INTEGRATING DIALECTICAL BEHAVIOUR THERAPY INTO MY CLINICAL PRACTICE MODEL AS A NORTHERN SOCIAL WORKER

by

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Abstract

A Master of Social Work practicum at Walmsley and Validity Counselling was completed in support of my desire to advance my general clinical skills and integrate Dialectical Behaviour Therapy (DBT) into my personal practice model. This report begins with a placing of self and localization of practice considerations to northern British Columbia. A literature review on DBT is provided as context for reflection on my learning goals, which explore topics of professional drift, private versus non-profit organization models, northern practice considerations, component versus comprehensive DBT practice, and the cultural safety of mindfulness and acceptance-based therapies. The wisdom and skills gained from this experience, particularly the integration of DBT-informed therapy into my personal practice model, are reviewed in chapters on learning outcomes and implications for practice. This practicum resulted in a strong desire to continue to practice emotion and family focused social work in Prince George, British Columbia.

Acknowledgements

To all those who have walked alongside me during this journey- we did it!

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Chapter One: Introduction

Clinical social work practicum placements provide the opportunity for clinical observation and direct experience within the framework of the values and ethics that guide the social work profession. Under the guidance of trained supervisors, fledgling clinicians can explore and develop clinical skills and their personal practice model. According to the British Columbia Association of Social Workers (2016), supervision is the cornerstone of continuing professional development and ongoing ethical practice. The Canadian Counselling and Psychotherapy Association (2019) states, "Clinical supervision is a crucial component in the training of helping professionals" (para.1). Clinical supervision simultaneously facilitates professional growth while ensuring ethical practice and necessary safeguards are in place to preserve and promote the wellbeing of clients and the general public. In addition, from a psychotherapeutic standpoint, supervision is a necessary component for becoming certified in many standardized psychotherapeutic interventions, including Cognitive Behaviour Therapy (Beck Institute for Cognitive Behaviour Therapy, 2016), Emotion-Focused Family Therapy (Institute for Emotion-Focused Family Therapy, 2017), and Dialectical Behaviour Therapy (DBT-Linehan, 2019).

The completion of my social work practicum in a clinical agency arose from recognition and respect for the necessity of clinical supervision to develop professionally and practice ethically, especially in what I regard as the foundational years of my practice. My first clinical practicum completed with Intersect Youth and Family Services Society, a non-profit agency offering comprehensive mental health services and programming in Prince George, British

Columbia, provided me with many of the initial skills essential for clinical practice. This included ample time for reflexivity and the integration of practice and theory, which resulted in the development of my personal practice model. During this time, I also recognized a strong desire to seek specialized training and supervision in psychotherapeutic interventions that align with my professional values and interests, one of which is Dialectical Behaviour Therapy (DBT). As the more comprehensive models of DBT practice are limited in Prince George, I immediately sought out Walmsley and Validity Counselling, a combined fee-for-service and employer benefit package contract holder. Walmsley and Validity Counselling specializes in Cognitive Behavioural Therapy (CBT) and DBT. In completing my practicum at Walmsley and Validity Counselling I saw an opportunity for general and specialized professional growth under the guidance of DBT trained clinicians with years of professional practice experience. I am very grateful for the privilege of having this practicum opportunity, and the professional blessing of clinicians who value the passing of their knowledge and experience on to emerging clinicians.

Outline of Practicum Report

This practicum report begins with an overview of my personal practice model, which includes my theoretical orientation and practice values. I then provide a comprehensive literature review of DBT, from theoretical etiology to practice schedules. Following that, I give a more detailed orientation to my practicum placement, which includes a positioning of self and agency in community. This contextualization afforded me the detail necessary to review northern practice considerations that I viewed as an integral learning opportunity for localizing clinical practice. The final two chapters of this report include a reflection on my learning goals and experiences during the practicum and the broader implications for my social work practice.

Chapter Two: Personal Practice Model

Both Kip Coggins (2016) and Malcom Payne (2014) emphasize the need for reflection and reflexivity in connecting use of self to theory that will then guide a personal model of practice. In beginning this process, it was helpful for me to "make meaning" out of my transition from the discipline of psychology to social work. The following statement by Coggins (2016) not only summarizes the rationale for this transition in relation to my personal and professional values, but also contextualizes my personal practice model: "The holistic nature of competent social work practice is what makes social work different from other professions" (p. 320).

For me, the deep roots of positivism reflected in psychological discussions of objectivity, statistical methods, and randomized control trials always felt limiting, as if it were minimizing the human experience. In Robin Wall Kimmerer's (2013) novel *Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge and the Teachings of Plants,* she describes her own conflicted experience with science as the following: "My natural inclination was to see relationships, to seek the threads that connect the world, to join instead of divide. But science is rigorous in separating the observer from the observed, and the observation from the observer" (p. 49). In building my career I longed for connection, for appreciation of context and subjective experience represented in the constructionist lens from which I view the world. Social work as a profession offered me a career of balance, wherein I could professionally synthesize seemingly opposing worldviews and desires in my clinical practice model.

Framing My Personal Practice Model

My practice model is eclectic due to my core value of person-centered practice and support of common factors in clinical practice (Cameron, 2014; Coggins, 2016). Common factors refer to the importance of client, service provider, social and environmental factors that

promote positive therapeutic outcomes over and above theoretical orientation and techniques (Cameron, 2014). The common factors approach can be traced back to the "Do-Do Verdict" where meta-analyses reviewing effectiveness of clinical approaches pointed to their general equivalency (Budd & Hughes, 2009; Cameron, 2014). The common factors approach also indirectly challenges the reliance on evidence-based research, as well as the assumptions and generalizability of western randomized control trials determination of "best practice" (Christ, 2014), something that clearly aligns with my healthy skepticism of the superiority of westernized researched methodologies promoted in the psychology discipline.

Initially I struggled to narrow down common factors that are central to my personal practice model, align with my personal and professional values, and are relatively within my realm of control. I was finally able to achieve this by engaging in a visualization exercise where I saw my personal practice model as a house. I adapted it from a family therapy exercise I had completed with clients and found the visualization activity very transferable and useful. Below I share how I conceptualized various components of my eclectic, common-factors model of clinical social work practice as a house.

The horizon: Structural social work.

In the visualization of my personal practice model as a house, no matter which vantage point you looked from, you would find structural social work theory on the horizon. Structural social work theory views social problems as inherent products of hierarchal and capitalistic systems, which serve to oppress the majority population through practices of marginalization for the benefit of the privileged few (Mullaly, 2010; Payne, 2014). Structural social work theory applies a critical lens to the development and maintenance of social problems (Mullaly, 2010). Through a structural social work lens, a dialectical analysis allows both the personal and political

sides of social problems to come into view (Mullaly, 2010). This is important to my practice as it illuminates the limitations of deficit-based, individualized problem-solving approaches when used by helping professions. Mullaly (2010) describes social workers as having the option to work with systems as hands of the state, many of which serve to maintain the current status quo, or to challenge these oppressive systems that contribute to the maintenance of social problems. By incorporating a structural social work lens, my values of social justice and agency are upheld through striving to pursue social change at all levels (individual, community, and structural). By positioning structural social work theory on the horizon of my practice model, I ensure that I am constantly referencing the need for larger structural change, and its impact on the personal and community level problems experienced by my clients.

Foundation: Humanism and person-centered practice.

