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## Building a Life Worth Living During a Pandemic and Beyond: Adaptations of Comprehensive DBT to COVID-19

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*Our team at the Jefferson Center City Clinic for Behavioral Medicine has recently been challenged to find a synthesis between the need to adapt to circumstances associated with the COVID-19 pandemic, while at the same time retaining the spirit and essential components of comprehensive DBT. This fine balance between unwavering centeredness and compassionate flexibility is central to DBT (Linehan, 1993), and has proven essential during these times of uncertainty. This short article highlights challenges and innovations faced by our DBT Team, Skills Group, individual DBT sessions, phone coaching, and also our community at large, as we strive to help our patients and team members build a life worth living during and following a pandemic.*

**D**IALECTICAL BEHAVIOR THERAPY (DBT; Linehan, 1993) is an empirically supported treatment for individuals presenting with a variety of problems (i.e., emotion dysregulation, substance use, suicidality), with a mission of building a life worth living. Comprehensive DBT comprises four components: weekly skills group (2 to 2.5 hours long, with modules consisting of Mindfulness, Emotion Regulation, Interpersonal Effectiveness, and Distress Tolerance), weekly individual therapy, 24/7 in vivo phone coaching, consultation team (attended by all DBT therapists). Despite being an intensive treatment, DBT is associated with reduced health care costs, due in large part to reduced hospitalizations (Amner, 2012; Meyers et al., 2014; Wagner et al., 2014). During the COVID-19 pandemic, avoiding utilization of scarce resources and exposure associated with Emergency Room visits and psychiatric hospitalization is of paramount importance.

Jefferson Center City Clinic for Behavioral Medicine provides a wide array of outpatient mental health services for patients with a chronic health condition and concurrent psychiatric concern. Housed in urban Philadelphia, we are a designated evidence-based program, accredited by the Evidence-Based Practice and Innovation Center (EPIC), a Philadelphia organization

operating under the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) with the mission of improving access for low-income patients needing evidence-based practices. As such, our patient population comprises nearly exclusively patients who receive government assistance.

Our full model (comprehensive) DBT program serves patients with a wide variety of presenting problems, including borderline personality disorder, chronic suicidality, nonsuicidal self-injury, opioid addiction, other substance use disorders, binge eating, problematic rage behaviors, and chronic posttraumatic stress disorder. By word of mouth and patient testimonials, our clinic has also become known throughout Philadelphia as a place where trans/nonbinary/gender-expansive patients can receive competent and caring treatment. As a result, our DBT program currently comprises about 40% trans/nonbinary/gender-expansive participants. In addition, the vast majority (about 85%) of the patients in our DBT program have a concurrent chronic health condition such as HIV, cancer, narcolepsy, traumatic brain injury, and chronic pain, including fibromyalgia.

The author and clinic director, a DBT-Linehan Board of Certification Certified Clinician, is extensively trained in DBT and has been practicing this treatment since 2002. Adaptation of DBT for patients with concurrent chronic health concerns and for trans/nonbinary/gender-expansive patients has been the focus of the author's clinical work to date. Ours is also a large training clinic, with 7 practicum students (master-

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level clinicians working toward their doctoral degrees in clinical psychology), access to Jefferson Psychiatry Residents, and consultation with primary care and specialist team providers.

### **Adapting DBT to Telehealth for COVID-19**

Given the nature of our patient population, the majority of whom are immunocompromised and living with chronic illnesses such as HIV, we preemptively sought to eliminate exposure risk associated with coming in to clinic for in-person treatment during COVID-19. Therefore, we moved our whole clinic to telehealth using Zoom, 2 weeks prior to the city of Philadelphia “shutting down” and enforcing social distancing regulations. This early adoption of telehealth allowed individual therapists time to orient their patients to features of Zoom, and for our team to work out associated pitfalls (e.g., one patient didn’t have access to a smartphone and was able to borrow a tablet from a family member; several patients initially weren’t comfortable with the video feature, although were able to practice exposure to this in individual therapy).

