Understanding the Experience of Novice Dialectical Behavior Therapy Co-leaders to Improve the Fidelity of Skills Training Groups

Kayla Paige Brubacher

School of Nursing, Oregon Health & Science University

DNP Quality Improvement Project

Tara O'Connor, DNP, PMHNP—Project Chair

March 11, 2025

Abstract

Dialectical Behavior Therapy (DBT) is an evidence-based treatment that was developed for treatment of individuals with borderline personality disorder (BPD). Skills training in the four core competencies of DBT—emotional regulation, distress tolerance, interpersonal effectiveness and mindfulness—is a key feature of DBT. Graduate students are often utilized to co-lead skills training groups alongside licensed clinicians but despite the longstanding use of student co-leaders, there is a lack of standardized training protocols for their role. This lack of guidelines is relevant given the often complex and high-risk nature of individuals with BPD often referred to DBT. This project, conducted at a large outpatient DBT clinic, sought to better understand novice co-leader experiences and identify areas of improvement utilizing the Institute for Healthcare Improvement (IHI) Model for Improvement. A survey of co-leaders examined the perceived effectiveness of various training components including orientation, active co-leading of skill training groups, supervision, and independent study. This initial survey indicated that co-leaders value the immersive learning experience that co-leading offers but also suggested room for improvement specifically in the Orientation/Onboarding process and in Group Supervision. Preliminary findings suggest that co-leaders would benefit from clearer role expectations and improved communication with group leaders. Adjustments to training and supervision content and structure may be called for to meet the needs of novice co-leaders.

Introduction

Problem Description

Dialectical behavior therapy (DBT) was adapted from cognitive behavioral therapy (CBT) in an effort to address features of borderline personality disorder (BPD), namely chronic suicidality and non-suicidal self-injury (NSSI), that were insufficiently managed by traditional CBT or other modalities available (Linehan & Wilks, 2015). It's been reported that 60-70% of those with BPD will attempt suicide at least once in their lifetime and up to 10% die by suicide—a rate 50 times that of the general population (Harley et al., 2023; Rizvi et al., 2017). BPD has become a highly stigmatized diagnosis, in part due to the perception that these life-threatening behaviors cannot be treated (Rizvi et al., 2017).

Marsha Linehan, founder of DBT, developed a comprehensive treatment program inclusive of individual therapy, skills training groups, phone coaching, and a consultation team; full fidelity DBT programs provide all four components (Harned & Schmidt, 2022; Linehan, 2015). Skills training groups are to be conducted by a primary group leader and a co-leader (Linehan, 2015). The group leader is an experienced, DBT-specialized therapist. Co-leaders are often graduate students or clinical interns but may also be a second licensed therapist. Linehan (2015) notes that student trainees have filled the co-leader role since DBT's inception, yet minimal guidance exists on best practices for utilizing student co-leaders (Lungu et al., 2012; Matsunaga et al., 2022; Rizvi et al., 2017). The lack of guidelines is relevant, particularly given the often complex and high-risk nature of clients often referred to DBT (McCarthy et al., 2021; Noll et al., 2020; Rizvi et al., 2017).

Academic programs have reported on the benefit of student co-leaders but also identify that clearer guidance on implementing student co-leaders would be beneficial (Lungu et al., 2012; Rizvi et al., 2017). While some facilities use two licensed mental health clinician to co-lead therapy groups, clinics confront the financial implication of insurance only reimbursing for one licensed therapist, further supporting the utilization of student co-leaders (Matsunaga et al., 2022). Outpatient DBT clinics have developed programs to place practicum-ready students in the role of skills group co-leader, however, no

singular approach has been identified as most effective to assess student readiness to step into the role (Naylor et al., 2023; Noll et al., 2020).

Available Knowledge

A literature review regarding evidence-based approaches for implementation of the co-leader role in DBT programs was completed using American Psychiatric Association (APA), EBSCOhost, PubMed, CINAHL, and Ovid databases. Various combinations of the search terms ("DBT" OR "dialectical behavior therapy") and (“student” OR "intern" OR "trainee" OR "co-leader"). In place of DBT-specific terms, ("therapy" AND ("psychology" OR "psychiatry")) and ("practicum" OR "training") were also used to consider how co-leaders are implemented in other forms of group therapy. A Google search yielded practicum outlines used in doctorate programs. At least 20 additional sources were yielded from the reference lists of previously identified papers.

The dialectical backbone of DBT is the concurrence of acceptance and change (Linehan, 2015; Zalewski et al., 2021). In skills training groups, the group leader and co-leader are meant to embody this dialectic; the group leader promotes change with skills training, and the co-leader offers acceptance and validation of the client’s current experience (Linehan, 2015; Matsunaga et al., 2022). The co-leader also addresses therapy interfering behaviors (TIB) by contacting truant group members and offering individual coaching to clients in crisis (Matsunaga et al., 2022; Zalewski et al., 2021). Co-leadership is utilized in various therapy modalities and presents an opportunity for students to build therapeutic competencies by working alongside experienced therapists (McCarthy et al., 2021). It is beneficial for clients to see modeling of healthy behaviors and interpersonal relations (Huffman & Fernando, 2012; Zalewski et al., 2021).