The principles of humanism and core tenets of Carl Rogers' person-centered practice (PCP) form the foundation of my personal practice model. Humanism perceives caring interpersonal relationships as the hub of humanity and highlights the natural capacity for human growth and development (Coggins, 2016). Rogers embodies the principles of humanism in the following three conditions of PCP: unconditional positive regard, authentic and congruent practice, and empathetic understanding (Payne, 2014). As summarized by Coggins (2016), "A person-centered approach provides the foundation for engaging clients, developing a collaborative relationship, and initiating services that are of concern to clients" (p. 120). From a professional standpoint, I see the principles of Rogers' PCP as a theme that is emphasized throughout the Canadian Association of Social Worker's (2005) professional values, including respect for inherent dignity and worth of persons, and service to humanity. Given that PCP

appears to be foundational in our professional standards of social work practice, and clinical practice overall, I see it fitting as the foundation for the house representing my practice model.

Roof: Trauma-informed care.

Trauma-informed care (TIC) (Levenson, 2017) forms the roof of my personal practice model because TIC prioritizes safety above all else. Furthermore, TIC achieves safety in a way that is collaborative and empowering through the promotion of choice, understanding, trust and transparency. As a social worker, I have specifically sought out a profession that works with vulnerable and marginalized people and strives to reduce inequality and oppression. TIC's person-in-environment, resiliency-oriented lens meets my professional values by highlighting the relationship between oppression and trauma (Levenson, 2017). In addition, TIC's framework acts as a guide for ethical decision-making in practice, through its focus on principles of transparency, choice and empowerment even in times of crisis to avoid harm and re-traumatization (Levenson, 2017).

It is important to distinguish that the primary goal of TIC is not to treat trauma but to view present issues in the context of the influence of early adversity and traumatic events (Levenson, 2017). TIC emphasizes the importance of meeting clients' basic human needs and understanding the functions of their behaviours prior to engaging in any transformational therapeutic work. I view Maslow's (1943) hierarchy of needs as the supportive pillars that connect TIC as my roof and PCP as my foundation, both simultaneously emphasizing human potential whilst recognizing the need to prioritize basic human needs, including psychological safety and human connection (as cited in Abulof, 2017). TIC's holistic orientation and view of maladaptive coping as a response to prior experience (Levenson, 2017) aligns with the strong

biosocial theoretical influence on my conceptualization of mental illness and addiction, as well as my belief of the overall adaptiveness and resiliency of human behaviour.

Walls: Overall strength-based approach.

The walls of my personal practice model represent my desire to strive for a consistent, strength-based practice. According to Payne (2014), adopting a strength-based approach involves identifying and facilitating resiliency and sharing a collaborative, future-oriented view to presenting issues that rejects a problem-solving approach to individual helping. Strength-based techniques in practice involve working towards positive objectives and building non-judgementally on achievements in peoples' lives, which can include linking existing skills and helpful coping behaviours to the presenting issue (Miller, 2012). However, I agree with Payne's (2014) criticisms that pure strength-based practice may be silencing and/or not meet the needs of certain clients. In my work with youth experiencing multiple, complex barriers, I had noticed that overly positive or optimistic comments could minimize a client's experience and negatively impact therapeutic alliance. Therefore, in my practice I define a strength-based approach as the recognition that all human behaviour is adaptive and functioning to meet a need, and behaviour itself does not need to be regarded as either "positive" or "negative", but one of survival and resilience (Matè, 2008; van der Kolk, 2014). When this approach is combined with genuine validation and acceptance, it allows room to embrace the functionality perspective and explore a client-determined route for change (Matè, 2008).

Windows: Anti-oppressive practice.

The windows of my personal practice model provide the framing for my anti-oppressive approach to social work practice, which helps me to observe and respect the warmth of diverse cultural and spiritual practices and traditions. Anti-oppressive practice also highlights the

importance of being able to see outside, to the environment, and to the horizon which connects directly with structural social work theory. Anti-oppressive practice means being critically aware of the power relations inherent to the helping professions (Payne, 2014). Furthermore, anti-oppressive practice considers the impact of power and privilege and reflects on the impact of personal and professional privilege and power in our therapeutic relationships.

I am a white, English speaking, educated, able-bodied, cis-gendered, heterosexual, Canadian citizen, from a working/middle class background. Aside from the privilege and power that is inherent to my clinical position, on a personal level I may almost always be more privileged than the clients I work with. This is the nature of the work I desire to do. From an anti-oppressive lens, my acknowledgement of my own privilege empowers and guides me on how to best try to also be an ally in my professional practice (Bishop, 2015; Payne, 2014). In clinical practice, one of the strongest applications of interpersonal anti-oppressive practice comes from transparency regarding power differentials, collaborative approaches to assessment and intervention planning, and making space for diverse healing practices (Baskin, 2016; Bishop, 2015; Mullaly, 2010; Payne, 2014). Furthermore, when I place anti-oppressive practice as the windows in my practice model, the approach encourages me to work towards increased equality and cultural safety at the larger structural level; it is through the windows that I can connect my anti-oppressive practice to structural social work on the horizon.

The fireplace: Attachment theory.

In the visualization of my personal practice model as a house, attachment theory is the fireplace. The fireplace is a gathering place to connect with others while it warms the entire home. Fire also reminds me of the innate, survivalist function of human emotion and behaviour. While structural social work theory provides the viewpoint for analyzing the production and

maintenance of social problems within a broader societal context (Mullaly, 2010), my clinical orientation also requires micro-level theories of human behaviour. I have been heavily influenced by and deeply connected to the core tenets of attachment theory. I view human behaviour as survivalist and adaptive (Holmes, 2012). I also see the role of early interpersonal connection as serving the important function of facilitating social and emotional development in addition to protection (Fitton, 2012; Holmes, 2012). This attachment lens integrates nicely with cognitive and behavioural interventions whereby dysfunctional behavioural and emotional dysregulation are viewed as adaptive coping tools, influenced by mental representations of self/others/world and shaped by principles of conditioning and reinforcement (Coggins, 2016; Fitton, 2012; Marrone, 1998). Attachment theory, in its broadest sense, provides a biopsychosocial lens to human development and behaviour, that is clearly reflected in the etiology of DBT.

Chapter Summary

This chapter explores my academic transition to graduate studies in social work and the components of my personal practice model prior to entering my final practicum placement. I described my practice model as an intentionally eclectic combination of structural social work, person-centered practice, trauma-informed care, strength-based, anti-oppressive, and attachment theory. I believed the next stage of development in my personal practice model was to begin integrating specialized therapeutic modalities. This resulted in my pursuit of a DBT-based practicum with Walmsley and Validity Counselling.

Chapter Three: Literature Review

This literature review provides a comprehensive introduction to Dialectical Behaviour Therapy (DBT), including Linehan's development of this psychotherapeutic intervention (Linehan, 1993). DBT emerged from CBT, therefore a brief introduction to CBT is also provided. Furthermore, an overview of the three theoretical foundations of DBT are explored and a description of the core components and skills of DBT identified. Finally, research support for DBT is provided and considerations for use of DBT practice in a northern region is examined.

Development of Dialectical Behavioural Therapy

DBT was developed by Marsha Linehan in the 1980s (McFarr, et al., 2014; Van Dijk, 2012). DBT originally began as an intervention for clients with severe and chronic suicidality, however, Linehan (2015) later narrowed the intervention specifically to the outpatient treatment of people with Borderline Personality Disorder (BPD) (McFarr, et al., 2014; Rizvi, Steffel, & Carson-Wong, 2013). BPD is a mental health disorder characterized by intense emotional dysregulation, impulsivity, difficulty forming and maintaining healthy interpersonal relationships, poor self-image, and high risk of suicide completion and self harm (Linehan, 2003). Since Linehan specifically developed DBT as a treatment for BPD, DBT theory and its therapeutic components focus primarily on reducing life threatening behaviours, emotional regulation, and the development of interpersonal and communication skills (Linehan, 2015; Van Dijk, 2012). DBT is categorized as an acceptance and mindfulness-based therapeutic approach that evolved from the third wave of CBT (Cheng & Sue, 2014). Linehan (2015) emphasizes the importance of understanding the etiology and theoretical foundation of DBT prior to engaging in its use in practice.

