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The Relation between DBT Skills Training and Attitudes Towards Individuals with BPD

Kenny Gonzalez
CUNY John Jay College, kenngonzalez13@gmail.com

Program Director Thesis Approval

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Author: Kenny Gonzalez

EMPLID: 23222117

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Program Director Initials: 

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Kenny Gonzalez

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Abstract

Attitudes towards individuals with BPD are generally pessimistic (Cleary, Siegfried, & Walter, 2002; Fraser, 2001; McIntosh, 1998). Training as an intervention, in the form of different theoretical orientations, has been shown to improve attitudes among mental health professionals. However, few studies (Fraser, 2001; Hazleton et al., 2006; Carmel, Fruzzetti, & Rose, 2014) have investigated whether Dialectical Behavior Therapy (DBT; Linehan, 1991) can improve attitudes towards individuals with Borderline Personality Disorder (BPD). The current study was conducted at a 3-day DBT skills training workshop and sought to examine the impact of DBT skills training on attitudes towards individuals with BPD. Using a pre-and post-test design, confidence and knowledge regarding the practice of DBT, and attitudes towards individuals with BPD, were compared prior to and after the 3-day DBT skills training workshop. Results indicate a significant increase in participant's willingness to treat individuals with BPD after completion of the DBT skills training workshop. Results are discussed as they pertain to continued professional development, with limitations and future research delineated.

Keywords: *Dialectical behavior therapy, borderline personality disorder, professional training*

The Relation Between DBT Skills Training and Attitudes Towards Individuals with BPD

Borderline personality disorder (BPD) is a complex personality disorder encompassing high rates of suicide, self-harm, substance abuse, severe functional impairment, and comorbid mental disorders (Leichsenring, Leibing, Kruse, New & Leweke, 2011). Diagnostically, borderline personality disorder is characterized by (1) interpersonal criteria; efforts to avoid real or imagined abandonment and a pattern of unstable and intense interpersonal relationships; (2) cognitive criteria; transient, stress related paranoid ideation or severe dissociative symptoms and identity disturbance; (3) behavioral criteria; recurrent suicidal behavior, threats or self-mutilation behavior; and (4) affective criteria; inappropriately intense anger or difficulty controlling anger, chronic feelings of emptiness and affective instability (American Psychiatric Association, 2013). Because of the complex symptomology, BPD is regarded as a difficult disorder to treat (Bodner, Cohen-Fridel & Iancu, 2011; Dimeff & Linehan, 2001).

The etiology of BPD is inconclusive; however, current prevailing theories are diathesis-stress theories (Crowell, Beauchine, & Linehan, 2009). Diathesis-stress theories posit there is an interaction between a person's genetic vulnerability and growing up in an invalidating environment (Gunderson & Lyons-Ruth, 2008; Paris, 2005). Biologically, affective instability and impulsivity are heritable factors (Torgersen, Lygren, Oien, Skre, Onstad, Edvardsen, Tambs & Kringlen, 2000). Within the family environment, many patients report sexual or physical abuse in the home during childhood (Paris, Zweig-Frank & Guzder, 1994). Additionally, patients often report family dysfunction, some form of trauma, and mood and impulsive symptoms in childhood (Paris, 1997). Indeed, in a study exploring childhood experiences of individuals with BPD, 84% retrospectively reported biparental neglect, emotional abuse and the emotional denial of experiences before the age of 18 (Zanarini, Frankenburg, Reich, Marino, Lewis, Williams &

Khera, 2000). Thus, it appears that a biological impairment in mediating affect and arousal, coupled with exposure to an aversive environment including neglect, abuse, or some form of maltreatment, can contribute to the development of BPD.

Attitudes towards BPD

Within the clinical population, BPD is one of the most commonly diagnosed personality disorders, with prevalence estimates of 10% among individuals in outpatient settings, and 20% in psychiatric inpatients (Gunderson, 2011). As a result, the likelihood of a mental health professional encountering a patient with BPD is high. However, those professionals who come into frequent contact with patients with BPD are often faced with frustration and a poor prognosis for the patient. Specifically, mental health professionals often struggle to find empathy for individuals with BPD and report having limited skills and confidence in their ability to provide adequate services (Black, Pfhol, Blum, McCormick, Allen, North, Phillips, Siever, Silk, Williams, & Zimmerman, 1999) thus reinforcing negative attitudes (Krawitz, 2004). Most empirical studies examining the perceptions and reactions of mental health professionals towards BPD have used samples of psychiatric nurses (Sansone & Sansone, 2013) and have found that psychiatric nurses were more helpful to patients with a diagnosis of major depressive disorder than to patients with a diagnosis of BPD (Forsyth, 2007); responded to patients with BPD in a less empathic manner (Fraser & Gallop, 1993); and, when asked to summarize their feelings towards patients with BPD, used descriptors such as “destructive whirlwind” (Woollaston & Hixenbaugh, 2008). Studies looking at mixed samples of mental health clinicians and psychotherapists have found similar results (see Bodner, Cohen-Fridal & Iancu, 2011).

Indeed, many clinicians hold negative attitudes when it comes to the treatment and management of BPD (McIntosh, 1988). In a study examining psychotherapist reactions to

randomized written patient case vignettes, patients with BPD were more likely to elicit feelings of anger and irritation (Brody & Farber, 1996). Furthermore, Brody & Farber (1996) also found psychotherapists were less likely to invoke positive feelings such as empathy towards patients with BPD when compared with attitudes towards patients with schizophrenia or depression. In a qualitative study, Common-Treloar (2009b) set out to provide the opportunity for clinicians to comment on their experiences working with BPD patients. An overall theme arose demonstrating clinician's attitudes towards BPD patients as negative and derogatory. Specifically, BPD patients generated an uncomfortable and personal response from clinicians, who produced statements such as: "I feel challenged," I find them too difficult to deal with," and "they cause increased arousal and conflict in the team." Furthermore, characteristics of individuals with BPD that contributed to negative clinician attitudes included chaotic, manipulative, time consuming, and constantly present in crisis. In sum, mental health professionals' attitudes towards BPD are generally negative, which can impact the care individuals with BPD receive.

