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ORIGINAL ARTICLE

High fidelity dialectical behaviour therapy online: Learning from experienced practitioners

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ABSTRACT: *Dialectical behaviour therapy (DBT) is an effective treatment for borderline personality disorder and other problems underpinned by difficulties with emotional regulation. The main components of DBT are skills training groups and individual therapy. The COVID-19 outbreak forced a rapid adaptation to online delivery, which largely mirrored face-to-face programmes using videoconferencing technology. This study aimed to elicit and describe the experiences and learning of therapists involved in providing high-fidelity DBT programmes via the Australian DBT Institute, which established an online delivery platform called DBT Assist™ prior to the COVID-19 pandemic. The report conforms with the consolidated criteria for reporting qualitative research (COREQ). Seven therapists were interviewed. Data were transcribed and analysed thematically. Delivering skills training online, either exclusively or in hybrid form (with face-to-face individual therapy), was acceptable and even preferable to therapists and clients. It was considered safe, the programme was associated with few non-completers, and it improved the accessibility of DBT to those who might otherwise not be able to engage in a face-to-face programme. Skills training utilized a 'flipped-learning' approach which improved the efficiency of online delivery. Other unique and helpful features of the online programme were described. The best outcomes associated with online DBT are likely to be achieved through careful adaptation to the online environment in accord with the principles of DBT rather than mirroring face-to-face processes. Further research is required to determine the efficacy of online therapy relative to face-to-face, and who might be best suited to different modes of delivery.*

KEY WORDS: *borderline personality disorder, COVID-19, DBT, dialectical behaviour therapy, telehealth.*

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Dialectical behaviour therapy (DBT) is a well-evaluated therapeutic programme for the treatment of borderline personality disorder (BPD) (Cristea *et al*. 2017). DBT is also helpful in treating intentional self-harm and suicidality (Kothgassner *et al*. 2021). Despite a limited evidence base (Harvey *et al*. 2019), DBT is rapidly being accepted as a transdiagnostic programme for clients presenting with difficulties with emotional regulation. DBT emphasizes skill acquisition and generalization in the spheres of distress tolerance, emotional regulation, interpersonal effectiveness, and acceptance. This positions therapists and health professionals primarily in coaching rather than consultancy or 'expert' therapist roles. DBT has been adapted to public health services where it is often provided by clinicians not otherwise engaged in or formally trained in other forms of psychotherapy (Lakeman *et al*. 2021; Lakeman & Emeleus 2020). For many people it is the only treatment option available. The Australian DBT Institute (see: https://dbtinstitute.com.au/) provides 'high fidelity' DBT programmes. That is, programmes include all elements of a standard DBT programme, therapists are accredited and highly qualified, and there is scrupulous attendance to adherence to the principles of DBT as described by Linehan (2015). This project aimed to explore how therapists and skills group facilitators have been providing DBT online in high fidelity programmes for several years.

When mandated social distancing was introduced in response to COVID-19, many DBT programmes were profoundly impacted. In order to continue or sustain programmes, DBT therapists needed to rapidly adapt and provide services online (Lakeman & Crighton 2021). There have been no randomized controlled trials of high fidelity DBT programmes adapted for tele-psychotherapy. The literature relating to online delivery has consisted mainly of expert commentary on the rapid transition to online platforms, or focused more narrowly on different methods of between-session contact, such as the use of mobile applications (Dark *et al*. 2022; van Leeuwen *et al*. 2021).

BACKGROUND

The provision of psychotherapeutic services via telehealth by general practitioners and some allied health professions was supported by the Australian Federal Government through subsidies via the Medicare Benefit Schedule (MBS) programme, 'Better Access' during the pandemic (Australian Government 2021). The MBS is the primary means by which the Australian Government funds services in primary care. 'Better Access' is a scheme established in 2006 which allows some allied health professionals to provide subsidized 'focused psychological strategies' at the cost of over $15 million dollars per week (Jorm 2018; Lakeman 2021). Whilst there has been a rapid uptake of telehealth initiatives in mental health, the evidence that it is or has been effective is assumed rather than demonstrated by robust evaluations (Reay *et al*. 2020). It is unclear whether more people have accessed programmes such as DBT during the pandemic. Treatment of BPD is not subsidised under 'Better Access', and DBT programmes delivered face-to-face in public services were initially disrupted (Lakeman & Crighton 2021). Broadbear *et al*. (2021) reported on the transition to tele-psychotherapy of a specialist psychotherapy service for people diagnosed with BPD in a metropolitan area in Australia (which included the provision of DBT) at the beginning of the COVID-19 pandemic. The majority of therapists reported that attendance was regular and non-completion less common in online programmes, which may have been due to people being restricted from working and travelling, as much as the benefits of technology.