#### **DBT Skills Group**

Once social distancing rules were implemented in Philadelphia, 2 weeks later, all of our patients had access to and familiarity with Zoom. Our first peripandemic DBT Skills Group (held on a Monday, as usual) comprised nine participants, about three more than our average group attendance. Without transportation-related obstacles, our group had its best turn-out ever. We taught the ABC PLEASE skills, in particular the PLEASE component to reduce vulnerability to emotion mind. PLEASE is a DBT acronym to capture skills for taking care of your mind by taking care of your body. PLEASE stands for treating Physical illness, balancing Eating, avoiding mood-Altering substances, balancing Sleep, and getting Exercise. *We chose to emphasize these skills* as lack of sleep is associated with decreased immunity (Besedovsky et al., 2012) and establishing a consistent routine regarding eating, sleeping, exercise, taking medications as prescribed, treating physical illness, and avoiding mood-altering substances seemed particularly relevant during this time of transition.

Next, given that the pandemic represents a crisis for all of us, our group leaders flexibly adapted and switched from our prior module (Emotion Regulation, which we had just begun prior to the pandemic) to Distress Tolerance, in order to best meet the needs of the group as we all attempted to get through a crisis without making things worse. Patients found the ACCEPTS

skills to be particularly effective. ACCEPTS is a DBT acronym to capture seven sets of distracting skills: Activities, Contributing (to someone else’s well-being), Comparisons (to refocus attention away from oneself to others), Emotions (generating different emotions to distract from the current situation), Pushing away (leaving a painful situation physically and/or mentally blocking it out of one’s mind), Thoughts (fill short-term memory with other thoughts so as not to reactivate the painful emotion), and Sensations (intense sensations can focus attention away from emotional distress—ice, spicy tastes, loud music are examples of this).

In addition, we taught distress tolerance IMPROVE skills—another DBT acronym to help us remember skills designed to make the present moment easier to tolerate by making it more positive. IMPROVE stands for Imagery (e.g., visualizing a safe space), creating Meaning from one’s suffering, Prayer (to a higher power or to one’s wise mind), Relaxing actions, One thing in the moment (keeping the focus on just this moment), taking a Vacation (a brief, planned break from adulthood), and Encouragement (positive self-talk). Participants reported, both in the skills group and to their individual therapists, that this set of skills was particularly timely and effective during the initial phase of the COVID-19 pandemic.

Finally, we taught distress tolerance skills of Radical Acceptance (whole-hearted acceptance of the current situation, including the pain involved) and Willingness (doing what works). Given that the pandemic was something outside of our control, these skills were very well-received. For weeks to come, patients reported during home practice review that they had been using both Radical Acceptance and Willingness in order to adjust to the reality of COVID-19.

Dialectical abstinence skills also proved relevant, given increased risks for addictive behaviors during idle time quarantined at home. These skills focus on whole-heartedly engaging in abstinence from one’s addictive behavior (e.g., substance use, excessive spending, gambling) and, at the same time, creating a harm-reduction plan in the event a lapse occurs. This is another skill which, months later, patients mention during home practice review both using and benefiting from. We have also witnessed an instance when a more senior patient mentioned using this skill, a newer member asked for clarification, and the more senior patient was able to explain the concept of dialectical abstinence in a way that many group members voiced finding useful.

Given much greater than usual attendance rate and enthusiasm for the material, we offered a second weekly skills group, to be held on Fridays for 1 hour

only. This Supplemental Skills Group is optional, not counting as a “miss” toward the “4-miss rule” of DBT (more on this later). Similar to our regular DBT Skills Group, the Supplemental group comprises a leader and a co-leader, includes a mindfulness practice, and focuses entirely on skills, including review of prior DBT skills and teaching of new skills each group session.

The Supplemental Skills Group was intended to focus more on COVID-19-related adaptations. Topics included self-management: making a self-soothe basket in one’s home, and setting up for success during telehealth sessions by sitting at a desk preferably (or on the floor using the bed as a writing surface). These sessions were created in response to several patients lying in bed, seeming less engaged or sleepy, or becoming more dysregulated than usual during skills group. Supplemental Skills Group sessions also comprised a deeper dive into some DBT principles and skills that we sometimes do not have time to cover comprehensively during the 6–8 weeks that we spend on each major module. Topics included apparently irrelevant behaviors, dialectical dilemmas (aka secondary targets), coping ahead for the end of the pandemic, self-validation, and a weekly overall review of what skills patients and leaders tried that week: what worked and what didn’t. Despite optional attendance and scheduling conflicts, the Supplemental Skills Group is attended by an average of six patients weekly.