Additional contributing factors to negative attitudes potentially include a lack of knowledge and stigma. The professional literature on attitudes towards individuals with BPD is filled with pervasive stigmatized language (McIntosh, 1988). In fact, the word "manipulative" is used in the DSM-IV (American Psychological Association, 1994) to describe individuals with BPD. While the DSM-V mentions the word "manipulative," the context of the manipulativeness does not refer to gaining money, power or material gain. Instead, the manipulativeness stems from a need to gain the concern of caretakers. This pejorative language still creates a sense of concern when working with BPD patients. While the McIntosh (1998) study was qualitative in nature, results showed more than 50% of clinicians believed that "manipulation" and "anti-social" behavior were defining characteristics of BPD patients. However, anti-social behavior is

not listed as one of the diagnostic criteria in the DSM-V. Additionally, 43% felt that lying was also characteristic and 50% of clinicians expressed some form of discomfort when treating BPD. Consequently, these negative reactions can lead to counter therapeutic conditions, such as, but not limited to: premature termination of treatment, rationalization of treatment failures, a lower likelihood of forming an effective treatment alliance with patients, emotional and social distancing, difficulty empathizing, a lack of belief in recovery, and perceptions of patients as dangerous, manipulative, and more in control of their behaviors than other patients (Markham, 2003; Markham & Trower, 2003).

Yet within the psychotherapy literature, research has shown there are specific clinician attributes that facilitate a strong therapeutic alliance and promote positive client change and growth; specifically, a positive attitude on the part of the mental health professional. As proposed by Carl Rogers (1957), clinicians should embody acceptance, positive regard, and empathy. Egen (1994) posited that competence and respect are necessary for effective therapy (Egen, 1994). Egen viewed empathy as both an action and a communication skill. Specifically, an effective therapist decreases interpersonal anxiety in the relationship, increases trust and builds an interpersonal climate where clients can openly discuss their problems (Deffenbacher, 1985). A therapist actively fulfilling the previous conditions will allow the client to be more actively involved in treatment. As a result, there is an improvement in the outcome of the behavioral intervention (Baillargeon, Coté and Douville, 2012). Past research has long indicated that the quality of the therapeutic relationship is the key to change (Rogers, 1957; Wright & Davis, 1994). To promote client growth, attitudes within a therapeutic relationship best predicted treatment outcome (Rogers, 1957).

Relatedly, Linehan (1993) proposed that patients with BPD should be treated with compassion in terms of the dialectical dilemmas they experience. To further illustrate this, Linehan compared the emotional difficulties of a patient with BPD to a third-degree burn patient; even the slightest touch can create intense suffering due to having no emotional skin. As a result, it is imperative that mental health professionals approach any client with BPD with the upmost caution and manage any negative attitudes. To do this, mental health professionals should have the necessary tools and strategies. With the introduction of evidence-based dialectical behavior therapy (DBT; Linehan. 1993), an effective means of treating individuals with BPD, further knowledge on personality disorders, and effective strategies for clinicians in high stress interactions were provided (Chapman, 2006).

Dialectical Behavior Therapy (DBT)

Numerous studies have found dialectical behavior therapy (DBT) to be the most effective therapeutic technique for individuals with BPD (Gunderson, 2001; Swenson, 2000). So much so that DBT has been designated as "empirically supported" by the clinical psychology division of the American Psychological Association (Robins & Chapman, 2004). Originally, the treatment was developed to treat suicidal clients and targeted suicidal behavior, behaviors that interfere with treatment delivery, and other severe, dangerous behaviors (Linehan, Comtois, Murray, Brown, et al., 2006). However, further adaptations include a multitude of populations across settings including substance abusing women (Linehan, Schmidt, Dimeff, Craft, Kanter & Comtois, 1999), eating disorders (Telch, Agras & Linehan, 2001), elderly depressed patients (Lynch, Morse, Mendelson & Robins, 2003), attention-deficit/hyperactivity disorder (Hesslinger, Tebartz van Elst, Nyberg, Dykierek, Richter, Berner et al., 2002), couples (Fruzzetti & Levensky, 2000), and forensic settings (McCann, Ball & Ivanoff, 2000).

DBT combines behavioral and cognitive therapies with Zen philosophy techniques (Rizvi & Linehan, 2001) with the overall goal of increasing adaptive behaviors. The main dialectic in DBT refers to acceptance and change. DBT modules include: weekly individual psychotherapy, group skills training, telephone consultation (as needed), and weekly therapist consultation meetings (Linehan, Comtois, Murray, Brown, et al., 2006). In order to make sure the patient develops and transfers adaptive behavior to everyday life, the five functions of treatment must be fulfilled. These functions include: enhancing positive capabilities, generalizing capabilities, improving motivation, reducing dysfunctional behaviors, enhancing and maintaining therapist capabilities, and motivation and structuring an environment (Chapman, 2006).

The first function, enhancing capabilities, focuses on the assumption that patients with BPD lack or need to improve on important life skills (Linehan, 1991). The second function focuses on generalizing skills learned. Homework assignments allow these skills to generalize to the patient's everyday environment. The therapist is also available by phone outside of group sessions in case a patient needs assistance in applying these skills or finds him/herself in a distressing situation. The third function involves improving motivation to change and reducing dysfunctional behaviors. This is done through individual therapy sessions where the goal of each session is to discuss any dysregulated behavior that occurred in the week. The overall goal is to acquire problem-solving skills and translate them into behaviorally appropriate skills and/or to regulate emotions better. The fourth function of DBT is catered more to the treating therapist. Barely and colleagues (1993) found DBT increases clinician satisfaction through the components of the fourth function. To provide support, feedback and continuing training, DBT includes a consultation team that meets once a week for 1 to 2 hours. The consultation team allows for the team to come up with strategies to implement specific clinical challenges. The last function

structures an environment for the patient. The structured environment should not reinforce maladaptive behavior. Instead, the environment should promote progress and personal growth (Chapman, 2006).

