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Lessons Learned Conducting Dialectical Behavior Therapy via Telehealth in the Age of COVID-19

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Given the severity and suicide risk of patients typically treated by Dialectical Behavior Therapy (DBT) and the absence of guidelines regarding delivery of DBT via telehealth, it is crucial that the DBT treatment community gather and rapidly disseminate information about effective strategies for delivering DBT via telehealth. The current study surveyed DBT providers (N = 200) to understand challenges and lessons learned as they transitioned to conducting DBT via telehealth during the COVID-19 pandemic. Open-ended responses to challenges and lessons-learned were coded. Most frequently noted challenges were Therapy-Interfering Behaviors and elements related to the provision of Individual Therapy and Skills Training Group. The majority of providers offered advice for implementing group skills training, avoiding or overcoming therapist burnout, and emphasized continued adherence to treatment principles, even in the context of this new treatment modality. Overall, this qualitative study marks a starting point on identifying best practices delivering DBT via telehealth for which it is anticipated that clinical recommendations in this area will evolve, informed by clinician, researcher, and consumer input.

The emergence and spread of COVID-19 created enormous challenges to public health systems throughout the world, including the delivery of behavioral health services. The rapid transformation of behavioral health services has spurred numerous scientific and popular press articles about the use of telehealth for mental health treatment that detail the special challenges, difficulties, and even opportunities posed by this transformation (Carey, 2020; Gruber et al., 2020; Pierce et al., 2020; Waller et al., 2020). Behavioral health providers, along with other treatment providers, rapidly moved service delivery to telehealth platforms due to stay-at-home recommendations required to contain or reduce the spread of COVID-19. The provision of Dialectical Behavior Therapy (DBT) via a telehealth platform is especially noteworthy due to the population treated—individuals with Borderline Personality Disorder (BPD), who may present to therapy with complex treatment challenges (Chalker et al., 2015) and have heightened suicide risk (reported estimates are that 8–10% of individuals with BPD die by suicide; American Psychiatric Association, 2003; Leichsenring et al., 2011). Due to the high-risk nature and problem severity of the treatment population, DBT is a multi-modal treatment relying on a robust set of treatment principles and structures which, previous to COVID-19, have primarily been presented in a face-to-face context. Consequently, it is expected that DBT providers treating BPD patients may face unique challenges compared to those treating less severe clients when moving to telehealth delivery. Yet, there has been limited research on the provision of DBT via telehealth. An 8-week form of internet-delivered skills training (iDBT-ST) delivered via videos and interactive tools instead of involving real-time communication with a provider delivering the skills in an interactive way (Wilks et al., 2017; Wilks et al., 2018) showed promise in reducing suicidal ideation, alcohol consumption, and emotion dysregulation. However,

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this relatively new intervention is not yet widely used by DBT providers (Lungu et al., 2019) and, further, is not meant to encompass the full model of DBT. Moreover, in contrast to the format of the iDBT-ST, the transition to doing DBT via telehealth refers to shifting the modes of DBT to be done via synchronous video conferencing platforms. To date, there has been no published research on comprehensive DBT delivered via telehealth.

As a treatment for BPD, DBT was developed specifically to address the challenges associated with this population, including the higher rates of suicidal and nonsuicidal self-harm behaviors, multiple co-occurring disorders, frequent unrelenting crises, and severe emotional and interpersonal dysregulation, which often occur within sessions (Linehan, 1993). DBT outlines four stages of treatment that correspond to level of disorder. Stage 1 is defined by "behavioral dyscontrol" and has the primary goal of achieving behavioral control. Given the complexity of clinical presentations seen in Stage 1 DBT, behavioral dyscontrol may have unique implications for being managed via telehealth, and therefore is the focus of this paper. In Stage 1, treatment targets are ordered as follows: decreasing (1) life-threatening behaviors, (2) therapy-interfering behaviors, and (3) behaviors that interfere with quality of life, while simultaneously increasing skillful behaviors. To achieve the goals of Stage 1 (i.e., behavioral control), the full model of DBT prescribes four modes: individual therapy, skills training group, phone coaching, and consultation team. Within each Stage 1 target and each mode of the treatment, the DBT therapist brings a dialectical position of acceptance and change. A more detailed overview of DBT is outside the scope of this paper; interested readers are encouraged to see Rizvi et al. (2013).

The nature of the BPD diagnosis coupled with the complexity of the treatment have undoubtedly introduced serious challenges when rapidly transforming DBT to telehealth delivery, especially as guidelines for DBT via telehealth do not currently exist. Without such guidelines available, DBT providers relied on alternative sources to inform their telehealth practice. In the time frame since, acceleration of the knowledge gained in the "how-to" of DBT delivered via telehealth has undoubtedly been rapid. The effortful and creative lengths DBT providers have taken to acquire these skills to treat their clients creates an opportunity to harness and disseminate this knowledge back to the DBT treatment community. The explicit goal of this article is to depict challenges and lessons learned applying DBT delivered via telehealth, from descriptions provided directly by DBT providers.

Methods

This study received approval and was determined to be exempt by the University of Oregon Institutional Review Board. Study invitation emails were sent to an international DBT listserv for clinicians who have completed a minimum of 40 hours of structured training in DBT as well as several mailing lists for individuals who run and staff DBT clinics. The survey was available to complete for approximately 2 weeks (June 25–July 8, 2020). Interested providers clicked on a Qualtrics link, consented, and then completed an approximately 10-minute anonymous survey.

Participants

A total of 221 participants initiated the survey with 200 providers completing all of the close ended questions of the survey and 180 providers additionally contributing to the open-ended questions. Descriptive data is calculated from the 200 providers who completed that information. The majority of providers (89.5%) were from the United States with 34 states represented. Other providers were from seven other countries, including Australia, Canada, Ireland, Israel, New Zealand, Russia, and the United Kingdom.

Survey Questions

The first section of the survey asked questions about the following: geographic location; setting of DBT telehealth practice (Outpatient, Intensive Outpatient, Partial Hospitalization, Inpatient, Other); age group the provider treated with DBT (Children, Adolescents, Adults); modes of DBT offered typically and since transitioning to telehealth (Individual, Skills Training, Phone Coaching, and Consultation Team); if the provider used telehealth prior to COVID (Yes, No); and the approximate number of DBT sessions delivered via telehealth (ranging from less than 10 to more than 100). In addition, DBT providers were asked to rate how effectively they were able to translate the DBT principles to any of the modes of DBT they were conducting with telehealth, on a 5-point scale ranging from *1 = not at all effective* to *5 = extremely effective*.