Our use of Zoom telehealth technology presented various challenges and also innovations, particularly during DBT Skills Group. Aside from predictable hiccups regarding learning how to use the camera, unmuting before speaking, ensuring that lighting is sufficient for others to see one’s face, sharing screens when teaching from handouts and using the whiteboard feature, our group encountered some challenges that may be unique to our specific patient population.

Many of our patients, as explained by the biosocial theory of borderline personality disorder (Linehan, 1993), experience heightened sensitivity to stimuli, often accompanied by sensory processing difficulties. The Zoom webcam environment can be particularly overstimulating, and since the goal of Skills Group is the teaching and learning of new skills, we offer the following suggestions to optimize learning in this environment. The group leaders can disable the chime/alert sound that will otherwise sound when someone joins the group. Also, handouts can be posted directly into the chat, allowing easy downloading and access by all group members. Group members can use the “gallery view” option so that all members and leaders are visible at once, rather than the default “speaker view” which

will enlarge the image of whoever is speaking, resulting in frequent screen changes. In addition, group members can choose to “pin their video” to the group leader while teaching is occurring. This enables the leader’s face to be enlarged, allowing less distraction during teaching.

As mentioned earlier, a significant proportion of our current DBT program comprises trans/nonbinary/gender-expansive patients. Associated body/face/voice-related gender dysphoria has been heightened due to the Zoom format, and targeting these issues in individual DBT has allowed us to enhance our patients’ learning experience while in group. For example, many of our patients have noted that seeing their face/body on camera is very distracting and induces shame and body dysphoria. While this is certainly a great target to be addressed in individual DBT, the goal of skills group is to learn skills, so we have encouraged patients to turn off their self-view, eliminating this distraction while allowing the rest of the group to see them. We also experienced a Zoom glitch whereby a patient’s voice echoed repeatedly for a few moments, until the co-leader was able to mute this patient. This caused a major increase in gender dysphoria for the patient who, while the co-leader was giving her in-session skills coaching to help her remain present in group, reported “I sound like a man . . . I hate myself.” This shame reaction is a highly relevant target to be addressed in individual DBT, although poses a major obstacle to learning skills during skills group.

Another obstacle that is likely common across all forms of telehealth, although may occur more frequently when working with DBT patients, who are often high on impulsivity, is the ease with which a patient can click a button and disconnect from the session. This challenge was met by the same DBT principles as would apply if a patient were to leave group in person: the co-leader tries to reengage them and encourage them to rejoin the group (this can occur via text, email, phone), and, if this fails, then the co-leader engages the patient’s individual DBT therapist in order to manage the patient’s behavior, mirroring what would happen in person.

At the same time, the Zoom telehealth format afforded our DBT Skills Group some great innovations. First, observers (other DBT practicum student therapists) can easily observe group sessions with their video off and muted. Observers are helpful to group leaders, as they may notice certain patterns of behavior during group that the co-leaders may miss (this is done behind a one-way mirror during in-person groups). During a break, the leader can check in with the observers so that the leader can then adapt to enhance learning within the group. Similar to in-person groups, the lea-

der can enter a breakout room in Zoom to receive observer feedback. Zoom observers can also turn their videos on and unmute in order to greet patients via Zoom at the end of the group, similarly to how they would enter the group room after an in-person DBT group. Also, the chat feature in Zoom has allowed many patients who tend to be more reserved or shyer to participate by typing their comments. This participation effort can be used to drag out new behavior when the leaders read a patient's comment aloud and then encourage the patient to elaborate on their comments verbally. For example, participants will often write "Same" in the group chat, to communicate a shared experience or understanding as the participant who is speaking. The leaders can then reference this comment, asking participants to elaborate on their shared experience.

Coaching while in skills group is also easily accessible via the chat feature. Patients are encouraged to private message the co-leader for coaching when needed. Coaching is focused on using skills in the moment in order to regulate emotions so that new learning can occur. The co-leader can also private message patients who are notably dysregulated or possibly dissociating, to check in and offer coaching, just as they would during in-person skills groups. For example, one of our patients (a transwoman in her 30s) has a self-reported tendency to dissociate in response to trauma cues. While serving as the co-leader, I observed what I thought could be this dissociative process (her eyes appeared glassed over and her face was suddenly expressionless). I private messaged her ("Hey lady, you with us??? Would a coach be helpful?") and the flashing chat alert on her screen got her attention, following which she replied "I fuzzed out, yeah, a coach would be good." I then instructed her to get an ice pack from her freezer and hold it for a few minutes, feel her feet on the floor, and focus on attention on the skill being taught. She was able to do so and reengage with the group.

