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Practice What You Preach: DBT Therapists' Skill Utilization in Burnout Prevention

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Practice What You Preach: DBT Therapists' Skill Utilization in Burnout Prevention

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social work research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to examine the relationship between DBT practitioners' skill use and consultation team on burnout and stress levels. The study was exploratory in nature and used a mixed methods convenience sample that surveyed DBT practitioners through an international list serve. Burnout and stress were measured along with skill use, perspectives on consultation team, and demographic information. The sample included 135 survey responses and participants varied in demographic information. Results found that there was a negative correlation between burnout and skill use and that in general practitioners use the skills on a frequent basis and find the skills helpful in reducing stress. On a whole, the sample of respondents had very low burnout scores with only 3.7% of those surveyed falling above the burnout threshold. Respondents had mixed views around consultation team but in general found it helpful in alleviating stress around their DBT cases. Since the study was exploratory in nature, future research should aim at duplication of the study as well as looking at mindfulness practice in mental health practitioners not involved in DBT and its influence on stress and burnout.

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Practice What You Preach: DBT Therapists' Skill Utilization in Burnout Prevention

Burnout among individuals in the mental health field is a pervasive problem that has received extensive attention throughout the years. While the exact percentage of the mental health population that is affected by this problem is not always clear or consistent, the general understanding is that this is an issue of which individuals in this field need to be aware. Type social work and burnout into any search engine and over 3,000,000 links are supplied. Burnout, as originally identified by Herbert Freudenberger during the 70's, refers to a particular type of stress and overwork that mental health professionals are at risk of developing (PubMed Health, 2013, para 1).

While burnout is defined as “exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration” (Merriam Webster Dictionary, 2013, para 1), the actual elements of burnout have been expanded to include “emotional exhaustion,” “alienation from (job related) activities,” and “reduced performance” (PubMed Health, 2013, para 3). It has been suggested that burnout can include not only emotional symptoms but also mental health issues and physical complications (Ratliff, 1988). A core element of burnout has also been linked to the stress related to the work that one is expected to perform (Cherniss, 1980 as cited in Ratliff, 1988).

Findings around the prevalence of burnout have varied considerably. One study suggested that of a sample of 1,121 mental health workers, 13% of the participants met criteria for having an increased likelihood of developing burnout (Sprang, Clark & Whitt-Woosley, 2007). Another case that examined 460 mental health workers found that over half of those surveyed, 56%, displayed emotional exhaustion in the moderate to high range (Acker, 2011). Clinical staff, which did not just include therapists and counselors, but also nurses, at a VA

hospital found moderate ranges of emotional exhaustion in 62% of the sample (Newell & MacNeil, 2011). Even though these rates vary, it has been postulated that anywhere between 21% and 61% of professionals in this field have signs of burnout (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012). While burnout does not have one precise definition, and symptoms can be present in various forms for different people, it is nonetheless a problem that has been shown to affect individuals working in the mental health field.

Burnout can have a variety of effects on the mental health practitioner including a plethora of serious health concerns. According to the APA (2006), burnout can lead to a heightened likelihood of health issues such as cardiovascular problems, stroke, type II diabetes, and sleep problems. The APA Practice Organization (2013) also points out that when practitioners fail to act on problems related to work stress, depression, substance use and/or abuse, isolation, dissatisfaction related to work, and other symptoms can occur. Additionally, stress can have tremendous effects on the clients being served, which could result in unethical practice, risk of suicide due to practitioner malpractice, and increased symptoms (APA Practice Organization, 2013).

Mental health professionals need to be aware of the impact that stress levels and potential burnout can have on the mental health provider. It is necessary to take into account the effect therapist stress can have not only on the practitioner, but also the clients being served. If a therapist is experiencing stress or symptoms of burnout, then it is likely that the highest quality of care is not being provided to the client in need. This would go directly against the social work code of ethics, which specifies that social workers be expected not to allow psychological stress to interfere with their work, and if it does they are required to act right away to remedy the problem (NASW Code of Ethics, 2008). Therefore, it is extremely important that the therapist be

continually focused on ways to incorporate possible stress reduction techniques into their own lives in order to prevent any likelihood of stress or burnout becoming a problem.

One specific therapy, Dialectical Behavior Therapy, has a component of therapist self care built into the program that could potentially aid in reduced therapist stress and burnout. DBT was originally adapted from a cognitive behavioral model and focuses on allowing the client to work on changing self-destructive and self-harming behaviors (Behavioral Tech, 2013). Traditionally used with clients who have borderline personality disorder, and the high suicidal behaviors that accompany the disorder, DBT can also be used with other populations as well (NAMI, 2013). As part of the program, DBT therapists are required to attend a consultation team each week as a form of constant support, supervision, and technique enhancement (Behavioral Tech, 2013). This unique component of the DBT program provides the therapist with one outlet of support that could assist in stress reduction. While a consultation team can potentially serve as a buffer against therapist stress and burnout, the goal of the current paper is to take this a step further and assess how other components of the DBT model, such as the specific skills used with the client, may assist in providing therapists with a tangible set of tools to assist in their own stress management.

Literature Review

In order to understand how the skills of DBT may alleviate stress experienced by DBT therapists, it is important to provide a rationale and understanding of what DBT is all about. Specifically, the following will review the history of DBT, the different components of the program, skills taught in the program, and types of clients that may benefit from DBT.

What is Dialectical Behavior Therapy?

Marsha Linehan developed Dialectical Behavior Therapy, otherwise known as DBT, in the late 70's early 80's (Behavioral Tech, 2013; Neacsiu, Ward-Ciesielski & Linehan, 2012). Linehan had found that when attempting to treat clients with symptoms characteristic of borderline personality disorder such as suicidal ideation and non-suicidal self-injury behaviors, the standard cognitive behavioral treatment was not effective (Behavioral Tech, 2013). Because of this, Linehan created a separate therapy drawing from the concepts of cognitive behavioral therapy and other therapeutic techniques and principles (Behavioral Tech, 2013). Specifically, DBT utilizes the concepts and underlying principles of behavioral techniques, Zen philosophy, and dialectics (Neacsiu et al., 2012). Dialectics refers to the “tension or opposition between two interacting forces or elements” (Merriam Webster Dictionary, 2013, para 6), with the main dialect in DBT being acceptance and change (Neacsiu et al., 2012). The therapy holds an environment of validation and understanding, acceptance, while at the same time pushing and encouraging the client to make substantial changes within his or her life.

Assumptions of DBT. DBT relies on seven underlying assumptions for both the client and the therapist (Linehan, 1993 as cited in Neacsiu et al., 2012). As can be seen below, a few of the assumptions underlying DBT relate directly to therapist stress and point out the fact that therapists, along with clients, require support. For the clients the following assumptions apply:

- Clients are doing the best they can
- Clients want to improve
- Clients must learn new behaviors in all relevant contexts
- Clients cannot fail in DBT
- Clients may not have caused all of their problems but they need to solve them anyway

- Clients need to do better, try harder, and/or be more motivated to change
- The lives of suicidal borderline individuals are unbearable the way they are lived
(Linehan, 1993 as cited in Neacsiu et al., 2012, p. 1007).

For the therapist the following assumptions apply:

- The most caring thing a counselor can do is help clients change in ways that bring them closer to their ultimate goals
- Clarity, precision, and compassion are of the utmost importance in the conduct of DBT
- The therapeutic relationship is a real relationship between equals
- Principles of behavior are universal, affecting counselors no less than clients
- Counselors treating borderline clients need support
- DBT counselors can fail
- DBT can fail even when counselors do not (Linehan, 1993 as cited in Neacsiu et al., 2012, p. 1007).

Different stages in treatment. Clients begin DBT in what is called the pretreatment phase (Koerner, 2012). During this time the therapist and the client are reviewing what DBT is, how it works, and whether it could be beneficial to the individual client. Before treatment is able to begin, a thorough assessment must be completed so that the therapist and the client understand what the goals of treatment would be, and how the program could assist the client in making changes in their life. Both the client and the therapist must agree that DBT is a good fit and the client and therapist need to be willing to make a full commitment to the program. Once the client's presenting problems have been addressed and the client has agreed to participate in the DBT program, the therapist and client can then move into the appropriate stage of treatment to

meet the presenting needs of that client (Koerner, 2012). One benefit of pretreatment is that it allows the therapist to set an expectation of how future sessions will run and what the client can expect. It could be argued that this level of structure and contractual agreement would allow the therapist to experience less stress later on in the process because all expectations are explicitly covered in pretreatment.

