a variety of techniques, using DBT as the treatment of choice. Specifically, the present study explored how therapists conduct DBT individual psychotherapy with clients, focusing on factors that could account for decisions regarding modifications of DBT. This study also investigated how therapists integrate DBT into their primary approach to therapy, as an example of assimilative integration. Therapist theoretical orientation, client diagnosis, and intensity of DBT training were examined as possible predictors of therapists' decisions to both modify the DBT protocol and to assimilate it into their typical therapeutic approaches. Understanding how DBT is being utilized in actual practice settings, including how therapists assimilate it into their work with clients, is an important piece of the ultimate goal of learning whether modifications to protocols lead to more or less effective treatment than strict adherence to more manualized treatment packages.

It has been suggested that DBT is appealing to therapists from a wide range of theoretical orientations because the treatment shares elements with other approaches to therapy (Heard & Linehan, 1994; Lau & McCain, 2005), yet in fact, DBT employs primarily cognitive-behavioral principles and techniques. Consequently, therapists who identify themselves as primarily behavioral or cognitive-behavioral may make fewer, if any, modifications to the DBT protocol. Conversely, non-CBT therapists may be more likely to make changes when they use DBT with their clients.

Swenson (2000) hypothesized that the reason many therapists are embracing DBT as a treatment option is that it has been shown to be useful in working with clients with BPD, a personality disorder that is especially difficulty to treat. Therapists who typically see clients with BPD may adhere more to the standard DBT protocol, while those who work with clients without BPD may be more likely to make modifications.

In fact, therapists have an ethical obligation to make adjustments to their therapeutic approaches in order to provide treatment that is specialized for the specific client population they are working with. For example, A. L. Miller, Rathus, Linehan, Wetzler, and Leigh (1997) adapted the standard DBT protocol for adults to make it more responsive to the needs of suicidal adolescents. They thus took developmental and family factors into account by incorporating parents into both skills training groups and individual therapy sessions, highlighting core issues of adolescent development (e.g., unstable relationships, mood lability, identity confusion), and simplifying the DBT language so that adolescents could better learn the skills. Additionally, McCabe and colleagues (McCabe et al., 2004; McCabe & Marcus, 2002) modified standard DBT for use with clients diagnosed with eating disorders, including anorexia nervosa. They argue that DBT is especially useful in eating disorders because treatment resistance can be reduced through validation of the client's point of view with a simultaneous focus on a need to change dysfunctional behaviors. In this adaptation for the life-threatening condition of anorexia, therapists must arrange treatment for the medical consequences of severely restricted food intake. Further, a failure on the client's part to maintain a minimum weight or to follow through on medical interventions is treated as therapy-interfering behavior.

Finally, DBT is a conceptually complex and comprehensive treatment package (Swenson, 2000). Thus, those therapists who choose to receive the most intensive DBT training may be more knowledgeable and committed to DBT, and thus may be more likely to adhere to the complex protocol.

Method

Participants

Participants were among 2,053 therapists who had completed at least one type of DBT training offered by Behavioral Tech, a company that trains mental health professionals how to use DBT and other empirically supported treatments. In total, 129 therapists accessed the online questionnaires and completed at least one measure, with 116 completing all scales. Of the 129 who participated in the study, 102 (79%) were female, and therapists ranged in age from 25 to 65 (M=43.97, SD=10.10). Further, 95% of the participants were White/Caucasian, 2% were Hispanic/Latino, 1% were African-American, and 2% reported being "other." Geographically, the 129 participants came from all regions of the United States: Northeast (24.4%), Midwest (31.5%), Southeast (10.2%), Southwest (3.2%), and West (22.8%). Approximately 7.9% of participants were from other countries.

Procedure

To protect privacy and confidentiality, Behavioral Tech sent an email on behalf of the investigators to all 2,278 therapists who had completed their sponsored DBT

workshops, and a total of 2,053 different individuals received this invitation to participate in our research. After reading a brief description of the study, therapists who had conducted individual DBT with at least one client were invited to access the questionnaires by clicking on a link to the research website in the email request. The questionnaires took approximately 30 minutes to complete. No incentives were offered.