A brief introduction to CBT.

CBT was founded by Aaron Beck in the 1970s and developed out of the intersection of behaviourism and Rational Emotive Therapy (RET) (Coggins, 2016; Miller, 2012). Albert Ellis' RET influenced the cognitive component of CBT by offering an explanation for the relationship between cognitive schemas (also known as our mental representation of ourselves, others, and the world around us) and emotions (Miller, 2012). Ellis (2017) theorized that all humans have irrational, negative elements within their cognitive schemas, known as *negative attributional styles*. These negative attributional styles unconsciously construct emotional difficulties by shaping an individual's perceptions and beliefs through a negative lens. Therefore, it is the perception of situations, and not the situations per se, that result in emotional disturbances. Cognitive interventions focus on developing awareness of how our beliefs about the situation influence our emotional reactions (Ellis, 2017; Payne, 2014).

CBT is well known for the development of the *cognitive triad*, a visual representation of a client's cognitive schema that is useful in helping the client identify their negative attribution style by exploring how they perceive themselves, the future, and the world (Beck & Haigh, 2014; Coggins, 2016). A clinician can then assist clients to categorize unhelpful thinking styles that misrepresent reality, known as *cognitive distortions*, and challenge clients to develop alternate ways of thinking (Beck & Haigh, 2014; Coggins, 2016; Miller, 2012). Beck's cognitive interventions for CBT are strongly influenced by Ellis' RET in that they mirror models of chain analysis. In CBT, thought records are a central tool that is utilized to track cognitive distortions and bring awareness to their behavioural consequences.

Behaviourist interventions contributed to CBT through a belief held that behaviours are learned through principles of reinforcement and punishment and, therefore, can be modified

through operant conditioning (Coggins, 2016).Operant conditioning is a model which describes how behaviours are learned through association with consequences that either increase or decrease the likelihood that the behaviour will be performed in the future (Coggins, 2016). Consequences viewed by the individual as positive are more likely to reinforce, or increase, the behaviour, while consequences that are perceived as negative are more likely to decrease, or extinguish, the behaviour (Coggins, 2016). In addition, behavioural theory suggests that thoughts, feelings, and overt actions are developed through observation of the environment and can be increased, decreased or maintained via principles of reinforcement and punishment (Rizvi, Steffel, & Carson-Wong, 2013; Staddon & Ceruttti, 2003). The behavioural tenets of CBT are reflected in the role of maladaptive coping behaviours in maintaining negative cognitive biases through the process of operant conditioning (Coggins, 2016). Examples of this are apparent in gradual exposure techniques often used when working with individuals with anxiety, and behavioural activation techniques when working with individuals with depression (Beck & Haigh, 2014).

Third wave mindfulness and acceptance-based therapies.

CBT continues to adapt, most recently in recognition of the benefits of alternative forms of healing. In 2004, Steven Hayes introduced the new, third wave of CBT in response to a variety of psychotherapeutic interventions that appeared to deviate from the traditional structure of CBT in favour of more contextually-based, flexible, experiential, and relationship driven therapeutic interventions. Hayes (2004) argued that while the basic cognitive and behavioural assumptions held true, additional theoretical perspectives and techniques were being included, primarily those of acceptance and mindfulness.

Masuda (2014) proposes three reasons for the rise of mindfulness and acceptance-based therapies (MABT), including DBT, within Western psychotherapeutic practice:

1. Acceptance-based interventions focusing on the benefit, and at times necessity, of being open to negative or irrational experiences were established as evidence-based practice.
2. An increased academic and public acknowledgement of a holistic approach to wellness.
3. Greater recognition of the ubiquity of the human experience of pain and suffering, which includes the acceptance of painful experience as part of life.

While CBT focuses on directly challenging dysfunctional thought processes and negative emotions, MABT directs attention to recognizing context and emotion without attempting to change or avoid them (Cheng & Sue, 2014). Therefore, the goals of MABT, and DBT in general, include increased awareness in the present moment without judgement and movement towards living a fulfilling life (Cheng & Sue, 2014). That being said, the DBT model also incorporates a broad array of cognitive and behavioural strategies, such as contingency management, exposure, problem solving, skills training, and cognitive restructuring (Linehan, 2015). At its essence, DBT is an intervention of balance, of change and acceptance (Linehan, 2015; Van Dijk, 2012). Furthermore, DBT mirrors traditional CBT in its emphasis on handouts, homework, precise therapeutic goals and clear treatment targets including ongoing assessment of, and data collection on, current behaviours (Linehan, 2015).

Linehan (2015), Van Dijk (2012) and others suggest the differences between CBT and DBT are eroding with the general synthesis of acceptance and mindfulness techniques into individual and group-based therapeutic interventions. Regarding how DBT specifically differs

from CBT, Van Dijk states, “DBT is really just CBT using a different language, with the addition of mindfulness and acceptance techniques. DBT takes the judgement out of CBT so the way clients are thinking isn’t ‘wrong’, ‘erroneous’, or ‘distorted’” (p. 7). Furthermore, DBT is principle driven, inherently more flexible than CBT, places more significant weight on the therapeutic relationship, and has a more holistic theoretical basis, which includes a dialectical framing (Elliot, 2010; Rizvi, Steffel, & Carson-Wong, 2013).

Theoretical Foundations of DBT

DBT is guided by three overarching theories: dialectical, biosocial, and behavioural (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013).

Dialectical theory.

Dialectical theory takes the form of a fundamental worldview that positions reality as a construction of interrelated opposing forces that are in a perpetual state of change (Rizvi, Steffel, & Carson-Wong, 2013). As summarized by Elliot (2010), “In brief, dialectics represents the mind’s way of understanding concepts by understanding and appreciating their polar opposites” (para. 3). Linehan (2015) describes the dialectical worldview as serving three core functions in DBT:

1. Emphasizing the fundamental wholeness or interrelatedness of reality.
2. Framing reality as derived from “internal opposing forces” which require synthesis in order to process and move forward (p. 4).
3. Reminding clients that reality is based on principles of change and process

In summary, dialectical theory as the foundation of DBT frames life itself as being in a constant state of transition which can help clients feel more comfortable with the simultaneous process of change and acceptance (Linehan, 2015; Van Dijk, 2012). In DBT, the understanding

of a client's symptoms is facilitated through appreciating the function and natural complexity of holding opposing perspectives (ie. acceptance and acknowledgement of the client's will to both die and live or to stay sober and continue to use substances). A lack of acknowledgement of the truth in opposing viewpoints can result in tension, conflict, judgement, discomfort and resistance to change. Rizvi and colleagues (2013) suggest that rigidity, judgement, and difficulty tolerating contradictory beliefs is often the result of experiencing invalidation during childhood. When the clinician takes a dialectical stance, and teaches this philosophical worldview to the client, it enables focus to be both on change and acceptance.

Biosocial theory.