Linehan describes four different stages that the client may expect to work through in treatment (Neacsiu et al., 2012). For clients who are in Stage I, the goal of treatment becomes to work with the client on issues of suicide and non-suicidal self injury, any behaviors that can interfere with the therapeutic process, and any behaviors that are significantly impacting the client's personal functionality (Koerner, 2012; Neacsiu et al., 2012). Stage II of treatment examines, and works on, issues that the client may be experiencing around intensive emotions and trouble processing those experiences in an effective manner (Koerner & Linehan, 1992 as cited in Neacsiu et al., 2012). This could include working on things such as reducing problematic symptoms related to mental health diagnoses, specifically post traumatic stress disorder, and focusing on adaptive ways to cope with challenging emotions (Koerner, 2012). This also encompasses working on experiencing and mastering emotions through both formal and informal exposure treatment (Personal Communication, Bev Long). Treatment in Stage III focuses more on the problems surrounding basic everyday life and helping the client to utilize the skills and treatment that they have learned in therapy to engage more fully in their environment (Behavioral Tech, 2013; Neacsiu et al., 2012). Finally, clients in Stage IV work on resolving any feelings around being incomplete or not quite whole (Neacsiu et al., 2012). Much of this work is done individually and not in a treatment or therapeutic setting (Personal Communication, Bev Long). While not explicitly discussed in the research, it could be postulated that clients in

pretreatment and Stage I of treatment could potentially cause more stress in the individual therapists life. Because the client is experiencing suicidal ideation and non-suicidal self injury behavior, the therapist could be in a constant state of alert to make sure the client is not at a risk to themselves. This could lead to high levels of stress.

Components of DBT. Dialectical behavior therapy, as any comprehensive treatment, is structured around five different functions. Specifically it is the goal to “a) enhance and maintain client motivation to change; b) enhance the client’s capabilities; c) ensure that the client’s new capabilities are generalized to all relevant environments; d) enhance the therapist’s motivation to treat clients while also enhancing the therapist’s capabilities; and e) structure the environment so that treatment can take place” (Linehan, 1993 as cited in Behavioral Tech, 2013, para 8). The DBT program is comprised of four different components: one-on-one individual therapy with a DBT therapist, a DBT group that focuses on teaching applicable skills that the client can utilize, availability of after hours phone coaching with the therapist, and a weekly consultation team for the DBT therapists (Neacsiu et al., 2012). Consultation team is considered vital as part of the process in DBT and focuses directly on facilitating “support for the provider in treating the client effectively by preventing dysfunctional behavior, burn out, or rigidity on the part of the provider” (Linehan, 1993a, 1993b as cited in Neacsiu et al., 2012, p. 1013). The consultation team process is very structured and gives the therapists the opportunity to use DBT on each other (Personal Communication, Bev Long). This idea of professional support through consult is directly related to the second research question which explores how helpful practitioners find consultation team as a form of stress reduction and stress prevention.

Skills taught in DBT. The skills group for DBT clients is structured around four different skill modules that work on helping the client to create skills in the areas of mindfulness,

interpersonal effectiveness, emotional regulation, and distress tolerance (Neacsiu et al., 2012). The mindfulness skills are the first set of skills that clients are taught and focuses on teaching the participants how to use their “wise mind,” which is a balance between an individual’s “reasonable mind” and “emotional mind” (Linehan, 1993, p. 109). In core mindfulness, clients learn the “what” skills, which teach the client how to “observe,” “describe,” or “participate” in any given situation or moment (Linehan, 1993, p. 111). Additionally, clients utilize the “how” skills, which allow them to act “non-judgmentally,” “one-mindfully,” and “effectively” (Linehan, 1993, p. 113). The mindfulness module is taught between the other skills modules, and a mindfulness exercise is done at the beginning of each group, and is therefore focused on continually throughout the skill group. Additionally, therapists are strongly encouraged to be engaged in their own mindfulness practice, and each consultation team meeting begins with a mindfulness exercise (Personal Communication, Bev Long).

The three other skills modules are then able to build off the basic skills that have been taught in the mindfulness module. Skills for emotional regulation focus on helping “clients learn a range of behavioral and cognitive strategies for reducing unwanted emotional responses as well as impulsive dysfunctional behavior” (Neacsiu et al., 2012, p. 1012). With this, the client is “taught how to identify and describe emotions, how to stop avoiding negative emotions, and how to increase positive emotions” (Neacsiu et al., 2012, p. 1012). The distress tolerance module “teaches a number of impulse control and self-soothing techniques aimed at surviving crises without using drugs, attempting suicide, or engaging in other dysfunctional behavior” (Neacsiu et al., 2012, p. 1012). This would also include working toward reality acceptance (Personal Communication, Bev Long). Finally, in the interpersonal effectiveness module “clients learn a

variety of assertiveness skills they can use to achieve their objectives while maintaining relationships and self-respect” (Neacsiu et al., 2012, p. 1012).

Since some of the individual therapists are the ones teaching the skills to the clients, it could be argued that many of these skills would become second nature for the therapist and relate directly to stress reduction. Specifically, the core mindfulness skills can be used for relieving stress and being focused on one thing at a time without judgment. Additionally, the mindfulness techniques are incorporated into every consult team meeting, which starts out with a mindfulness exercise. Therefore, some of the skills may be used more or less frequently by the therapist than others.

Clients served by DBT. While DBT was initially developed to assist in the treatment of individuals with borderline personality disorder who had suicidal ideation and behaviors (Neacsiu, Rizvi, & Linehan, 2010), the model has since been adapted to work with other populations and other presenting problems. For example, adapted DBT programs have been shown to help in working with clients who are suffering from various eating disorders, depression, additional personality disorders, and individuals affected by domestic abuse (Harley, Sprich, Safren, Jacob, & Fava, 2008; Iverson et al., 2009; Lynch, Morse, Mendelson, & Robins, 2003; Lynch et al., 2007; Safer et al., 2001; Telch, Agras, & Linehan, 2001 as cited in Neacsiu et al., 2012). Other populations have included clients with ADHD, younger clients with oppositional-defiant characteristics, and substance abuse disorders (Hesslinger et al., 2002; Nelson-Gray et al., 2006 as cited in Neacsiu et al., 2010; Dimeff, Comtois, & Linehan, 1998 as cited in Neacsiu et al., 2012). DBT has also been used when working with adolescents who are struggling with eating disorders (Salbach-Andrae et al., 2008), and adolescents with bipolar disorder (Goldstein, Axelson, Birmaher, & Brent, 2007). Due to the level of acuity associated

with clients who are affected by borderline personality disorder and some of the more severe and reactive disorders mentioned above, it could be argued that this could lead to a higher potential risk for the therapist developing burnout.

Symptomology, Prevalence, and Contributions of Burnout

As previously discussed, burnout is a problem that has been shown to affect a number of individuals working in the mental health field and is composed of a variety of components and symptoms. It should be noted that while some studies have found higher rates of burnout in some populations of mental health workers and therapists, it has also been argued that burnout is a term that is over used and that rates of true burnout are actually much lower with only 2-6% of mental health workers experiencing this (Farber, 1990). However, more recent research seems to suggest that this rate may actually be higher than previously suggested (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012; Sprang et al., 2007). While findings may vary on the actual prevalence of burnout, it is still possible to experience many of the symptoms associated with this problem, without truly being completely burned out (Faber, 1990).

In terms of what burnout can look like in individuals, it has been suggested that burnout is made up of three separate areas: “emotional exhaustion, depersonalization, and reduced personal accomplishment” (Maslach & Leiter, 1997 as cited in Newell & MacNeil, 2011, p. 27). Broken down further, “burnout includes psychological and/or physiological exhaustion, a negative shift in responses to others, and a negative response toward oneself and toward personal accomplishments, and that burnout is a response to emotional strain of working with others who are troubled” (Ackerly, Burnell, Holder, & Kurdek, 1988, p. 624).

Symptoms associated with burnout have been found to affect a range of mental health practitioners who possess different backgrounds, degrees, and experience. One study looked at

mental health workers and found that 56% scored in the moderate to high range for emotional exhaustion, 73% scored in the moderate to high range for role stress, and 50% of those surveyed reported feelings of wanting to leave their place of work (Acker, 2011). Other studies have found similar findings with 39% of participants displaying high levels of emotional exhaustion, 32.7% of participants displaying moderate levels of emotional exhaustion (Ackerly, Burnell, Holder, & Kurdek, 1988). Similar to the findings of the previous study, 21% of those surveyed in this study stated that they would prefer to be in a different career.

It should also be noted that it is not just those who work in direct practice that can be affected by the symptoms of burnout. Newell and MacNeil (2011) looked at individuals at the VA hospital and examined the prevalence of burnout between mental health workers and administrative personnel. Surprisingly, rating on the Professional Quality of Life Scale revealed that for the direct mental health workers 89% of the sample had moderate to high scores for burnout while 93% of the individuals in administration had moderate to high scores for burnout. This could suggest that even being associated with the mental health field, while not directly practicing with individuals, could have an influence related to burnout symptomology.

Related to these findings, the literature also suggests that not all individuals are affected in the same way and that there are actually some characteristics that pose a higher risk for developing burnout. Research has shown that when looking at emotional exhaustion, Caucasian individuals tend to have higher scores than do their non-Caucasian counterparts (Acker, 2001; Newell & MacNeil, 2011). Studies have also found mixed results on whether gender plays a role for being at a higher risk for burnout. Specifically, some studies have found that females displayed higher burnout scores (Sprang, Clark, & Whitt-Woosley, 2007) as well as higher emotional exhaustion scores (Newell & MacNeil, 2011). However, this is not a consistent

finding throughout the literature and other studies have found no difference when comparing gender (Ackerly, Burnell, Holder, & Kurdek, 1988; Farber, 1990). Additionally, it has been shown that being younger can contribute to higher scores of emotional exhaustion (Ackerly, Burnell, Holder, & Kurdek, 1988), higher risk for burnout (Faber, 1990), and higher levels of stress (Hellman, Morrison, & Abramowitz, 1987). Furthermore, throughout the literature it has been found that those in private practice display less symptoms of burnout (Acker, 2001; Ackerly, Burnell, Holder, & Kurdek, 1988; Faber, 1990).