Measures

Therapist Background Questionnaire (TBQ)

Originally developed by Lyhus et al. (2009) to assess therapists' use of EMDR, this questionnaire was modified for use in the present study. Questions on therapist professional background, psychotherapy experience, and *DSM-IV* clinical diagnoses assigned to current clients are similar to those on the original TBQ. The present version includes items on therapists' use of DBT during the first year of working with a client, such as whether they use group skills training, consultation teams, and telephone consultations. In addition, therapists provide information about the type(s) of DBT training they received. Therapists also rate their comfort level with intense affect in a session, as well as the amount of experience they have working with difficult clients, on 7-point Likert scales. The TBQ also contains 10 open-ended questions for which therapists provide, where applicable, information about DBT skills modules they review in individual psychotherapy, decisions on whether to use DBT with all clients, therapeutic approaches used in combination with DBT, the integration of typical approaches with DBT, DBT components used within non-DBT individual psychotherapy sessions, and modifications made to standard DBT.

Therapist Theoretical Orientation Questionnaire (TTOQ)

The present study used a modification of the TTOQ (Glass, Arnkoff, Shapiro, Marmarosh, & Piergrossi, 2000), which was based in part on Norcross, Farber, and Prochaska's (1993) survey and Orlinsky et al.'s (1999) study in which psychotherapists provided categorical and dimensional evaluations of their theoretical orientations. The revised TTOQ asks therapists to rate on a scale from 1 (*not at all*) to 7 (*to a great degree*) the extent to which they believe their work with clients is guided by the following theoretical frameworks: applied behavioral analysis/radical behavioral, cognitive/cognitive-behavioral, humanistic/experiential/existential (humanistic), psychodynamic/psychoanalytic (psychodynamic), and systems/family systems (family systems). Therapists also indicate which of the above choices represent their primary and (if relevant) secondary theoretical orientations. Lastly, therapists rate the degree to which they consider their orientation to be eclectic/integrative on a scale from 1 (*not at all*) to 7 (*to a great degree*).

Client Background Questionnaire (CBQ)

The CBQ, developed by Lyhus et al. (2009) to study therapists' use of EMDR, was modified so that it was relevant for the practice of DBT. Therapists were asked to complete this questionnaire based on an individual therapy client with whom they had conducted psychotherapy during the past year using DBT as the primary treatment modality. Like the original CBQ, the modified CBQ asks therapists to provide client demographic information (e.g., gender, age, ethnicity), and to indicate the client's primary (and secondary, when applicable) clinical diagnosis. Additionally, the modified CBQ contains five open-ended questions that ask therapists, where applicable, to explain whether they conducted group skills training with this client, and to describe whether they incorporated skills training into their DBT individual therapy sessions. Therapists are also asked to describe a typical DBT treatment session with this client, as well as any difficulties that may have arisen during the treatment that caused them to modify the DBT protocol. Lastly, the CBQ asks therapists to comment on whether they believe the changes to the protocol had an impact on the treatment/outcome with their chosen client.

Inventory of DBT Individual Psychotherapy Sessions (IDBTIPS)

This questionnaire was developed for the present study to more closely examine how therapists conduct individual DBT with their clients. The 31 techniques listed in this measure are based both on Linehan's (1993) manual that describes the checklists individual therapists commonly use when conducting DBT, and on material provided during Behavioral Tech's 2-day DBT individual psychotherapy workshop. When completing this inventory, therapists are instructed to refer to the client they selected on the CBQ. Those therapists who did not have a client who met the criteria for completion of the CBQ are told to choose any client with whom they had used DBT in the past 12 months. Therapists are asked to identify the techniques they *used without modification*, as well as those *used with modification* at some point during their work with the client so that these methods differed from how they were presented during their DBT training. A total DBT adherence score was calculated based on the difference between the number of techniques used without modification minus the number of interventions used with modification. The last section contains four open-ended questions in which therapists who have made modifications can explain what changes they made and why, in addition to commenting on whether the changes influenced the treatment outcome. Therapists are also asked to elaborate on additional techniques/methods they use as part of DBT individual therapy.