A review of the adaption of DBT programmes in response to COVID (Lakeman *et al*. 2022) found that most published reports suggested that moving online was safe, acceptable, and may have improved retention in treatment. However, most accounts relating to adaptation of DBT in response to COVID-19 were reactive. That is, they discussed essentially mirroring the face-to-face process and content of the standard DBT programme in an online environment (using common videoconferencing applications). Some commentators reported concerns about maintaining group cohesion and identity online, and 'therapy interfering' behaviour. Some privately-run DBT programmes (which are often funded directly by service users or subsidized by health insurance) have already established online platforms to support the delivery of DBT in novel ways. However, to date, these programmes and adaptations have not been evaluated.

The Australian DBT Institute is a private mental health service established in 2004. The DBT Institute was formed following a formal partnership with Marsha Linehan's training organization Behavioural Tech LLC. Behavioural Tech LLC's senior trainers travelled to Australia between 2003 and 2008 providing the DBT Institute's clinical leadership with extensive mentoring in the application of DBT and supervision, training, and delivery of DBT professional development

workshops to mental health practitioners. Currently, the DBT Institute's Australian based mental health practitioners assist in developing approximately 1000 mental health practitioners annually through professional development workshops, clinical supervision and mentoring throughout the Asia Pacific region.

Several documented outcomes have been reported following the DBT Institute's professional and service development contracts. Prendergast and McCausland (2007, p. 32) reported outcomes from two DBT groups at a local mental health service stating, 'number and length of hospital stays decreased over both groups, from 62 days to 19 days, saving the local hospital system $49 520 during the 6-month DBT program'. These savings followed an intensive DBT training program with the DBT Institute. Clinical staff in a randomized controlled trial (RCT) delivering youth-based DBT services were required to attend Australian DBT Institute training. The RCT employed a staggered, parallel-group design in which 120 participants (aged 16–25 years, and scoring high on measured of emotional dysregulation) were randomized into either an intensive 16-week programme (which included weekly individual therapy and group skills training), or an 8-week group skills programme only (Davidson *et al*. 2019). The trial found improvements in both groups, but those in the 16-week DBT programme showed significantly greater improvement on measures of '…quality of life, and suicidality risk' (Davidson *et al*. 2019, p. 19). In addition to service development and professional development of mental health practitioners, the DBT Institute facilitates eight DBT programmes each week through the telehealth service DBT Assist™.

DBT Assist

Developed in 2014, DBT Assist is an Australian DBT Institute developed telehealth platform. DBT Assist was initially developed to address the needs of some clients who reported feeling uncomfortable participating in DBT group sessions. The requirement of face-to-face attendance and participation in group skills training has been proposed as a potential source of social anxiety and a reason cited for non-completion in some naturalistic evaluations of DBT programmes (Lakeman *et al*. 2021). Since 2018, the DBT Assist platform has been expanded to an updated interactive education portal for DBT group-specific content and resources that clinicians and participants use during telehealth based DBT groups and individual therapy. The DBT Assist platform provides participants with access to skill-specific teaching videos, worksheets, weekly reminders of group-based tasks, homework tasks, mechanisms to review each DBT module, and skill implementation support from facilitators. DBT Assist provides individuals with access to the DBT resources at any time.