In examining potential causes and contributions to the risk of burnout, the literature suggests a variety of circumstances that could potentially lead to burnout of the mental health practitioner. It has been stated that “the process of burnout is progressive, occurs cumulatively over time, and is thought to result from organizational factors such as poor training, high caseloads, and poor supervision rather than from personal factors” (Maslach, 2001 as cited in Newell & MacNeil, 2011, p. 27). Another factor that can cause stress for the clinician is when they do not feel like they are making any headway with the client and therefore see themselves as being unsuccessful in the therapeutic process (Faber, 1990; Ratliff, 1988). It has also been found that severity level of the client has an effect on the level of burnout symptoms that a practitioner is experiencing with more severe client symptoms relating to higher contributions to burnout (Acker, 2011; Ackerly, Burnell, Holder, & Kurdek, 1988; Maslach, 1978; Sprang, Clark, & Whitt Woosley, 2007).

Stress and Burnout in the DBT Therapist

Since DBT was primarily created to deal with clients who have borderline personality disorder and struggle with suicidal ideation and non-suicidal self injury or self-harming behaviors (Neacsiu, Rizvi, & Linehan, 2010; Linehan, 1987), it could be argued that this

population would fall within the category of high symptom severity. Additionally, suicide attempts for individuals with borderline personality disorder are relatively high with 60-70% of individuals attempting and 8-10% of individuals completing (Oldham, 2006). Since research suggests that more severe client symptomology can potentially increase the risk of developing burnout, it could therefore be assumed that DBT therapists would be at a higher risk (Acker, 2011; Ackerly, Burnell, Holder, & Kurdek, 1988; Sprang, Maslach, 1978; Clark, & Whitt Woosley, 2007). However, not all research has found this to be the case, and DBT therapists actually appear to experience lower levels of stress and burnout.

One study by Miller et al. (2011) examined burnout, well being, and cortisol levels, the hormone that measures stress in the body, in a sample of six clinicians who were either practicing DBT or more psychodynamic focused therapy with clients experiencing borderline personality disorder symptomology and suicidal ideation. Between the two groups there was no difference in burnout levels or overall well-being with all clinicians having relatively low burnout, some symptoms of emotional exhaustion, and good overall well-being. Interestingly, the study found that DBT therapists had lower levels of cortisol than the psychodynamic treatment therapists. Specifically, “findings indicate that control counselors were marginally less stressed initially ($p=.005$), but exhibited a trend toward being more stressed over this yearlong study...[but] this tendency to show an increase in AUC-I over time was not evident among DBT counselors, who instead exhibited a trend toward lower physiological stress over time” (Miller et al., 2011, p. 354). It was also found that DBT therapists experienced more stress in the beginning of the program, which has been found in other studies.

Perseius, Kaver, Ekdahl, Asberg, and Samuelsson (2007) conducted a study with 22 psychiatric workers using DBT and working with females who were experiencing borderline

symptomology and non-suicidal self-injury behavior. It was found that while “psychiatric health professionals experience treatment of such patients as very stressful [and] DBT was also seen as stressful in term of learning demands [it] decreased the experience of stress in the actual treatment of the patients” (Perseius et al., 2007, p. 641). Additionally, participants found that working with other individuals and having positive supervision to be extremely helpful, and some also believed that the mindfulness component of DBT were able to transfer to other work tasks. Another study found that merely being exposed to training in DBT could have a positive effect on the components related to burnout (Little, 2000). Specifically, after being exposed to 80 hours of training in DBT, clinicians had higher scores related to feelings around personal accomplishment, which were statistically significant. Additionally, while not statistically significant, scores were lower in regard to emotional exhaustion and depersonalization after the training.

Research Question

Dialectical behavior therapy has been shown to reduce certain aspects of burnout and stress in clinical practitioners working with clients who have borderline personality characteristics (Little, 2000; Miller et al., 2011; Perseius et al., 2007). Additionally, other components of DBT have been worked into the model as a preemptive form of burnout and stress reduction through the consultation team (Neacsiu et al., 2012). While consultation team has been suggested to be helpful in assisting therapists, the goal of the current paper is to explore consultation team and other components of the DBT program, like the DBT skills, that could be beneficial in reducing stress in the therapist through two research questions. First, how helpful do dialectical behavior therapists find the use of consultation team as a form of stress reduction and burnout prevention? Second, to what extent do dialectical behavior therapists utilize the DBT

skills in their own life as a mediating factor for stress reduction and stress management in burnout prevention?

Conceptual Framework

Job Demands-Control Model

The Job Demands-Control Model is one way of looking at the way individuals process any kind of stress being experienced in the work environment (Dewe, O’Driscoll, & Copper, 2012). This model was developed by Karasek (1979) and argues that “the amount of strain people experience in their work will be determined by whether or not they have any control over the demands they have to deal with” (Dewe et al, 2012, p.32).

In understanding DBT therapists’ level of stress and how they process it, the Job Demands-Control Model can be helpful. On the one hand, DBT therapists are working with clients who fall into a high-risk category for suicide, which can be stressful. Paired with this, the therapist does not have much direct control over what the client chooses to do. However, on the other hand, DBT is a rather structured therapy and gives the therapist a lot of tools, techniques, and strategies to use with the client, which does give a sense of control and could therefore lead to lower stress levels.

While this model does not specify what control can look like to the individual, either objective or subjective, “most research on this model has focused on workers’ perceptions of control, arguing that how much control the individual feels they have over their work environment is more critical than some kind of objective index of control” (Dewe et al., 2012, p. 33). In this sense, the DBT model format could give the therapist a feeling of being more in control than other therapies might allow.

Social Support Theory

Since one of the four components of the DBT model is consultation team, it is important to understand how social support can impact an individual's level of stress. Social support theory suggests "support reduces the effect of stressful life events on health...through either the supportive actions of others...or the belief that support is available" (Lahey & Cohen, 2000, p. 30). This theory proposes that social support can help to alleviate stress and can also increase the coping ability that individuals possess. Additionally, one definition of social support suggests that it has the capability to "reduce uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one's life experience" (Albrecht & Adelman, 1987, p. 19 as cited in Mattson's Health as Communication Nexus, 2011, p. 182).

One benefit of the social support theory is that it addresses the way that the consultation team can act as a buffer in reducing stress in the practitioner. Since the DBT practitioners are receiving frequent support in weekly consultation team, social support theory helps to explain how this could be viewed and experienced as beneficial by the practitioner. Due to the level of stress that could be generated by the clientele that DBT practitioners are seeing, the support received through consultation team could influence how the practitioner's stress could be mediated and lessened by the support of others.

Method

Research Design

The current study was a cross sectional mixed methods design made up primarily of quantitative questions and a few qualitative questions. An anonymous online survey was used

with a convenience sample of practitioners to measure whether the use of the DBT skills and consultation team assist in stress management and burnout prevention.

Sample

The participants in this study were all therapists currently practicing in the clinical field as a DBT practitioner in some capacity. This could have included providing individual DBT therapy, DBT skills group, or both. For the purpose of this study, a convenience sample was used to meet the specific qualification of the participants needed: DBT practitioners.

Protection of Human Subjects

Recruitment. The survey used in this study was posted on an international online list serve for DBT practitioners. One of the committee members posted the link to the survey in an e-mail to all members on the list with an explanation stating that she was on the committee of a student working on a research project that required DBT practitioners for participants.

Individuals on the list serve were made aware that they did not need to participate in the study and that they only needed to complete the survey if they wanted to and that their participation was greatly appreciated. Additionally, since the survey was anonymous there was no way to identify who responded to the survey and who did not.

Confidentiality and anonymity. Qualtrics data collection software was used to collect the survey responses. The survey was anonymous and so there was no way to identify individual participants from their responses. Even though all the responses could not be linked to any particular participant, additional measures were taken to ensure that the data remained protected. All responses were sent directly to Qualtrics and the anonymous data were only made available to the researcher. Additionally, all data was kept on a computer that is password protected to help insure confidentiality. The only person who viewed the raw anonymous data was the researcher.

Informed consent. While all DBT practitioners on the list serve were given access to the survey, it was made explicitly clear that they were not required to participate in the study. Specifically, once clicking on the survey link, participants were taken directly to the “Letter of Informed Consent” and were required to read and agree to participate before being taken on to the actual survey. After agreeing that they understand the purpose of the study and gave consent to participate, participants were then directed to the actual survey questions. Moving onto the survey was considered to be an indication of consent (Appendix A).