Coding System for Open-Ended Questions

Prior to coding, client responses to nine selected open-ended questions of greatest interest were separated into units based on content. Each unit of information represented a grammatically and/or conceptually distinct idea (Gershefski, Arnkoff, Glass, & Elkin, 1996; Lyhus et al., 2009). For example, conceptually distinct interventions/methods/theories/ therapeutic approaches used with the client were each placed into individual units of information to be coded. The first author unitized all of the responses, and a licensed clinical psychologist additionally unitized approximately 22% of responses from each of the open-ended questions. The overall degree of agreement (kappa) on the unitizing was .85.

Coding systems were developed for therapists' responses to each of these open-ended questions, eight from the TBQ, and one from the CBQ (therapists' descriptions of a typical individual psychotherapy session using DBT with their chosen client). The remaining open-ended questions from the TBQ, CBQ, and IDBTIPS were not coded because responses were found to be highly similar to those for the nine selected questions. The first author trained the same clinical psychologist who assisted with unitizing, using the coding manual and sample responses, until they reached a kappa criterion of .94. The coders were highly reliable in their categorization of data (kappa=.93), and coding discrepancies were resolved by the first author.

Results

Therapist Characteristics

Professional Background and Practice Settings

Over half of the participants (62.9%) reported that they held a master's-level degree, while 37.1% held doctoral-level degrees. Therapists reported an average of 10.7 (*SD*=8.1) years of clinical experience, ranging from less than 1 to 33 years. With regard to professional training, most therapists had received training in clinical psychology (32.3%), social work (30%), or counseling psychology (9.4%), and the remaining participants in other professional areas such as counseling, psychiatry, nursing, and marital and family therapy. In terms of location of practice, 43.3% of therapists practiced in private settings, 32.3% worked in community mental health centers, 18.1% worked in psychiatric hospitals, and 11.8% practiced in outpatient clinics.

Theoretical Orientation

Over two-thirds of the participants reported a primary orientation of cognitive/cognitive-behavioral (CBT; 70.3%), followed by applied behavioral analysis/radical behavioral (ABA; 11.9%), humanistic (7.6%), psychodynamic (6.8%), and family systems (3.4%).

On the 7-point dimensional ratings of theoretical orientation, the highest overall mean rating was for CBT (M=6.00, SD=1.25), followed by family systems (M=4.13, SD=1.69), ABA (M=4.02, SD=1.94), humanistic (M=3.72, SD=1.78), and psychodynamic (M=3.16, SD=1.81). The mean rating for the degree to which they regarded their orientation as eclectic/integrative was 5.11 (SD=1.76), second only to CBT. A repeated-measures ANOVA and Bonferroni t-tests revealed significant differences, $F(5, 545) = 45.62$, $p<.001$, with CBT rated significantly higher and psychodynamic significantly lower than the other approaches.

Therapists of different primary orientations also differed on their ratings of the degree to which they regarded their work as being eclectic/integrative, $F(4, 111) = 4.62$, $p=.002$. Specifically, ABA therapists reported significantly lower eclectic/integrative ratings (M=4.21) compared to both humanistic therapists (M=6.33) and psychodynamic therapists (M=6.63).

Training and Experience in DBT

Over half of the therapists (63.8%) had taken the 2-day skills training, 57.5% the 2-day DBT individual psychotherapy training, and more than a third (39.4%) the 10-day intensive DBT individual training. Fewer had done the 5-day mindfulness workshop (6.3%) or the 5-day advanced DBT individual training (4.7%). On average, therapists reported that they were currently using DBT with 7.52 clients (SD=9.22, range=0 to 65), and had previously conducted DBT with an average of 16.31 clients (SD=23.95).

Description of Therapists' Use of DBT

In response to the open-ended question describing a typical individual DBT psychotherapy session with a specific client, nearly two-thirds of therapists reported that they incorporated what was coded as a review of skills and use of diary cards/homework sheets in their sessions (see Table 1). Over half also said they used chain analyses of behavior. Less than half mentioned the use of a review of session goals or a review of the target hierarchy, and even fewer described the implementation of validation, problem solving techniques, or dialectical strategies.

With respect to the TBQ open-ended question on the use of individual DBT components in non-DBT individual psychotherapy sessions with clients in general, 30.2% of therapists said they used DBT behavioral chain analyses to identify and understand the precursors and consequences of the problematic behavior; 20.9% reportedly used DBT core strategies (e.g., validation, problem solving), and 15.1% used DBT dialectical strategies to teach clients a more synthesized way of understanding their world.