The second part of the survey asked three open-ended questions developed by five of the authors (M. Z., C.J.W., S.R., A.W.W., & L.D). We piloted the open-ended questions with 6 DBT providers to ensure the questions had face validity, as well as to assess if the questions elicited the type of feedback that may be helpful to other providers. At the start of the survey, providers were instructed to focus on DBT rather than general telehealth. Questions included: (1) What have been the greatest challenges you and your consultation

team have faced doing DBT via telehealth? (2) What do you wish you'd known at the beginning of doing DBT delivered via telehealth that you've since learned? and (3) If you were consulting with a colleague about how to do DBT over telehealth well, what do you think would be important pieces of advice to give them? A complete copy of the survey can be found in Appendix A.

Qualitative Approach

Content analysis (Boyatzis, 1998) was used to examine the existence and frequency of unique lessons learned from the DBT providers' responses to the 3 open-ended questions for which emerging themes were identified and systematically categorized (Elo & Kyngäs, 2008). As the goal of this paper was to solicit *Challenges* and *Lessons Learned*, Question 1 was coded for challenges and Questions 2 and 3 were coded together as lessons learned. Specifically, the content analysis used a three-step inductive approach. The first step was that all 180 written responses were carefully examined by the first author (M.Z.) to develop a comprehensive codebook to capture the themes emerging from the data. During this review of the responses, notes were written in the text and possible themes were noted. Following the initial full review, 5 co-authors examined the themes more closely, while referencing the providers' responses. The DBT treatment structure from the original treatment manual (Linehan, 1993) was used to continue refining the themes. Specifically, the organization for both *Challenges* and *Lessons Learned* was based on the following recurring themes of the DBT treatment structure: pretreatment and DBT treatment hierarchy; DBT modes of treatment; core strategies; and non-DBT-specific issues. The second step involved two co-authors (C.J.W. & A.W.W.) reviewing the providers' responses to assess the comprehensiveness of the codebook and further refine it. Collaborative discussion between the codebook developer and these two study co-authors was utilized to finalize the themes included in the codebook. Finally, two co-authors who were not involved in steps one and two (C.G.M & J.R. O.) coded all 180 DBT providers' answers. They both read each entry and together used consensus coding to achieve the final rating (Boyatzis, 1998; DeCuir-Gunby et al., 2011). Each subcategory was coded as a '1' if it was mentioned in the response. It should be noted that providers were allowed to comment on as many challenges and lessons learned as they wanted. Any response could be rated as representing more than one theme, such that the totals across themes exceed the number of participants. For more details on the codebook and coding process, see Appendix B.

Results

Across the 200 providers who answered the close-ended questions, 180 providers said that they worked with adult populations, 122 worked with adolescents, and 19 providers worked with child populations. The majority of providers worked in outpatient settings ($N = 186$), followed by intensive outpatient hospitalization programs ($N = 15$). The majority of providers indicated that of the DBT modalities they offered in person, they had switched to offering these same modalities via telehealth (88% individual therapy; 86% skills training group; 87% consultation team). Using telehealth was new for the majority of providers, with 74% stating they had not used telehealth prior to COVID-19. At the time of completing the survey, about two-thirds of providers indicated having done 51 + sessions via telehealth, with the remaining providers responding they had done 50 or fewer sessions. Finally, in terms of how effectively providers viewed each modality delivered via telehealth, the modal response across DBT modalities was either moderately effective (3) or very effective (4). Specifically, the mean rating for individual was 3.73 (range: 2 to 5), group was 3.42 (range: 1 to 5), phone coaching was 4.27 (range: 1 to 5), and for consultation team, 3.94 (range: 1 to 5). Across all modalities, $\leq$ 10% providers rated any modality delivered via telehealth as not at all effective or slightly effective.

Open-ended qualitative responses were coded as described above and are presented in the following sections as "Challenges" and "Lessons Learned." The total number of times a subcategory was mentioned is quantified. Quotes from providers are included throughout to illustrate the subthemes presented, with participant ID numbers included in parentheses following the quotation. Table 1 summarizes the lessons learned and can be used by consultation teams to check what additional strategies they may consider to improve their delivery of DBT via telehealth.

Challenges

Pretreatment and Stage 1 DBT Treatment Hierarchy

Pretreatment

The DBT pretreatment phase, which focuses on orientation and commitment, has the goal of the therapist and client making a mutual and informed decision to work together as well as address any dysfunctional beliefs a client may hold about the work that could later interfere with treatment (Linehan, 1993).

Table 1
Collection of Lessons Learned From DBT Providers

Themes	Summary of Key Findings
Applying DBT to oneself DBT principles and skills and Sticking with DBT principles	• Providers to use the skills on themselves in life: Wise Mind, Cope Ahead, Radical Acceptance, Crisis Survival Skills, Check the Facts • Providers to use crisis survival skills between sessions • Observing Limits • Balancing structure and flexibility • Unwavering centeredness • Remember "You are doing the best you can and you can do better" • Reference the treatment manuals
Pretreatment and Stage 1 hierarchy	
Pretreatment	• Telehealth-specific orientation • Discuss limitations and benefits of telehealth • Help clients identify private spaces to do telehealth • Accept that the pretreatment phase may take longer to complete • Spend adequate time developing rapport with clients • Help teen clients anticipate balancing the demands of online schooling and online treatment • If possible, consider face-to-face session for pretreatment sessions • Do a dry run telehealth session to get client familiar with platform and problem solve technology issues
Life-Threatening Behaviors	• Create crisis survival kits for clients • Develop suicide and crisis management strategies with clients in advance of treatment • Utilize available resources to build a suicide crisis plan (e.g., http://www.suicidesafetyplan.com/) • Remember that DBT therapists have been managing suicide remotely (phone coaching) since the inception of DBT
Therapy-Interfering Behaviors	• Decide on what "engaged behaviors" look like during orientation • Anticipate possible TIBs for each client given their history • Coach clients to remove distractions in their environment (removing their cell phone, using settings to hide their own video) • Consider what is not visible onscreen that might be a TIB (violating confidentiality by having another person in the room) • In group, consider defining group TIBs and behaviors that demonstrate engagement • Remind clients that expectations for group are the same as in-person • Accept there will be TIBs you could not have anticipated
DBT modes of treatment	
Skills Training Group	• Learn to maximize interactive capabilities of video conferencing platform • Use PDF markup and other tools to share screen and do worksheets • Use quiz functions to increase participation • Get materials to clients in advance • Get homework in advance of group for leader/co-leader to review • Identify activities for which clients may already have materials at home • Identify mindfulness exercises that are amenable to video conferencing • Allow clients to join group 10 minutes early to facilitate group cohesion • Co-leader serves additional function of troubleshooting client technology issues • Co-leader to follow up with clients via phone if client leaves session or appears distracted
Individual	• Get diary cards or chain analysis worksheets to clients in advance • Checking in more about client emotions throughout the session