Throughout the modules, the therapist must take into consideration the biosocial etiology of BPD as it relates to the manifestations of maladaptive behaviors. The biosocial theory is one of the basic theoretical foundations for DBT. Developed specifically for BPD, the biosocial theory posits that persons with BPD are biologically inclined toward emotional vulnerability (Chapman, 2006). Specifically, people react to low levels of stimuli with a slow return to baseline. Coupled with an aversive environment, the biosocial theory explains the core dysfunction of BPD, emotion dysregulation. While standard DBT employs the modules listed above, there is a growing interest in DBT skills training as a stand-alone treatment (Valentine, Bankoff, Poulin, Reidler & Pantalone, 2014).

DBT skills training encompasses: mindfulness skills, distress tolerance, emotion regulation, and interpersonal effectiveness. These skills are taught through weekly group sessions which include homework assignments to help patients practice skills between sessions with the overall goal of reducing maladaptive behavior and promoting new behavioral, emotional, and thinking patterns (Valentine et al., 2014). Mindfulness skills allow the client to learn to live in the moment and act from the wise mind, the overlap between the reasonable mind and emotional mind. By non-judgmentally observing the current experience, the client is able to objectively problem solve. Distress tolerance teaches how to endure pain skillfully. In this module, the goal is to practice radical acceptance—defined as accepting the situation as it is and to avoid making interpretations—and learn distract activities. Emotion regulation aims to identify and influence emotions strategically in environments that may cause distress.

Interpersonal effectiveness skills help individuals learn to respond effectively to interpersonal conflicts.

Training as an Intervention

Studies examining potential interventions for reducing negative attitudes and increasing positive attitudes toward individuals with BPD are few. Krawitz (2004) assessed the effects of a two-day training workshop on clinician attitudes towards individuals with BPD. In this study, workshop content included BPD diagnosis, etiology, prognosis, identifying an effective treatment system structure and a treatment system culture that promotes cohesion and integration of services. The study included 418 participants who completed a survey at three points in time: pre-workshop, post-workshop and a 6-month follow-up. Professional groups were diverse including nurses (46%), psychologists (14%), social workers (14%), occupational therapists (8%), and doctors (5%). Results showed a positive increase in participants' optimism, enthusiasm, confidence, and willingness to work with people with BPD. Additionally, results from the 6-month follow-up either maintained or showed nonsignificant decrease. While Krawitz (2004) did use a survey and workshop specifically designed for this study, the results should not be overlooked.

Independent treatment programs, such as the Systems Training for Emotional Predictability and Problem Solving (STEPPS), have also been used as an intervention to increase positive attitudes towards patients with BPD (Shanks, Pfhol, Blum & Black, 2011). The STEPPS program is a 20-week group treatment program for outpatients with BPD that combines cognitive-behavioral elements with skills training and psychoeducation (Black, Blum, Pfhol, & St. John, 2004). Shanks and colleagues (2011) hypothesized that clinician education through the STEPPS program can improve attitudes towards individuals with BPD. Indeed, participants were

more likely to endorse feeling competent to care for these patients and less likely to prefer to avoid these patients. While most of the trainings focused on foundational learning, there were studies to look at specific therapeutic orientations and their effects on attitudes.

Previous research has not explored distinctions between therapeutic frameworks and their effects on attitudes towards individuals with BPD (Common-Treloar, 2009a). As a result, Common-Treloar (2009a) set out to examine how cognitive-behavioral and psychoanalytic frameworks compared in changing clinician's attitudes toward self-harm behaviors in BPD. Results showed positive attitudes post intervention for both theoretical orientations. However, at the 6-month follow-up, only the psychoanalytic condition maintained elevated attitudes, albeit with a small effect size. This finding suggests participants who received education on the unconscious processes underlying deliberate self-harm may have developed a greater ability to empathize with the patient. Furthermore, the cognitive-behavioral framework implies a level of consciousness by patients who self-harm thus leading to participants to have difficulty in generating compassion (Common Treloar, 2009a). While negative therapeutic alliances continue, research has maintained that mental health professionals should continue to increase their knowledge regarding BPD (Bodner, Cohen-Fridal, & Iancu, 2011).

Studies investigating the effects of DBT training on attitudinal change toward BPD are limited. Hazelton et al. (2006) examined the effects of a two-day DBT training on nurses' attitudes towards BPD pre-training, 1 month, and 6 months after training. While the training program was based on DBT skills training, the survey was developed specifically for the study and included both quantitative measures exploring attitudes, knowledge, and experience working with BPD and qualitative measures in the form of a focus group pre-and post-training. While the purpose of the Hazelton study was to report on the focus group data, the responses raise

interesting implications. Before training, nursing staff used phrases such as: “They have a way of getting under the skin of other patients... and it is also difficult for all of the staff to stay united in dealing with them.” By using phrases like “dealing with them,” the focus does not seem like creating a therapeutic environment. Additionally, focus group responses showed that staff felt there was no consistent approach for the management of individuals with BPD. As a result, this led to pessimistic attitudes. Post-training, responses showed a shift toward a more optimistic outlook. Specifically, one participant reported: “I now understand more about borderline personality disorder ... I can't help but think now in retrospect that there was a lot of times I probably made things worse, by continuing ... to invalidate them ... you know it doesn't feel so hopeless anymore.” Overall, after completing DBT skills training, nurses were more positive about their attitudes towards individuals with BPD. The nurses were very reflective on their past behaviors incorporating their new knowledge on BPD. Major points from the report include that a clearer understanding of BPD coupled with newly acquired DBT skills led to more empathic responses. Interestingly, attitudes maintained at the 6-month follow up further showing the resiliency of DBT skills learned during training.

Current Study

Overall, training shows promising results for increasing positive attitudes towards individuals with BPD. However, there is very little research on the impact of DBT skills training on attitudes towards individuals with BPD. Furthermore, it is important to gauge knowledge and confidence in practicing DBT and the relation to willingness to work with individuals with BPD. As a result, the current study examined attitudes of mental health professionals pre- and post-DBT skills training and hypothesized that the following changes would occur after DBT Skills training: (1) an increase in participants’ positive attitudes toward individuals with BPD; (2) an

increase in knowledge regarding DBT skills will correlate with an increased willingness to work with individuals with BPD, and (3) increased confidence in practicing DBT skills will correlate with an increased willingness to work with individuals with BPD. While not the focus of the current study, an exploratory endeavor was pursued to examine knowledge of BPD symptomatology among participants.