Data Collection Instrument and Process

The survey in this study was comprised of 52 questions (Appendix B). The first 10 questions in the survey were basic demographic questions assessing information about the participants including age, gender, and work experience. The following 13 questions assessed stress level, the extent that the participants used the DBT skills in their daily life, how they felt those skills assisted in stress management, and how helpful they found the consultation team in reducing their stress level. The three following questions assessed where they fell on the therapist continuum scales. The Bergen Burnout Indicator – Modified scale was used to assess for burnout in each participant (Ladegård, 2011). The scale is made up of 24 items all scored on a 7-point Likert scale and was shown to have a Cronbach’s alpha of .89. Potential scores range from 24 to 168. A score above 100 would suggest a likelihood of the participant experiencing burnout symptomology (Nordang, Hall-Lord, & Farup, 2010). It should be noted that the scale used for this study was the modified version and therefore was one question short of the original Bergen Burnout Indicator. The 100 score threshold was still utilized as a cut off point for responses even though the modified scale was one item short from the original scale. The final

two questions on the survey were open ended and asked about skill use and consultation team. The survey took between 20 and 30 minutes to complete.

Data Analysis

A majority of the data analysis involved descriptive statistics in order to understand how frequently DBT practitioners experience stress and how helpful they found the DBT skills in alleviating stress. Additionally, correlations were run to determine if some of the demographic data had any influence on the level of stress that a participant was experiencing. Additional analyses were also run to compare whether frequency of skill use played a role in the practitioners burnout score and how high they rated their stress level. Finally, a thematic analysis was conducted on the open-ended questions to look for general themes across participants.

Findings

The analyses of this research looked at a variety of factors but focused primarily on the relationship between DBT therapist skill use and consultation team and their perceived stress and burnout levels. In order to accomplish this, burnout scores and stress scales were assessed in conjunction with skill use along with other variables. The original sample size consisted of 164 respondents. However, since a composite burnout score was required to perform the analyses, the data was cleaned and respondents who had not answered all of the burnout questions were removed. After this was completed, there was a remaining sample size of 135. Therefore, this cleaned data sample was used to complete all of the following analyses.

Demographics

Of the 135 survey responses that were utilized, 121 (89.6%) of the respondents were female, 12 (8.9%) were male, and 1 (.7%) was transgender. Respondents ranged in age from 27 years old to 72 years old, with a mean age of 45.98. In regard to the types of clients that

respondents worked with, response percentages for specific populations identified are listed below in Table 1. It should be noted that respondents could check multiple categories.

Table 1

Types of Clients Served

Client Type	% of Respondents
Adults	86.7
Adolescents (alone)	31.9
Adolescents (with parents)	34.1
Borderline Personality Disorder	82.2
Other Personality Disorders	31.1
Suicidal	74.8
Chemical Dependency	32.6
Depression	73.3
Bipolar	51.5
Other	28.9

Respondents varied in the amount of time that they had been practicing DBT with a range of 8 months to 38 years with a mean of 8.89 years. It should be noted that it is possible that some respondents were instead commenting on the number of years that they had been in clinical practice since it is not possible to have been practicing full DBT for 38 years given the timeline for the development of the therapy. Respondents were asked about the type of setting in which they were employed and 107 (79.3%) of the respondents identified being in an outpatient setting, 6 (4.4%) in an inpatient setting, and 21 (15.6%) in some other kind of setting. Specifically, related to the type of DBT work that respondents were performing in their place of employment, 15 (11.1%) of respondents stated that they were individual DBT therapists, 6 (4.4%) stated they were skills group DBT therapists, 107 (79.3%) stated that they were both individual and group DBT therapists, and 6 (4.4%) stated that they performed other DBT work at their place of employment. Additionally, 119 (88.1%) of respondents stated that they use the Linehan model,

14 (10.4%) used some kind of adapted Linehan model, and 1 (.7%) used some other model. Finally, in regard to the consultation team requirements for the DBT program, 119 (88.1%) stated that they attended weekly consultation team meetings and 15 (11.1%) said that they did not attend weekly consultation team meetings and gave reasons why this was the case.

Skill Use

Since a primary focus of the research was to establish the extent to which DBT therapists utilize the DBT skills in their own life, skill use in general was examined. From the 35 possible skills that were listed, a composite score was created to establish how many of the skills were being used by each individual therapist on a regular basis. For the 135 respondents, the skill use total ranged from 5 skills to 34 skills with an average skill use of 21.46. Paired with this, frequency distributions were conducted on each skill separately to establish which of the skills respondents were using more frequently in general. The results of these distributions are presented in Table 2 and reflect the percentage of respondents who endorsed using the skill in their daily life. The skills that made up the mindfulness category included the first eight skills listed, Observe through Alternate Rebellion. The skills that made up the interpersonal effectiveness category included skills nine through 18 starting with Attending to Relationships and ending with FAST. The skills that made up the emotion regulation category included skills 19 through 25 starting with Observe/Describe Emotion and ending with Mindfulness of Emotions. Finally, the skills that made up the distress tolerance category included skills 26 through 34 starting with TIP and ending with Mindfulness of Thoughts.

As can be seen in Table 2, there was a large range around the frequency in which the respondents used each skill. Specifically, the most used skill was Non-Judgmental Stance with 94.8% of respondents stating that they used the skill, followed closing by Radical Acceptance

with 92.6% and Observe with 90.4%. Comparatively, the least used skill was Factors/Intensity Level with 15.6% of respondents stating that they used the skill, followed by TIP with 18.5%, Alternate Rebellion with 19.3%, and Pros/Cons of using DT with 20.0%. Looking at the results it can be seen that out of the four different categories the individual mindfulness skills and emotion regulation skills as a whole were endorsed at a higher frequency than the other two categories. However, in general, 28 of the 35 skills were used by at least 50% percent of the respondents with only Urge Surfing, Alternate Rebellion, Factors/Intensity Level, Interpersonal Priorities, ABC, TIP, and Pros and Cons of using DT falling below this mark.

As stated in the introduction, skills fall within one of four different categories that are taught in the different modules and include mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. In the survey there was a set of questions that asked the respondents not to respond to individual skills, but instead, to respond to techniques used within the category as a whole. Because of this, analyses were run to see how often respondents used the techniques within the given category, and how useful these techniques were in reducing stress in their everyday life. The goal of this was to examine whether respondents found one category of skills more helpful in alleviating stress than another category of skills.

For these analyses, skills were not specified, and instead, respondents were asked to identify how often or how useful they found the techniques in mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Responses were scored on a 5-point Likert scale and ranged from “not at all helpful” to “extremely helpful” and “never” to “always” for frequency.

Table 2

Individual Skill Use in Daily Life

Specific Skill	Skill Use %
Observe	90.4
Describe	79.3
Participate	78.5
Nonjudgmental Stance	94.8
One-Mindfully	77.8
Effectiveness	82.2
Urge Surfing*	36.3
Alternate Rebellion*	19.3
Attending to Relationships	73.3
Balance Priorities/Demands	68.1
Balancing Wants/Shoulds	57.0
Cheerleading Statements	51.1
Mastery and Self-Respect	69.6
Factors/Intensity Level	15.6
Interpersonal Priorities	42.2
DEAR MAN	65.9
GIVE	71.1
FAST	51.1
Observe/Describe Emotion	68.9
Check the Facts	77.8
Opposite to Emotion	69.6
Problem Solving	75.6
ABC*	40.0
PLEASE	72.6
Mindfulness of Emotions	72.6
TIP*	18.5
Self-Soothe	75.6
IMPROVE the Moment	57.0
Pros and Cons of Using DT	20.0
Distracts with ACCEPTS	52.6
Radical Acceptance	92.6
Turning the Mind	70.4
Willingness	83.7
Mindfulness of Thoughts	74.8

**Note: These skills are not in the original manual and therefore may not be as well known*

In regard to how often respondents used the skill categories, means were relatively high. For the mindfulness techniques, responses ranged from 2 to 5 with a mean score of 4.16. For the interpersonal effectiveness techniques, responses ranged from 2 to 5 with a mean score of 4.01. For the emotion regulation techniques, responses ranged from 2 to 5 with a mean score of 4.13. Finally, for the distress tolerance techniques, scores ranged from 2 to 5 with a mean score of 4.01. Overall, mindfulness and emotional regulation techniques were used quite frequently, followed closely by interpersonal techniques and distress tolerance techniques.

Respondents were also asked to rate how helpful they found the skill categories in reducing stress in their daily life. For the mindfulness techniques, scores ranged from 2 to 5 with a mean score of 4.50. For the interpersonal effective techniques, scores ranged from 2 to 5 with a mean score of 4.12. For the emotion regulation techniques, scores ranged from 2 to 5 with a mean score of 4.42. Finally, for the distress tolerance techniques, scores ranged from 2 to 5 with a mean score of 4.36. The mindfulness techniques were found most helpful in reducing stress followed closely by the emotion regulation and distress tolerance techniques, with the interpersonal effectiveness techniques being the least helpful in reducing stress in daily life.