Table 1 (*continued*)

Themes	Summary of Key Findings
	• Tell clients they may need to express their emotions in words more than required for in-person sessions
	• Therapist may want to sit back from camera so client can see therapist gestures
	• Remind clients of limitations and benefits of doing DBT via telehealth
	• Be proactive and model problem solving with video conferencing issues
	• Seek feedback from client
	• Continue to monitor progress towards treatment goals
Consultation Team	• Find new ways and times to connect with teammates outside of consultation team both formally and informally
	• Seek consultation outside of team regarding telehealth decisions
	• Use team to troubleshoot technology issues or practice new mindfulness activities before doing it in group
	• Maintain adherence to team in terms of structure and timing
	• Reduce distractions while participating on team
Therapist Burnout	• Evaluate new coping skills and how effective they are for oneself
	• Be deliberate about setting new routines
	• Practice self-validation and acceptance
Applying Core Strategies	
Core Strategy: Validation	• Amplify voice and facial expressions when communicating validation
	• Validate clients that shift to telehealth can be hard
Problem Solving/Change	• Think creatively about all available reinforcement in client's current environment
	• In group, use emoticons as reinforcement
	• Use whiteboard or other tools to collaboratively complete chain analyses
	• Continue to do behavioral rehearsal
Non DBT Specific Issues	
Technology and Access	• Obtain best HIPAA compliant platform you can afford
	• Assess client's technological capabilities prior to starting treatment
	• Recognize DBT may be more accessible for some because of telehealth and problem solve alternate options for those who can't access via telehealth

Brief Definitions of DBT terms used in Table 1:
Wise Mind = Mindfulness module; an integration of reason and emotional states; Cope Ahead = Emotion Regulation module; rehearsal of skills in advance of a challenging situation; Crisis survival skills = Distress tolerance module; focus on not making a situation worse; Radical Acceptance = Distress Tolerance module; to fully accept a past or present reality; Observing Limits = observing one's limit in relation to a client as to prevent resentment and burnout; Unwavering centeredness= "...believing in oneself, in the therapy, and in the patient. It is calmness in the middle of chaos..."

Major challenges doing pretreatment for new clients via telehealth were noted nine times. These providers commented that obtaining commitment and building a relationship with the client was more challenging during this stage via telehealth. The client-therapist relationship is a primary reinforcer for many BPD patients and, according to Linehan (1993), may be an important factor keeping a suicidal patient alive. Therefore, commitment matters and failing to achieve it can be a serious obstacle to treatment goals. One provider stated, "*starting therapy for the first time through telehealth creates some challenges in making the personal, relation-orientation connection....also for some clients who are struggling with commitment, it's more difficult to get the 'foot-in-the-door'*" (ID# 152).

Stage 1: Life-Threatening Behaviors

While the phrase "life-threatening behavior" was not used in most providers' responses, challenges to applying risk management principles via telehealth were noted by some providers ($n = 10$). Providers noted that conducting risk assessments with new clients was more challenging. Overall, these providers commented that intervening with any life-threatening behaviors was challenging, with one provider stating, "*Anything related to [life threatening behavior]. It is much harder to assess risk,*

make clinical decisions in the moment, and make treatment decisions without seeing someone in-person in the room" (ID# 169).

Stage 1: Therapy-Interfering Behaviors

Individuals in DBT frequently present with therapy-interfering behaviors (TIBs). In order to protect the integrity of the treatment, TIBs are extensively targeted when they occur. TIBs were mentioned extensively by providers as posing significant challenges in DBT delivered via telehealth (n = 63). TIBs were noted across both skills training groups and individual sessions. Many providers commented on novel TIBs their clients engaged in via telehealth, including clients avoiding sessions, logging off sessions early, or clients turning off their video so they could not be seen, with several providers stating their clients report not liking seeing themselves on camera. Further, clients engaged in TIBs during skills training that would be harder or impossible for them to do if attending in person (i.e., smoking, drinking, falling asleep, being in bed, playing with their pet), which was noted to be distracting to other clients in group. One provider stated, "*I have had a couple of clients who have hung up on me via telehealth when emotions become (sic) too overwhelming for them; I have found 'hanging up' to be a much easier behavior for my clients to engage in, compared to leaving a physical room. And, this hanging up behavior also then occurred when I attempted to address the behavior in the subsequent session as a TIB*" (ID# 219). Another theme that was mentioned repeatedly was client susceptibility to distraction. Several providers noted that while distraction was an issue for many clients, it seemed particularly problematic for clients who struggled with attentional issues prior to telehealth. One provider working with adolescents stated, "*One teen, who was previously distractible became more so when she had all the distractions of her bedroom*" (ID# 27). Perhaps due to engagement in TIBs, 11 providers specifically stated that working with adolescent or child populations via telehealth was more difficult than working with adult clients. Difficulties maintaining engagement were also noted for providers who work in intensive outpatient and partial hospitalization programs in which programming is three to four hours at a time. Other forms of TIBs noted were that homework compliance and completing worksheets or diary cards was lower.

In addition to client TIBs, providers also described their challenges in responding effectively to TIBs. Specifically, providers described challenges in getting clients to reengage (i.e., log back on) if they abruptly logged out of a session or struggled with how to engage client willfulness in the moment. The lack of physically being with the client was noted as a challenge, illustrated by one provider stating, "*for example, if a client were to 'leave' skills group by either turning off their camera or signing out of the video platform…in person, the co-leader might run after them in the hallway and offer skills coaching, but over telehealth this was tricky to navigate*" (ID# 200).