Method

Participants

Data were collected from a sample of mental health professionals attending a 3-day DBT skills training workshop in Texas. Participants (N=63) were primarily female (94%) and were comprised of psychologists (41%), counselors (27%), social workers (19%), and other related professions (13%). Of the 63 participants, 52 were licensed to work in their respective fields and presented a variety of degrees (e.g., LSW, PhD, PsyD and M.D). The three highest degrees received were an MA/MS (41%), followed by a Ph.D. (12.7%), and an MSW (11.1%). This was a convenience sample consisting of mental health professionals who signed up for a 3-day DBT skills training. All participants took the initial training, participation was voluntary, and no form of deception was used. Participants were free to withdraw from the study at any time and did not receive remuneration for their participation. This study was approved by and conducted in accordance with the policies of CUNY's Institutional Review Board.

Materials

A pre-and post- training survey was adapted from the work of Hazelton and colleagues (2006; see Appendix A & B). The survey assessed knowledge and experience working with individuals with BPD. Questions asked participants for their level of agreement, confidence, and knowledge regarding treating individuals with BPD and practicing DBT on a four- or five-point

Likert-type scale. The following is a sample question from the survey: "Please rate your level of agreement with the following statements related to providing adequate treatment for clients with BPD" with answer choices including but limited to: "I am able to adequately treat my clients with BPD," "BPD-specific training is necessary to adequately treat BPD," and "I have the training necessary to treat BPD." An example of a confidence question includes: "How confident are you in your ability to do the following" with the following potential answer choices: "Identify BPD," "Assessment of BPD," "Ongoing management of BPD," "Awareness of specialist services for BPD" and "Referral to specialist services for BPD."

Additionally, a modified version of the Attitude Assessment Questionnaire (AAQ; Fraser, 2001) was administered for the purposes of this study. The AAQ is comprised of 15 items to measure attitudes towards BPD individuals. Higher scores on items 1, 3 ,4, 5, 6, 7, 8 and 12 indicate greater willingness to work with individuals with BPD. Item 12 (Treating a client with BPD makes me uncomfortable) is the only item that is reversed scored. Likewise, high scores on items 2, 9, 10 11, 13, 14 and 15 indicate greater knowledge on etiology and treatment of BPD. Sample questions include: "I feel fulfilled working with clients with BPD," and "I am comfortable working with BPD clients." The items use a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Originally, developed by McIntosh (1998), it was adapted by removing questions by Fraser (2001). In the current study, it was further adapted by removing one question due to relevance for a total of 15 questions. The measure is the only of its kind (as far as the author is aware of) specifically designed to measure attitudes towards BPD. There was no pilot testing for the revised version of the AAQ used in the current study.

Procedure

To test the impact of training on attitudes, a within-subjects pretest-posttest design was used. A survey, consisting of two parts, was developed: a pretest (Appendix A) and posttest (Appendix B). The pretest included questions about demographics, knowledge and confidence regarding the practice of DBT, and knowledge, confidence, and attitudes towards the assessment and management of BPD. The posttest did not include the demographics questions but was otherwise was the same as the pretest.

Prior to the training, a researcher (other than the primary investigator [PI] and training instructor) recruited by explaining the purpose of the study, answering questions about the study, and obtaining informed consent (Appendix C). Participants were then asked to complete the pretest, which was adapted from Hazelton et al., 2006, and an adapted version of the Attitude Assessment Questionnaire (AAQ; Fraser, 2001).

The 3-day in-person training focused on DBT skills training. First, participants learned about the background of DBT including the theoretical background, research base and noteworthy issues to consider. Next, participants learned about core mindfulness, interpersonal effectiveness skills, emotional regulation skills, and distress tolerance skills. Finally, training touched upon different applications for DBT, such as with adolescent and forensic applications. In addition, throughout training, participants discussed strategies for successful implementation and potential applications of DBT skills to their respective sites.

After three days of DBT training, participants were then given the posttest, followed by a debriefing form (Appendix D), which explained the purpose of the study and provided the contact information of the PI.

Results

Hypothesis 1: Participants' (positive, receptive) attitudes toward individuals with BPD will show an increase from pre- to post-training. A paired sample t-test was conducted to compare total willingness score pre- and post- training. Results showed a significant difference in total willingness to work with individuals with BPD scores increasing between pre-test ($M = 27.10$, $SD = 5.10$) and post-test ($M = 28.31$, $SD = 4.23$); $t(47) = -2.22$, $p = .031$. Cohens effect size value ($d = 0.25$) suggested a small practical significance. Additionally, a paired sample t-test was conducted on each individual willingness item to see which item improved posttest. Results showed significant differences in scores for two willingness items post intervention. Specifically, there was a positive improvement in the following statements: Working with clients with BPD is enjoyable, $t(49) = -2.768$, $p = .008$, and Treating a client with BPD makes me uncomfortable, $t(49) = 2.226$, $p = .031$. These results show an expected positive direction with participants becoming more willing to treat individuals with BPD.

Hypothesis 2: Increased knowledge regarding DBT skills will be associated with increased willingness to work with individuals with BPD. First, a paired sample t-test was used to show increased knowledge regarding DBT skills post-training. Results showed a significant difference in knowledge between pre-test ($M = 2.16$; $SD = .996$) and post-test ($M = 3.51$, $SD = .947$); $t(56) = -8.378$, $p = .000$. Then, a Pearson's r correlation was calculated to measure the relation between knowledge and willingness to treat individuals with BPD using data from the post-test. Results indicate a positive correlation at the 0.05 level between the two variables, $r = .285$, $n = 50$, $p = .045$. Overall, results using data from the post-test show a weak positive correlation between knowledge levels of DBT and willingness to treat individuals with BPD.