Corroborating the need for clearer training guidelines, Linehan and her team published a paper on how they prepare co-leaders at their DBT training clinic at the University of Washington. They use a combination of theoretical DBT didactics, teaching DBT in the community, and clinical practicum inclusive

of all components of DBT (Lungu et al., 2012; Rizvi et al., 2017). Since then, various programs have reported on the experiences of master's and doctoral-level students entering DBT practicum, some with little to no prior exposure to DBT (Naylor et al., 2023). Most though, have at least some DBT didactics or practice with peer-led skills groups prior to entering the clinical practicum setting (Field, 2016; Noll et al., 2020; Rizvi et al., 2017). One study found that even with minimal training, graduate students were able to co-facilitate DBT groups with 88% practice fidelity, adding support for student co-leaders, even while still in the process of learning fundamental concepts of DBT (Rizvi et al., 2017; Toms et al., 2019).

In addition to didactics, students reported experiential immersion in DBT skills training, personal application of DBT principles, and well-supervised, supportive environments as beneficial for acquisition of DBT concepts (Naylor et al., 2023). This approach, a combination of didactic and experiential learning, aligns with best practices identified by other group therapy modalities (Goicoechea & Kessler, 2018). Another common practice is a stepwise approach of didactic training, shadowing or observation, co-leading, then sometimes, independently leading groups (Field, 2016; Lungu et al, 2012; Noll et al., 2023).

Rationale

A review of the literature regarding co-leader training and implementation in DBT treatment programs revealed an absence of a standardized, evidence-based approach to training the novice co-leader (Lungu et al, 2012; Rizvi et al., 2017). There was little information regarding the impact of co-leaders with varying levels of preparation and of group leader – co-leader dynamics. It is recognized that systematic training in group therapy, both in DBT and in other psychotherapeutic modalities, warrants more attention (Fall & Menendez, 2002; Goicoechea & Kessler, 2018; Noll et al., 2023). These issues were explored at a DBT clinic in the Pacific Northwest that utilizes student co-leaders in practice.

The Institute for Healthcare Improvement (IHI) Model for Improvement offers a framework of iterative planning, doing, studying, and acting (PDSA) cycles to aid in understanding and improvement (Langley et al., 2009). The IHI model was utilized to understand the experiences of novice co-leaders and

develop recommendations for practical improvements to the co-leader training program at the implementation site. An assessment of current processes and relevant people were identified in a fishbone cause-and-effect diagram (see Appendix A). It was considered that co-leader skill level and interactions between group leaders and co-leaders may impact a client's skills training experience (Huffman & Fernando, 2012; Zalewski et al., 2021). The experiences of novice co-leaders as they integrate into their role was identified as the initial point to explore.

Specific Aims

The key aim of this project was to better understand the experiences of novice co-leaders and how they develop understanding of the four core competencies of DBT (emotional regulation, distress tolerance, interpersonal effectiveness, mindfulness). One aim was to gather information from co-leaders on the methods perceived as most effective for obtaining understanding of DBT and more generally, their understanding of the role of co-leader. Another intention was to develop suggestions for practical improvements to the co-leader program to relevant clinic stakeholders for consideration.

Methods

Context

The DBT clinic where this project was conducted is one of the largest free-standing, outpatient DBT clinics in the country. They adhere to full fidelity DBT protocols, offering standard outpatient programs, Intensive Outpatient Programs (IOP) for adults and teens along with specialty groups for eating disorders, post-traumatic stress disorder (PTSD), and substance use disorders (SUD). The clinic shifted to a telehealth model during the COVID-19 pandemic and largely continues to operate virtually with some in-person programs reinstated. The primary team is composed of DBT-specialized licensed clinical therapists (PhD, PsyD, LCSW, LPC), psychiatric mental health nurse practitioners (PMHNP), registered dietitians, and administrative staff managing organization operations and research. Students, typically those completing practicum, join as skills training group co-leaders.

Intervention & Study of Intervention

The intervention was a survey (Appendix E) of co-leaders regarding their experiences with onboarding to the co-leader role and co-leading skills training groups. This survey gathered information on what co-leaders deemed most helpful to understand DBT core competencies, group leader actions identified as constructive to the novice co-leader and how to improve upon the co-leader experience. Quantitative and qualitative findings were analyzed, summarized and shared with clinical stakeholders.

Measures

The co-leader survey (Appendix E) utilized Likert scales and multiple-choice questions to assess understanding of the DBT core competencies and efficacy of different experiences (e.g., orientation, supervision, actively co-leading skills groups) in obtaining that knowledge. Open-ended questions elicited feedback on specific experiences co-leading groups and interacting with group leaders. The survey gathered general information on education and clinical training (e.g., degree type) as well as information specific to experience at the clinic (e.g., co-leading start date, number of hours co-leading weekly) with the intention of identifying if these variables impacted perceived experience as a co-leader.