Biosocial theory considers the development and maintenance of mental health issues as arising from an interaction between biological influences and conditions in the environment (Linehan, 1993). In DBT, the primary biological deficit is in emotional regulation, which results in heightened emotional sensitivity and reactivity (Linehan, 1993; 2003; 2015). There is physiological and neurological evidence that sensitivity to emotional cues, impulsivity, and a tendency towards negative affectivity are heavily influenced by heredity, intrauterine factors, and physical injury (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013; Van Dijk, 2012). According to Linehan (2015), all these factors are "biologically based precursors to emotion dysregulation" (p. 7). Emotional vulnerability is characterized by baseline negative affectivity, high sensitivity and intense response to internal and external emotional stimuli, and a delayed or slow return to emotional baseline (Linehan, 2015). As put by Van Dijk (2012),

> Emotional vulnerability refers to a biological predisposition or temperament where an individual is born more emotionally sensitive…. The emotional reaction is more intense

> than warranted by the situation, and takes longer than the average person to recover from that reaction and return to emotional baseline. (p. 9)

When this biological tendency towards heightened emotional sensitivity is coupled with adverse conditions in the environment, primarily invalidation, it results in emotional dysregulation that may cause significant impairment in communication and interpersonal relationships (Linehan, 2015).

Invalidating environments occur when a child's experiences do not align or are nullified by the environment, including their caregivers' responses (Linehan, 1993; 2015). Van Dijk (2012) states,

> In invalidating environments, the expectation is usually that the child should be able to control the expression of her emotions (which, because of the emotional vulnerability of the child, is unrealistic) and should not express "negative" feelings. When she is unable to succeed in meeting these expectations the environment punishes her for communicating these negative experiences and responds to her emotional displays only when she escalates, essentially teaching her to alternate between stifling her emotions and communicating emotions in extreme ways in order to get help. (p. 10-11)

Emotional dysregulation provides a prime learning environment wherein intense emotional reactions are reinforced, and emotion regulation skills are not learned during childhood and adolescence (Linehan, 2015). This then results in the development of maladaptive coping tools, or the behavioural problems often associated with emotion dysregulation, including substance misuse, suicidality, self-harm, and disordered eating (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013). Biosocial theory suggests a transactional model whereby the individual and the environment influence each other over a series of microevents that contribute to the development

and maintenance of unhelpful ways of thinking and behaving (Rizvi, Steffel, & Carson-Wong, 2013). In the end, the transaction between the biological predisposition for emotional sensitivity and an invalidating environment significantly impedes the development of healthy coping, problem-solving, and interpersonal skills which can impact multiple areas of functioning and later restricts symptom reduction (McFarr, et al., 2014).

Behavioural theory.

B.F. Skinner's behaviourism popularized the view that human actions were a product of social learning and interaction with the environment, particularly through models of classical and operant conditioning (Coggins, 2016). Principles of conditioning essentially refer to how individuals develop, maintain, and reduce habitual behaviours through schedules of reinforcement and punishment (Staddon & Ceruttti, 2003). Therefore, behavioural interventions focused on modifying unhelpful or undesirable behaviours reject the idea that insight development is necessary to produce individual behavioural change (Coggins, 2016; Payne, 2014).

In DBT, behavioural theory contributes its core tenets of operant conditioning and observational learning, which compliments biosocial theory's transactional model of individual and environment influence on symptom development and maintenance (Linehan, 2015). DBT incorporates principles of behaviourism into reducing problematic or harmful behaviours, increasing helpful or effective behaviours, as well as cognitive, emotional and behavioural tracking (Linehan, 2015). In addition, in DBT the interruption of associations and consequences with symptoms is taught during skills coaching and clinicians are trained to consider behavioural contingencies in all their client interactions (Linehan, 2015; Van Dijk, 2012). Furthermore, behaviourism in DBT contributes to the intervention's non-judgemental stance on the

development and maintenance of harmful or problematic behaviours (Linehan, 2015; Van Dijk, 2012). This is important because individuals with complex and life-threatening mental health symptoms, and specifically those individuals diagnosed with BPD, can be labeled as untreatable or manipulative by professionals, family and friends, as well as themselves (Linehan, 2015).

Introduction to Comprehensive DBT

DBT provides an evidence-based intervention for multiple, complex mental health disorders (Rizvi, Steffel, & Carson-Wong, 2013). DBT was standardized by Marsha Linehan in her *DBT Skills Training Manual,* with a second edition in 2015. According to Linehan (2015), "the overall goal of DBT skills training is to help individuals change behavioural, emotional, thinking and interpersonal patterns associated with problems in living" (p. 3).

DBT is guided by a four-tiered treatment hierarchy, which first, prioritizes therapeutic commitment; second, addresses any suicidal and parasuicidal behaviours; third, focuses on any therapy interfering behaviours; and fourth, addresses quality of life interfering behaviours (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013). All tiers may include addressing maladaptive coping behaviours, such as substance misuse, compulsive behaviours, disordered eating, and interpersonal conflict. DBT treatment is also divided into three linear stages: (1) the development and application of skills; (2) target symptoms of post-traumatic stress or trauma; and (3) increase self-respect and work towards personal goals (Linehan, 2015; McFarr, et al., 2014). Perhaps most importantly, DBT is comprised of four modes of treatment delivery that are conducted concurrently: individual psychotherapy, telephone consultation, case consultation, and group skills training (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013; Van Dijk, 2012).

Mode of treatment: Individual psychotherapy.

Individual psychotherapy provides the opportunity for therapists and clients to address interpersonal and environmental factors (e.g., crisis, willfulness, buy-in) that interfere with the learning and application of adaptive and skillful behaviours (McFarr et al., 2014). In its comprehensive form, individual psychotherapy includes a review of daily diary cards which track emotions, suicidality, and other target behaviours. However, Linehan (2015) notes that not all individual sessions must be provided by DBT trained clinicians, which occurs most frequently when resources are limited.

Mode of treatment: Telephone consultation.

DBT offers after-hours telephone consultation to clients by clinicians on an as-needed basis. These brief ten to fifteen-minute consultations provide an opportunity for the clinician to guide a client in real-time, acute distress with problem-solving and skills application, which enhances and generalizes skill development (Linehan, 2015; McFarr, et al., 2014; Rizvi, Steffel, & Carson-Wong, 2013). In addition, phone consultations facilitate open communication between the client and their clinician which can help to address misunderstandings or ruptures in the collaborative nature of the therapeutic relationship prior to these issues interfering with therapy (McFarr, et al., 2014).

Mode of treatment: Case consultation.

Case consultation is designed to fulfil the dual function of clinical supervision and burnout reduction through debriefing, validation, and the clinician's own DBT skills application (Van Dijk, 2012). As noted by Linehan (2015), "skills trainers and individual therapists meet on a regular basis not only to support each other, but also to provide a dialectical balance for each other in their interactions with their clients" (p. 15). Case consultations more indirectly benefit

the client by increasing the wellness of the clinician and the therapeutic integrity of the intervention (Linehan, 2015).

Mode of treatment: Group skills training.

Finally, weekly group skills training for clients focuses on teaching the four core skills of DBT in a psychoeducational format. Group discussion is often centered on the previous week's homework assignments and facilitates the daily application of skills (Linehan, 2015). In comprehensive DBT, all components of DBT occur on a weekly basis, with the exception of the as-needed after-hours telephone consultations. DBT continues for up to 12 months with 11 different possible group skills training schedules (Linehan, 2015). Regardless of the schedule and time commitment, all interventions are centered around the same four skills: core mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013; Van Dijk, 2012).

Skill: Core mindfulness.