Hypothesis 3: Increased confidence related to the practice of DBT skills will be associated with increased willingness to work with individuals with BPD. An additional paired sample t-test was used to show increased confidence regarding DBT skills post-training. Results showed a significant difference in confidence between pre-test (M = 2.28; SD = 1.136) and post-test (M = 2.97, SD = .936); t (57) = -4.368, p = .000. Next, an additional correlation was calculated to measure the relation between confidence in practicing DBT and willingness to treat individuals with BPD using data from the post-test. Results did not indicate a significant correlation between the two variables, r = .244, n = 52, p = .081.

Exploratory analyses: A series of chi-square tests were used to determine whether participants' knowledge of BPD symptomatology changed between pre- and post-training. Results indicated that there were significant differences post intervention on 4 items. Differences were seen in endorsement in the following symptomatology post intervention: Anti-social behavior, $\chi 2 = 14.785$, p = .000; Difficulty expressing anger, $\chi 2 = 10.717$, p = .001; Presence of self-damaging acts, $\chi 2 = 5.999$, p = .014; and Extensive psychotic episodes, $\chi 2 = 5.183$, p = .023. Specifically, proportions of participants who endorsed antisocial behavior as a symptom increased by 16.8% post intervention (42.4% to 59.3%); those who endorsed difficulty expressing anger as a symptom increased 13.6% (59.3% to 72.9%); those who endorsed the presence of self-damaging acts as a symptom increased by 5% (81.4% to 86.4%); and those who endorsed extensive psychotic episodes as a symptom increased by 6.7% increase from pre- to post-training (10.2% to 16.9%).

Discussion

The purpose of the current study was to examine the impact of a DBT skills training on mental health professional's attitudes towards individuals with BPD. Indeed, many clinicians

report burnout and the subsequent hesitation to provide treatment to this population (Chapman, 2006). These negative attitudes can potentially negatively impact different aspects of treatment including treatment outcome (Linehan, 1991). The current study measured attitudes towards BPD individuals using a pre/post survey after a three-day DBT skills training. Prior research has shown that training can increase positive attitudes towards individuals with BPD using foundational workshops (McIntosh, 1998; Hazelton et al., 2006), a STEPPS workshop (Shanks et al., 2011) and cognitive-behavioral and psychoanalytic approaches (Common Treloar, 2009). In contrast to previous studies, the current study also attempted to explore the relation between knowledge and confidence in practicing DBT, and attitudes towards individuals with BPD. Additionally, the current study aimed to explore knowledge of BPD symptomatology among participants.

The results of the current study suggest that exposure to information about new and effective approaches, specifically DBT skills, may improve the attitudes of clinicians toward individuals with BPD. These results were seen in the positive change on the AAQ willingness scale post-intervention. However, Cohen's *d* showed a small practical significance ($d = .25$). While the significant results did not yield strong practical significance, the results lend promising support for future follow-up research. Past research has used follow-up studies at the 3-and 6-month period to measure whether significance is maintained over time (see Commons-Treloar, 2009a, Hazelton et al., 2011). To show the importance of using training to improve knowledge and attitudes of mental health professionals who work with individuals with BPD, future research is encouraged.

While not all of individual items were statistically significant post-intervention, it is important to highlight the items that showed significance. Participants, post intervention, were

more likely to agree "working with BPD is enjoyable" and less likely to agree "treating a client with BPD makes me uncomfortable." This change on two key items is hopeful. Past research has shown that an effective therapeutic alliance is predictive of positive treatment outcomes (Rogers, 1957) with DBT being an example of a treatment approach that emphasizes the therapeutic alliance (Lejuez & Hopko, 2006). As a result, the current results lend some support to DBT skills training potentially strengthening therapeutic alliances between the clinician and individual with BPD. Additionally, there were two items approaching significance. Specifically, "I feel fulfilled working with BPD patients" and "If given a choice, I would accept BPD clients with BPD in my practice." With a larger sample, it is hypothesized that these two items can reach significance. If significance is reached, then these two items can provide us with a strong rationale for the continued study on the efficacy of the skills training on attitudes towards individuals with BPD. Overall, a possible reason for the increase in positive attitudes can be the skills taught in the workshop to work through client crises and other highly stressful interactions. Practicing core DBT skills training has been shown to maintain clinician motivation and hope (Dimeff & Linehan, 2001).

The current study also demonstrated a significant increase in both knowledge and willingness to treat individuals with BPD from pre- to post-training. While the statistical relationship was weak, these results are promising as clinicians who have increased knowledge in DBT skills training may be more willing to treat individuals with BPD. Lack of knowledge in DBT can lead to rigid treatment plans that can adversely affect the individual (Miller, Spengler, & Spengler, 2015). However, the results of the current study did not show a significant positive correlation between confidence and willingness to treat BPD. DBT encompasses many theories (i.e., biosocial theory, dialectic dilemmas) with DBT skills training offering various useful

strategies. As a result, it could be the case that participants might need time to digest the information they learned and time to practice the skills learned. Regardless, future research should incorporate confidence and knowledge scales.

Finally, the lack of a significant relation between confidence and willingness to treat BPD might stem from the long-standing belief that BPD has a poor prognosis (Fraser, 2001). The specific items used in the current study looked at willingness to treat individuals with BPD and not the belief that BPD can be treated. As a result, the items might have captured the uncertainty that participants may have about the treatability of BPD. While not the focus of this study, future research should explore the degree of therapeutic pessimism surrounding the treatability of individuals with BPD.

The exploratory research question yielded surprising results. More than half of participants endorsed anti-social behavior as a symptom of BPD post-training. While not an overwhelming percentage of participants endorsed psychotic episodes as a symptom of BPD, it nonetheless increased in endorsement by about 10% post intervention. However, these results did show that an overwhelming majority of participants endorsing correct BPD symptomatology. In the current study, it is difficult to know the extent of the consequences for endorsing incorrect symptoms. However, there are serious implications within a clinical setting for incorrectly endorsing symptoms including the potential for misdiagnosis and inadequate treatment plans including unnecessary medication.