Analysis

Qualtrics, a web-based survey tool, was used to gather and analyze survey responses. The survey was distributed to co-leaders through email, and it was mentioned during co-leader group supervision on two occasions. Counts and percentages for nominal and ordinal variables, largely gathered with Likert scales and multiple-choice questions, were organized into graphs and tables for presentation and comparison (Appendix F). Qualitative content elicited from open-ended questions was reviewed and organized by themes. A summary of these findings was shared with organizational stakeholders.

Ethical Considerations

Co-leaders, largely graduate students completing practicum at the DBT clinic, were informed of the project intent and informed that participation was voluntary. Their choice to participate made no

impact on their clinical standing or evaluation by the clinic. All responses were anonymous and stored electronically on a password-protected device. This project did not require patient involvement. A request for determination was submitted to the OHSU Institutional Review Board (IRB) and the project was determined to be not research involving human subjects (Appendix D).

Results

The survey broadly addressed three categories of information—co-leader education and clinical experience, DBT core competencies (emotional regulation, distress tolerance, interpersonal effectiveness, mindfulness), and understanding the co-leader role. Within each of these categories, the various activities that co-leaders participate in were assessed. The survey was distributed to 11 co-leaders and there was a 73% completion rate (n=8). One incomplete response was excluded.

Co-leader education and clinical experience

Respondents were asked about level of education achieved or currently being obtained as well as previous experience with DBT. Half (n=4) of the participants selected “doctorate degree or program”, one quarter (n=2) selected “master’s degree or program”, and one quarter (n=2) selected “bachelor’s degree or program” (Appendix F, Figure 1). Half (n=4) reported being “not at all” familiar with DBT prior to co-leading, a quarter (n=2) reported being “moderately” familiar, and one ach chose “slightly” and “very” familiar (Appendix F, Figure 2). If already familiar (n=4), they were asked about previous experience—40% (n=2) selected “didactics in education,” 20% (n=1) selected each “professional/non-academic,” “practicum in current education,” and “other,” elaborating they were previously a DBT client themselves (Appendix F, Figure 3). Respondents were also asked, on average, how many hours they co-led groups weekly. The majority (n=3) selected greater than nine hours per week, two reported “3-5 hr” and one each for “1-3 hr,” “5-7 hr,” and “7-9 hr” per week (Appendix F, Figure 4).

Understanding DBT core competencies

Co-leaders were surveyed about six different training components (*Orientation/Onboarding, Actively Co-leading Skills Groups, Group Supervision, Individual Supervision, Independent Study of DBT* and *Other Clinical or Didactic Training*), to compare perceived effect on understanding DBT core competencies (Appendix F, Figure 5). All co-leaders participate in an *Orientation/Onboarding* session prior to co-leading groups. Ranked alongside the other training components, when asked how *Orientation/Onboarding* helped them understand DBT, it was rated as "moderately" to "very" effective by 76% of participants (Appendix F, Figure 5). Alternatively, when asked specifically how well they understood DBT core competencies following *Orientation/Onboarding*, 75% (n=5) reported "slight" to "moderate" understanding (Appendix F, Figure 6). *Actively Co-leading Skills Groups* was deemed most effective for learning DBT core competencies, with 88% (n=7) ranking it either "very" or "extremely" effective.

Group Supervision is a twice monthly meeting where co-leaders learn DBT skills from the co-leader program lead and discuss specific questions or situations that have arisen while co-leading. Ratings were evenly split, with half finding it "not" or "slightly" effective and half "very" or "extremely" effective. *Individual Supervision* is available if co-leading six or more hours of groups weekly. Of those who ranked this item (n=4), 75% (n=3) ranked it "very" or "extremely" effective (Appendix F, Figure 5).

Independent Study of DBT and *Other Clinical or Didactic Training* were included to assess alternative methods for learning DBT (Appendix F, Figure 5). *Independent Study of DBT Topics* (n=7) was ranked "very" or "extremely" effective by 71% (n=5) and was recommended in qualitative feedback (e.g., "Dr. Linehan's book") (Appendix G). *Other Clinical or Didactic Training* had mixed results.

Respondents were asked to name and define the four core competencies of DBT (Emotional Regulation, Distress Tolerance, Interpersonal Effectiveness, Mindfulness). Six of eight respondents correctly named and defined all four core competencies. One correctly named and defined three competencies but answered "skills training" in place of "distress tolerance." Another respondent

correctly named all four competencies but then seemingly ranked (i.e., "average," "above average," "below average") their understanding of the competency instead of defining it.

Understanding the co-leader role

Respondents were asked additional questions about how well they understood the Role of Co-leader following their co-leader orientation (Appendix F, Figure 6). Half (n=4) selected “slightly” or “moderately” well and half (n=4) stated “very” or “extremely” well, with most (38%) selecting “moderately.” Qualitative feedback (Appendix G) included, “Orientation/onboarding didn't fit with actual experiences as a co-leader" and it focused on "the worst-case scenarios." One respondent requested more realistic expectation setting.