DBT Modes of Treatment

Skills Training Group

Skills acquisition, strengthening, and generalization are the major functions of skills training group (Linehan, 1993). A significant number of providers (n = 66) noted challenges that interfered with these core functions while conducting DBT skills groups via telehealth. Providers found it difficult to make the groups participatory and interactive, with one provider noting, "*sometimes I feel as if I am just talking into a void*" (ID# 128), reflecting the experience of groups as being less rewarding for clinicians. This is noteworthy because if groups are experienced as less rewarding for clinicians, they may struggle to provide behavioral reinforcement for skillful behavior via video. Related, providers frequently commented that therapist and client lack of access to typical materials, such as the whiteboard, handouts, and stimuli related to skills demonstrations, made it harder to teach the skills and for clients to acquire the skills.

The cohesiveness and cooperation between members of a traditional skills group is helpful to increase acquisition of new skills. Traditionally, group members often praise each other for skillful behavior and homework completion. Providers noting challenges to group cohesion referred to group members' lack of bonding with both one another (e.g., there is not space or time to socialize with one another, more distractions are present) as well as the skills leaders. Of providers noting these various challenges, some further commented that they perceived these group challenges as related to poorer attendance or drop-out rates. One therapist commented, "*clients are more easily distracted during the group, participate less, and some are uncomfortable showing their faces which has led to not attending groups or dropping out of DBT*" (ID# 13). Another prominent theme was about maintaining confidentiality and privacy. Confidentiality challenges were raised mainly about clients violating the group members' confidentiality (allowing someone else to be in their room but off-screen). Privacy issues were raised mainly in regard to clients having challenges securing private spaces in their own homes, a theme especially noted among those treating adolescents who might be concerned a family member is listening to the session. Finally, less frequently noted but specific to skills group were challenges for under-

standing how the tasks of the co-leader could be fulfilled via telehealth (see Linehan, 2014, for discussion of co-leader role), as it was more difficult to complete some of the main functions of this role, which include observing and attending to TIBs.

Individual Therapy

Many providers ($n = 78$) noted challenges and obstacles doing individual DBT therapy via telehealth for which, in most settings, the individual therapist is responsible for organizing treatment and follows the treatment hierarchy listed earlier. Frequently commented on were challenges related to treatment structures that have traditionally taken place using face-to-face methods, such as the reviewing of diary cards (a data tracking tool commonly employed in individual DBT to facilitate session agenda-setting based on treatment hierarchy). The challenge was again related to the lack of access to typical materials, with a provider further linking this to interfering with collaboration as it prevented working through written materials together. Another major theme noted about individual DBT involved challenges in observing emotion during the session, a significant concern due to both emotion regulation deficits of individuals in DBT and the potential for accidental invalidation of emotions by the provider due to limited visual or auditory cues. One provider noted, "*it is hard to pick up on behavioral evidence of emotion in the moment. . .which at times can feel like it blunts the effectiveness of a session*" (ID# 47). Emotion was commented on by another provider, but as related to how observing emotion in the room affects the therapist-client relationship, "*I find I cannot, or haven't yet, been able to help my clients sit with those emotions as well through telehealth. Subtleties in body language are missed*" (ID# 46). Further, providers noted the challenge of responding effectively to dissociation and extreme emotion dysregulation displayed during telehealth sessions in individual therapy. Several providers also commented on the challenges of goal setting, with some noting that there was a sense between both client and the therapist, during COVID-19, of "*waiting until real life or real therapy to get going again*" (ID# 72) such that previous goals may have been dropped. In addition, it was mentioned that it was harder to develop behavioral or environmental interventions given limitations within patients' current environments.

Consultation Team

A primary agreement for DBT providers is that the principles of behavior (i.e., learning theory) affect therapists just as much as clients, and therapists need support in delivering the treatment with fidelity. To this end, a required mode of DBT for adherent treatment is a therapist consultation team. A number of providers ($n = 36$) reported concerns with conducting consultation team via telehealth. A frequent challenge noted was providers feeling disengaged or not connected with their team members. Some providers noted team members and/or themselves were more distracted during team because of doing other tasks on their computers. Also noted was a lack of more informal consults or times and spaces to catch up with team members, which interfered with team member rapport building, with a provider noting, "*we don't have downtime to build our relationships*" (ID# 88). Some providers also noted that they or a team member had small children at home, and that this interfered with the team members fully participating. Another theme noted several times was that adherence to the consultation team structure was drifting, such as members coming to consultation team late or teams meeting less frequently. A distinct theme noted, similar to themes noted in other modalities, is that providers observed that it was harder to orient new team members with whom they had not met in person. The challenge noted here related to both orienting the new team member as well as feeling connected to the new team member.

Therapist burnout. Many providers ($n = 42$) used the term "burnout" to describe additional issues relating to providing DBT via telehealth which would traditionally be addressed in the context of a consultation team. These examples included: the significant increase in time spent looking at a screen; decreased motivation because providers mentioned uncertainty in the effectiveness of conducting DBT over telehealth given the lack of research on the topic; and providers mentioning that in the context of the pandemic, they too had lost access to many of their own coping strategies and/or were struggling to manage finding their own private space or help with childcare. Finally, while potentially a behavior related to burnout, some therapists commented on their own "therapist-interfering behavior," including struggling to maintain their own attention on team or in sessions. For example, providers noted their own distraction during group and others stated it was challenging to pay attention to all of the individuals on the screen at once.

Applying Core Strategies

The core strategies of DBT are integrated into the treatment modalities and provide a mechanism from which to flexibly apply the treatment. Anchoring to the core strategies of DBT provides a necessary and vital method for extending the treatment into areas where a robust research literature may not exist by leveraging theoretical principles rather than modifying the treat-

ment in an ad-hoc manner. Examples of the core strategies are listed below and were noted in therapist discussion of doing telehealth across the various modes of DBT.