Another TBQ open-ended question asked about skills training modules used in non-DBT individual psychotherapy, without reference to a specific client. Nearly all of the therapists (89.5%) used at least one of the skills modules, with almost half (47.4%) using mindfulness

Table 1
Percentage using DBT Components in a Typical Individual DBT Psychotherapy Session

Therapy components	Overall	10-day Workshop	No 10-day Workshop	χ^2 (1)
Review/Application of Skills	63.9	47.5	75.0	7.62 **
Diary Card/ Homework	63.9	77.5	55.4	5.00 *
Chain Analysis of Behavior	52.6	62.5	44.6	2.98 +
Review Session Goal/ Current Issues	40.2	40.0	41.1	0.01
Target Hierarchy	35.1	55.0	21.4	11.50 ***
No Suicidality	29.9	45.0	19.6	7.12 **
Suicidality	7.2	12.5	3.6	2.75 +
Validation	18.6	15.0	19.6	0.35
Cognitive-Behavioral Interventions	13.4	10.0	14.3	0.39
Problem Solving	11.3	10.0	10.7	0.01
Dialectical Strategies	6.2	2.5	8.9	1.65
Teach New Skills	6.2	5.0	7.1	0.18
Other	18.6	20.0	17.9	0.07

Note. Based on 97 therapists who gave at least one response to the CBQ question: "Please describe what a typical individual psychotherapy session using DBT with this client consists or consisted of." 10-day = therapists who participated in 10-day intensive DBT training (n = 33). No 10-day = therapists who did not participate in 10-day intensive DBT training (n = 60). χ^2 tested for relationship between 10-day DBT training and use of therapy components.

+ $p < .10$.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

skills. Also, 38.9% of all therapists used distress tolerance skills, followed by interpersonal effectiveness skills (25.3%) and emotion regulation skills (24.2%).

When asked about modifications made to the standard DBT protocol, in DBT work with clients generally, 31.6% of therapists reported modifying the diary card to increase its applicability to clients. Slightly fewer (28.6%) indicated they made structural changes to the telephone consultation component of the protocol, either by eliminating it or reducing its use. Other changes made by therapists involved modifying the design of diary cards (26.5%), modifying the design of homework sheets (21.4%), and making structural modifications to the consultation team (16.3%).

On a separate TBQ question, therapists were asked to report on factors that influenced their decision to modify the standard DBT protocol. Nearly 40% of therapists said that client diagnoses influenced their decisions, while fewer (28.4%) made changes to improve clients' understanding of the DBT material. Less than 20% of therapists made modifications due to agency policies (18.9%) and therapist factors (e.g., time constraints) (17.9%).

Client Diagnosis and the Use of DBT

DBT Adherence

An ANOVA yielded significant between-group differences in overall adherence to the DBT protocol, as a function of client diagnosis, $F(2, 86) = 3.91$, $p = .02$. Specifically, Bonferroni t-tests indicated that therapists whose chosen client had a primary diagnosis of BPD adhered to the DBT protocol significantly more ($M = 19.81$) than did therapists treating an anxiety disorder ($M = 8.62$), while those with mood-disordered clients ($M = 15.59$) were not significantly different from those reporting on BPD or anxiety-disordered clients.

DBT Components Used Within Individual Psychotherapy

When asked how they use DBT (without reference to a specific client), therapists who indicated that they treated clients with BPD utilized telephone consultations more frequently ($M = 4.10$) than did those who did not treat BPD clients ($M = 3.23$), $t(112) = 2.12$, $p = .036$. There were no significant differences, however, on reported use of skills groups or consultation teams.

Theoretical Orientation and the Use of DBT

DBT Adherence

When therapists referred to a specific client, no significant between-group difference for primary theoretical orientation was found for adherence to the DBT protocol, $F(4, 101) = .66$, $p = .62$. However, therapists' ratings on the dimensional ABA scale of the TTOQ were positively correlated with DBT adherence, such that the more therapists viewed their work with clients as being guided by an ABA theoretical framework, the more they adhered to the DBT protocol, $r = .25$, $p < .01$.