They were also asked about understanding of Group Leader Expectations following orientation. One chose “not well” and 63% (n=5) chose “slightly” or “moderately” well (Appendix F, Figure 6). When asked if expectations of the co-leader are consistent between group leaders, 71% stated “no” (Appendix F, Figure 7). Qualitative feedback (Appendix G) included that some group leaders "outline what they want, while others treat co-leaders simply as group participants.” Some "prefer a more active role whereas others prefer more logistical support and helping when clients are in crisis."

Discussion

Summary

Findings from this initial survey suggest that co-leaders find the experience of co-leading skills training groups to be rewarding and informative. Most respondents also reported lapses, particularly regarding expectation setting and communication early on in their orientation to the role that, if better addressed, could improve the experience.

Interpretation

Supporting previous literature on the topic, this survey yielded significant positive regard for the learning experience that the immersive nature of co-leading offers. It also highlighted some apparent areas in training and interaction that may benefit from further attention. The two training components

that present the greatest room for improvement are *Orientation/Onboarding* and *Group Supervision*. One of the key co-leader responsibilities during skills training groups is supporting clients who are in crisis. The co-leader role in crisis coaching is addressed in *Orientation/Onboarding* but a key theme of feedback shared was that the focus on "worst case scenarios" during orientation was perhaps out of line with the "actual experiences as a coleader" (Appendix G). Some respondents felt there wasn't necessarily more "prep" to offer and that "a lot of the important learning was through watching leaders" (Appendix G). It was considered that differences in *Orientation/Onboarding* staff could have impacted this experience, but based on start date, it appears most co-leaders had the same staff for *Orientation/Onboarding*. No qualitative feedback was provided about *Group Supervision*, but it received the lowest rating with regard to efficacy for learning DBT. During *Group Supervision*, co-leaders complete a mindfulness activity, review homework assigned during the previous supervision session, complete case consultation, and then are taught one of the DBT skills. It is possible that the allotted time (two one-hour sessions monthly) for *Group Supervision* is not sufficient to effectively complete all of these intended tasks. It is also possible that co-leader learning styles or needs otherwise don't align with the current structure of *Group Supervision*. For both *Orientation/Onboarding* and *Group Supervision*, additional evaluation would help elucidate what co-leaders believe could improve these experiences.

It appears good communication and proactive engagement with group leaders play an important role in a novice co-leader's perception of their experience and ability to confidently step into the role. A point not clearly addressed in this survey was the interpersonal dialectic between co-leaders and group leaders during skills training groups. One respondent shared, "Dr. Linehan's book on how to perform a DBT session really helped me understand where I belonged in the dialectic" (Appendix G). It's unclear though how well or how often co-leaders and groups leaders hold the dialectical tension that Linehan intended (Linehan, 2015). It begs the questions of how integral this interpersonal dialectic is to the fidelity of skills training groups and to the client's experience.