Mindfulness is the central skill in DBT, which is why core mindfulness is the first skill taught and is reviewed prior to the introduction of all other skills. Van Dijk's (2012) definition of mindfulness is, "doing one thing at a time, in the present moment, with your full attention, and with acceptance" (p. 67-68). This is in contrast to some of the automatic, habitual and rote behaviours that we tend to engage in in our day-to-day lives. Mindfulness is essentially the ability to fully experience things, without judgement, and without trying to change them (Linehan, 2015; Van Dijk, 2012). Mindfulness is a place of awareness, a place of acceptance, a place of tolerance, a place of non-judgement, and thus, it is always the starting place in DBT. For example, when mindfulness skills are applied to help manage dysregulation of the self, it is through focusing on observing internal and external stimuli and reactions from a non-

judgemental and accepting lens without a distortion of reality. The client is then able to come to a place of either letting go or problem solving, instead of being consumed by their emotions and engaging in impulsive maladaptive coping behaviours (Linehan, 2015; Van Dijk, 2012). As summarized by Linehan (2015), mindfulness includes the "repeated effort of letting go of judgements and letting go of attachment to current thoughts, emotions, sensations, activities, events or life situations… Mindfulness practice teaches us to move into the moment and become aware of everything in it, functioning from there" (p. 152).

Skill: Emotion regulation.

In order to best understand skills taught for emotion regulation, it is helpful to review the chronic consequences of emotion dysregulation, including an inability to express and regulate arousal, difficulty tolerating painful or distressing experiences, and a lack of self-validation resulting in an overreliance on, and hyper-sensitivity to, the environment for external sources of validation (Linehan, 1993). Many interventions, techniques and skills are required to begin teaching a client to emotionally regulate themselves. The four segments of DBT emotion regulation skills are: (1) understanding and naming emotions; (2) changing unwanted emotions; (3) reducing vulnerability to emotion mind; and (4) managing extreme emotions (Linehan, 2015, p. 318).

Linehan (2015) proposes that emotion regulation is one of the most important skills developed during childhood. In the context of the development and application of DBT, Linehan (2015) defines emotions as "brief, involuntary, full-system, patterned responses to internal and external stimuli" (p. 6). Furthermore, DBT as an intervention emphasizes the evolutionary function and adaptive value of emotions in keeping with biosocial theory. According to Van Dijk (2012), "the goal of emotion regulation is to achieve a balanced state of consciously managing

the experience and expression of emotion" (p. 9). Furthermore, Linehan (2015) states, "Dysfunctional behaviours, including suicidal behaviour, substance use disorders, overeating, emotion suppression, overcontrol and interpersonal mayhem, are often behavioural solutions to intolerably painful emotions" (p. 318). For clients, it is the uncomfortable and painful feelings that are often the "problems to be solved" (Linehan, 2015, p. 318). In DBT, however, it is the painful emotions that are validated, and the maladaptive coping used to control or avoid painful emotions which are challenged. Given that emotion dysregulation is formed within an invalidating environment, development of emotion regulation requires an atmosphere of emotional self-validation (Linehan, 2015). Mindfulness is particularly helpful in providing this environment through the process of becoming aware of, identifying and validating emotional experiences, prior to learning non-judgementally about current emotional reactions that they (the client) would like to alter (Linehan, 2015; Van Dijk, 2012).

Skill: Distress tolerance.

Many mental health interventions focus on changing or challenging distressing events or situations, however, DBT focuses on the relevance of "accepting, finding meaning for, and tolerating distress" as an essential practice of holistic wellness (Linehan, 2015, p. 416). Distress tolerance skills begin developing with the acknowledgement that pain, distress, and discomfort are a part of life (Linehan, 2015). In addition, tolerating distress and discomfort are important aspects of making meaningful change, as avoidance of distress and discomfort is often the result of unwanted or unhelpful coping behaviours. The majority of distress tolerance behaviours targeted in DBT aim to help clients tolerate and survive a crisis, as well as accept being in the moment (Van Dijk, 2012). Linehan (2015) states, "By definition crisis survival skills are short-term solutions to painful situations" (p. 417). The goal is to utilize distress tolerance skills to

come to a place where problem solving can begin, resulting in a more desirable outcome, or placing/moving the client forward on a path to a life well lived (Linehan, 2015; Van Dijk, 2012).

Skill: Interpersonal effectiveness.

As noted by Van Dijk (2012), "As social beings, we humans need other people in our lives in order to be happy" (p. 163). Relationships can have a tremendous impact on mood and, for individuals who experience emotion dysregulation, it can be challenging to develop and maintain stable interpersonal relationships (Linehan, 2015; Van Dijk, 2012). Furthermore, when interpersonal relationships are in turmoil, insufficient or absent, self-destructive behaviours and feelings of isolation as well as depression may occur (Van Dijk, 2015).

Interpersonal effectiveness skills are taught based on the assumption that many individuals possess the knowledge and skills for interpersonal effectiveness in a general sense but struggle to apply these skills to their own lives, or struggle to find what works for them in particular interpersonal relationships (Linehan, 2015). In DBT, interpersonal effectiveness skills are divided into three units: (1) obtaining personal objectives while maintaining relationships and self-respect; (2) decreasing interpersonal isolation by developing skills for building healthy relationships and ending destructive ones; and (3) balancing acceptance and change in the context of relationships (Linehan, 2015). This module also spends time introducing dialectical theory as a way to consider the validity of other people's perspectives and experiences, as well as developing skills in self-validation (Linehan, 2015). The goal of this module in DBT is for clients to increase their ability to identify their goals in interpersonal situations, communicate them assertively, and increase the likelihood that their goals will be accomplished, and their needs will be met in interpersonal interactions.

DBT Research Support

According to Masuda (2014), DBT's broad clinical application is noteworthy, and it is the most rigorously studied of the MABTs. McFarr and colleagues (2014), found randomized control trials indicate DBT "is effective in reducing suicidality, frequency and duration of hospitalizations, and increased emotional regulation" in adult and adolescent populations (p. 76). While evidence has strongly supported the use of DBT with clients diagnosed with BPD (Linehan, 2015), McFarr and colleagues (2014) also highlighted several clinical trials supporting the use of DBT with other psychiatric conditions including substance use disorders, treatment resistant depression, and disordered eating, across multiple age ranges and demographics. Additionally, DBT has been reported as an effective intervention for the treatment of posttraumatic stress disorder (Barnicot & Crawford, 2018), including survivors of childhood sexual abuse (Steil, et al., 2018), as well as executive functioning deficits in adolescents (Smith, Freeman, Montgomery, Vermeersch, & James, 2018), and building emotion regulation skills in parents (Zalewski, Lewis, & Martin, 2018). As stated by Linehan (2015),

> Many mental disorders can be conceptualized as disorders of emotion regulation, with deficits in both up- and down-regulation. Once you realize that emotions include both actions and action tendencies, you can see the link between emotion dysregulation and many disorders defined as behaviour dyscontrol (e.g. substance use disorders). DBT skills are aimed directly at these dysfunctional patterns. (p. 11)

According to Zalewski, Lewis, and Martin (2018), emotion dysregulation is transdiagnostic and, therefore, DBT is recognized as an effective intervention for many disorders, ages, and demographics. In her own practice, Van Dijk (2012) states,

> In my opinion, DBT can be effective for most clients. In my own practice I have used DBT to help clients deal with bipolar disorder, depression, anxiety, bulimia and binge eating disorder, chronic pain, grief, low self-esteem, relationship issues, and anger. (p. 2)

Research on DBT has been completed worldwide supporting the use of DBT with some marginalized and underserved populations; yet it is important to note some of the limitations of the research (Masuda, 2014). Research on DBT has predominately focused on the treatment of individuals formally diagnosed with BPD, which is disproportionately observed in females. There is, however, an increasing recognition of a need for research with male participants (Cannon & Umstead, 2018). In addition, while Masuda (2014) speaks to the cultural competency of DBT from a theoretical standpoint, aside from support of the effectiveness of DBT in work with Alaskan Indigenous adolescents (Beckstead, Lambert, BuBose, & Linehan, 2015), little research speaks directly to diverse cultural applications of DBT. As such, Masuda (2014) strongly encourages ongoing research of cultural adaptations of DBT interventions specifically, but also for all MABTs in general. Furthermore, given the urban development and urban-dominated research of DBT, research and practice considerations should also be made when adapting DBT practice to place in northern, rural, and remote regions. Finally, there have been additional research concerns related to the practice of only some components of the DBT model and DBT-informed individual therapy conducted by minimally trained clinicians (Koerner, 2013).