Other demographic variables were also looked at in conjunction with skill use including respondents' gender, age, and number of years practicing. An independent-samples t-test was run to compare total skill use in male and female respondents. Since only one individual identified as transgender and did not give a large enough sample size, only those who identified as male or female were examined. In regard to skill use and gender, there was not a statistically significant difference in female ($M= 21.50, SD=6.76$) and male ($M= 21.17, SD=6.09$) total skill use ($t(131)=-.162, p=0.871$). In this sense, it appears that both male and female DBT practitioners use

the same amount of skills nearly equally, and one group does not use more skills than the other group.

In looking at age and skill use, a number of correlations were run to see if there was a relationship between respondents' age and how they use and perceive the skills. For total skill use and age, a positive weak correlation was found ($r=.234$, $p=0.007$), suggesting that as age increases so does total skill use. For frequency of skill use in daily life within each category and age, there was a positive weak correlation found for the mindfulness techniques ($r=.202$, $p=0.021$) where the older the respondent, the more likely they are to use the mindfulness techniques in their daily life. This was not the case for age and the interpersonal effectiveness techniques ($r=.091$, $p=.303$), emotion regulation techniques ($r=.117$, $p=.185$), and the distress tolerance techniques ($r=.027$, $p=.763$), which were all shown not to be statistically significant. However, when it came to age and how helpful the respondents found the skills from the categories in reducing stress in their daily life, there was a positive weak correlation for the mindfulness techniques ($r=.186$, $r=.035$), interpersonal effectiveness techniques ($r=.177$, $p=.044$) and age, but not the emotion regulation techniques ($r=.060$, $p=.497$) or the distress tolerance techniques ($r=.005$, $p=.955$) and age.

There were also some significant findings with number of years that the respondents had been in practice and frequency of skill use. Specifically, there was a weak positive correlation found for years of practice and the frequency of the mindfulness techniques ($r=.265$, $p=0.002$), interpersonal effectiveness techniques ($r=.235$, $p=.0006$), and the emotion regulation techniques ($r=.223$, $p=0.009$) suggesting that the more years a person spends practicing DBT, the higher the frequency in which they practice skills from these categories. This was not the case for the distress tolerance techniques ($r=.071$, $p=0.418$). Additionally, weak positive correlations were

found for number of years in practice, and the helpfulness of the skills in reducing stress for the mindfulness techniques ($r=.190$, $p=0.028$) and the emotion regulation techniques ($r=.183$, $p=0.035$), but not the interpersonal effective techniques ($r=.137$, $r=0.115$) or the distress tolerance techniques ($r=.046$, $p=0.595$).

Burnout and Stress

The Bergen Burnout Indicator - Modified was given as part of the overall survey. A composite score was made from the 24 individual items to give an overall burnout score. Again scores could range from 24 to 168 with higher scores suggesting more symptoms of burnout. In examining the burnout scores for the 135 respondents, scores ranged from 27 to 131 with a mean score of 60.66 ($SD=20.43$). In order to get a better understanding of the dispersion of the scores, a histogram is presented (see Figure 1). As can be seen, most of the respondents are clustered around the 50 to 70 ranges. Additionally, only 5 of the respondents fell above the 100 score burnout threshold.

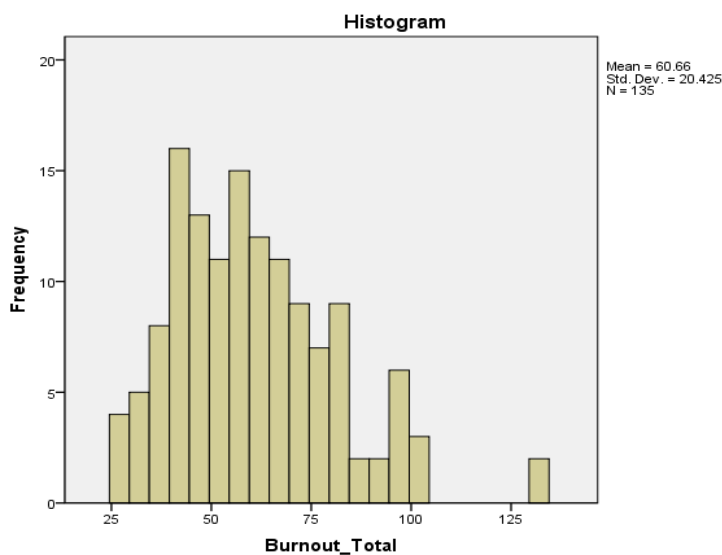


Figure 1. Burnout score figure distribution

Paired with the burnout scores, descriptive statistics were run on questions that asked about stress related to work and how often that stress interfered in the respondents' daily life. Work stress was scored on a 10-point Likert scale with higher scores indicating more stress and was ranked from "not at all stressed" to "extremely stressed." Responses ranged from 2 to 9 with a mean score of 5.36 (SD=1.79). Taking this a step further, how much this stress interfered in respondents' daily life was also examined and was scored on a 5 point Likert scale ranging from "never" to "sometimes" to "always." Respondents' scores for this question ranged from 1 to 5 with a mean score of 2.72 (SD= .676). In general, respondents appeared to be somewhat stressed in work, and found this stress sometimes interfering in their life.

In order to look at some of the claims that were made in the literature around burnout being more prevalent when working with certain populations and if the practitioner is a certain gender, statistics were run to see if this was the case for DBT practitioners. An independent samples t-test was run to compare burnout scores in males and females. Again, since only one respondent identified as transgender, only male and female scores were compared. In comparing burnout scores, there was a statistically significant difference in female respondents' (M=59.45, SD=19.25) and male respondents' (M=74.50, SD=27.72) scores ($t(131)=2.47, p=0.015$). In this sense, females actually appeared to have lower burnout scores on average than did their male counterparts. However, it should be noted that the male group only comprised 12 individuals so there was larger room for outliers to have an effect.

Additional factors were also examined around the type of client that the respondents worked with, specifically, clients with borderline personality disorder and suicidal tendencies, and the level of burnout symptomology they experienced. An independent samples t-test was run on total burnout score and whether or not respondents worked with clients with borderline

personality disorder. It was found that there was not a statistically significant difference in those who worked with clients who have borderline personality disorder ($M=61.13$, $SD=20.54$) and those who did not work with clients who have borderline personality disorder ($M=58.50$, $SD=20.16$) on burnout scores ($t(133)=-.570$, $p=0.570$). The same was also true for suicidal clients in there was not a statistically significant difference for those who worked with suicidal clients ($M=60.71$, $SD=20.54$) and those who did not work with suicidal clients ($M=60.50$, $SD=20.93$) on burnout scores ($t(133)=-.052$, $p=0.958$). In other words, respondents who worked with clients who have borderline personality disorder and suicidal tendencies did not have higher average burnout scores than those who did not.

Burnout and Skill Use

In order to establish whether skill use had a potential impact on burnout symptomology and scores, a number of analyses were conducted. Specifically, a variety of independent sample t-tests were run recoding the frequency of skills questions into low skill use and high skill use. It was found that none of the t-tests were statistically significant for utilization of the techniques within each of the categories and the total burnout score. However, a correlation was run for total skill use and total burnout score and even though the relationship was found to be weak, a statistically significant negative correlation did occur ($r=-.175$, $p=0.042$). This would again suggest that the more skills the respondents were using on a daily basis, the lower their burnout scores tended to be.

A variety of other correlations were also run looking at the amount of stress that the respondent was experiencing in his or her life, and the frequency in which they used the techniques from the different categories. It was found that there was a weak positive correlation for work stress and the emotion regulation techniques ($r=.229$, $p=0.008$) as well as the distress

tolerance techniques ($r=.223$, $p=0.009$). However this was not the case for work stress and the mindfulness techniques ($r=.089$, $p=.304$) or the interpersonal effectiveness techniques ($r=.054$, $p=.532$). These findings simply suggest that the more stressed out the respondent was at work, the more likely they were to use the emotion regulation and distress tolerance skills on a more frequent basis.

Qualitative Responses for Skill Use and Stress

One of the qualitative questions in the survey asked respondents to respond to the question “How do you feel the skills you have learned in facilitating DBT have contributed to your ability to manage stress in your daily life?” A majority of the respondents answered this question in some form or another, and a large number of the responses were of a positive nature. Specifically, respondents spoke about having a positive way of approaching their life and work, feeling that the skills were tremendously helpful and invaluable, as well as helping them immensely in working with their stress and burnout. Specific skills were mentioned throughout the responses, and respondents frequently commented on the use of mindfulness. When talking about the skills being beneficial in helping with life and work, some respondents commented as follows:

I don't know how I would manage the pressures of being a full time clinician, professor, wife, mother, daughter or friend without the skills DBT has taught me. They are like a life boat. Constant, present, and always available to assist me in any situation.

I don't think I could survive either my work or personal life without DBT skills. They have saved my soul! (on many, many occasions).

DBT skills have created a work life worth living. I am more centered in my work with clients because of the skills.

I've been able to create a balance between work and my private life. I'm aware of my stress and able to use skills from all modules to alleviate or manage the stress.

I am much more grounded, patient, calm and easy going. I think more now before I speak and find myself less bothered by daily stressors. My personal relationships are also much stronger, open and honest.