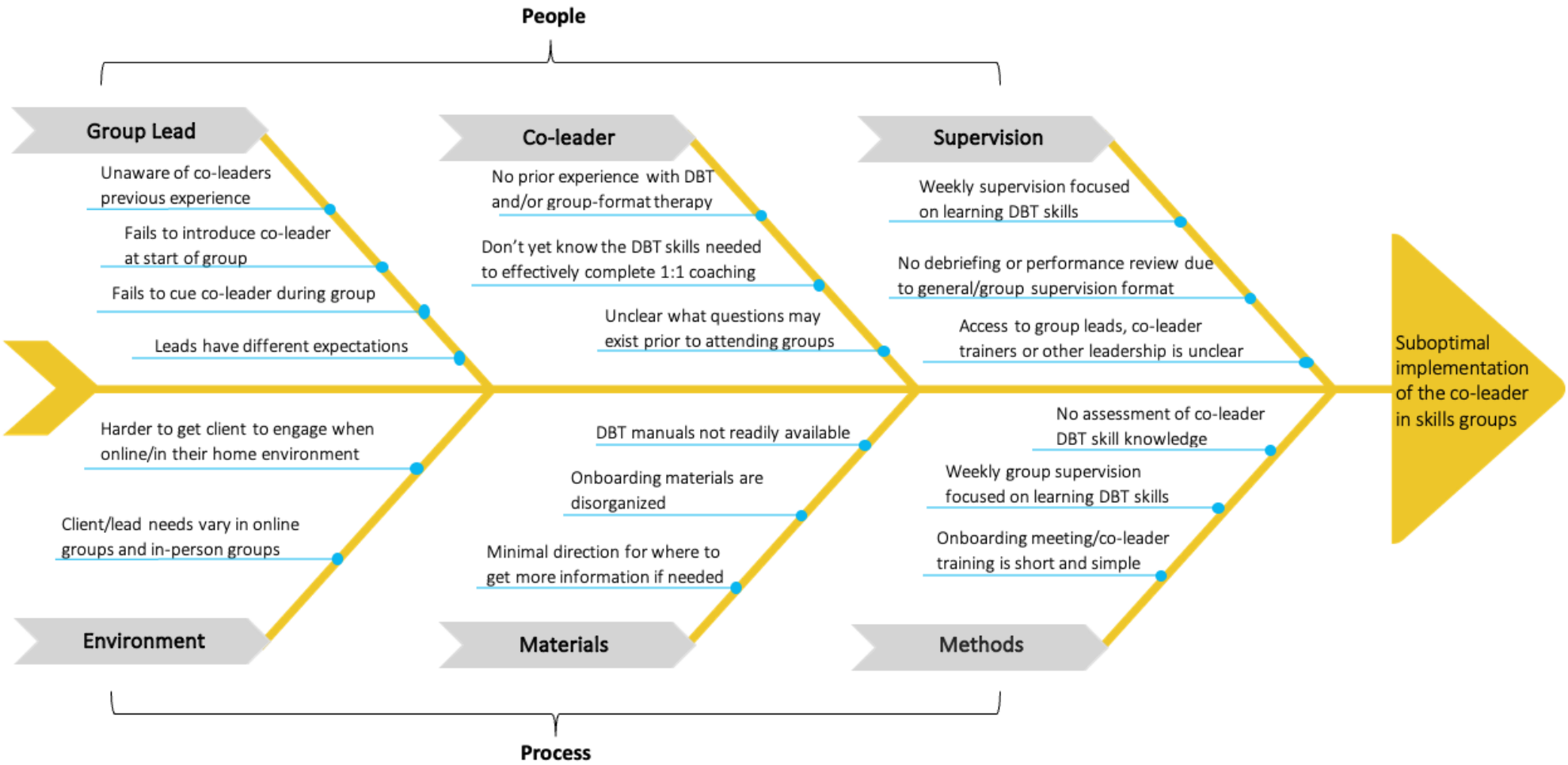
Limitations

Despite the small sample size (N=8) for this project, there was a strong response rate (72%) with robust qualitative feedback. Variation in co-leader tenure, outside experiences with DBT as well as the form of supervision (e.g., Group, Individual) received could have impacted results. Communication and stakeholder-related barriers notably impacted the scope and direction of the project. Early on, this included inadequate access to proper stakeholders with knowledge of current organizational needs and improvement initiatives that were already being implemented. Once access to the correct stakeholders was gained though, there was concern that this project may place undue stress or expectations on clinicians. This was addressed by narrowing the project scope to focus solely to co-leader experiences rather than assessing both clinician (i.e., group leader) and co-leader experiences.

Conclusion

This project aimed to explore an apparently understudied feature of DBT—training and utilization of students as skills training group co-leaders. Various researchers, and even DBT -founder Marsha Linehan, have identified that a clear protocol for training co-leaders is lacking but heretofore there have not been any clear efforts to address that gap. This project sought to learn more about the experiences of novice co-leaders, firsthand from those filling that role. Clinics utilizing student co-leaders, who are most often novices in DBT, may consider more clearly addressing role expectations of the co-leader during orientation. Commitment by clinician group leaders to engage in more consistent expectation setting and communication with group co-leaders may also be beneficial. Finally, the interpersonal dialectic held between group leader and co-leader on warrants further exploration to assess impact on skills training group fidelity and client experience.

Appendix A: Cause & Effect Diagram



Appendix B: Timeline

	Spring - Original timeline	Spring/Summer 2024				Fall 2024			Winter 2025		
		June	July	August	September	October	November	December	January	February	March
1	Complete project proposal										
2	IRB submission/determination										
3	Preliminary co-leader ssurvey to help determine project direction										
4	Work on education session for group leads										
5	Work on onboarding materials										
6	Conduct ducation session with group leads (+ pre/post surveys)										
7	First round of co-leader onboarding with updated materials (+ survey)										
8	Data analysis										
9	Follow up co-leader survey										
10	Data analysis, complete paper & prepare for project dissemination										

	Summer - Updated timline	Spring/Summer 2024				Fall 2024			Winter 2025		
		June	July	August	September	October	November	December	January	February	March
1	Edit project proposal										
2	Approval for updated project proposal										
3	IRB submission/determination										
4	Co-leader survey										
5	Develop summary co-lead feedback										
6	*Disseminate summary of recommendations pending clinic approval*										
7	Data analysis, complete paper & prepare for project dissemination										

	Final timeline	Spring/Summer 2024				Fall 2024			Winter 2025		
		June	July	August	September	October	November	December	January	February	March
1	Project proposal edited --> approved										
2	IRB submission/determination										
3	Co-leader survey updates and approval										
4	Conduct co-leader survey										
5	Develop summary co-leader feedback										
6	*Disseminate clinically relevant recommendations pending clinic approval*										
7	Data analysis, complete paper & prepare for project dissemination										

Appendix C: Letter of Support from Clinical Agency

Date: 08/14/2024

Dear Paige Brubacher,

This letter confirms that the DBT Clinic, allows Paige Brubacher (OHSU Doctor of Nursing Practice Student) access to complete their DNP Final Project at our clinical site. The project will take place from approximately 8/1/2024 to 1/31/2025.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison.

Project Site(s): DBT clinic

Project Plan:

Practicum-ready students often fulfill the role of DBT skills group co-leader, however, there is little guidance available on how to effectively assess student readiness to step into this role nor guidance on best practices for training the novice co-leader. This project will utilize the Institute for Healthcare Improvement (IHI) Model for Improvement framework to better understand the experience of the novice co-leader and if relevant, develop recommendations for improvement.