Validation

Linehan (1993) viewed validation as an essential aspect of DBT that differs from the traditional problem-solving focus of cognitive behavior therapy and is used to convey acceptance of the client as they are, in order to build the relationship between the therapist and client (Linehan, 1997). While validation was not commented on extensively (n = 5), providers noted challenges in this area due to difficulty observing client emotion, which is essential for providing accurate (and effective) validation. Interestingly, level 3 validation in DBT, in which the task is to read emotions and thoughts and check for accuracy, was mentioned more than once. A provider described this challenge stating, "*for me, it is difficult to 'read' a person via telehealth, which impacts my ability to conduct Validation Level 3 and to help them observe and label emotions*" (ID# 54). Other providers commented that the video platform itself, in which the microphone can only grab one audio at a time, interferes with the subtle forms of validation therapists can offer that signal to a client the therapist is paying attention to them and understanding them.

Problem Solving/Change

Behaviorism (which views cognition as a behavioral element) creates the platform for change-based strategies in DBT. Providers mentioned challenges with certain change skills such as doing "opposite action" via telehealth (n = 19). The skill of opposite action involves acting opposite to the urge of the emotion. Specifically, one provider noted that practicing opposite action to shame, in which eye contact may be a component of a client's opposite action, was more complicated to do via telehealth. Further, it was mentioned that rehearsing skills with clients was more challenging. Another strategy employed frequently by DBT providers that directly facilitates behavioral change, is reinforcement, whereby the therapist responds in a way that aims to increase the likelihood of the client engaging in that behavior again. Methods of reinforcement, such as using snacks as rewards during skills group for teens, giving out stickers for homework completion, or providing certificates or gifts for skills group graduation, were noted as impossible or harder to do. A form of reinforcement, cheerleading ("the therapist validating the inherent ability of the patient to overcome her difficulties"; Linehan, 1993, p. 243), was noted to be a challenge when doing in-session exposures. The last type of reinforcement mentioned regarded therapists' perceptions that the therapeutic relationship was less reinforcing for both the client and the therapist. Given that the therapeutic relationship is often one of the more powerful tools DBT therapists leverage in order to facilitate behavioral change and/or keep suicidal clients alive, it is a concern that therapists believe the therapeutic relationship cultivated through telehealth may be experienced as less reinforcing. The challenge of sharing visual content was also mentioned as making chain analysis more time consuming, with chain analysis being a tool facilitating behavioral functional analysis and problem solving. Finally, while more of a dialectical strategy than a change-oriented strategy, some providers commented on challenges overall with "movement, speed, and flow," a principle acknowledging therapists' ever-moving balance between engaging in acceptance and change strategies when enacting any part of the treatment.

Non-DBT-Specific Issues

Technology and Access Issues

Although not inherently specific to DBT, challenges with technology and access issues were mentioned extensively (n = 76). Non-DBT-specific technology issues raised mainly had to do with some patients' lack of access to devices, poor or unreliable internet connection, or having to share devices within a home, thus interfering with the quality of sessions or preventing them from participating at all. "Glitches" or internet connection cutting out was raised frequently. Some providers had the sense that clients who only had phones, and not computers, had poorer attendance and greater dropout.

Administrative Issues

Administratively, providers mentioned receiving conflicting advice from institutional leadership about how to handle billing, and further, providers mentioned the uncertainty about telehealth being covered by insurance, with these issues being mentioned 19 times. Providers also described administrative tasks such as session documentation taking more time to complete and seen as more draining. In addition, providers described frustration regarding resistance from leadership to fund upgraded technology platforms that resulted in increased difficulty to switch to DBT via telehealth.

Lessons Learned

Sticking to DBT Principles

While a similar format to the challenges section is used here, a major difference between the responses provided to the challenges versus lessons learned open-ended questions had to do with providers empha-

sizing the need to adhere to DBT principles. Several providers commented that it was helpful for them to remember the DBT principles (n = 43). For example, a provider commented that some DBT principles have taken on a whole new meaning for them, such as the notion of a therapist demonstrating "unwavering centeredness," which Linehan defines as "...believing in oneself, in the therapy, and in the patient. It is calmness in the middle of chaos..." (Linehan, 1993, p. 110). Further, providers advised to "*try your best to stick to the DBT structure and hierarchy and allow yourself some flexibility*" (ID# 13). Providers offered motivation to others that they believed this treatment could be done via telehealth, so long as principles of DBT were adhered. Specifically, one provider stated, "*Find ways to make your practice as close as possible to providing services in person. Maintain the frame you set in person*" (ID# 171).

Pretreatment and Stage 1 DBT Treatment Hierarchy

Pretreatment

Providers shared numerous examples of lessons learned regarding the pretreatment and orientation phase (n = 37). The importance of orientation was emphasized across all treatment modalities, both in terms of switching to telehealth mid-treatment and also when initiating treatment using telehealth for new clients. Several providers suggested doing a "telehealth-orientation" session specifically and/or doing a dry run session to address technology challenges. One provider summarized several additional items that should be covered in a telehealth orientation session, stating, "*I would recommend having orientation discussions with clients at the start of telehealth sessions, to include expectations of being on camera, more open discussions about nuanced emotions due to the limitations of telehealth, and discussions about helping clients find confidential spaces at home in order to fully participate in treatment without interruptions or fear of others hearing them*" (ID# 33). Given the unique factors that must be addressed when doing telehealth with DBT patients, many providers commented that they learned to accept that orientation may simply take longer to complete in order to properly address the unique telehealth concerns while also having sufficient time to develop rapport and establish commitment from the client as would be the major pretreatment goals when doing treatment face-to-face. In orientation for adolescent clients, therapists may want to consider discussing the demands of virtual school and virtual therapy, and how the teen client anticipates balancing this without burning out. While not possible for all, providers who were able suggested having initial commitment sessions in person (with protective gear) and then switching to telehealth. Last, several providers mentioned that it was important to orient clients to the unique benefits of telehealth, with one provider listing out a few benefits: "*ability for clients to see their own facial expressions and nonverbal communications, ability for therapists to offer in vivo experiential assistance within the client's home environment*" (ID# 217).

Stage 1: Life-Threatening Behaviors

Lessons learned about life-threatening behaviors specifically (n = 14) emphasized the necessity of applying evidence-based risk management protocols to develop agreements regarding crises in advance of treatment. Providers commented on the need to maintain elements of DBT related to crisis survival skills and in regard to risk management. One provider made a compelling point: "*don't be afraid to manage suicide risk via telehealth, as it can be done effectively and in fact has been done since DBT came out (phone coaching)*" (ID# 40). This sentiment about approaching suicide risk "*in the same way as always*" (ID# 144) was noted by another provider as well and supports the use of existing risk management strategies within the DBT protocol (e.g., tracking urges for suicide, use of crisis survival skills, use of telephone coaching, maintaining hierarchy of targets, etc.).