The face-to-face DBT skills group follows a standard format outlined by Linehan (2015). The skills group is largely didactic in focus and provides an efficient means to teach skills (Linehan 1993). Skills are taught in modules which explore emotional regulation, distress tolerance, interpersonal effectiveness, dialectics and mindfulness. Modules may be abbreviated but typically are of around 6 weeks duration and closed to new referrals during each module. A typical group session might last from 2 to 3 h and consist of a mindfulness exercise, homework review, the teaching of one or more skills as outlined in a manual (Linehan 2015), practice or role play, the setting of homework and closure involving further mindfulness practice. The DBT Assist online skills training is run over 27 weeks and aligned to the Queensland school term. This is divided into three discrete, 9-week modules addressing distress tolerance, emotional regulation and interpersonal effectiveness. Each module commences with 2 weeks of mindfulness training. The final week reviews the entire module (see Table 1). The philosophy of DBT and associated skills such as dialectics and radical acceptance (which is sometimes incorporated as a discrete module) is interwoven in each module.

This aim of the study was to elicit and describe the experiences and learning of therapists involved in the provision of high-fidelity DBT programmes via the Australian DBT Institute in the context of using DBT Assist as needed or required during the COVID-19 pandemic.

METHODS

Ethics approval was obtained from the Southern Cross University Human Research Ethics Committee (2021/097) to undertake semi-structured interviews with key informants and to subject these data to thematic analysis. The report conforms with the consolidated criteria for reporting qualitative research (Tong *et al*. 2007).

Contracted therapists at the Australian DBT Institute were sent an email inviting them to consider participating in a brief survey and a recorded face-to-face zoom meeting regarding their experiences of providing DBT online. Participants were invited to 'opt in' by

clicking on a link to an on-line survey where the informed consent procedure was outlined. They were asked, if they choose to continue, to provide basic demographic information, as well as contact details and preferred times for the interviews. This purposeful sampling method (Palinkas *et al*. 2015) was chosen to elicit participation from those who had the experience of providing DBT online using this platform.

A semi-structured interview schedule was developed based on questions arising from a review exploring the provision of online DBT undertaken by the project team (Lakeman *et al*. 2022). The interview schedule (outlined in the Appendix S1) was used as a prompt for topics to cover. These primarily addressed generic issues in DBT programmes and how they were addressed in different modes of delivery. For example, how content is delivered differently, how safety is maintained, how facilitating skills training differs when delivered online and how therapy interfering behaviour is addressed. The interviews were conducted by three researchers via zoom (KC, JH, and RL) who had no affiliation to the Australian DBT Institute and were not known to respondents. All were experienced mental health nurses with knowledge of the language used in DBT, but assumed a naïve stance and asked open and exploratory questions in order to elicit explanation from participants. Interviews took place in late 2021 (a time when COVID-19 social distancing mandates were beginning to ease in Australia). Interviews lasted between 30 and 57 min (M = 46 min) and were audio recorded and transcribed.

The thematic analysis of the transcripts was undertaken with the assistance of the software package NVIVO by the first author (RL) using the inductive approach outlined by Corbin and Strauss (2014). Such an approach systematically derives concepts and themes from readings of the raw data (in this case, interview transcripts) rather than testing a theory (The SAGE Dictionary of Qualitative Management Research 2008). This involved an initial reading of the text clustering responses to questions into broad themes relevant to the research aims. This was followed by iterative process of re-reading, clustering and recoding, until all responses were represented under the broad themes. The interviewer reviewed the thematic structure and agreed that it captured the responses and issues which they discussed. The findings are presented as a narrative synthesis, representing as much of the variance within responses as possible.

Sample

Seven therapists were invited and agreed to be interviewed, three males and four females. Their ages ranged from 23 to 49 years (M = 37, SD = 9). The professional affiliations of therapists included: mental health nurse, medical doctor, occupational therapist, social worker, provisional psychologist, clinical psychology registrar, and aboriginal health worker. All had received extensive training in DBT as well as training in one or more forms of psychotherapy in addition to their professional training. One held a PhD, another a Master's degree and all but one reported holding a Bachelor's degree or equivalent. One person reported being in their first year of practice and working under supervision as a co-facilitator in skills group training. The remainder reported 1–20 years of practice as a DBT therapist (M = 6.5, SD = 6.7). Two (less experienced) respondents reported working primarily in skills group facilitation. The remainder reported being primary therapists for at least 10 clients. Excluding the most experienced therapist (who reported being primary therapist for 150 clients online over more than 10 years), the remaining four reported being primary