A key aim of this project is to better understand the experience of novice co-leaders as they integrate into their role. Of particular interest is how co-leaders develop understanding of DBT core competencies. Acting as an informal needs assessment, co-leaders will be surveyed to better understand co-leader knowledge of DBT core competencies and to identify the methods most effective in obtaining that knowledge. Experiential themes and practical improvements identified by the survey will be shared with relevant clinic stakeholders for consideration.

All data will be de-identified, and participation will be voluntary. Participation will have no impact on the co-leader's standing at or evaluation by the clinic. The DNP student will distribute surveys through email and will securely maintain data gathered. This project will be submitted to the OHSU Institutional Review Board (IRB) for approval prior to beginning. The project may be subject to secondary review by the IRB committee specific to the clinic. During the project implementation and evaluation, the DNP student will collaborate closely with relevant members of the clinical team and will provide regular updates to the DNP Project Preceptor and any other relevant team members.

If there are any concerns related to this project, the clinical agency can contact Paige Brubacher and Tara O'Connor (student's DNP Project Chairperson).

Regards,

Appendix D: OHSU IRB Determination

IRB MEMO

Research Integrity Office
3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

September 11, 2024

Dear Investigator:

On 9/11/2024, the IRB reviewed the following submission:

Title of Study:	Understanding the Experience of Practicum Students in the Role of Novice Dialectical Behavior Therapy Skills Groups Co-leader
Investigator:	Tara O'Connor
IRB ID:	STUDY00027546
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the {HYPERLINK "https://o2.ohsu.edu/information-technology-group/hipaa-and-research"} and the {HYPERLINK "https://o2.ohsu.edu/information-technology-group/information-privacy-and-security-policies-and-resources"} for more information.

Sincerely,

The OHSU IRB Office

Appendix E: Co-leader Survey

Highest level of education achieved or currently being obtained:

- ○ Bachelor's degree or program
- ○ Master's degree or program
- ○ Doctorate degree or program
- ○ Other - please list

Approximately, when did you start co-leading?

Month _____
Year _____

Approximate hours co-leading per week:

- ☐ 1-3
- ☐ 3-5
- ☐ 5-7
- ☐ 7-9
- ☐ > 9
- ☐ Other - please elaborate

Do you have other clinical involvement at the clinic (e.g., practicum includes individual therapy)?

- ○ No
- ○ Yes

***Prior to starting* as a co-leader, how familiar were you with the core competencies of DBT?**

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Very
- ○ Extremely

If already familiar with DBT, what was your previous experience:

- ☐ Didactic within current education
- ☐ Clinical/practicum within current education
- ☐ Professional/non-academic
- ☐ Other - please elaborate
- ☐ Not applicable

Identify how each of the following helped enhance your understanding of DBT core competencies:

	Not applicable	Not effective	Slightly effective	Moderately effective	Very effective	Extremely effective
Co-leader orientation/onboarding session	○	○	○	○	○	○
Actively co-leading skills groups	○	○	○	○	○	○
Co-leader group supervision	○	○	○	○	○	○
Individual supervision	○	○	○	○	○	○
Independent study of DBT topics	○	○	○	○	○	○
Other clinical or didactic training	○	○	○	○	○	○
Other - please elaborate	○	○	○	○	○	○

Without referencing materials, please briefly *name* and *describe* the four core competencies of DBT:

***Following co-leader orientation*, how well did you understand the following:**

	Not well	Slightly	Moderately	Very well	Extremely well	Not applicable
DBT core competencies	○	○	○	○	○	○
Role of the co-leader	○	○	○	○	○	○
Group leader expectations of co-leader	○	○	○	○	○	○

Are the expectations of you as a co-leader consistent between group leaders?

- ☐ Yes
- ☐ No
- ☐ If no, please elaborate, providing specific examples if possible:

Please share any other experiences particularly as a novice co-leader, that felt helpful/supportive for your learning of DBT:

Is there anything else you would like to share regarding your experience with orientation/onboarding, or more generally about the co-leader role?