Stage 1: Therapy-Interfering Behaviors

Similar to suggestions around life-threatening behaviors, providers suggested doing sufficient planning ahead of time in order to problem solve and cope ahead with therapy-interfering behaviors (TIBs) occurring in sessions (n = 30). Specifically, providers suggested deciding on what "engaged behaviors" look like ahead of time with each client and discuss any associated consequences if the patient engages in TIBs. In the group setting, this can be even further elaborated upon in a discussion including behaviors that can and cannot be engaged in over the video platform (e.g., is it ok for pets to be around, for clients to eat on camera, retrieve a snack?). Several providers suggested reminding clients that expectations around behavior were the same as they would be for in-person. One provider stated, "*to follow the same rules that we institute in in-person groups such as arriving on time, removal of distractions such as cell phones, not engaging in side conversations*" (ID# 59). Even with planning, and similar to in-person therapy, providers mentioned to be ready for TIBs that could not have been anticipated.

DBT Modes of Treatment

Skills Training Group

Skills training group was a frequently commented on topic regarding lessons learned, perhaps due to the inherent complexity in running groups in an online setting ($n = 60$). For leaders to make the groups more interactive and engaging, providers advised learning the interactive capabilities of the video platform, using the markup feature of a PDF viewer when completing worksheets, using the whiteboard feature of Zoom, creating additional positive rewards for on-topic behaviors, and using the quiz function to promote active participation. Leaders and co-leaders should search for and adapt group exercises to those that are optimally suited to be done over a video platform. To improve engagement and participation within the limitations of video platforms, it was suggested for homework review that leaders consider calling on clients (as opposed to only waiting for someone to volunteer to share) and that this expectation be set in advance. To further enhance participation, providers suggested getting materials in advance to clients, noting that clients rarely have access to printers to print materials and that obtaining printed copies was preferred over emailed copies. If mailing is not an option, some providers suggested having clients or agencies buy skills workbooks for clients. Some providers also suggested requesting clients send them a copy of their homework prior to group starting so the leader or co-leader could review it. To address challenges of group cohesion, providers suggested starting group 10 minutes early (using a passcode instead of a wait room to access the telehealth platform) for clients to join in order to mimic in-person group sessions, in which clients interact with each other less formally in the small pockets of time before and after group. A provider suggested that group cohesion was enhanced by encouraging clients to post validating statements to one another on the chat and/or post fun ideas to share, with providers saying they would practice doing this together with the group prior to encouraging clients to do it.

Working with co-leaders to target TIBs of group nonattendance or nonengagement was noted by several providers. As outlined by the Linehan skills training protocol (2014) leaders and co-leaders have clear and distinct roles. In a nutshell, while the leader is primarily responsible for the skills training content and often has to play the role of "taskmaster," the co-leader is primarily responsible for group cohesion, modeling effective group member behavior, and focusing on issues related to attendance (missing members or members arriving late/leaving early). Several providers suggested that leaders and co-leaders maintain their roles during telehealth groups. However, DBT providers also suggested that the co-leader put greater time and effort into getting group participants to join and stay in group in order to allow the group leader to focus on group content and cohesion.

Individual Therapy

Lessons learned for individual therapy were mentioned 53 times. Several providers commented on the importance of getting the diary cards to clients in advance, whether that be through electronic medical records, mail, or other approved telehealth methods of sharing the information. Some providers noted that it was preferable for them to complete their telehealth sessions in their offices rather than their own homes in order to have better access to materials and privacy. Mentioned across modalities, but emphasized the most in individual DBT, providers recommended discussing limitations with the client about how the provider cannot see the client's body and therefore will miss certain body language clues about emotions. Because of this, clients will be asked more often to express their emotions through words. One provider also suggested that the therapist sit back from the camera as to allow the client to view the therapist's gestures. In addition to discussing any telehealth limitations with the client, it was suggested that it is important to address potential benefits as well, such as for some clients, the new modality seemed to make it easier for clients to self-disclose and that being able to see into the client's actual environment helped providers be more effective coaches to their clients. Similar to bringing awareness to the benefits of the telehealth approach, several providers noted that doing individual via telehealth was effective, with one provider stating, "*you don't have to feel like you are delivering a lesser quality product or reducing your fees*" (ID# 98). While confidence in this modality via telehealth was expressed by several providers, being proactive about problem-solving issues with the client was also emphasized. Related, providers also suggested seeking feedback from clients regarding what is working well in the transition to telehealth, as well as continuing to assess and monitor progress on treatment goals.

Consultation Team

Lessons learned for consultation team were frequently suggested ($n = 25$) and centered around team cohesion and prevention of provider exhaustion. Providers recommended finding ways to connect with team members, some of which could be during team, including suggestions to "*allocate more time in consult team than you typically would to just connect with colleagues*" (ID#

191) and/or finding times on the weekend to connect more informally. Also emphasized was the reminder to "*not sacrifice your consult team meetings*" (ID# 49), to seek consultation even more, and to be sure you are on a consultation team with other providers who are also doing DBT via telehealth. It was also recommended to seek consultation and material from others outside the team who are more familiar with doing telehealth. Practically, providers recommended using consultation team to practice new mindfulness exercises before bringing them to a client group. While team was originally designed to include space for role-plays or practicing new skills, it should be remembered that this can apply to practicing technology-related skills and/or testing DBT skills or principles with team members in consultation teams. Last, several providers explicitly mentioned appreciating their team more now than ever.

Therapist burnout. As noted previously, providers used "burnout" as a broad term to refer to issues that increased levels of stress and decreased effectiveness with work or their personal life. Providers (n = 61) highlighted the need for applying the skills to themselves in a manner that was both targeted to the individual, and was also tracked and prompted by the treatment team. The suggestions for skills application recognized the need to both accept (e.g., accept they may be less efficient at work) as well as use change based strategies (e.g., prepare materials ahead of time for video sessions) in order to help them stay energized for treatment. Many providers emphasized taking breaks, separating work from personal time, and going for quick walks.