DBT Considerations: Comprehensive or Component DBT

Rizvi, Steffel and Carson-Wong (2013) differentiate between comprehensive and component DBT practice. Comprehensive DBT includes all modes of treatment and skills, as well as processing through the three stages and the treatment hierarchy (Linehan, 2015).

Furthermore, comprehensive DBT interventions include all four modes of delivery over a full twelve months. However, research has supported the effectiveness of comprehensive DBT interventions over shorter periods of time (Linehan, 2015; Rizvi, Steffel, & Carson-Wong, 2013). In addition, the use of components of DBT, for example DBT skills training in conjunction with individual CBT or group-only skills training, and DBT-informed practice has become popular with clinicians due to limitations in training and resources (Linehan, 2015; Van Dijk, 2015). Given increased use, and adaptation of DBT as a therapeutic intervention across multiple settings and with diverse populations, there is controversy regarding how this impacts the scientific validation of the model and possible limitations to its practice (Koerner, 2013).

It appears there is a strong divide in the support for component versus comprehensive DBT practice. Rizvi, Steffel, and Carson-Wong (2013) advocate for increased research on the practice of DBT skills only, and full disclosure of component-only practice including a rationale for why comprehensive DBT is not being offered. On the other hand, Van Dijk (2012) published *DBT Made Simple*, in response to her own challenges of offering comprehensive DBT and desire to make DBT training more accessible and adaptable for clinicians. She advocates for increased clinician training in DBT because the skills are beneficial to a variety of populations and can be easily adapted as needed. In Linehan's (2015) *DBT Skills Training manual*, she differentiates between randomized control trials for comprehensive DBT practice from group skills training only and provides multiple group skills training schedules. Furthermore, she states "skills training alone is a promising intervention for a variety of populations, such as persons with drinking problems, families of suicidal individuals, victims of domestic abuse, and others" (p. 3).

Linehan (2015) originally developed DBT as a comprehensive intervention for complex, treatment resistant, chronically suicidal clients. Under these circumstances, the multiple

components of DBT provided adequate time and opportunity to conduct skills training while also managing motivational issues, life threatening crisis, and therapy interfering behaviours that tend to plague work with complex and high-risk populations. Comprehensive DBT is intentionally time and resource intensive in its effort to move clients forward on their path of a life well lived, as opposed to chronically getting stuck in crisis management. It seems appropriate that it would not be necessary to provide the same intensity of service for less complex clients, and clients who are not experiencing chronic crisis, such as suicidal ideation and self harm. However, the greater adaptability and use of DBT-informed practice, the more challenging it is to scientifically validate and define DBT. In identifying DBT component practice we need to differentiate between whether clients are receiving individual therapy as well as the group skills training, and whether the therapists are DBT trained, or offering an alternative or amalgamated style of psychotherapeutic intervention. We can also question whether after hours telephone consultation is available. Furthermore, we could investigate clinicians' own access of case consultation, and personal practice of mindfulness and dialectics. For some, myself included, the diversity and flexibility of the application of DBT is viewed as a strength and not a limitation (Van Dijk, 2012), yet from an empirical and ethical standpoint it is also important to provide evidence-based interventions (Christ, 2014).

Challenges of Northern DBT Practice

There is a lack of specialized mental health professionals and resources in rural, northern, and remote communities. As noted by Gillespie & Redivo (2012), "The more rural the community, the more limited is the access to specialized child and youth psychiatrists, psychologists, and other mental health professionals" (p. 21). The Northern Health Authority headquarters is located in Prince George, British Columbia , yet it services the entire region

spanning over 600 000 square kilometers across the northern half of the province (Government of BC, n.d.). The large geographical area often necessitates long distance travel to obtain specialized medical and mental health services. Given the considerable influence of resources in Prince George on the northern half of the province, there is a need for special consideration regarding the complexity of offering an urban-based, mental health service in a northern city that also serves diverse individuals from outlying communities. These special considerations and possible complications of practicing DBT in a northern city include clinician training and time, northern climate and travel, dual relationships and visibility.

Clinician training and time.

DBT, especially in its comprehensive form, is an intensive psychotherapeutic intervention that requires significant clinician training and time commitments from therapists and clients alike. This intensity of the commitment of DBT is significant for two reasons particular to northern practice. The first is limited and stretched resources, which is a common challenge across northern and rural regions (Bodor, Green, Lonne, & Zapf, 2004; Brown & Green, 2009; Schmidt & University of Northern British Columbia, 2008). Comprehensive DBT requires a minimum of two DBT certified clinicians that clients have nearly unlimited access to (Linehan, 2015). As noted by Rizvi, Steffel and Carson-Wong (2013), "Comprehensive DBT is a complex treatment for a complex population, and learning DBT takes time and dedication" (p. 77). In her article titled "A Week in the Life of a Rural Psychologist," Dyck (2013) shared that she was only able to begin developing a modified DBT program in rural Manitoba after the amalgamation of her regions with another clinician. This allowed for the two clinicians needed to consult and share the load of a DBT program. In addition, higher rates of staff turn-over in northern and rural

clinical practice (Brown & Green, 2009), may interfere with the congruency of service and integrity of the DBT model.

Northern climate and travel.

The second reason the commitment and structure of comprehensive DBT is of significance for Prince George is related to its northern climate, and its role as a mental health hub for northern practice. Travel by road during the winter season is limited due to unsafe and hazardous driving conditions. Participants traveling from outlying areas may be restricted to accessing services in dryer and warmer seasons when highways are not subject to closures and extreme winter driving conditions. This challenge is accentuated for individuals who are taking time off work to participate in DBT sessions twice a week, which is true for locals to Prince George and those residing in outlying areas that may require hours of additional travel to access services.

Dual relationships and high visibility.

Additional considerations for the implementation of comprehensive DBT in Prince George are common concerns for most psychotherapeutic interventions, and helping professions in general, that occur in northern, remote, and rural regions. Most prominent of these concerns and considerations is strains on, or differences in, interpersonal dynamics, both between clients themselves and between clients and the clinicians, that result from increased visibility and limited resources within these regions (Brocious, et al., 2013; Halverson & Brownlee, 2010; Schmidt & University of Northern British Columbia, 2008). For those clinicians residing in urban centers with higher populations, dual relationships, which occur when multiple roles exist between individuals, are an ethical concern that can often be avoided (Brocious, et al., 2013). However, in smaller communities, dual relationships are often an unavoidable reality that occurs

due to smaller populations, limited resources, and high visibility (Brocious, et al., 2013; Halverson & Brownlee, 2010).