I feel that it is central to be able to model the skills, and so I came to this more by duty than need. Yet once I learned to generalize many of the skills, they proved to become a way of life that offered many rewards, including a decrease of the stress levels associated with working in this field in general, and with this population in particular.

DBT is not just a therapy it's a mindset and a way if life. I have truly enjoyed growing with my patients while learning this together through all the trial and errors. I use DBT as often as I can, I try to make a point to schedule it into my daily life (particularly mindfulness) and the great thing is that I get to share all that with my patients and colleagues and we are there to support each other through.

I do not believe that I would be able to do my job if I did not practice the DBT skills personally.

While the respondents above spoke directly to the effect that it has had on their life, both personally and in their work environment, other respondents commented on the way that it has helped not only in their stress reduction in general, but also in their lack of burnout. Some respondents that spoke to this idea said the following:

They allow me to continue to work effectively without burning out. They also help me recognize when I am feeling burned out and provide me with concrete ways to manage emotions and problem solve in a compassionate and validating manner.

They have been a huge help. 2 years ago my answers to these questions would have been much more dire.

Transformed it entirely. I moved from an anxious management style to one focus on non-anxious skill choice.

The DBT skills have a significant impact on how I manage my own stress, and have helped me to find a job that I love.

They are "life" skills, so they are so easily transferrable to day to day stressors. By teaching them on a regular basis, I owe it to my clients to practice what I preach. I feel grateful to know the skills to help keep my stress from rarely becoming unmanageable.

Finally, some of the respondents spoke specifically about the skills that have been most beneficial. While specific skills were mentioned, quite a few of the respondents talked about the

power of mindfulness practice and what it has done for them personally. Respondents who spoke about this and other skill categories said some of the following:

I now have more awareness of distress tolerance and emotion regulation skills that I was already doing, and am learning which skills are helpful in which circumstances/for which emotions. Mindfulness has helped me a great deal in terms of slowing down my thoughts at times and helping me get grounded. The concept of acceptance has also been useful in managing stress.

I am much more mindful of when my emotional stress is increasing. I am able to use skills in regulating my emotions and behaviors so that I am much more effective in both my professional and personal life.

Mindfulness has been key to my stress management. I burnt out a few years ago and since returning to work I actively use mindfulness to take a step back.

They have helped tremendously. Mindfulness has been the core to becoming more aware of my emotions and relationships and where I want them to be. It has also helped me with setting boundaries interpersonally and working towards my personal goals.

I use my skills constantly in my day to day life! They have had a significant positive impact on my ability to manage stress - especially the mindfulness skills.

As can be seen from the above excerpts, DBT practitioners appear to receive a variety of benefits from the skills including not only the impact that the skills have in working with their stress and burnout levels around work, but also in helping to navigate the everyday stressors that come up in their life.

Consultation Team and Burnout

Since consultation team is such an engrained part of the DBT program, it was important to establish the effect that this had on the respondents and their burnout. An independent samples t-test was run using a recoded Likert scale item that asked how helpful respondents found consultation team in reducing stress related to their DBT cases. This item was then recoded into helpful and not helpful. It was found that there was a statistically significant difference in those who did not find consultation team helpful in reducing stress for their cases ($M=71.61$,

SD=25.38) and those who did find consultation team helpful in reducing stress for their cases (M=57.23, SD=17.97) on their burnout scores ($t(127)=3.40, p=0.008$). This would then suggest that those who found consultation team more helpful in reducing their stress related to their DBT cases also appear to have lower average burnout scores. The same was also found when a correlation was run, and there was a moderate negative relationship found between total burnout score and helpfulness of consultation team in reducing stress related to DBT cases ($r=-.312, p<.001$). However, this was not the case for reducing stress in their daily life. Specifically, the t-test for burnout score and respondents finding consultation team helpful in reducing stress in their daily life was not statistically significant. In other words, respondents seemed to find consultation team more helpful in reducing stress related to their DBT cases (M=4.17, SD=.945) than they did in reducing stress in their daily life (M=3.47, SD=.985).

Qualitative Responses for Consultation Team and Stress

The second qualitative question in the survey asked the respondents to answer the question “How does consultation team affect your stress levels related to your DBT cases?” Surprisingly, responses around this question were both positive and negative in nature. Specifically, respondents spoke about feeling a sense of support, understanding, validation, as well as gaining a new perspective from consultation team members while others felt more stressed by consultation team. Some of the more positive perspectives are reflected in the following:

My team reminds me of my blind spots, helps me address the situations I can not see myself and enables me to be the best clinician I can be. They are my other life line.

I am sometimes anxious to bring up cases in team, and I usually am glad that I did after. It is helpful to get other people's perspectives, and my stress usually decreases after team.

It lowers and minimizes the stress I experience with my challenging clients. If I did not have the consultation team my work would not be as effective.

I usually find validation, support, and helpful direction that keeps me motivated in therapy.

It decreases my stress as I do not feel as if I'm working on difficult cases alone. It helps to get feedback and to discuss with trusted colleagues my struggles and doubts.

Just knowing that there are people "in my corner" who I can call when I am needing consultation is helpful.

Consultation is invaluable in reducing stress. Provides a lot of validation, positive affirmation, and the knowledge that I'm not required to know everything because I have an entire team of people I can use as resources.

Consultation team is the ONLY thing that has allowed me to continue doing DBT with our populations.

While a majority of those surveyed had positive comments around consultation team, there was a subset of respondents who found consultation team stressful or non-effective in its purpose.

Some of the sentiments from these respondents are as follows:

Sometimes reduces stress, and other times adds to stress.

Our consultation team meetings operate like hospital rounds. No mindfulness and case review, rather than helping therapists learn.

Sometimes causes more stress.

Does not cause more stress just at times there are so many personalities and so many people that want to share or need the time that it can feel overwhelming.

Frequently hearing other clinicians cases in consultation team increases my stress due to worry about how my colleagues are handling things.

We have had a disruptive team member and people who aren't fully bought-in, so consultation team is usually more of a stressor than an aid.

I often feel more stressed out after team.

In looking at the responses around consultation team, a large majority of respondents appeared to find support from their team members and found consultation team to be a helpful asset.

Additionally, even though there was a subset of respondents who had more of a negative

experience with consultation team, a few of them related the stress or frustration to specific events to help explain where the problem was coming from.

Discussion

As previously stated, the purpose of this research was to establish to what extent DBT practitioners use the DBT skills in their daily life and how the skills impact their stress and burnout levels. Paired with this, the use of consultation team was also explored in the effect that it plays around burnout prevention in the practitioners. While consultation team has been worked into the DBT model to assist in burnout prevention (Neacsiu et al. 2012), there is a gap in the research around whether practitioner skill use has an effect on burnout. Therefore, this research aimed at filling that gap to better understand how skill use by the practitioner, along with consultation team, influences burnout scores and symptomology. It should be noted that since a majority of this research was exploratory in nature, specifically around skill use, there will not be comparative research findings; rather, this study was aimed toward the facilitation of future research.

Skill Frequency in Respondents

In general, overall skill use for respondents was relatively high in regard to both individual skill use and general skill use within the four categories of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. In looking at each skill individually, it appears that practitioners in their everyday life use quite a few of the skills. Since the DBT model begins each consultation meeting with a mindfulness activity and encourages practice of mindfulness by practitioners, it was, therefore, not surprising that the mindfulness skills in general appeared to be used most frequently by practitioners in their daily life compared to the other skills from different categories. Paired with this, the mindfulness skills are the ones taught

between each model, and are, therefore, reviewed most frequently by the practitioners, which could make them more familiar with the skills (Linehan, 1993). It is also not surprising that some of the skills that were used least by practitioners related directly to skills that are aimed at preventing the client from engaging in some sort of self-destructive behavior. It could be postulated that these skills are, therefore, used less frequently since many practitioners do not have as much of a need of them in their daily life as they do some of the other skills. However, it could also be possible that these may be blind spots of the practitioner and they could actually benefit from the skills if they used them. It should also be noted that some of these skills were the ones that were not in the original manual and may not be as well known.

In examining the skill frequency within the categories as a whole and not individually, respondents rated emotional regulation and mindfulness techniques slightly higher than interpersonal effectiveness and distress tolerance techniques. However, all of the means were still relatively high with all means falling above a 4 on the 5 point Likert scale. The fact that the mindfulness techniques and emotion regulation techniques had a higher mean would simply suggest that skills from these categories are used more frequently than the other two categories and is partially reflected in looking at the frequencies for the individual skills within each category. Similar results were also found in regard to how helpful respondents found the skills in reducing stress in their daily life, with the mindfulness techniques being most helpful followed closely by emotion regulation and distress tolerance techniques. The interpersonal effectiveness techniques were found to be least helpful in reducing stress. Since it was found that skills from this category were not used as frequently, nor were they found to be as helpful in reducing stress, it is possible that practitioners do not use these skills because they do not need assistance in this area of their life.