Appendix F: Quantitative Survey Results

Figure 1

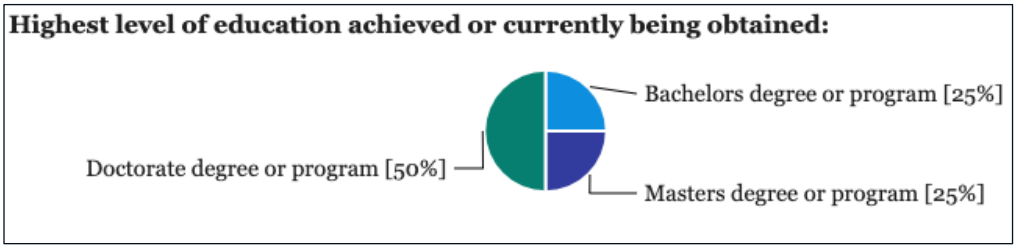


Figure 2

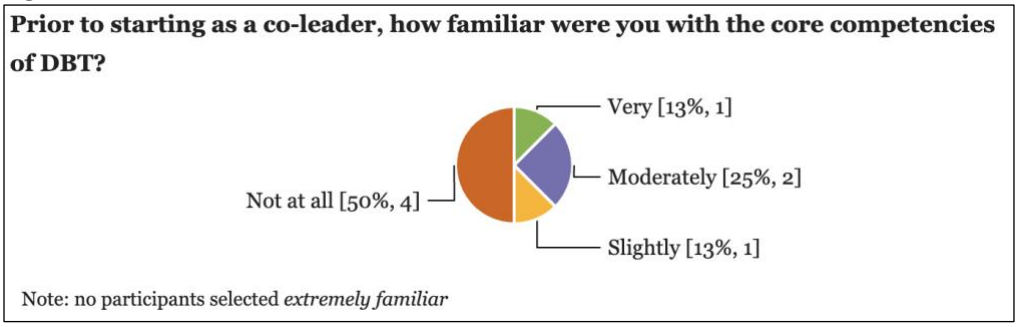


Figure 3

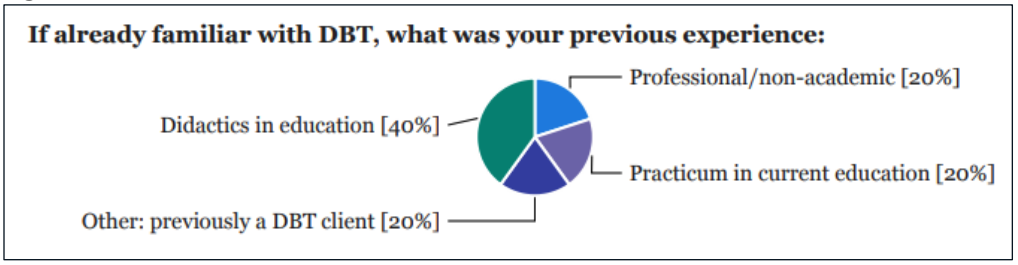


Figure 4

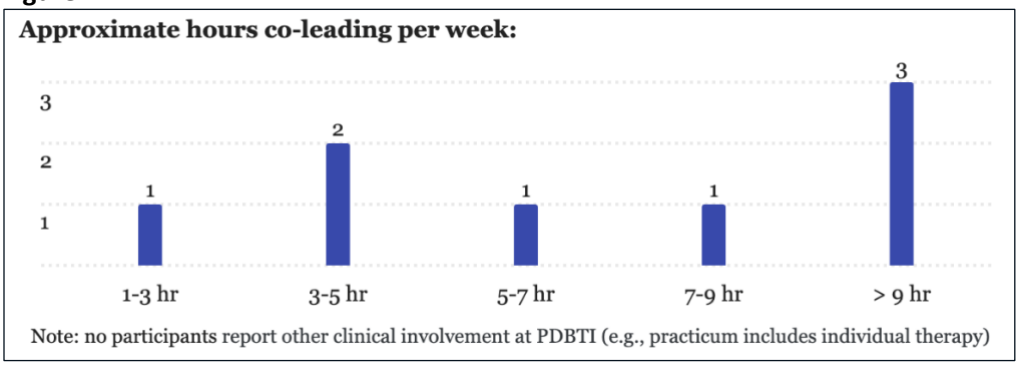


Figure 5

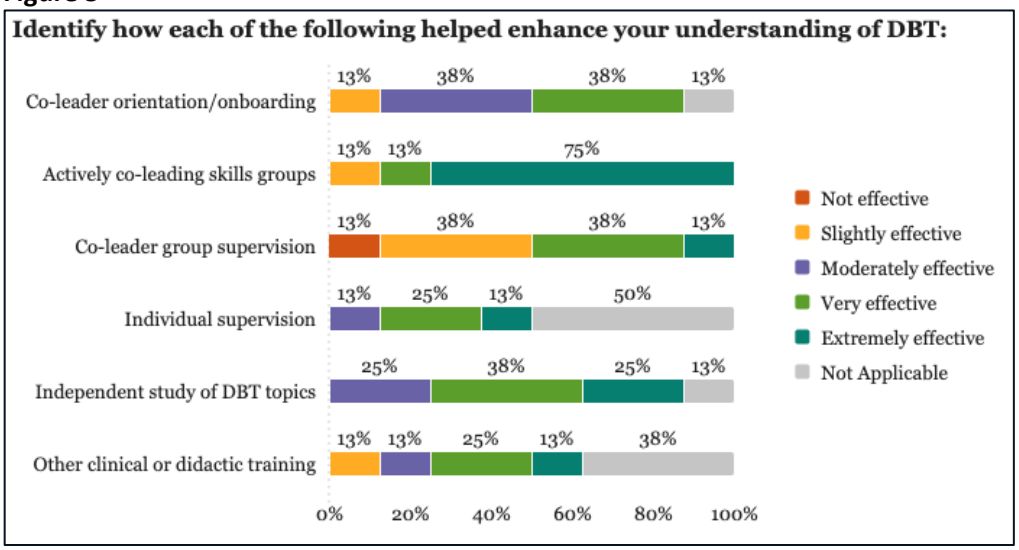


Figure 6

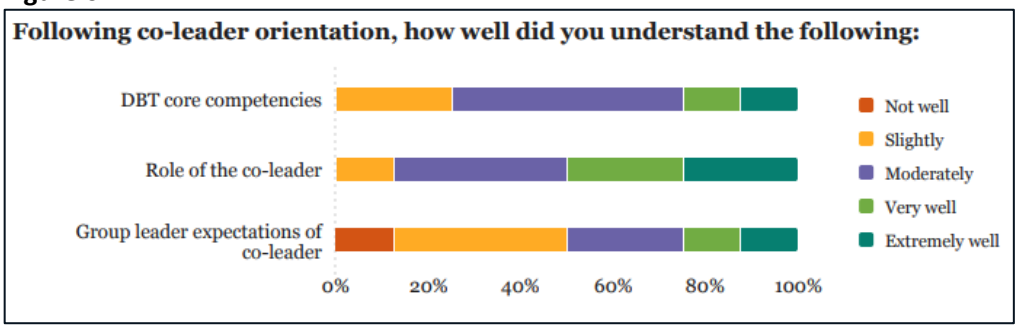
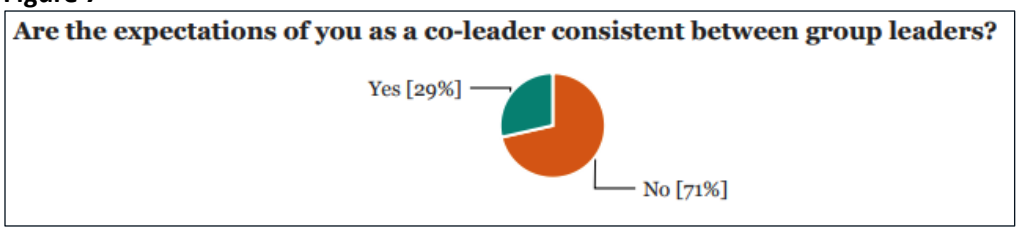


Figure 7



Appendix G: Qualitative Survey Responses

Question	**Response** (numbered by survey respondent)
Are the expectations of you as a co-leader consistent between group leaders?	**R1**: "*Some leaders prefer a more active role whereas others prefer more logistical support and helping clients are in crisis*" **R2**: "*It seems that co-leaders operate quite differently, and group leaders have different expectations. Some group leaders outline what they want, while others treat co-leaders as simply participants."* **R5**: "*One of the groups I co-lead is for parents of teens who are in treatment, so the context for my role is different because the participants of that group aren't in treatment (versus in the adult group I co-lead)."* **R8**: "*some groups have rating scale posting and some don't have; policy of turning on camera; some group leader will give me roster ahead of time, some won't provide me contact number until they need me to reach out to some group members*"
Do you have any specific examples of how group leaders have been helpful/supportive to you, particularly as a novice co-leader?	**R1**: "*Learn validation skills early and use them generously*" **R2**: "*Meeting with me to let me know how I could be helpful, and providing feedback*." **R3**: "*my call with my leader telling me what was expected of me in session*" **R5**: "*The readings assigned prior to starting; meeting with leaders before the first session; co-leader supervision sessions; being a client in a DBT group in the past (which helped me understand how DBT can be helpful to issues I've lived through)."* **R6**: "*I think for me as a new co-leader, focusing on the "basics" - reminding clients of their own skills, doing my own homework to understand the process a client is going through, and having a judgement-free stance has been very helpful for me."* **R7**: "*Choose one of your EST groups and do the weekly homework*."