DBT Components Used Within Individual DBT Psychotherapy

There were no significant differences based on primary theoretical orientation in therapists' reported use of DBT skills groups, consultation teams, or telephone consultations with clients in general. However, the more therapists saw their work with clients as being guided by an ABA theoretical framework on dimensional ratings, the more frequently they said they used skills groups, consultation team, and telephone consultations, $r = .39$, .44, and .25, $p < .001$, .001, and .04, respectively.

In response to the open-ended question about DBT skills training modules used in non-DBT individual psychotherapy, over two thirds of the non-CBT therapists (78.6%) said they used mindfulness skills, compared to less than half (41.9%) of therapists with a behavioral or CBT primary orientation, χ^2 (1, $N = 88$) = 6.35, $p < .01$.

Integration of DBT With Other Approaches

Two-thirds of therapists (66.7%) reported using CBT approaches in combination with DBT, when DBT was not used alone, while fewer than 15% reported using other approaches (e.g., psychodynamic, humanistic, family systems). However, nearly half of the non-CBT therapists (45.5%) used family systems approaches in combination with DBT, compared to only 6.3% of behavioral or CBT therapists, χ^2 (1, N=59) = 11.74, p<.001.

Intensive vs. Less Intensive DBT Training and the Use of DBT

DBT Adherence

When therapists replied regarding a specific client, no significant differences were found on overall adherence to the DBT protocol between therapists who had and had not taken the 10-day intensive DBT workshop (see Table 2).

DBT Components Used Within Individual Psychotherapy

Therapists who had done the intensive DBT workshop incorporated skills groups, consultation teams, and telephone consultations more frequently into their individual DBT therapy with clients in general than did therapists without this training (see Table 2 for effect sizes). Further, in their responses to the open-ended question describing a typical individual DBT psychotherapy session with a chosen client, significantly more therapists with the intensive training described using diary card/homework sheets and reviewing the target hierarchy (with and without a discussion of suicide) compared to those who did not receive the training (see Table 1). More therapists who had participated in the intensive DBT training (39.5%) also reported using interpersonal effectiveness skills in non-DBT individual psychotherapy compared to those who did not receive the training (17.5%), χ^2 (1, N=95) = 5.66, p=.02.

When describing modifications made to the DBT protocol, more therapists with the intensive DBT training (33.3%) reported modifying the design of homework sheets (e.g., developed new homework sheets) compared to therapists without the training (13.8%), yet fewer made structural changes to the consultation team, e.g., eliminated and/or reduced use of teams (5.1% versus 24.1%), χ^2 (1, N=97) = 5.25, 6.12, p<.02 and .01. Significantly more therapists with the intensive DBT training (25.0%) indicated that they felt their modifications led to a positive outcome (increased client understanding of DBT) compared to those without the training (7.35%), χ^2 (1, N=91) = 5.58, p<.05.

Table 2
Means and *t*-tests for DBT Practice Variables and Intensity of DBT Training

DBT practice variables	Participation in 10-day workshop			
	Yes (n=50)	No (n=77)	t	Effect Size
Adherence Variables				
DBT adherence	18.07	13.13	1.68	.16
DBT usage	23.86	21.07	1.73	.17
DBT modification	5.79	7.93	−1.50	−.15
Frequency of Use of DBT Components				
Skills group	6.51	5.11	4.58***	.41
Consultation team	6.41	5.12	3.70***	.34
Skills group and consultation	6.08	4.64	3.93***	.36
Telephone consultation	4.49	3.41	3.45**	.30
Theoretical Orientation Rating				
ABA	4.62	3.58	2.91**	.27
CBT	5.79	6.12	−1.40	−.13
PD	3.09	3.22	−0.39	−.04
Humanistic	3.49	3.85	−1.08	−.10
Systems	3.74	4.39	−2.01*	−.19
Eclectic/Integrative	4.96	5.21	−0.74	−.07

Note. Frequency of use of DBT components with clients in general as indicated on the TBQ. ABA = Applied Behavior Analysis/Radical Behavioral; CBT = Cognitive/Cognitive-Behavioral; PD = Psychodynamic/Psychoanalytic; Humanistic = Humanistic/Experiential/Existential; Systems = Systems/Family Systems. Degrees of freedom range from 92 to 124.

* p<.05.
** p<.01.
*** p<.001.