Applying DBT to oneself. In addition to lessons learned regarding burnout, many therapists specifically mentioned using DBT skills on themselves. Applying the treatment to oneself is fundamental to being a DBT provider and was mentioned by a number of providers (n = 18) regarding the switch to telehealth. Providers described using the Wise Mind (*Mindfulness module; an integration of reason and emotional states*), Cope Ahead (*Emotion Regulation module; rehearsal of skills in advance of a challenging situation*), all of crisis survival skills (*Distress tolerance module; focus on not making a situation worse*), and Radical Acceptance (*Distress Tolerance module; to fully accept a past or present reality*) most frequently. One provider stated, "*I initially felt extremely nervous about treating NSSI and suicidality via telehealth, but 'checking the facts' helped me see that the fear was unjustified*" (ID# 17). Providers noted the importance of observing limits, which is about observing one's limit in relation to a client as to prevent resentment and burnout, and mentioning various strategies they used to accomplish this.

Applying Core Strategies

Validation

Providers (n = 20) suggested finding behavioral ways to match the Linehan (1993) levels of validation to the context of telehealth. For example, providers suggested exaggerating facial affect and voice tone in order to demonstrate understanding of client experience. On a similar note, providers recommended validating the shared experience of the notable difference between therapy via telehealth versus in-person treatment, with one provider stating, "*normalizing to patients that this IS difficult was one of the wisest things we did as a practice. . . .it helped reduce the added invalidation when it was hard and they hated it*" (ID# 2).

Change/Problem Solving

In a manner similar to validation, providers (n = 25) suggested adding reinforcers or modifying reinforcers to better work in the telehealth context, such as increasing relational reinforcers (e.g., quick notes or marks on the screen to show interpersonal rewards) as well as adding in additional reinforcers (e.g., token economies, gift cards, etc.). Several providers mentioned tips for making chain analyses more reinforcing, such as using a whiteboard function, the screenshare function for PDFs, or other fillable chain analysis PDFs. Finally, providers echoed similar sentiments expressed above of retaining the principles, in that behavioral rehearsal or other techniques will work via telehealth but only if the therapist does them.

Non–DBT-Specific Issues

Technology and Access Issues

Not surprisingly, many nonspecific DBT ideas were offered on how to address technology and access issues in general (n = 68). Providers offered several tips on how to use technology effectively, such as researching platform capabilities ahead of time, using Ethernet cables instead of relying on wireless connections, and having secure means for transferring and saving files. Providers generally noted the need to hold standard agreements regarding consultation and the need to reach out for consultation when there is a difficult technology issue.

Administrative

Several providers noted lessons learned in response to administrative barriers (n = 20). In particular, providers commented on having learned that the switch to a secure telehealth platform was expensive. Providers also mentioned the need to advocate for more support and guidance from their team or agency, such as

receiving better training and/or higher-quality video platforms that are compatible with the Health Insurance Portability and Accountability Act (HIPAA). Finally, it should be noted that in terms of transitioning to telehealth and advocating for continuing to do DBT in this modality, thirty-two providers were coded as having stated, "*it works*."

Discussion

In order to provide services during the pandemic, mental health providers, including those practicing DBT, rapidly transitioned to telehealth modalities. Only 26% of the respondents to this survey had used telehealth prior to COVID-19. Without existing DBT telehealth treatment guidelines available, DBT providers who made the transition to telehealth had to develop their own strategies for how to implement DBT via telehealth. The current article reports on data from 200 DBT providers who shared their challenges and lessons learned in doing DBT via telehealth.

The responses to the questions "What do you wish you'd known at the beginning of doing DBT delivered via telehealth that you've since learned?" and "If you were consulting to a colleague about how to do DBT over telehealth well, what do you think would be important pieces of advice to give them?" indicated that it is indeed possible to deliver DBT over telehealth and there were numerous lessons learned in doing so. Many providers commented on areas that, while not unique to DBT, are certainly integral to the treatment—for example, applying the treatment to yourself, conducting a careful pretreatment and orientation phase, and the importance of addressing behaviors that may interfere with the progress of therapy (Rizvi et al., 2013).

An overarching lesson learned in transitioning DBT to telehealth involves providers adhering to treatment principles. The original DBT text (Linehan, 1993) emphasizes treatment principles rather than a set of prescribed techniques and dovetails DBT Skills Training Manual where specific implementation of techniques for group are illuminated (Linehan, 2014). Although these texts were not written with telehealth in mind, the principles that are delineated can be flexibly and creatively applied to this new service delivery medium. As such, providers are reminded to prioritize principles of the treatment over a checklist of suggestions and to seek ways in which aspects of telehealth are in fact not novel to DBT providers. For example, through phone coaching, DBT providers have always been part of and had unique access to information about a client's environment. In addition to phone coaching, context and environment are inextricably embedded within the behaviorist framework of DBT, for which careful and continual assessment of contributing environmental factors to behaviors are emphasized. Interestingly, the telehealth platform may even provide new opportunities to learn more about clients' environments or to practice skills in vivo. Another fairly unique aspect of DBT that may have aided in the transition to telehealth is that DBT providers have routinely managed suicide risk without the client being in the room as providers are trained to coach clients over the phone (or via text/email) in the use of skills instead of NSSI or suicidal behaviors (Rizvi & Roman, 2018). Taken together, these points do not mitigate the reality that transitioning to telehealth possesses novel challenges, but instead, is a reminder to DBT providers that certain elements of telehealth may be more familiar to them than they originally considered.

As DBT providers are trained to make "lemonade out of lemons," the opportunity that comes from doing DBT via telehealth must be recognized. DBT is an evidence-based treatment for many complex presenting disorders, yet access to evidence-based psychotherapeutic treatments is a significant barrier for much of the population, including those with a diagnosis of BPD (Hermens et al., 2011). Telehealth reduces many barriers to access that were previously not seriously considered or pursued by DBT therapists (with few exceptions). As promoted by the National Minority Health and Health Disparities Research Framework (National Institute on Minority Health and Health Disparities, 2020), the National Institute of Health (NIH) is focused on improving health and well-being among individuals and communities who have typically not benefited from, or been included in, research trials on treatment efficacy. Disparities in health internationally are largely a result of insufficient access to services (Gonzales & Papadopoulos, 2010). The telehealth modality can be seen as one tool that can help reduce these disparities, particularly in rural settings, by providing access to DBT to those not typically able to receive it. However, it must continue to be acknowledged that many individuals face significant barriers to receiving telehealth services, including access to technology, reliable internet connection, and accessibility due to disability status and age (e.g., Zhai, 2020).