Limitations and Future Research

While the current study did demonstrate some significant findings, there were several limitations. Specifically, the current study did not have a control group so it was not possible to examine the issue of causality. Future research could address this issue by using multiple control

groups including different training modules as used in previous studies (see Commons-Treloar, 2009a). The survey used in the current study was a modified version of the one used with nurses by Hazleton and colleagues (2011). The survey had not been used with mental health professionals and was not pilot tested beforehand. As a result, there is insufficient reliability data. Additionally, because the survey was self-report, social desirability might have been a factor for participants trying to present themselves in a good light. Future research should address this by using a more validated measure for attitudes toward BPD. Lastly, there is the possibility of a test/retest effect due to the repeated administration of the pre/post survey. Other limitations are related to the sample. Participants chose to attend this training and may have been more inclined to change. Finally, a majority of the current sample's highest degree held was a M.A/M.S. Future research is encouraged to recruit a varied sample of educational background to further extend the significance of this study.

Conclusion

Participants who attended this training were provided with new strategies and tools through DBT skills training. As a result, participants may have been more hopeful about the treatment and management of individuals with BPD. These results show that access to clinical education can potentially benefit those who come into contact with patients with BPD. Consistent with previous research, the positive change shown in the current study can potentially allow clinicians to be more open to treating BPD individuals and more involved in the therapeutic process thus potentially increasing positive treatment outcomes. However, future research is needed to determine whether attitudes remain positive over time as a result of the DBT skills training.

The results of this study suggest that training can improve attitudes among a wide range of mental health professionals. Specifically, the unique skills taught in DBT provide clinicians with the tools they need to not only treat and manage BPD but also to change attitudes towards individuals with BPD. However, more research needs to be conducted in order to extend the significance of a DBT skills training to diverse educational backgrounds and applied settings. In addition, results from the current study demonstrate the profound impact that clinicians' attitudes might have on treatment. Clinical training should focus on attitudes in addition to implementing and memorizing therapy techniques. Potential strategies to curb negative attitudes may include strategies from DBT skills training. This recommendation is even more imperative for clinicians, both new and veteran, who work with individuals with BPD.

Historically, attitudes towards BPD have been negative (Fraser, 2001; Black et al., 2011; Bodner et al., 2011). This might be due to lack of knowledge surrounding BPD or the personal toll that treating an individual with BPD can take. Results from the current study can be used to underscore the need for continued training. Training should continue across the career span and not be limited to a specific time frame. By having well-trained clinicians in the field, with a wide variety of strategies, best practices can be further promoted for the well-being of the individual being treated and the community at large.

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Appendix A

Demographic Survey

Age: _____

Gender:
Male _____ Female _____

Race and/or Ethnicity: _____

Country of Residence: _____
If United States, which state?: _____

Please indicate your profession:
_____ Psychology
_____ Psychiatry
_____ Social Work
_____ Other (please specify) _____

Degree(s) and year(s) received: _____

Indicate the specialty track of your highest degree:
____ Clinical
____ Neuropsychology
____ Industrial/Organizational
____ Counseling
____ Geriatric
____ Health/Rehabilitation
____ Forensic
____ Other (please specify) _____

Are you currently a student?
_____ yes _____ no
If yes, what degree are you pursuing?
_____

If you are a student, how many years have you completed in your current program? ____

Are you licensed to practice psychology? Yes____ No_____

Year of first licensure in psychology: _____

Number of years post-doctoral practicing: _____

State(s) or Country in which you practice: _____

Please indicate the number of years of experience in your current profession: _____

What percentage of your time is devoted to: (total should equal 100%)
____ Therapeutic intervention
____ Assessment
____ Management/administrative duties
____ Other – Please specify _____

Primary Employment setting (please choose one):
____ Private Practice
____ Outpatient Mental Health Clinic
____ University (faculty)
____ Medical
____ University (student)
____ Private Psychiatric Hospital
____ State Psychiatric Hospital (non-forensic)
____ Research (non-university)
____ VA Hospital or Clinic
____ Prison or other Correctional Setting
____ Forensic Psychiatric Hospital
____ Community Service Agency
____ Other (please specify) _____

Clinical Experience Survey

1. Have you ever received specific training on Dialectical Behavioral Therapy (DBT)?

_____ No
_____ Yes - Please provide the approximate dates and a description of the training:
_____
_____
_____

2. When was your most recent DBT training?

____ In the last two years
____ 2-5 years ago
____ More than 5 years ago

3. How knowledgeable are you in DBT?

Not knowledgeable at all	Somewhat knowledgeable	Not sure	Knowledgeable	Very knowledgeable

4. How confident are you in practicing DBT?

Not confident at all	Somewhat confident	Not sure	Confident	Very confident

5. How confident are you in utilizing the following DBT skills for the treatment and management of individuals with BPD:

	Not at all confident	**Somewhat confident**	**Not sure**	**Confident**	**Very Confident**
Mindfulness	1	2	3	4	5
Distress tolerance	1	2	3	4	5
Interpersonal effectiveness	1	2	3	4	5
Emotion regulation	1	2	3	4	5

6. Have you ever received specific training on the care of people with a diagnosis of Borderline Personality Disorder (BPD)?

_____ No
_____ Yes - Please provide the approximate dates and a description of the training:
_____
_____
_____

7. Approximately how many clients with BPD did you treat in 2016? _____

8. Approximately how many clients with BPD have you treated throughout your career? _____

9. How knowledgeable do you consider yourself in each of the following areas:

	Not at all	**Somewhat**	**Moderately**	**Very**
The identification of BPD	1	2	3	4
The assessment of BPD	1	2	3	4

The management of BPD	1	2	3	4

10. How confident are you in your ability to do the following:

	Not at all	Somewhat	Moderately	Very
Identify BPD	1	2	3	4
Assessment of BPD	1	2	3	4
Ongoing management of BPD	1	2	3	4
Awareness of specialist services for BPD	1	2	3	4
Referral to specialist services for BPD	1	2	3	4

11. Please rate your level of agreement with the following statements related to providing adequate treatment for clients with BPD:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I am able to adequately treat my clients with BPD	1	2	3	4	5
BPD-specific training is necessary to adequately treat BPD	1	2	3	4	5
I have the training necessary to treat BPD	1	2	3	4	5
I have the experience necessary to treat BPD	1	2	3	4	5
There is a shortage of services for clients with BPD	1	2	3	4	5
Clients with BPD require specialized care	1	2	3	4	5
Clients with BPD are difficult to treat	1	2	3	4	5

12. Check all of the following criteria which you believe to be indicators for a diagnosis of Borderline Personality Disorder.