TABLE 1 *Weekly topics in the three DBT skills modules*

Week	Distress tolerance	Emotion regulation	Interpersonal effectiveness
1	Intro & Wise mind	Intro & Wise mind	Intro & Wise mind
2	Mindfulness	Mindfulness	Mindfulness
3	TIPP skills	Dialectics	Validation
4	Dual awareness	Model of emotions	Changing behaviours
5	Distraction skills	Model of emotions	GIVE skills
6	Pros & Cons	Opposite action	FAST skills
7	Half smile/Willing hands	PLEASE & Pleasant	DEAR man skills
8	Radical acceptance	Events values & Priorities	Evaluating options
9	Module review	Module review	Module review

therapists for an average of 36 clients (and an average of 10 exclusively online). The number of online skills groups facilitated ranged between 1 and 53 (M = 18.4, SD = 19.7). Two reported being extremely competent and capable of facilitating and managing online DBT skills training, and the remainder (n = 5) reported being quite competent (4 on a five-point Likert scale).

FINDINGS

Differences between the standard DBT skills group and the DBT Assist programme

With DBT Assist, therapists or facilitators have flexibility as to how they run skills group. However, a key area of difference from usual skills group procedures (which emphasize teaching skills on the day and providing handouts to take-away) is that participants are expected to access the multimedia resources and handouts for the week before attending the skills group:

> Everybody gets five minutes to describe their homework from the previous week's skill. The only difference is rather than teaching the skill like we used to we have people watch videos in preparation for group and we just review the videos. So we say, "how did you go with watching the videos? Anything that you need clarifying? Was the skill understandable?" Then we set homework related to that skill. So basically, what happens is the online platform focuses more on the homework review and clarification of the skill. [Therapist 1]

As a consequence of this 'flipped learning' approach of reviewing content before attendance, online sessions were often shorter (90 min or less). A feature of the platform is that a record of what and when participants review online material is accessible to therapists. Participants also upload worksheets and homework exercises online and can engage in asynchronous discussion forums about the skill or other issues. Not every therapist monitored access to materials, but those that did were often surprised by the level of engagement and preparedness of participants:

> My men... are in there... all the time, it's really interesting... they discuss or say, "I don't get this, this doesn't make sense to me". They post all their homework... They're really engaged in the actual platform... Young people, not so much. They'll do their homework, but they won't engage with each other. [Therapist 2]

Some reported the 'flipped learning' model (rather paradoxically) to have made the online skills group sessions more interactive than would typically be experienced in face-to-face groups. Having researched the skill, at least some participants wanted to explore the application of that skill to their life in more detail than therapists had come to expect in face-to-face groups.

> ...they preferred the sessions a lot more when they are more interactive. I think that's also just to sustain the concentration..., and then also the energy levels too. [Therapist 4]

Therapists noted differences between DBT programmes run in the public sector and those run by private practitioners. Most respondents had worked in both sectors. In the public sector, they noted that DBT participants were often 'followed up' by other professionals, team members or administrative assistants who would assist with scheduling. In their experience of the private sector, ensuring follow-up was the individual therapist's responsibility. However, it was an impression of all respondents that the Australian DBT Institute programme was more faithful to the principles of DBT and included all programme components, which were sometimes not provided in the public sector. Often DBT practitioners in the public sector have multiple roles, which sometimes require working in ways that conflict with the spirit of DBT:

> ...my experience is in DBT programs in the public system, is that generally the clinicians don't have time for consult groups... I used to manage a DBT program ... so that was my experience. People get really wrung out because they're running caseloads at the same time. DBT consequences start to be used as punishments, and they're not trauma informed. So, that's why I think people drop out. [Therapist 2]

Therapists noted that the programme, as well as individual clinicians, were genuinely trauma-informed and authentic. As one person noted, this manifested in subtle ways such as 'externalising the skills' through initially learning them via videos or their favourite movie characters rather than immediately applying skills to their own lives. Some homework tasks involved participants finding and uploading media that demonstrated a particular skill:

> So, the ability to have the clips and the videos and it allows you to be learning about people's learning styles as well... If I'm working with particularly adult men, they really enjoy the videos, rather than this didactic kind of teaching style. So, that's good, you teach the skill and then you use videos to [go] back to the skill, back to a video. You still use the worksheets in groups and in session... you'd just be filling them out together