Is there anything else you would like to share regarding your experience with orientation/onboarding, or more generally about the co-leader role?	**R1**: "*I don't know if there's more that the onboarding can do to prep coleaders, a lot of the important learning was through watching leaders and gaining experience in breakout rooms*"

	R2: "*While I found co-leading exceptionally helpful, I think the program could be improved upon. The orientation/onboarding didn't fit with my actual experiences as a coleader*." **R3**: "*I found it was on me to create a meeting with my leader, and was lost and overwhelmed up until that meeting. could have been more effort put into expectation setting on what realistically would be expected of co-leaders, rather than scaring them by only training them on the worst case scenarios and not providing much more information*." **R5**: "*Because I am a novice, I feel skeptical of my ability to fully inhabit the role of the co-leader, since I have barely any training and am not licensed. So though I'm trying my best during the sessions, it's hard to feel like I'm providing enough to the clients just because of my lack of formal training and licensure*." **R6**: "*Before i began co-leading, i took the time to read Dr. Linehan's book on how to perform a DBT session really helped me understand where i belonged in the dialectic, as well as having a basic understanding of the therapeutic relationship. Between those two things, and regularly becoming more familiar with the content I have been able to be more effective as a co-leader*." **R7**: "*It was absolutely extraordinary and should be recommended for all clinicians regardless of discipline or license*."

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