On another occasion, a newer patient private-messaged my co-leader to inform that she was feeling very dysregulated by what she perceived to be a trivial home practice example. She wrote, "I hate this group, this girl's problems are stupid, she needs to get over herself." The co-leader asked, "Are you open to coaching?" and the patient responded, "I guess." The co-leader was able to offer some typical DBT suggestions, such as practicing willing hands (palms resting faceup as a way to radically accept with the body), trying to adopt a nonjudgmental stance, recalling our assumptions that everyone is doing the best they can) as well as some Zoom-specific suggestions including pinning her video to the group leader, or to the co-leader.

The patient was able to reengage and share her own home practice example.

Another unexpected by-product of virtual DBT Skills Group sessions has been increased group bonding and camaraderie. While our skills group typically operates like a classroom, with some time for chatting during the break and occasional friendships forming, our current group, which comprises a couple of members who joined immediately prior to the pandemic so have met in person only once or twice, has become much closer than usual. Perhaps this is due to meeting twice-weekly, or to enduring a pandemic together. Patients spontaneously requested virtual "tours" of each other's living spaces during the break, and greatly enjoy "meeting" each other's pets. Several patients also reported feeling closer to the student observers, due to observer participation in weekly patient-led group chat prompts (e.g., "What song is motivating you today?")

Patients have also enjoyed Zoom's ability to choose a screen name. Patients have reported enjoying putting their "most genuine name" (often a nickname) as their Zoom name. Our trans/nonbinary/gender-expansive patients have specifically reported enjoying seeing their chosen/real name (as opposed to their dead-name/birth name) as their Zoom name. Every few groups, we encourage all group members and leaders to include their pronouns alongside their name, which reduces misgendering/microaggressing.

Moving to telehealth, with its related hiccups, has also allowed much room for humor and effective skill practice. Most recently, a patient was able to talk aloud through her process of "checking the facts" when the skills teacher's screen froze during the patient's sharing of her home practice. The patient reported observing the skills teacher's lack of response, described what she perceived as the teacher "stonewalling her," described the thought, "she must be really mad at me," and used dialectical reasoning ("this isn't like her—what's being left out?") to come to the conclusion that this was not an intentional communication, and that the teacher's screen had frozen. Skills group members and leaders all had a great laugh about this opportunity for deployment of many skills, and commended the patient for talking through this process aloud.

Despite its strengths, the telehealth-specific adaptation that has proven the most controversial to our program, provoking much discussion on our team and in Skills Group, remains the group chat feature. This sidebar allows leaders and members to write comments, ask questions, etc., in a public, written forum, viewable by all attendees. Though this feature has proven most useful for allowing participation even when the patient must be muted due to loud ambient noise (in the case



of loud family members or construction noise), and thus can provide opportunity for participation without interruption, at the same time, the chat can prove distracting and can be considered “doing two things at once” rather than engaging in a one-mindful practice of skills learning and teaching.

After much discussion, including considering pros and cons of options of disabling the chat feature, enforcing rules regarding the chat, and allowing the chat to exist unmonitored, our team arrived at the following syntheses, which are subject to change as needed. The skills teacher will not use the chat as it is ineffective and too confusing to be teaching and reading/writing in the chat simultaneously. The co-leader will monitor the chat, looking for and attending to coaching requests, and will ask about divided attention (“Are you doing two things at once?”) when the chat is veering off-topic or proving distracting. The co-leader will also monitor for any problematic content, such as attacks on other members; however, to date, the chat has been entirely supportive. Indeed, the most frequent use of the chat is to validate and echo support for the experiences of other patients. Subjectively, this feels more akin to the many muttered “yeah, me too”s that are frequently shared in person, in response to patients and leaders sharing examples of skill practice in their own lives. When meeting via telehealth, such utterances could prove distracting when voiced simultaneously by several members. The chat often serves as a supportive and encouraging vehicle for encouragement of skill use. And at the same time, the chat may also serve as a distraction, as comments are being typed while a member or leader is speaking.