Integration of DBT With Other Approaches

More therapists who received the intensive DBT training (25.0%) reported using humanistic approaches in combination with DBT (when DBT was not used alone) compared to those without the training (6.5%), χ^2 (1, N=66) = 4.47, p<.04. However, about a third of therapists without the intensive DBT training (32.6%) indicated on another open-ended question that they integrated at least one DBT skills module into their typical therapeutic approach, compared to significantly fewer of the therapists with the intensive training (5.9%), χ^2 (1, N=60) = 4.62, p=.03.

Theoretical Orientation

Therapists with the intensive DBT training were significantly more likely (on the dimensional scales) to rate their work with clients as being guided by an ABA theoretical framework, and less likely to view their orientation as being influenced by family systems, compared to those without the intensive training (see Table 2 for effect sizes).

Discussion

Although some therapists have begun modifying the DBT protocol (see Dimeff & Koerner, 2007), practice research to date has not yet examined how DBT is specifically used with clients. Consequently, the present

study explored how therapists use DBT individual psychotherapy, and whether they incorporate DBT components into their non-DBT work as a form of assimilative integration (Messer, 1992). Therapists' variations in use of DBT appear to be a function of client diagnosis, therapist theoretical orientation, and the intensity of the DBT training they received.

Therapists reporting on a client with BPD indicated that they adhered to the standard DBT protocol to a greater degree than did therapists treating anxiety disorders. This finding was expected, given that the DBT protocol was developed for the treatment of BPD (Linehan, 1993), and it directly addresses borderline features (e.g., emotion dysregulation, perception of invalidating environment) that may hinder treatment. Foertsch, Manning, and Dimeff (2003) also suggest that therapists treating clients with BPD may follow the standard DBT protocol more rigidly due to the difficulty of these clients and to prevent obstacles in therapy. The protocol incorporates a balance between change and acceptance, offering clients a sense of perceived validation and understanding, likely making it palatable to clients who might otherwise be resistant (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

However, many therapists who treated clients with disorders other than BPD (specifically, anxiety disorders) appeared to modify aspects of the DBT protocol to a greater degree to better fit the needs of their clients. For example, some therapists indicated that they modified aspects of the protocol (e.g., homework sheets, diary cards) to make the behavioral targets more applicable to clients with anxiety disorders or varying levels of cognitive functioning. This also supports prior assertions that therapists modify standard DBT to make it more suitable to the types of clinical issues their clients present with and to increase clients' satisfaction with the treatment they receive (see Dimeff & Koerner, 2007; Liem & Pressler, 2005; Wisniewski & Kelly, 2003).

Although there were no differences in DBT adherence according to therapists' primary theoretical orientation, the more they indicated on dimensional ratings that they viewed themselves as being guided by an ABA framework, the more frequently therapists tended to use the standard DBT behavioral components (i.e., skills group, consultation team, and telephone consultation) in their DBT individual psychotherapy sessions and the more they adhered to the protocol. On the other hand, compared to ABA and CBT clinicians, non-CBT therapists reportedly more often "exported" DBT skills components, specifically mindfulness skills, into their *non-DBT* psychotherapy. As mindfulness training may have seemed like a less behavioral part of DBT (M. Linehan, personal communication, August 27, 2007), our findings are consistent with previous literature that indicates that therapists value and assimilate into their work with clients those aspects of a standard protocol that are more consistent with their primary theoretical orientations and are less likely to use those elements that are perceived to be different (DiGiorgio, Arnkoff, Glass, Lyhus, & Walter, 2004; Lyhus et al., 2009; Zabukovec, Lazrove, & Shapiro, 2000). In general, however, nearly all therapists incorporated at least one of the skills modules into their non-DBT therapy. Nonetheless, we do not know the clinical outcomes of these attempts at integration, given that Koerner, Dimeff, and Swenson (2007) suggest that "adding DBT skills training to non-DBT individual psychotherapy did not add any benefit" (p. 20). Furthermore, they caution against calling any program "DBT" or even "DBT-informed treatment" unless it adheres to the principles, modes, and strategies of the standard comprehensive model.