> or share screen... you just have to know how to use a platform. [Therapist 2]

DBT Assist provides asynchronous access to resources in a highly portable fashion, with participants able to access resources on smartphones as well as via computer. They are able to find and revisit skills very flexibly. There were various ways that access was incentivized:

> So, on your profile you actually get badges... young people like that stuff...So, there's different ways to engage them...the platform's always there... this is the great stuff... You might've done distress tolerance and you're in interpersonal effectiveness... but it's been really challenging for you... something's happened... you've always got the platform with you, to go back and engage in the distress tolerance... and you don't have to carry around folders. [Therapist 2]

DBT Assist is populated with a rich library of multimedia resources, including videos of former programme participants providing testimonies regarding skills use.

Preparing for online delivery

Online therapists, as well as programme participants, require preparation to work successfully online. The confidence and competence of therapists using technology varied considerably, although all therapists perceived that they had adjusted well.

> Clinicians need more education and support in delivering online services. That's the key. Clinicians have the skills in teaching DBT... that's not a problem. But the anxiety around the platforms, the anxiety around Zoom and a whole range of things, I think that that's the missing piece for online work is to have some education about using this... [Therapist 1]

Programme participants often needed orientation to work online, and in particular, before engaging in groups. One experienced therapist emphasized the importance of the 'pre-commitment' phase in DBT and, during this time, introduced people to the platform and discussed expectations about how to interact online. Whilst, introductory videos were acknowledged as helpful for many, others required intensive coaching:

> ...I do intakes. I ask questions such as, "Do you have a computer? Do you know how to use it? Have you worked with Zoom before?"... Those are like screening questions but from there until I can ensure that they know how to use it... we could improve by having sessions or workshops on how to use them. [Therapist 6]

The same therapist recommended older adults bring their computers into the clinic for a trial run and noted that they were generally enthusiastic about learning about using the technology but often needed more time for that than younger people.

Acceptability of the programme and non-completion

Whilst not everyone preferred this way of operating, most therapists were highly impressed with the online facilities but noted they needed to be prepared to undertake online therapy. One therapist reported having a well-resourced office with four screens and a whiteboard in camera view (preferring to use a real whiteboard rather than an online virtual whiteboard).

> I just think it's wonderful, I'm a big fan...I've thrown myself into it... if you're someone that likes to be prepared... it's great... online requires preparation. [Therapist 2]

> I was absolutely amazed with how responsive the people going through the skills were and collaborative in general. Especially the sense of confidence that you'd see when they've picked up something really well... [Therapist 7]

Most people reported few non-completers, especially in the hybrid group. When participants missed a face-to-face group, they were able to catch up with DBT Assist.

> The concept of DBT Assist for my face-to-face groups is they've got access to the videos at home. One thing that I have always asked them is as part of when you get the email for the next week, I want you guys to all re-watch one of the videos just to cement that idea ... you've got access to it at home... [Therapist 5]

The attrition from online groups surprised some. It was suggested that this occurred due to a lack of cohesion and identification with others in the online group:

> Surprisingly the youth groups that we have set up have had quite a high attrition rate. It seems that young people actually find online more challenging than some of our older participants, which is interesting...that's possibly just the fact that it is much easier to tune out and then drop out. Whereas when they are coming face-to-face they kind of subconsciously build that connection

with the group once they have been a couple of times. [Therapist 3]

Other therapists noted high attrition in some groups that they were involved with. One highly experienced therapist suggested that some people did not feel as committed to the online skills group and perceived that they could more easily terminate their 'membership'. On the other hand, one therapist noted that attending a face-to-face group and waiting in a therapy waiting room can be enormously anxiety-provoking for some people, and the online option reduced anticipatory anxiety considerably. Overall, it appears that the potential increase in access to DBT online more than offset the problem of potential premature termination:

> We're in the Gold Coast, and a lot of people we work with are in Sydney, Melbourne, Tasmania, South Australia, Western Australia, Northern Territory, and they're grateful to be able to access a DBT program…We have one person who's a truckie and he's never been able to attend any groups because he's always on the road. But he can always pull over on the road and perhaps spend 90 min… he joins in the group in the back of his truck… I would say there's probably been about a 10 to 15 per cent of people who have just said, 'I prefer face-to-face groups', and we've had a little bit of dropout related to that…. So those people will wait until the next time we've got face to face groups. [Therapist 1]

Challenges and therapy interfering behaviour

The Australian DBT Institute enables some clients of therapists who are external to the Institute to access online groups. It was observed that some such clients appeared less motivated, seemed less well engaged or did not complete homework tasks as regularly as others. This was thought to be due to poorer adherence, on the part of therapists, to the principles of DBT:

> So, people… have individual therapists outside the clinic… They present with more [therapy] interfering behaviours than when the clinician is one of us at the clinic because…it's more difficult to ensure that the individual session follows all the structure of a DBT session… and that's the reason why they [the client] don't really come with homework. [Therapist 6]

Most potentially therapy interfering behaviours are similar in online environments to face-to-face therapy and are dealt with in the same way through responding in accordance with DBT principles. However, there are some unique potential and common problems working online.

> … So there's two types of therapy interfering behaviours… one from the clinicians including myself delivering the content and then the other from individual clients… So the individual client's therapy interfering behaviour includes not having their computers on, not being on time, not wanting to talk… so pretty similar to what happens in usual groups. People not being on time, not wanting to talk, not wanting to do homework, there's no difference there but there is the little bit of the added thing of, 'my computer's not working'… [Therapist 1]

It was acknowledged that it was easier to disengage online than in face-to-face groups. A co-facilitator was deemed useful to respond to people in distress and encourage participation via private chat so as not to disrupt the group. It was noted that some people, for various reasons, do not like seeing themselves on video, or they feel uncomfortable being seen by others. This was noted to be a particular problem for people with gender dysphoria or body dysmorphophobia. It was observed that if people turned their cameras off, then that could lead to 'camera contagion' whereby other people would also switch theirs off. Discussing expectations about camera use and if necessary, setting up the device to minimize self-observation was considered important in the pre-commitment phase of therapy. Additionally, reinforcing expectations about being present, dealing with distractions, maintaining the privacy and not messaging people during group activities often needs revisiting with the group from time to time.

As previously noted, people were often more interactive online, and this could potentially lead to overdisclosure in online groups. One therapist noted that people could interrupt others:

> …another therapeutic interruptive behaviour might be… feeling quite confident to just interrupt someone else's participation… I think people are just more brave or… impulse control can be quite challenging for people… the physical nature of having people around you, helps you regulate those things. [Therapist 2]

A consequence of people engaging in online therapy from an environment of their choosing is that there may potentially be background distractions, interruptions, the presence of pets, children, and the ubiquitous presence of mobile phones. Therapists suggested that being distracted was okay but being disruptive was not.

> . . .if they're distracted, they're welcome to be distracted, but if they're being disruptive, I think that's really harmful to the rest of the group. That if someone is doing something that is not appropriate, that is where I would stop it. [Therapist 5]

People cited examples of people appearing intoxicated or smoking whilst in groups as being problematic. At the same time, other behaviours such as eating or messaging others sometimes might be seen as interfering. Facilitators need to be role models of appropriate behaviour, finely attuned to the impact of behaviours on individuals in the group and ready to sensitively and assertively address therapy interfering behaviour:

> How do I address that [therapy interfering behaviour? I individually message people as we might be watching videos or something like that. . . then they will know. . . and then obviously their behaviours addressed at the individual session to follow it up and do their chain analysis. . . [Therapist 2]

Maintaining safety online

Some therapists stated that they had experienced no problems with any client they had been involved with. This was credited to effective triage of people into the programme and not rushing the pre-commitment phase, which included an orientation to online working and the development of crisis plans. If clients do not have an individual therapist directly employed by the Australian DBT Institute, that person will have an 'intake' and 'orientation' with clinic staff, so they are aware of expectations relating to group behaviour and also to ascertain whether the online group will be a 'good fit' for them. In response to the question about safety concerns, one therapist stated:

> . . . they were all seeing individual therapists, and nothing really came up that sparked concern, or that required us to do a suicide risk assessment or anything. At the start, they fill out telehealth forms, which include that they are in a safe space, that someone is home, some details of who else that we could contact [if we have concerns]. . . So, we did get all of that information. . . [Therapist 4]

The importance of having two facilitators in online groups was emphasized as a means to respond to distressed clients. This had not always been the case:

> . . . I have only had one sort of incident right back early on. . . with a youth group. I had a young person who wasn't doing so well. . . and they turned their camera off. Fortunately, I had somebody else in the clinic with me and I was able to ask them, "can you go and phone this young person for me and make sure that they're okay?" They were actually able to do that. So, another safety component is to be able to access support from another clinician if somebody . . . drops off and you're a bit concerned about them. . . and having somebody there that can make contact. Usually that's what the second facilitator would be able to do. [Therapist 3]

All therapists discussed the importance of being genuinely trauma-informed as well as being aligned to the principles of DBT. It was an expectation that all therapists attend a weekly 'consult group' at which therapists talk about anyone not attending, having trouble with group content, or who might have engaged in therapy interfering behaviour. It is at this meeting that individual therapists hear about the progress that their clients have made or any issues which need to be addressed in individual therapy if they have not heard via the group facilitator or client concerned.

> . . .they don't generally stay in group if they're intoxicated, they'll jump off. But then I will follow up with them, because I don't want them to be dysregulated and feel shame, I need to be able to make sure they're safe. So, linking in with them, might be a text message, sorry you missed out on group tonight, let's have a chat about it with your individual therapist, let's see how we can do this better next week. That kind of stuff, just validating what we need to validate, but address the behaviour and then carry on. [Therapist 2]

DISCUSSION

The findings in this paper are consistent with the findings of recent reviews of online DBT (Lakeman *et al*. 2022) and other therapeutic programmes, which have mainly reported on rapid adaptation to online provision due to COVID-19 and reported few difficulties (Dark *et al*. 2022; Schlief *et al*. 2022). These findings partly address and describe what Schlief *et al*. (2022) recommend is urgently needed, evidence for what makes a good 'telemental' health programme. The sample size was purposefully chosen and small, and given this and the inductive methodology, no claims can be made that the experience or insights of these therapists represent those of others who might be providing DBT online in high fidelity or well-functioning adaptations of DBT. However, the views and experiences of such therapists have not been systematically elicited and shared in this way before. Thus, this modest synthesis of the experiences of seven therapists might assist others to develop effective

programmes and adaptations of DBT, and encourage the DBT interested community to discuss how best to deliver DBT to those who might most benefit.

The therapists in this programme varied in the experience of providing DBT online, and for some, it was not their preferred mode. However, these respondents offer a unique perspective regarding online DBT, as when the COVID-19 outbreak occurred, they were able to seamlessly adapt to online work using a bespoke platform designed specifically for DBT. A distinctive feature of the online platform that greatly enhanced its acceptability was the flipped learning approach. This is rapidly becoming a preferred pedagogical approach in teaching (Hwang *et al*. 2015), including in the education of health professionals (Hew & Lo 2018). Until now, how the principles of the flipped learning approach have been applied to DBT skills training has not been articulated. The unique approach of the Australian DBT Institute in adopting a flipped learning approach has been to enable online participants to access all the multimedia resources they need to learn a skill in the week prior to the skills training group. These resources have included videos by clinicians and former program participants. Adapting the principles of a flipped learning to DBT skills training is likely to improve in-session engagement while decreasing social anxiety. Social anxiety has been noted as an impediment to successful engagement in face-to-face skills training (Linehan 2015, p. 30). It reflects a more client-centred approach in which individuals feel in control of their therapeutic and learning processes.

A further noteworthy innovation is the completion of worksheets, diary cards, and outcome measures online. These tasks assist clinicians and patients in maintaining visual information related to behavioural and cognitive changes over the course of treatment. For instance, the completion of weekly diary cards, providing numerical information (in Likert scales ranging from 0 to 4) about the individual's emotions, intensity, urges and skills use (Linehan 1993). The use of diary cards enables highly structured individual sessions with specific targets according to the scores recorded during the week. DBT participants are likely to attain the most benefit from the online programme when they have an individual therapist who is attuned to the progress of the person in the online skills group and can utilize the individualized and targeted resources to enhance the individual therapy sessions in keeping with the principles of DBT (Bedics & McKinley 2020).