### **Individual DBT**

The telehealth session format has produced some challenges for our weekly individual DBT sessions, particularly for patients who started treatment postpandemic so have never met their therapist in person. Patients report feeling less engaged, less invested in the treatment, as well as repeated concerns about their therapist being distracted. For example, I have the habit of intentionally looking away in order to compose my thoughts at times. I also take notes quite often during session. While I have never received feedback from an in-person patient regarding these behaviors, suddenly *all* of my patients were commenting on this, via Zoom, asking “Are you checking your phone?” “Are you distracted?” and “Am I boring you?” I allowed myself to be shaped by this feedback, such that for several sessions I would end up staring at my webcam, afraid to blink or take a sip of water or jot down a quick note, for fear of miscommunication. Naturally, this was

exhausting and a burnout risk. When I brought this up with the team, I was relieved to hear that all of my colleagues and teammates were experiencing the same phenomenon. We committed to discontinuing the “Zoom Stare,” as it fragilizes our patients, who are capable of using skills to tolerate their therapist looking away and the perception that they are distracted. Upon checking in during team over the next few weeks, it was encouraging to learn that therapists were no longer feeling the need to “Zoom Stare.” Some had addressed this behavior directly with their patients, others had made a mindful commitment to looking away, jotting down a note, and having a sip of water. We also made a point of validating patients’ reports of feeling less connected over Zoom.

And at the same time, it is important to note that therapists may need to modify their own behaviors to adjust to a telehealth format. Typical gestures and facial expressions are not as easily conveyed in telehealth as in person. Sometimes there is a slight video time-lag, which can also decrease connection and increase potential for miscommunication. Our team has found that facial expressions need to be more expressive, even exaggerated, over telehealth in order to communicate effectively. As a DBT practitioner who leans heavily into irreverence, I have received feedback both from my individual DBT patients and from my students during supervision, that I am coming across as “too harsh.” With a focus only on our faces, over a telehealth platform, body gestures that serve as cues to balance irreverent communication, or to cue the receiver that a joke is being made, are absent. Therefore, our team has made an effort in individual DBT to include hand gestures (e.g., thumbs up) as well as more dramatic facial expressions, when possible. Simultaneously, miscommunications continue to serve as grist for the mill of individual therapy.

Several central components of DBT require adaptation to a virtual format, which the Zoom platform is able to accommodate quite easily. The daily diary card, which is reviewed at the start of each session, can be filled out in session if it has not been completed beforehand. Mirroring in-person standard DBT, the patient can have time to complete the diary card (electronically, or via screen share with annotation functions, or on paper and text a photo to the therapist). Similarly, for chain analyses, a key DBT tool used to identify factors maintaining problematic behavior, the Zoom Whiteboard, can be used to create a behavioral chain. Low-tech options are also feasible: the therapist can draw a chain on their notepad, holding it up to the camera for the patient to see. The importance is to focus more on the content: identifying links in the

chain and associations between behavioral antecedents and consequences, and less on the format.

In addition, greater assessment of potentially problematic behavior is made possible due to meeting with patients virtually, in their own homes. For example, hoarding behaviors are more easily identifiable, as are other maladaptive behaviors (e.g., keeping one's room in darkness all day) that could be exacerbating depression.

Finally, we took a strong stance regarding the 4-miss rule, one of only two firm rules of DBT (Linehan, 1993). According to this rule, if patients miss 4 consecutive sessions of either skills group or individual therapy, they are out of treatment and cannot return until after their prearranged treatment end-date. We opted to maintain this rule, despite our move to telehealth. Lifting this rule would allow patients who do not attend therapy for a full month to erroneously believe that they actually are getting DBT, and that it just does not work for them.

### Phone Coaching

Not much has changed regarding in-vivo phone coaching, which is a central component of comprehensive DBT. That said, our team noticed an increase in more casual communications, which were not direct requests for coaching. This may have been due to increased social isolation, and increased electronic communication from therapists, particularly via text message, in order to keep patients informed regarding COVID-19-related programmatic changes. Many of our therapists reported increased burnout, as they felt compelled to respond to these increased and nonspecific communications, while also trying to manage their own adjustment to the pandemic.

As a team, we again committed to closer adherence to the DBT protocol. "Updates" from patients (e.g., "I was really stressed at the grocery store today, no one was wearing a mask but me") were treated as such, with no need for therapist response unless the therapist chose to respond at a convenient time. Vague complaints (e.g., "I'm feeling bad about this whole situation and don't know what to do") were responded to with a clarification question, "Are you seeking phone coaching?" and treated accordingly. Therapists were reminded to observe their own limits in order to prevent burnout. This latter point remains an ongoing challenge. Many of our therapists are students in very demanding graduate programs. The concept of observing limits is foreign to them. What often results is a "bounce" between failure to observe limits (e.g., spending an hour on a phone coaching call and missing lunch as a result) and overcorrection to limits that

are too rigid (e.g., refusing to reschedule a patient despite having time available to do so). We continue to address observing limits as a team.