In examining the findings related to age of the respondent and skill use, it was interesting that there was a relationship for age and skill use but only in regard to the total skill use and the mindfulness techniques. It is unclear whether this has something to do with the actual age of the respondent, or more to do with the fact that older individuals could have potentially been practicing longer in the field, and that is why they use all of the skills as well as the mindfulness techniques at a higher frequency. Again, since the DBT model is set up for the practitioners to work on their own mindfulness practice, it would make sense that older practitioners, who have potentially been doing DBT longer, would use these skills more. This would be supported in the fact that there were positive correlations in regard to years of practice and the mindfulness and emotion regulation techniques, which could suggest that frequency of skill use has less to do with age and more to do with years in practice. However, it could also be possible that age does indeed play a role and older individuals are simply more aware of what they actually need for themselves.

General Burnout and Skill Impact

Burnout in general was relatively low within the sample of respondents surveyed. Specifically, when looking at the sample as a whole, only 3.7% of the respondents fell above the burnout threshold of 100. This is a much lower burnout rate than previous literature has found in mental health practitioners. Specifically, previous studies have found that those working in the mental health field have burnout rates ranging from 21% to 61% (Morse et al., 2012) with individual studies having burnout rates from 13% (Sprang et al., 2007) to 89% (Newell & MacNeil, 2011). However, it should be noted that the original Berger-Burnout Indicator was made up of 25 items with a burnout threshold of 100 while the modified version only had 24 items (Ladegard, 2011; Nordang et al., 2010). It is important to note this because the 100 point

threshold was still utilized, and it is therefore possible that more than 5 respondents would have fallen above the threshold had the full 25 item scale been used. However, even if 7 points were added to each respondents score, only 7 additional respondents would have fallen above the burnout threshold for a total of 8.9% of the sample, which is still much lower than previous research findings.

The fact that only 3.7% of the sample fell above the burnout threshold deserves some exploration. While it is not possible to ascertain exactly what the cause of the lower burnout scores may be, it is still noteworthy that the sample of DBT practitioners had lower burnout rates than did previous studies examining other mental health practitioners (Morse et al., 2012; Newell & MacNeil, 2011; Sprang et al., 2007). Paired with the lower burnout scores, in general those surveyed had what appeared to be slight stress, a mean of 5.36 out of 10, related to work and that stress was interfering with their daily life on an average level with a mean of 2.72 out of 5. One potential cause of this could be the fact that practitioners are using the skills in their daily life, which would be supported by the fact that respondents rated all of the skill categories high in helping to reduce stress in their daily life. However, it is unclear where the stress related to work is coming from and could be associated with outside factors such as dealing with insurance companies.

Skill use as a potential cause of the lower burnout scores was also supported in the fact that even though the t-tests were all not found to be significant, there was a statistically significant negative correlation between total skill use and burnout scores. One explanation for the t-tests not being significant but the correlation being significant is that, in general, all of the burnout scores were relatively low. Additionally, the t-tests used the frequency of skill category variables while the correlation used the composite scores for both burnout and skill use. The fact

that a statistically significant correlation occurred would suggest that skill use does indeed have an impact in burnout of DBT practitioners. Additionally, it was clear from the findings that the respondents actually are using the emotion regulation and distress tolerance skills when they are experiencing stress at work. This could be one possible explanation for why DBT practitioners in general have had lower burnout symptoms both physically and mentally in previous research (Miller et al., 2011; Perseius et al., 2007; Little, 2000).

It is interesting that the findings from this study did not support previous literature around gender of the practitioner influencing burnout scores and symptomology. Specifically, unlike the studies by Sprang et al. (2007) and Newell and MacNeil (2011), that found women to have higher rates of burnout or the study by Ackerly et al. (1988) that found no gender differences in burnout, the current findings were that men actually had higher burnout scores on average. It is possible that women are doing something differently than their male counterparts, however, the data did not support skill use playing a factor in this, in that there was not a statistically significant difference in total skill use between the two groups. Additionally, as previously noted, the male group had a much smaller sample size, which gave larger room for outliers to have an effect.

Paired with the findings on gender differences, the current study also did not support findings from previous research around symptom severity of the client and burnout rates. Specifically, the current study found that there was not a difference in burnout scores when comparing practitioners working with clients with borderline personality disorder and suicidal tendencies with those who do not work with these populations. This then would not support previous claims that the severity level of the client and clients with more severe symptoms influence burnout (Acker, 2011; Sprang, et al., 2007, Ackerly et al., 1988; Maslach, 1987). The

fact that DBT is geared toward working with clients with more symptomology could explain why there was not a difference in burnout scores (Neacsiu et al., 2012). Specifically, since the DBT model includes consultation team and other stress reduction factors such as a mindfulness, it would, therefore, not be surprising that burnout scores do not differ between these two groups since so many factors are in play to help prevent burnout in the practitioner.

Consultation Team Impact on Burnout

In regard to the findings around consultation team, it would appear that consultation team does have an impact on burnout scores, but it has more to do with whether or not the practitioner perceived consultation team as helpful in reducing stress related to their DBT cases. In other words, it may not be so much consultation team alone that is effective in decreasing burnout scores, but more to do with the way that the practitioner views and receives the support from consultation team. This would be supported by the negative correlation related to practitioners' views on the helpfulness of consultation team in reducing stress related to their DBT cases and their burnout score. The way that the consultation team is structured could also play a role in the way that practitioners view the experience as was evidenced by some of the more negative qualitative responses. Additionally, it would appear that consultation team does not necessarily serve as a support outside of the work environment. Specifically, the results were only significant around reducing stress related to the DBT cases, but not when looking at stress in the respondents' daily life. Since consultation team is set up to focus on helping practitioners with their cases, it is not surprising that they perceived it as being more helpful in alleviating stress related to their cases than to their life (Neacsiu et al., 2012). However, it should be noted that if stress related to work is reduced, it could also be assumed that stress in one's life would also be reduced even if it not necessarily perceived that way.

Implications for Social Work Practice

While the study was aimed at DBT practitioners, there are implications that are also important for the field of social work to keep in mind when doing practice. Obviously, the main implication from this study is the fact that as a whole DBT practitioners had lower burnout scores than statistics have suggested for the mental health field as a whole. While social workers may not be able to gain all of the training necessary to practice DBT, they could still incorporate one of the cornerstones of DBT, which is mindfulness. Specifically, since those surveyed found the mindfulness techniques to be helpful in reducing stress, and used these skills frequently, it would make sense that other practitioners learn these skills and utilize them in their practice. Since mindfulness is a practice that can be learned and used by any person dedicated enough to work on the implementation into their life, it would make sense that social workers, and all mental health practitioners, would benefit from learning how to be more mindful with their clients and themselves. Since the mental health field as a whole struggles with burnout and stress, and mindfulness has been shown to be effective in reducing these issues, it would be important for social workers as a whole to become more conscious about incorporating a mindfulness practice into their life to better serve themselves and their clients.

This idea of taking care of oneself is integral in social work practice since social workers have an ethical obligation to provide appropriate treatment, and it is challenging to do this if the practitioner is burnt out or feeling stressed with their work. In order to provide the best possible care to the clients that are being served, the practitioner needs to be in a good place personally. While most individuals in this field of study are aware of the importance of self-care, the specifics of how exactly to do self-care can become a little hazy. Mindfulness provides a solution to this conundrum. While mindfulness takes dedication and practice, the current study shows the

effect that it can have in assisting practitioners in stress management. Since the prevention of burnout is so important to this field as a whole, it would make sense to pay more attention and start implementing some of the techniques that have been found to be effective in preventing these issues, like mindfulness.

Another important factor to take away from the current research is the importance of support in the work setting. While results were less concrete around how much effect consultation team had on reducing stress in the individual's personal life, it was found that it was helpful in reducing stress around their cases. While it should be noted that DBT consultation team focuses less on support and more on the responsibility of practitioners to teach each other and point out any flaws in their practice, it still has implications for social interaction and support around the cases at work. This then has implications around the use of support in the work setting, and the fact that it can be helpful in reducing stress around work and cases. While consultation team is not built into all work settings, many social work practice settings have group supervision that, if used appropriately, could prove beneficial in reducing stress and burnout in practitioners. Additionally, even if group supervision is not available, individuals could always talk more openly with their colleagues to gain a sense of support so they do not feel so overwhelmed and alone in the challenging aspects of their work.

Finally, it is important to recognize and remember that there are specific types of practices, specifically DBT, that have proved to be effective in working with clients who have borderline personality disorder and suicidal tendencies. This goes back to the ethical obligation of best practice, and in some instances, this could involve transferring a client to a service that provides more appropriate care like DBT. While research has suggested that more severe client symptomology can create higher levels of burnout in the practitioners, this does not appear to be

the case for DBT practitioners. Therefore, if a mental health practitioner is working with a client with borderline personality disorder or suicidal tendencies and is feeling overwhelmed or burnt out, it may be appropriate to consider finding them alternative care that not only is effective, but has less of a burnout impact on the practitioner.