Rural social workers have recommended strategies of transparency and clear boundaries when adapting practice to locations where dual relationships are a necessary part of living and practicing (Brocious, et al., 2013; Gillespie & Redivo, 2012). However, this experience can be perceived as challenging, uncomfortable, threatening to the therapeutic process, and potentially unsafe when dual relationships become a reality between the clients participating in therapeutic groups (Ginter, 2005). The core tenets of therapeutic group work are safety and reciprocity, and these may be challenged in northern, rural and remote communities where people are more likely to know one another socially or professionally, or even be members of the same family (Ginter, 2005). In addition, principles of confidentiality and anonymity are limited during group work, which can be particularly unnerving when participants know one another outside of the therapeutic setting. From a clinician perspective, dual relationships and high visibility can also compromise or contaminate a client's confidence in the clinician (Ginter, 2005).

Utility of DBT in a Northern Context?

While it is important to consider challenges of northern practice, it is just as important to note these challenges do not mean that DBT is poorly suited for northern practice. As exemplified by Dyck (2013), DBT is a psychotherapeutic approach that is suitable for northern adaptation. Both Linehan (2015) and Van Dijk (2012) speak to the adaptiveness and flexibility of DBT practice that is frequently required in community mental health and inpatient settings. Furthermore, many of the challenges for DBT practice in a northern context are not specific to DBT but are common to many forms of individual and group therapeutic practices. For example, all group-based mental health interventions, from peer-led support groups to therapeutic process

groups, that occur in northern, rural and remote areas must consider the impacts of travel, weather, dual relationships, high visibility, and potential fallouts that can occur as a result of the compromised confidentiality inherent to group work. Therefore, it is also integral to acknowledge the many benefits of DBT practice within a northern context. This includes DBT's dialectical lens and practice of mindfulness and acceptance which place it in a position to adopt a more constructionist perspective that values subjectivity and context, as well as creates a propensity for culturally specific adaptation when working with culturally diverse communities.

Considerations for culturally safe DBT practice.

There is evidence that Western models of evidence-based psychotherapies are "inaccessible, inappropriate, or poorly delivered" to and for cultural minorities (Cheng & Sue, 2014, p. 23). Furthermore, the inaccessibility of Western models of psychotherapy by cultural minorities has been linked to "the incongruence between the cultural values and expectations of ethnic minority clients and the practices of mental health services based on a Western-based paradigm" (Cheng & Sue, 2014, p. 23).

According to McFarr and colleagues (2014), DBT is "by design culturally competent and flexible" (p. 83). This is important to northern and rural practice when you consider the rates of cultural diversity in these communities; specifically, the higher proportion of Indigenous peoples (Bodor, Green, Lonne, & Zapf, 2004). McFarr and colleagues (2014) suggest the dialectical stance that is the backbone of DBT results in increased cultural adaptability. In addition, the biosocial lens accounts for the transactional relationship between intrapersonal and environmental processes. Together, biosocial and dialectical theory facilitate the validation of oppressive and discriminatory experiences while dually highlighting the importance of change and self-efficacy (Cheng & Sue, 2014). This is important when working with all cultural

minorities and vulnerable persons, but especially Indigenous peoples, who continue to experience the affects of colonization and intergenerational trauma (Gehl, 2013).

DBT also incorporates the clinician's reflection on their own culture and privilege which is an important component of culturally diverse and anti-oppressive practice (Walter, Taylor, & Habibas, 2011). Anderson, Lewis, Johnson, Morgan and Street (2014) note that MABT, including DBT, acknowledge that "biases and prejudices are part of the human condition" (p. 60). Furthermore, these approaches directly speak to the presence of power and privilege within all social interactions. This inherent awareness and reflexivity can strengthen the therapeutic relationship and aid in anti-oppressive clinical practice with cultural minorities, such as Indigenous peoples (Anderson, Lewis, Johnson, Morgan, & Street, 2014). Given the significance of structural social work and anti-oppressive theory as represented in my personal practice model, as well as my professional value of localized, person-in-environment practice, I believe it is essential for me to utilize this practicum opportunity to go beyond the development of clinical skills. In addition to outlining learning goals that include generalized and specialized clinical skill development, I have included the goal to reflect on how DBT practice in Prince George is influenced by culture and context and integrate this experience into my personal practice model upon completion of my practicum with Walmsley and Validity Counselling.

Chapter Summary

This chapter provides a thorough literature review on DBT, including its development as part of the third wave of CBT which incorporates mindfulness and acceptance theory and skills (Hayes, 2004). The three theoretical foundations of DBT are explored (dialectical theory, biosocial theory and behaviourism), and a review of four DBT components (individual psychotherapy, telephone consultation, case consultation, and group skills training) and skills

(core mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness) are provided (Linehan, 2015). Comprehensive DBT has significant support as an evidence-based therapeutic intervention for multiple psychiatric conditions, however, there is controversy regarding scientific validation of DBT-informed practice by minimally trained clinicians and component only DBT (Koerner, 2013). These considerations, and more, are discussed in the context of localizing practice to the northern city of Prince George, British Columbia.

Chapter Four: Practicum Placement Description

Prince George is home to approximately 87 000 individuals and is geographically located just east of the center of the province of British Columbia, Canada (Statistics Canada, 2017). According to Statistics Canada (2017), Prince George is the ninth largest population center in the province. Yet, in terms of proximity it is important to note that the closest large population center to Prince George is the city of Kamloops which lies 522 km, or a six-hour drive, south-east. As such, Prince George is regarded as a major service hub for outlying towns and communities in all directions, but particularly the northern half of the province which is made up of both settler and Indigenous rural and remote communities. This chapter focuses on a placing of self and agency in community, Prince George, as context for localized learning goals and practice considerations.

Placing of Self in Community

I was born in Prince George into a farming and foraging family with deep roots in the local German settlement community. However, by the time I was 18 years old, I had moved more than 10 times across British Columbia and into the southern United States, residing primarily in rural and remote communities. Prior to moving back "home" to Prince George, I lived in Metro Vancouver for nine years while obtaining my undergraduate degree. While in Vancouver, I often frequented Prince George to visit family and labelled Prince George as "north," both directionally, and in terms of its smaller size, colder weather, and limited resources. However, since moving back, I find myself referring to Prince George as "central", and "the city". This is in recognition of the more rural, remote, and northern communities that surround Prince George, as well as the people required to travel, sometimes in extreme winter weather conditions, to access its services. In witnessing this phenomenon and adopting a person-

in-environment lens to my clinical practice, it is important for me to understand how mental health services are provided and accessed by people living in these outlying communities.

Most of my human service experience has centered around working with youth and young adults experiencing complex socio-economic barriers, as well as mental health and substance misuse issues. Interventions used in my early human service work at a youth transition home were guided by a psychiatrist with a strong orientation to attachment theory and DBT. I know this experience had a significant impact on the development of my personal practice model. However, aside from this informal guidance and supervision, my use of DBT skills in my individual sessions with clients was self-taught.

I know DBT is a good fit with my professional values and interests because of my experience practicing CBT and other MABTs. For example, I am trained in the facilitation of two psychoeducational groups for youth and young adults, one of which is based in CBT and the other in Acceptance and Commitment Therapy. During my first social work practicum at Intersect Youth and Family Services Society I was provided with clinical supervision regarding the use of CBT in individual and group counselling for parents, children and youth. In addition, I began training in Emotion-Focused Family Therapy (EFFT) which has a theoretical orientation similar to that of DBT, and other MABTs, although the focus of the intervention is with caregivers. It is because of these experiences that I consider DBT to be a good fit within my personal practice model as a social worker in clinical practice. I looked forward to the opportunity to hone existing general counselling skills while developing a set of specialized skills congruent with my professional practice model.