The relatively few differences between therapists with different primary theoretical orientations may in part be due to the underrepresentation of therapists (18%) who were not behavioral or cognitive. Additionally, therapists who on dimensional ratings of orientation identified themselves as being guided by primarily psychodynamic or humanistic theoretical frameworks regarded their work with clients as being more eclectic/integrative than did those with an ABA orientation. These non-CBT therapists who seek out DBT training may already be more integrative in their approach, as demonstrated by their openness to the training. Alternatively, it is possible that learning DBT led them to broaden their practice in general and increased their commitment to more eclectic/integrative therapy.

Although therapists' adherence to the standard DBT protocol did not significantly differ based on whether or not they had received more intensive training, those therapists with the intensive training tended to use DBT primary components (i.e., skills group, consultation team, and telephone consultation) more frequently in their work with clients, and more often mentioned using diary cards and review of target hierarchy with their chosen client. They also rated their therapeutic interventions as being guided to a significantly greater degree by an ABA theoretical framework. These therapists appeared to be more committed to DBT and were more likely to use behavioral methods, and were thus less likely to leave out the major parts of the protocol. This is consistent with S. J. Miller and Binder's (2002) hypothesis that therapists with intensive manual-based training incorporate more major components from a specific protocol into their therapy.

Interestingly, therapists who received the intensive DBT training were also significantly more likely to use non-cognitive-behavioral therapeutic techniques (i.e., humanistic, client-centered) in combination with DBT than were those without the training. These clinicians also

tended to use interpersonal effectiveness skills in their non-DBT psychotherapy sessions more often, possibly because they saw the value of integrating parts of the protocol into their work with clients and felt comfortable doing so.

The present study has some limitations inherent with web-based data collection. Although we were able to contact all therapists who had received DBT training through Behavioral Tech, only 6.3% accessed and completed at least one of the questionnaires. People may perceive email requests for research participation to be less demanding of personal attention and therefore easier to ignore than questionnaires received in the mail, and some of our email invitations may never have reached potential participants due to increased use of spam filters. Furthermore, although contacted therapists all had received DBT training, they may not have had the opportunity to use individual DBT with at least one client, and thus would have been unable to complete all of the applicable questionnaires. It is impossible to determine whether therapists who participated differed in some important way (e.g., theoretical orientation) from people who did not respond to our survey. However, this first study of DBT clinicians offered the opportunity to study the DBT practice of over 100 therapists who were geographically distributed across the United States.

Because the majority of the participants in our study subscribed to behavioral or cognitive-behavioral orientations, future studies should attempt to recruit a more diverse sample, if at all possible, to further investigate the role theoretical orientation may play in the practice of DBT. In addition to therapists' self-reports of their use of DBT, future research should analyze audiotaped or videotaped sessions. The fact that less than half of the therapists in our sample reported the use of certain DBT strategies does not necessarily mean they use such methods (e.g., validation) less often; it may instead mean that they were less likely to write about them in response to an open-ended prompt, because other interventions may have first come to mind.

Given the ongoing discussion about whether or not therapists should strictly adhere to the DBT protocol, researchers should examine the extent to which therapists' use of DBT with modifications to the protocol (and/or integration of their typical approach with DBT) leads to more or less positive psychotherapy outcomes compared to those who demonstrate strict adherence to the standard comprehensive DBT model. It is suggested that future researchers conduct dismantling studies to determine which of the many components of DBT are necessary for effective treatment. For example, in adapting DBT for use with suicidal adolescents, it may be advantageous to compare the clinical utility of teaching all four skills training modules versus teaching only distress tolerance skills. Additionally, Koerner et al. (2007) suggested that studies evaluate whether modified versions of DBT that lack traditional components (e.g., weekly individual psychotherapy, consultation team meetings, after-hours phone capacity, 2 1/2 hour weekly skills groups) are more or less effective compared to standard DBT. Similarly, correlational studies might be designed to investigate hypothesized mechanisms of change in DBT (mindfulness, validation, targeting and chain analysis, dialectics; Lynch et al., 2006) as mediators and moderators of change, in relation to factors identified by the present study as being of interest (i.e., client diagnosis, therapists' theoretical orientation, and DBT training). In sum, practice research should continue to explore what therapists are doing in their psychotherapy sessions including clinical decisions, adherence to protocols, and modifications to standard treatments, to better understand and predict the treatment outcomes of DBT adherence versus modifications.

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