### Consultation Team

The challenge of building a life worth living during a pandemic has also taken its toll on our Consultation Team. DBT Consultation Team is intended to hold DBT practitioners in the model and prevent therapist drift, while also serving as "therapy for the therapists," whereby we publicly rate our own burnout and effectiveness and put ourselves on the team meeting's agenda to address these concerns, along with specifying what we want from the team: problem solving, assessment, validation, increasing empathy. Typically, our team is strictly adherent to DBT team principles and guidelines: we begin with a mindfulness practice, review a team agreement, create an agenda, an observer rings a mindfulness bell when judgments are made, polarity, and other team issues.

However, as soon as the pandemic hit, our team gravitated toward solely engaging in problem-solving, with our agenda comprising almost entirely patient-focused concerns. We had no time for mindfulness or agreements, and certainly no time to seek validation of our own pandemic-related suffering. The observer role was forgotten. As the Team Leader, I attempted to create balance by suggesting we have a second weekly team meeting later in the week, serving as a "Validate, Vent, & Support Session." Initially, this was well-attended and was reportedly a useful resource for our team, which comprises mostly graduate students who are living away from their families of origin, quarantining in small apartments in urban Philadelphia. In addition to loneliness and isolation, exposure risk is increased for these trainees, as grocery stores remain crowded, with many people not practicing social distancing or wearing protective gear. Distress was, therefore, high among our team, and this meeting seemed to help. However, after 2 weeks, attendance dwindled and this second meeting was perceived as a time burden, so was discontinued.

Our team quickly desensitized to burnout ratings of 5 out of 5 and effectiveness ratings of 1 or 2 out of 5. Typically, our team norm is to discuss burnout ratings of 4 and higher. While such ratings can occur during times of external stress (e.g., exams, dissertation proposal, other graduate school projects), our modal team burnout rating is usually 3. Effectiveness is typically quite high, closer to a modal rating of 4. So these ratings represented a marked change from our team norms. It became clear that several team members, particularly those who were quarantining alone, were not

coping well. Similar to our skills group patients, team members would sometimes turn off their cameras when dysregulated. Team members reported feeling invalidated by the team leader, who expected our team to increase patient care efforts in response to the pandemic. It became apparent that the team was polarized with the team leader pushing too vigorously for change while a few team members felt unappreciated and burned out.

Clearly this tension was unsustainable, and the team was becoming ineffective, thereby leaving members less effective in treating their patients. In order to address this, we held a team retreat with the goal of improving our effectiveness as a team. Several team members requested a return to increased adherence to DBT principles. We reinstated an active observer role, mindfulness practice, and reading and discussion of a team agreement each week. As our team leader, I also sought consultation with other DBT team leaders. I received a variety of helpful suggestions, including changing our routine ratings of “burnout and effectiveness” to “stress: in personal life and in professional life.” Ratings of greater than 3 out of 5 would result in that team member being put on the agenda and the team helping to identify a new behavior to address/reduce stress, eliciting a commitment from the stressed member to implementing this behavior, and troubleshooting barriers to doing so (Shari Manning, personal communication. May 1, 2020).

High ratings in stress tended to reflect a transaction of work stress and personal life stress. The requirement that one's home space (often a tiny, cramped apartment shared with roommates) was now to become one's clinical space was a major contributor to stress. Poor internet connections, challenges finding privacy, noise level due to traffic and construction were all stressors that team members voiced. Tensions with roommates (many of whom were off work during the initial weeks of the pandemic) over excessive noise exacerbated stress at home. Also, several team members returned to their families of origin during the initial stage of the pandemic. This posed its own stressors, while also intersecting with work-related stress as family members would be prone to barge in during therapy sessions.

Another intersection of stress reported by our team members involved the challenge of taking care of our own mental health needs while also taking care of our patients. Several of our team members, particularly those isolating alone in small apartments, reported an increase in psychological distress, reduced ability to cope, and increased vulnerability to painful emotions. At the same time, they were expected to continue to provide phone coaching, conduct individual therapy

session, and run groups for patients who were also experiencing elevated levels of distress.