The use of self-reporting tools and standardized outcome measures are widely promoted and reported in Australian health services (Brown & Pirkis 2009) despite some unresolved controversy regarding their usefulness (Lakeman 2004). In this online DBT programme, the use of these tools are tailored specifically to those with emotion regulation problems. This appeared to be overwhelmingly positive for participants and clinicians involved in their treatment. Participants develop specific awareness of dimensions of emotion regulation/dysregulation from the visual representation of their changes in perception of emotions, impulsive behaviour and ability to maintain focus on goals when confronted with aversive situations (Gratz & Roemer 2004). This sustained focus on problems of concern and relevance to the individual may partly explain the low rates of reported incompletion in this programme.

These therapists did not report problems with group cohesion and identity, as has been noted as problematic in some programmes (Lakeman *et al*. 2022). This is likely to be due to a combination of factors, including the availability of skilled facilitators, clear ground rules, and an engaging platform. Moreover, the framework of trauma-informed care (TIC), under which the Australian DBT Institute works, ensures that clinicians help participants function within the regulated zone. This is particularly important as many participants attending a DBT programme have some history of trauma, so by following the principles of TIC (Kezelman & Stavropoulos 2012), participants' needs can be met in a safe, compassionate and collaborative manner that minimizes the likelihood of re-traumatization.

Therapists also described scrupulous attention to the principles of DBT (Linehan 1993) rather than slavish adherence to treatment manuals or traditional ways of operating. This orientation includes an emphasis on preparing clients adequately and spending as long as needed in the pre-commitment phase of therapy. It also needs noting that participants pay for therapy (either directly or via insurance schemes). In psychotherapy, it has long been appreciated that there is a relationship between paying for service, motivation, and attendance (Carpenter & Range 1983).

The clients of this programme had access to technological resources (internet enabled devices). They were on the equipped side of the digital divide, in which some people do not have access to technology and which reinforces disparities in health outcomes (Brodie *et al*. 2000). It is unclear how great that divide is in Australia. One therapist, an Aboriginal health worker who had previously coached Aboriginal people in DBT skills, noted that he had encountered no Aboriginal

people accessing the online programme. The reasons were complex and not altogether about access to technology. Similarly, older participants appeared to not have the same access as their younger counterparts due to a lack of technological skills. Further research is needed to explore programme adaptations needed for groups who presently do not, or cannot access programmes such as DBT.

CONCLUSION

The therapists in this research have all been involved in the provision of DBT online as individual therapists or DBT skills group facilitators using a carefully crafted delivery platform. Whilst the provision of individual therapy via platforms such as zoom is no longer novel, what is novel is the provision of online skills training not directly mirroring face-to-face skills groups and using a platform developed exclusively for that purpose. The learning from the experience of these therapists will be valuable to those who may wish to develop or deploy high fidelity DBT programmes online. The experience of these therapists was that delivering skills training online, either exclusively or in hybrid form (i.e. providing online therapy as needed), was acceptable, even preferable for many; was safe; was associated with higher rates of completion that in face-to-face programmes; and greatly improved the accessibility of DBT to those who might otherwise not be able to engage in a high-fidelity DBT programme. Further research is urgently needed to confirm these findings that the online mode of DBT is as effective as face-to-face and to determine who might benefit most from either mode of delivery.

RELEVANCE TO CLINICAL PRACTICE

Access to complex therapeutic programmes such as dialectical behaviour therapy (DBT) is a challenge to many people who might benefit. Traditionally DBT has involved weekly skills training undertaken in a group, individual therapy and skills coaching as required. Adapting all or some components of DBT online can improve accessibility to DBT programmes and associated positive health outcomes. This research explored the provision of a carefully planned, online high fidelity DBT programme in which there were high numbers who completed and who came from geographically dispersed and remote locations engaged. A detailed description of the programme and a bespoke online platform called DBT Assist™ is provided, which assists in skills training through a flipped-learning approach.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's website:

Appendix S1 Semi-structured interview guide.