___ Instability in interpersonal behavior, mood, and self-image
___ Hypervigilance
___ Anti-social behavior (truancy, delinquency, vandalism, and initiation of fights)
___ Interference with social and occupational functioning
___ Difficulty expressing anger

___ Paranoid delusions
___ Unexplained weight loss
___ Presence of self-damaging acts
___ Extensive psychotic episodes
___ Manipulation
___ Use of primitive defenses (splitting and projective identification)
___ Insomnia

13. How important are the following resources when you are working with clients with a diagnosis of BPD?

	Not important	**Slightly Important**	**Moderately Important**	**Important**	**Very Important**
Information for distribution to clients	**1**	**2**	**3**	**4**	**5**
Information on where to refer clients	**1**	**2**	**3**	**4**	**5**
Regular in-service trainings about issues related to BPD	**1**	**2**	**3**	**4**	**5**
Skills training workshop	**1**	**2**	**3**	**4**	**5**
Increased education during undergraduate education/training	**1**	**2**	**3**	**4**	**5**
A specialist service for those clients who have a BPD	**1**	**2**	**3**	**4**	**5**
Standard protocols for management of BPD	**1**	**2**	**3**	**4**	**5**

_____ Other – please specify

_____
_____

Please read each statement below. Using the scale, circle the number that best represents your response.

	Strongly Disagree	**Disagree**	**Not sure**	**Agree**	**Strongly Agree**
1. I believe treating clients with BPD is rewarding.	1	2	3	4	5
2. Lying is a common behavior of clients with BPD	1	2	3	4	5
3. I prefer to work with clients with BPD over those with most other disorders.	1	2	3	4	5
4. I feel fulfilled by working with clients with BPD.	1	2	3	4	5
5. Working with clients with BPD is enjoyable.	1	2	3	4	5
6. I am comfortable working with clients with BPD.	1	2	3	4	5
7. I find working with clients with BPD a welcome challenge.	1	2	3	4	5
8. If given a choice, I would accept clients with BPD in my practice.	1	2	3	4	5
9. One of the primary goals in treating BPD clients is to address suicidal and para-suicidal behavior	1	2	3	4	5
10. Clients with BPD usually have a poor prognosis.	1	2	3	4	5
11. The etiology of BPD is primarily bio-social.	1	2	3	4	5
12. Treating a client with BPD makes me uncomfortable	1	2	3	4	5
13. BPD is a treatable disorder.	1	2	3	4	5
14. Clients with BPD can live functional lives.	1	2	3	4	5
15. Clients with BPD are riskier to treat than other clients.	1	2	3	4	5

Appendix B

Clinical Experience Post-Training Survey

1. How knowledgeable are you in DBT?

Not knowledgeable at all	Somewhat knowledgeable	Not sure	Knowledgeable	Very knowledgeable

2. How confident are you in practicing DBT?

Not confident at all	Somewhat confident	Not sure	Confident	Very confident

3. How confident are you in utilizing the following DBT skills for the treatment and management of individuals with BPD:

	Not at all confident	**Somewhat confident**	**Not sure**	**Confident**	**Very Confident**
Mindfulness	1	2	3	4	5
Distress tolerance	1	2	3	4	5
Interpersonal effectiveness	1	2	3	4	5
Emotion regulation	1	2	3	4	5

4. How knowledgeable do you consider yourself in each of the following areas:

	Not at all	**Somewhat**	**Moderately**	**Very**
The identification of BPD	1	2	3	4
The assessment of BPD	1	2	3	4
The management of BPD	1	2	3	4

5. How confident are you in your ability to do the following:

	Not at all	Somewhat	Moderately	Very
Identify BPD	1	2	3	4
Assessment of BPD	1	2	3	4
Ongoing management of BPD	1	2	3	4
Awareness of specialist services for BPD	1	2	3	4
Referral to specialist services for BPD	1	2	3	4

6. Please rate your level of agreement with the following statements related to providing adequate treatment for clients with BPD:

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I am able to adequately treat my clients with BPD	1	2	3	4	5
BPD-specific training is necessary to adequately treat BPD	1	2	3	4	5
I have the training necessary to treat BPD	1	2	3	4	5
I have the experience necessary to treat BPD	1	2	3	4	5
There is a shortage of services for clients with BPD	1	2	3	4	5
Clients with BPD require specialized care	1	2	3	4	5
Clients with BPD are difficult to treat	1	2	3	4	5

7. Check all of the following criteria which you believe to be indicators for a diagnosis of Borderline Personality Disorder.

___ Instability in interpersonal behavior, mood, and self-image
___ Hypervigilance
___ Anti-social behavior (truancy, delinquency, vandalism, and initiation of fights)
___ Interference with social and occupational functioning
___ Difficulty expressing anger
___ Paranoid delusions
___ Unexplained weight loss

___ Presence of self-damaging acts
___ Extensive psychotic episodes
___ Manipulation
___ Use of primitive defenses (splitting and projective identification)
___ Insomnia

8. How important are the following resources when you are working with clients with a diagnosis of BPD?

	Not important	**Slightly Important**	**Moderately Important**	**Important**	**Very Important**
Information for distribution to clients	**1**	**2**	**3**	**4**	**5**
Information on where to refer clients	**1**	**2**	**3**	**4**	**5**
Regular in-service trainings about issues related to BPD	**1**	**2**	**3**	**4**	**5**
Skills training workshop	**1**	**2**	**3**	**4**	**5**
Increased education during undergraduate education/training	**1**	**2**	**3**	**4**	**5**
A specialist service for those clients who have a BPD	**1**	**2**	**3**	**4**	**5**
Standard protocols for management of BPD	**1**	**2**	**3**	**4**	**5**

_____ Other – please specify

_____
_____
_____
_____

9. To what extent is the service in which you work able to provide support and treatment for clients diagnosed with borderline personality disorder?