As the team leader, the majority of my stress was related to balancing my clinical responsibilities with parenting two small children who were suddenly attending school remotely. Homeschooling while providing clinical work from home and serving as a clinical supervisor for 8 students certainly took its toll and I was aware of my own tendency toward irritation and demanding more from others than they may have been able to provide.

Consultation with other DBT team leaders yielded another great suggestion. We were challenged to encourage team members to identify a problematic behavior they engage in on team, along with a plan to address this, in efforts to improve team effectiveness (Shari Manning, personal communication. May 1, 2020). This last proved greatly beneficial. Team members rose to this challenge and identified problematic behaviors such as checking email during team, deciding ahead of time that the team leader's feedback wasn't applicable to them, and harsh judgments of certain patients discussed during team. We have since checked in on several teams regarding progress toward addressing these problematic team behaviors. Consistent with team members' reports that they are not engaging in the unobservable problematic behaviors (e.g., email checking), observable problematic behaviors on team are markedly reduced.

Instrumental validation was also greatly encouraged: team members were challenged to ask each other to take over onerous tasks (such as writing notes in the electronic medical record, which are typically divided between the two group leaders). We were encouraged to reach out to team members who were quarantining solo, to arrange crafting dates, virtual movie watching hangouts, virtual happy hours, etc. As the team leader, I made efforts to reduce burnout by arranging for a surprise guest to come to our team: Gizmo the Goat from Party Goats LA. This experience brought the team great joy and hilarity. It was offered only once, due to prohibitive cost; however, I also offered team members a “get out of notes free card,” whereby I would write the therapy notes for the group we co-led that week. This was offered repeatedly and has led to the development of a collective team note-taking effort whereby a team member will offer to take notes during skills group, allowing the group leaders to focus solely on teaching. Since our groups are observed by most team members, each member gets a chance to volunteer to write brief summaries of each patient's contributions during group, and send these to the leaders afterwards. This collective note-taking plan remains to this day. These efforts have yielded a greater return



to DBT adherence on our team, although continued self-monitoring and addressing of “elephants in the room” is required to prevent drift back to our prior imbalance. While weekly team burnout ratings remain slightly higher than usual, it is rare that a team member rates their burnout as a 4 or 5 out of 5, and these ratings are always addressed. Similarly, effectiveness ratings have returned to their prepandemic modal level of about 4 out of 5.

Out of all of our efforts to address team burnout/stress, the factor that seems to have made the greatest impact, based on team member report and behavioral observation on team, is the passage of time. Our team all possess strong and effective coping skills. While adjustment to the pandemic took a few weeks for some and a few months for others, we eventually all came to a place of balance, where we can employ skills to function effectively as a team. We have adjusted to this “new normal.” Team members report that the opportunity to discuss challenges associated with the pandemic, particularly working from home, in a radically genuine way, helped them feel supported and validated. In addition, instrumental validation in the form of asking colleagues to take notes, and serve as substitute group co-leaders when necessary, has been identified on team as a major contributor to feeling supported and less stressed. Finally, the ongoing reminders from the team leader to observe our limits, and the team leader’s modeling of this by taking vacation days, ending meetings 10 minutes early to allow time for a quick break, has also been identified by team members as helping reduce burnout.

The tension between insistence on maintaining our high standards for the training and implementation of adherent DBT, while validating and supporting trainees’ emotional needs as they navigate quarantine and exposure risk associated with the COVID-19 pandemic, poses an ongoing challenge. DBT principles of balancing unwavering centeredness with compassionate flexibility are important to hold during this unprecedented time. Challenging all team members to increase our own practice of DBT skills, including maintaining a daily mindfulness practice, has also proven essential during these challenging times. DBT’s foundational focus on providing support for therapists, encouraging us to observe our limits and, at times, stretch them, reminds us of our shared human suffering and the need to attend to our own struggles in order to provide effective treatment for our patients.

### **Community Involvement**

Our DBT team has been asked to create various resources to help patients, other DBT therapists, and

front-line health care workers cope with the COVID-19 pandemic.