Strengths and Limitations

One of the strengths of the current study is that to date nothing on this specific topic has been conducted. Since burnout is such a pervasive problem in the mental health field, it is extremely important to determine what, if anything, can help in combatting burnout symptomology in practitioners. The fact that the study was exploratory in nature gives new information and research to the field to build upon in the future. While a convenience sample was used, the study required a very specific type of participant, and so there was no other way to go about conducting the study without using a convenience sample. However, even though the study was geared toward DBT practitioners, the fact that the survey was posted on an international list serve would speak to the representativeness of the sample. Specifically, DBT practitioners from all over the world were given access to the survey, so the findings are, therefore, more likely to be a good representation of DBT practitioners as a whole. However, it should be noted that this was still a convenience sample and respondents could choose whether or not they wanted to participate. It is therefore possible that only a certain subgroup chose to participate. Paired with this, the survey got a good response rate, and the sample size was large enough to be able to do more complex statistical analyses to gain more comprehensive insight into the data. The mixed-method methodology was another strength of the current study. As a topic, which has received little attention and is still exploratory, the quantitative portion allowed

for gathering descriptive information, while the open-ended nature of the qualitative part invited reflection and broader understanding.

One of the main limitations of the method used in this study was that as an exploratory study, part of the survey was developed for the study, and, therefore, has not been tested previously. Because of this, it is possible that questions were not necessarily as refined as they could have been or could have been phrased differently to more appropriately gauge what the researcher was trying to ask. Therefore, without replication of the study, the findings need to be viewed simply as an exploratory study that requires duplication in the future.

Future Research

Since this study was relatively exploratory in nature future research should aim at duplication of the study to help validate the findings. Since no literature to date was able to be found on skill use in DBT practitioners this would be an area of research that could be expanded upon to help better understand the low burnout rate that was found. It would be helpful to survey additional DBT practitioners with a more highly recognized burnout scale such as the Maslach Burnout Scale to make sure that the results were not skewed in any way.

Because the findings on consultation team were not entirely clear, additional research should be completed to better understand the influence that DBT consultation team has on the practitioner. Completing a more qualitative study to help identify what makes a consultation team effective and where areas for growth lie in helping to support practitioners could be beneficial. It would also be helpful to further understand the effect that general colleague support has on other members within the mental health field and if there is a way to establish a more consistent sense of cohesion and support for those providing mental health services.

Since the effect of age and number of years in practice were hard to differentiate it would be important to look more closely at the effect that these factors have on the likelihood of burnout in practitioners. Additionally, since gender was shown to have an impact on burnout scores it would be important to decipher whether there is something specific about DBT that causes lower burnout scores in females or whether this was a single incident occurrence.

Finally, since mindfulness was shown to be very influential in the practice of DBT practitioners, and was shown to be useful in helping to alleviate stress, there are implications around future research with mindfulness practices in general with other individuals providing mental health services. While research has been done in this area, it would be interesting to see if there is something specific about the mindfulness practices used in DBT that makes it so effective.

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Letter of Informed Consent

I am conducting a study about practitioner's use of the DBT skills in their own life as a mediating factor in stress reduction and burnout prevention. Additionally, I am interested in how helpful DBT practitioners find consultation team in reducing stress. You were selected to participate in this study because you were identified as being a DBT practitioner who is currently practicing in the field. Please read through the entire form below before clicking on the link at the bottom of the page.

This study is being conducted by Kate Jergensen, a clinical graduate student in the Masters of Social Work program at University of St. Thomas/St. Catherine University and is being overseen and supervised by Jessica Toft, PhD., LISW.

If you agree to be a participant in this study, by clicking on the link below you will be directed to a short survey. The survey should not take more than 30 minutes to complete. The survey is composed of the following categories of questions: demographic, usefulness and frequency of DBT skills in personal life, and questions around stress.

There are no identifying risks by agreeing to be a part of this study.

Because the survey is being completed through a data collection server, all answers will be anonymous and there will be no way to link individual responses to specific participants. Additionally, all raw data will be kept confidential and secure on a password-protected computer as an additional precaution. If you happen to list any type of identifiable information in your answers it will be deleted and removed from the final report. I will be the only individual who will have access to the raw data.

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future standings with the agency in which you work, the University of St. Thomas/St. Catherine University, or the School of Social Work. Additionally, because the survey is anonymous your employer will not be made aware if you have chosen to participate in this study. If you decide to participate, you are free to stop at any time and simply exit out of the browser. You are also free to skip any question that you do not feel comfortable answering.

If you have any questions or concerns regarding this study you may contact me at _____. You may also contact the research advisor for this project, Jessica Toft, PhD., LICSW at _____. Additionally, you are free to contact the University of St. Thomas Institutional Review Board at _____.

By clicking on the link below you acknowledge that you have read and agree to the terms of the study and are giving your informed consent to participate.

Survey Questions

Please respond to the following items as indicated:

1. What is your age? (Closest year, i.e, 30) _____
2. What is your gender?
 - a. Male
 - b. Female
 - c. Transgender
3. Type of Agency
 - a. Outpatient clinic
 - b. Inpatient clinic
 - c. Other (please specify) _____
4. Number of Years in Practice (i.e. 5) _____
5. Primary Clientele (check all that apply)
 - a. Adults
 - b. Adolescents
 - c. Borderline personality disorder
 - d. Other personality disorders
 - e. Suicidal clients
 - f. Chemical dependency
 - g. Depression
 - h. Bipolar
 - i. Other (please specify) _____
6. Do you facilitate: Check one
 - a. Individual DBT
 - b. DBT Skills group
 - c. Both
 - d. Other (please specify) _____
7. Do you use and follow the Linehan model or an adapted model?
 - a. Linehan model
 - b. Adapted Linehan model
 - c. Other model (please specify) _____
8. Do you attend weekly consultation team meetings?
 - a. Yes
 - b. No (Please specify why not) _____
9. How long do you spend in consultation team each week (in hours, i.e. 2)?
10. What percent of consultation team is spent doing the following?
 - a. Business
 - b. Education
 - c. Viewing tapes
 - d. Therapist consult
 - e. Mindfulness
11. On a scale of 1 to 10 (with 1 being the lowest and 10 being the highest), where would you rate your stress level related to work on a daily basis?

a. Likert scale (1-10)

This section asks about the frequency in which you utilize the DBT skills in your daily life. Daily life is considered any time that you spend both in and out of work and is not restricted purely to leisure time. For the following questions please use the following scale: 1-Never, 3-Sometimes, 5-Always.

12. How often do you find job related stress interfering in your daily life?
13. How often do you use the mindfulness techniques in your daily life?
14. How often do you use the interpersonal effectiveness techniques in your daily life?
15. How often do you use the emotion regulation techniques in your daily life?
16. How often do you use the distress tolerance techniques in your daily life?

This section asks about how helpful you find the DBT skills and consultation team in your daily life in reducing stress. Again, daily life is considered any time that you spend both in and out of work and is not restructured purely to leisure time. For the following questions please use the following scale: 1-Not at all helpful, 3-Somewhat helpful, 5-Extremely helpful.

17. How helpful do you find the mindfulness techniques in reducing your stress levels?
18. How helpful do you find the interpersonal effectiveness techniques in reducing your stress levels?
19. How helpful do you find the emotion regulation techniques in reducing your stress levels?
20. How helpful do you find the distress tolerance techniques in reducing your stress levels?
21. How helpful do you find consultation team in reducing your stress level in your daily life?
22. How helpful do you find consultation team in reducing your stress level related to your DBT cases?

Please check all that apply:

23. Of the following skills, which ones do you find yourself using in your daily life?
 - a. All skills listed

Where do you fall on each continuum between the opposing characteristics?

24. Oriented to acceptance/Oriented to change
25. Unwavering centeredness/Compassionate flexibility
26. Nurturing/Benevolent demanding

Please answer the next questions using the following scale: 1-Completely Disagree and 7-Completely Agree.

27. Actually, I seldom have time off from work, as I often meet colleagues in my leisure time
28. I feel I give more of myself to other people than I receive
29. I often have a feeling that my efforts are insufficient
30. I have an emotional distance to other people
31. I frequently ask myself if my contributions are valued
32. I am not able to stimulate other people to the degree I want
33. I often feel downhearted at work and think of quitting
34. I often feel annoyed at work
35. I often sleep badly because of my work circumstances
36. I feel I have gradually less to give emotionally
37. I have problems socializing with others
38. When I started my job, I had larger expectations than I have at present
39. I find it difficult to engage in my colleagues' problems and needs
40. I have felt so worn-out lately that I have been compelled to reduce my social contacts at work
41. The pressure at work has caused difficulties in my private life
42. In my leisure time I think a lot of my work situation
43. I feel tired during my work day
44. I regularly consider finding a new job
45. Often, I find it difficult to concentrate on work matters
46. To be honest, I felt more valued earlier in my job

47. I feel I gradually lose interest in people I meet through work

48. I feel I never have sufficient time to help and support my colleagues

49. I feel there is a gap between my efforts and my economic rewards (salary)

50. I regularly feel guilty because I must give up my family for job matters

Please respond to the following open-ended questions:

51. How do you feel the skills you have learned in facilitating DBT have contributed to your ability to manage stress in your daily life?

52. How does consultation team affect your stress levels related to your DBT cases?