_____
_____
_____
_____
_____

10. How can DBT compliment the services indicated in question 9?

_____
_____
_____
_____
_____

11. Are there any other comments you'd like to make about treating clients with BPD?

_____
_____
_____
_____
_____

Please read each statement below. Using the scale, circle the number that best represents your response.

	Strongly Disagree	**Disagree**	**Not sure**	**Agree**	**Strongly Agree**
1. I believe treating clients with BPD is rewarding.	1	2	3	4	5
2. Lying is a common behavior of clients with BPD	1	2	3	4	5
3. I prefer to work with clients with BPD over those with most other disorders.	1	2	3	4	5
4. I feel fulfilled by working with clients with BPD.	1	2	3	4	5
5. Working with clients with BPD is enjoyable.	1	2	3	4	5
6. I am comfortable working with clients with BPD.	1	2	3	4	5

7. I find working with clients with BPD a welcome challenge.	1	2	3	4	5
8. If given a choice, I would accept clients with BPD in my practice.	1	2	3	4	5
9. One of the primary goals in treating BPD clients is to address suicidal and para-suicidal behavior	1	2	3	4	5
10. Clients with BPD usually have a poor prognosis.	1	2	3	4	5
11. The etiology of BPD is primarily bio-social.	1	2	3	4	5
12. Treating a client with BPD makes me uncomfortable	1	2	3	4	5
13. BPD is a treatable disorder.	1	2	3	4	5
14. Clients with BPD can live functional lives.	1	2	3	4	5
15. Clients with BPD are riskier to treat than other clients.	1	2	3	4	5

Appendix C

CITY UNIVERSITY OF NEW YORK
John Jay College of Criminal Justice

Department of Psychology

CONSENT TO PARTICPATE IN A RESEARCH PROJECT

Project Title: The Impact of DBT Skills Training on Attitudes, Knowledge and Experience working with Individuals with Borderline Personality Disorder

Principal Investigator: Kenny Gonzalez
Graduate Student
John Jay College of Criminal Justice
524 West 59th Street 10.65.00 NB
New York, NY 10019
Phone: (212) 484-1195

Faculty Advisor: Dr. Patricia Zapf
Professor
John Jay College of Criminal Justice
524 West 59th Street 10.65.34 NB
New York, NY 10019
Phone: (212) 866-0608

Introduction/Purpose: You are invited to participate in a research study. The study is conducted under the direction of Kenny Gonzalez, Dr. Patricia Zapf and John Jay College of Criminal Justice. The purpose of this research study is to examine mental health professional's opinions about working with individuals with BPD in a clinical setting.

Procedures: If you agree to be in this study, we would ask you to complete two questionnaires, one prior to and one after the DBT Skills Training, as honestly as possible and return them to the research coordinator. The time commitment is expected to be

approximately 30 minutes. Additionally, some participants will be asked to complete a follow-up survey in about 6 months.

Possible Discomforts and Risks: The foreseeable risks of participation in this study are minimal. In order to minimize any potential discomfort, you will be provided with a debriefing form at the end of the questionnaire.

Benefits: While there are no direct benefits for participating in this study, the knowledge and opinions that you share are a valuable part for advancing research.

Voluntary Participation: Your participation in this study is voluntary, and you may decide not to participate without prejudice, penalty, or loss of benefits to which you are otherwise entitled. If you decide to leave the study, please simply turn in the survey questionnaire without completing it. Regardless of participation of this study, you will still participate in the current training.

Confidentiality: The collected data will be accessible to the principal investigator, Kenny Gonzalez and the faculty advisor, Dr. Patricia Zapf. The researcher will protect your confidentiality by removing identifiable information from collected data by labeling data with a code number. The hardcopies of the consent form and collected data will be stored separately. Hardcopies of the consent form will be kept under lock and key in Dr. Zapf's John Jay office and the collected data will be stored in a password protected hard drive in Dr. Zapf's John Jay office as well. The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

Contact Questions/Persons: If you have any questions about the research now or in the future, you should contact the Principal Investigator, Kenny Gonzalez, kenny.gonzalez1@jjay.cuny.edu. If you have any questions about your rights as a research participant or if you would like to talk to someone other than the researchers, you can contact CUNY Research Compliance Administrator at 646-664-8918.

Statement of Consent:

"I have read the above description of this research and I understand it. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions that I may have will also be answered by the principal investigator of the research study. I voluntary agree to participate in this study.

Name (please print) _____
Signature_____

Date _____

Name (obtaining consent) _____
Signature_____

Date _____

Appendix D

CITY UNIVERSITY OF NEW YORK
John Jay College of Criminal Justice

Department of Psychology

DEBRIEFING FORM

Project Title: The Impact of DBT Skills Training on Attitudes, Knowledge and Experience working with Individuals with Borderline Personality Disorder

Principal Investigator: Kenny Gonzalez
Graduate Student
John Jay College of Criminal Justice
524 West 59th Street 10.65.00 NB
New York, NY 10019
Phone: (212) 484-1195

Faculty Advisor: Dr. Patricia Zapf
Professor
John Jay College of Criminal Justice
524 West 59th Street 10.65.34 NB
New York, NY 10019
Phone: (212)866-0608

The study you participated in was designed to explore the impact of skills training in dialectical behavior therapy (DBT) skills on attitudes, knowledge and experience working with individuals with borderline personality disorder (BPD).

Confidentiality: The collected data will be accessible to the principal investigator, Kenny Gonzalez, the faculty advisor, Dr. Patricia Zapf, and the Institutional Review Board members. The researcher will protect your confidentiality by removing identifiable information by labeling data with an ID number. The collected data will be stored in a password protected hard drive in Dr. Zapf's office.

Contact Questions/Persons: If you have any questions about the research, now or in the future, you should contact the Principal Investigator, Kenny Gonzalez, kenny.gonzalez1@jjay.cuny.edu or the faculty advisor at the contact information above. If you have any questions about your rights as a research participant or if you would like to talk to someone other than the researchers, you can contact CUNY Research Compliance Administrator at 646-664-8918.

Thank you for your participation in this study. The knowledge and opinions that you shared are a valuable part of our research endeavor.