During our first week of moving to telehealth (mid-March 2020), our team was approached by Jefferson Human Resources and asked to create a variety of DBT-informed open-source videos to provide coping skills to health care providers working in the COVID-19 pandemic. Topics include radical acceptance, mindfulness, creating time to emote, making meaning/accessing spirituality, clarifying values, self-compassion, and coping ahead. These were designed for audio and/or visual learners (one can listen and get the full message while driving home; or read the presentation via subtitles without sound; or both watch and listen). These videos can be found here: [https://www.youtube.com/playlist?list=PL\\_R6s7O7BzUcX7wugFW1vbFajf8f0MWR](https://www.youtube.com/playlist?list=PL_R6s7O7BzUcX7wugFW1vbFajf8f0MWR).

Jefferson Human Resources also requested that our team offer several weekly Coping Effectively with COVID-19 drop-in skills groups for Jefferson health care workers via Zoom. Jefferson’s Student Counseling Service also requested that we launch a weekly coping skills workshop for students and trainees. These groups draw on distress tolerance and emotion regulation skills and are well-attended and well-received.

I was invited by the EPIC program to serve as one of two DBT experts (the other was Shari Manning, Ph.D.) in a forum for all Philadelphia-area DBT and DBT-informed practitioners to attend virtually. This forum was offered with the intention of supporting DBT practitioners in providing DBT both via telehealth and also during the COVID-19 pandemic—two adaptations that were required with very little notice. Questions were submitted ahead of time, and asked live during the 90-minute forum. Consensus was that it is entirely possible to provide all aspects of adherent DBT via telehealth while remaining flexible to changing circumstances. We also emphasized how DBT provides our patients and our therapists with the tools we all need to build a life worth living during a pandemic.

Finally, in response to the tragic and highly publicized death by suicide of Dr. Lorna Breen in late April 2020, we were asked to create and record a suicide-prevention webinar, drawing on DBT skills as well as the core spirit of DBT, which is to build a life worth living.

### **Building a Life Worth Living After the Pandemic**

It is crucial that we maintain and even increase our mental health efforts after the initial COVID-19 pandemic remits and life returns to “normal.” Particularly among our DBT patients, we can expect an increase in distress after things return to normal. Many of our

patients are accustomed to coping well in a crisis, particularly after having learned DBT skills in order to do so. However, the emotional toll of the pandemic may not hit until the immediate crisis is resolved. Drawing from a large body of literature suggesting an increase in suicidality among military personnel following a crisis (Brenner et al., 2008; Kline et al., 2011; Spelman et al., 2012), we highlight the importance of attending to increases in psychological distress as patients deal with the aftermath of the pandemic. Depression, anxiety, trauma-related symptoms, and problematic behaviors, including suicidality, can be expected to increase following COVID-19, and we need to remain vigilant postpandemic.

Several of our DBT patients have voiced a dread regarding the end of the COVID-19 pandemic insofar as it represents the end of “not having to worry about forming new relationships.” Pressures to go on dates, find a partner, build a more supportive social network, seek meaningful employment, or confront scenarios that prompt urges for problematic behavior will be increased postpandemic.

Our team has been addressing the likely increase in emotional distress postpandemic by encouraging patients to cope ahead for the storm after the calm. More than the colloquial use of the term “coping ahead” is a specific DBT skill involving vivid imaginal exposure to anticipated painful emotional states before they occur. During this imaginal exposure, patients, with the assistance of their DBT therapist, rehearse what coping skills they will use, and imagine themselves doing so, including using specific skills to cope with a worst-case-scenario. Post-pandemic-related examples include coping ahead for easier access to problematic behaviors (e.g., illicit drugs, opportunities for overspending or overeating), adjustment to changes in family expectations regarding visiting more frequently, and removal of government regulations that prevent eviction during the pandemic. Finally, “coping ahead” for these scenarios will also be necessary: health anxiety, development of social anxiety in response to social distancing precautions, and, of course, ongoing fear of exposure.

In summary, our DBT patients possess and are continuing to acquire a wide array of coping skills designed specifically for tolerating a crisis. We need to remain vigilant for a post-crisis increase in distress

and accompanying suicidality after the pandemic has resolved. DBT skills can also prove life-saving for health care providers and for our community at large, when adjusting to the “new normal” of the COVID-19 pandemic, and again when adjusting to life postpandemic. The experience of adapting DBT skills to a variety of contexts in dealing with the COVID-19 pandemic inspires great confidence that these skills can foster resilience among our patients and our community at large, allowing us all to build a life worth living and engaging in fully.

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