While there were many lessons learned, our findings also highlight the significant challenges encountered in delivering DBT via telehealth. The key areas identified were managing TIBs, conducting DBT skills group via telehealth, individual therapy, and burnout. Given skills training group was the mode that providers rated as lowest in effectiveness relative to the other modalities when delivered via telehealth in the closed-ended questions, it is not surprising that conducting group

skills training via telehealth was one of the categories mentioned most frequently in the open-ended responses. It is noted that of the research in psychotherapy delivered via telehealth, more broadly than DBT, there is much more research regarding psychotherapy delivered individually than via a group modality (Marton & Kansas, 2016). Moreover, a systematic review reported decreased client comfort in group formats specifically delivered via telehealth compared to in-person (Jenkins-Guarnieri et al., 2015). Additionally, the challenges with TIBs may be emerging because most telehealth resources were not developed with having DBT clients in mind, for whom more are likely to engage in TIBs. Concurrently, existing published DBT literature on managing TIBs was written with face-to-face delivery and phone coaching in mind, rather than telehealth. As DBT providers doing telehealth consider all the TIBs listed in the challenges section, providers should consider the ways in which technology and access issues may elicit or exacerbate TIBs. For example, several providers have observed that clients who are doing treatment from their phones, as opposed to devices that have larger screens, seem to have more issues with engagement and attention during sessions. Careful assessment of how technology and access issues intersect with clients' telehealth behavior and level of engagement is critical.

Study Strengths and Limitations

This study has several strengths. A key strength is that it offers suggestions to DBT providers for areas to consider to improve delivery of DBT over telehealth. This is timely in that DBT via telehealth is routinely being offered and yet there remain very few DBT-specific telehealth resources. To generate lessons learned, DBT providers themselves were surveyed with a sizable number of providers responding in a short period of time followed by using a qualitative approach to extract the themes. Previous research has shown that when clinicians have more knowledge about delivering treatment via telehealth, they are more likely to have a favorable view of telehealth (McClellan et al., 2020) and clinician acceptance of telehealth is necessary for widespread adoption of telehealth (Wade et al., 2014). Another strength of this investigation is that the results draw on the recognizable structure of DBT itself, while remaining faithful to suggestions made by DBT providers. Further, by quantifying themes of how DBT providers responded, this offers valuable insight into how future research efforts, articles, and clinical training may be prioritized to address those issues most frequently endorsed as challenging. This study also has several limitations that serve as the basis for future research and clinical directions listed below. One such limitation is that even though the results were organized using a DBT structure, the open-ended questions were not formatted this way. Had providers been asked to comment on each of the DBT structures, more information or a more even distribution of ideas may have been revealed for each section. Another limitation is that we mainly captured challenges associated with those who had made the shift to telehealth; in that regard, this perhaps represents a biased sample. It is currently unknown how many providers, whether because of administration, their own concerns, or technology limitations, or other factors, did not make the transition to delivering DBT via telehealth.

A third limitation of the current work is that it cannot fully differentiate between those providing DBT via telehealth to adults versus adolescents or children. While it was mentioned by some providers that DBT for adolescents possessed novel challenges, particularly in regards to multifamily skills group (Rathus et al., 2015), the results obtained from this study did not afford enough information for a differentiated set of lessons learned when treating teens.

Overall, this study's limitations also reflect the state of the field: there is much to learn about doing DBT via telehealth. We intentionally framed this paper around lessons learned as opposed to best practices because of the absence of supporting evidence that these lessons are related to treatment outcomes. Even so, in the absence of any empirical research regarding outcomes for those participating in DBT via telehealth, as opposed to face-to-face, surveying DBT providers themselves is a credible method of accumulating best practices, which were further evaluated by international DBT experts (S.L.R. & L.D.).

Future Research and Clinical Directions

Out of necessity given the current situation, clinical provision of DBT via telehealth has moved ahead of the available data. Those providing treatment should consider ways it may be possible to contribute to research so that our understanding and effectiveness of DBT offered via telehealth can be expanded. The field simply cannot wait until a randomized control trial on DBT via telehealth is complete and results are disseminated before fully leaning into this modality. However, results of DBT telehealth studies produced during the pandemic, including the results we present here, will have to be contextualized as having been obtained during the pandemic. It is possible that outcomes presented may differ in postpandemic society and at that time, future research is needed to evaluate whether

there are differences in the outcomes of DBT delivered via telehealth compared with outcomes of DBT delivered face to face.

The following are several recommendations about future research directions, stemming from the current paper. These ideas are not exhaustive. First, as the current research focused on the experience of DBT providers, future research is needed to evaluate satisfaction levels of consumers doing DBT via telehealth and to hear their suggestions regarding ways to improve the experience of doing DBT via telehealth. Second, it would be valuable to know what proportion of DBT providers or clinics did not transition to telehealth and, for those who did not, inquire about their decision or barriers either through survey research or semistructured in-depth interviews. In the future, it will also be valuable to know how providers will make decisions about retaining a DBT telehealth practice, even when in-person therapy is permitted. Third, another domain in need of data collection and dissemination is the prevalence of suicidal behavior, treatment dropout during the telehealth transition, and the need to examine potential iatrogenic effects of DBT via telehealth. A final recommendation is the need for the DBT community to consider producing a "living document" or repository of lessons learned, tools, and resources directly related to the practice of DBT via telehealth that emphasize connection to treatment principles rather than an exhaustive set of rules.

Conclusion

DBT providers worldwide have made the switch to delivering the treatment via telehealth during the pandemic. The accumulation of knowledge of doing DBT via telehealth has been vast. DBT providers must continue to work together to refine doing DBT via telehealth as the pandemic is continuing. In addition, this experience has shown us that there are multiple advantages to the use of telehealth, such as reducing disparity of treatment provision, and it is likely that, beyond the pandemic, DBT offered via telehealth is here to stay. A major task of the DBT community is to research and strengthen DBT delivered in this modality and continue to build consensus on practice guidelines.

Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.cbpra.2021.02.005.

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