Placing of Agency in Community

Walmsley and Validity Counselling is located in Prince George and is co-owned by Jenny DeReis and Tracy Larson. In addition to counselling services provided by the co-owners, six other clinicians provide counselling services for the agency. Collectively, Walmsley and Validity Counselling provides support to 80 to 100 clients per week, with services being offered six days a week during regular business and evening hours.

Walmsley and Validity Counselling is a private, for profit, counselling center that offers self-pay services, as well as services for individuals with contract holders, such as employers offering extended health benefit packages. Employee and family assistance programs (EFAPs) typically offer a limited number of sessions per presenting issue, averaging on eight sessions at the agency, that are paid for by the employer. Private counselling practice offered by the agency utilize a pay-for-service model for individuals who have the means to fund services independently and want to access a variety of professional mental health and psychotherapeutic interventions. According to the Canadian Association of Social Workers (2005), social workers engaging in private practice have additional ethical responsibilities for ensuring they set responsible fees, avoid or declare conflicts of interest, and have sufficient insurance. Walmsley and Validity Counselling is a fully insured private counselling practice that chargers $115 per session for individual, couples, and family appointments, and $240 per six-week DBT skills modules.

Walmsley and Validity Counselling specializes in offering CBT and comprehensive DBT. In Prince George, CBT is a widely offered therapeutic intervention, however, access to comprehensive DBT interventions is limited. For adults, DBT is available from this private agency and specialized mental health services within the Northern Health Authority, which

require a referral from primary care teams and can have lengthy waitlists. Comprehensive DBT interventions for youth in Prince George are not offered at this time, however, Intersect Youth and Family Services Society offers adolescent DBT skills training annually.

During my 450-hour social work practicum with Walmsley and Validity Counselling, I hoped to engage in activities to enhance my overall clinical practice skills, as well as assist me in the development of specialized CBT and DBT skills. Specific activities I planned to participate in included individual CBT and DBT-based client sessions, observation and potential co-facilitation of DBT group skills training, attendance and participation in weekly DBT case consultation, and weekly supervision with my internal and external supervisors. My practicum supervisor at Walmsley and Validity Counselling was co-owner Jenny DeReis, a therapist with a master's degree in Counselling Psychology. External consultation during my practicum was provided by Clarie Johnson, an instructor at the College of New Caledonia with a Master of Social Work (MSW) degree. Consistent with my expectations, this practicum placement provided me with the opportunity to embed myself in DBT training, as well as observe and practice under the guidance of two supervisors with different professional backgrounds but similar practice frameworks. Furthermore, the context of my practicum placement, as both a northern and private practice, provided the opportunity to explore and observe how these unique contextual factors impact the comprehensive DBT model which is important to my value of localized professional development.

Chapter Summary

This chapter provides a description of my practicum placement at Walmsley and Validity Counselling in the northern city of Prince George, British Columbia. The location of Prince George relative to other major mental health services in the province helps to contextualize

northern practice considerations. I also place myself in the community of Prince George and explore my professional experience in mental health and with DBT. Walmsley and Validity Counselling provides some of the most comprehensive DBT services in Prince George as part of their combined EFAP and self-pay service model. Completing my practicum at Walmsley and Validity Counselling provided me with the opportunity to hone my general clinical skills, develop specialized clinical skills in DBT and CBT, and localize my professional development to include considerations of northern and private practice.

Chapter Five: Learning Experiences and Implications for Future Practice

I completed my practicum with Walmsley and Validity Counselling part-time, Monday through Wednesday, between April and September of 2019. During this time, I scheduled 164 sessions with clients; 87 clients were contracted through EFAPs, 43 were pro-bono, 30 were self-pay and four were paid for by a third-party. Of these 164 sessions scheduled, 115 were attended. The scheduling software used by the agency did not track specific reasons for sessions that were not attended, however, this number includes cancellations, some of which were rescheduled, and session no shows. Some of the reasons provided to me for cancellations included: ending counselling because goals had been achieved or they felt counselling was no longer helpful, and practical schedule changes such as return to work, vacation and illness. Based on my conversation with other clinicians in the agency and my own counselling experience, an approximate 30% non-attendance rate appears to be ordinary for counselling practice.

Most clients I saw were young people between the ages of 12 and 25, with the exception of four older adults who requested emergency sessions or agreed to see a younger practicum student. My caseload fluctuated significantly throughout my practicum placement, with me seeing an average of eight clients per week. During my practicum, I saw five clients that were referred specifically for DBT, or where DBT was recommended as an appropriate intervention by my agency supervisor. In addition, I co-facilitated 17 hour-and-a-half long weekly DBT groups and independently facilitated two additional DBT groups.

Review of General Clinical Skills Learning Goals

In my practicum proposal, I listed five general clinical skills which I had planned to improve upon during my practicum. These general clinical skills were:

- deepening validation,

- affective modulation and expression,
- use of immediacy,
- development and maintenance of therapeutic alliance,
- and balancing psychoeducation, skills development and process in individual and group sessions.

I believe that the clearest gauge of my achievement of these goals is my ability now to recognize how these general clinical skills are so strongly represented within DBT as a therapeutic modality. I still acknowledge that these skills are regarded as general clinical and facilitation skills that are represented across many different therapeutic modalities. For instance, validation is a general communication tool that facilitates relationship development because the act of validation is to convey understanding and acceptance (Linehan, 2015; Van Dijk, 2012). In addition, the importance of therapeutic alliance is epitomised in the theory of therapeutic common factors (Cameron, 2014), as well as many other specific models for therapy (ie., psychodynamics, solution-focused brief therapy, interpersonal therapy, and CBT) (Miller, 2012). However, I believe it is my ability to clearly identify and discuss where, how and why these more general clinical skills are represented within DBT that provides the best evidence for my greater understanding, more skilled use, and overall integration into my practice. I explore this learning outcome with each of my general clinical skills goals below.

Deepening validation.

In DBT the concept of validation is introduced to clients early on through the biosocial theory of emotion regulation. I discovered that providing this theoretical psychoeducation was often experienced as validating by clients because it normalized and explained their emotional experiences, problematic behaviours, and interpersonal difficulties that often began in childhood.

Reviewing and applying Linehan's biosocial theory of emotion regulation seemed to produce an atmosphere of validation through the creation of understanding and compassion, which included a non-judgemental stance on the development and maintenance of problems identified by the client. The non-judgemental stance and stories of invalidation that typically arose from explaining this theory made it easier for me as a clinician to be compassionate, empathetic and understanding in ways that were specific to the client. Furthermore, Linehan (2015) describes how the skill of emotion regulation "can be taught only in a context of emotional self-validation" (p. 318). I believe that my practice teaching the skill of self-validation created a strong accountability for me to further learn, practice, and model self and external validation in sessions. Furthermore, connecting concepts of validation and emotion regulation also enabled me to hone my skill of facilitating affective modulation and expression.

Affective modulation and expression.

Affective modulation and expression are trauma-focused CBT terms for the ability to identify, regulate, and appropriately express a range of emotional experiences (Salloum, Swaidan, Torres, Murphy, & Storch, 2016). In DBT, emotion regulation requires the insight and ability to observe, describe and appropriately express emotional experiences (Van Dijk, 2012). Therefore, in the context of my general clinical skills learning goals, it is important to recognize how emotion regulation skills in DBT are essentially the skill of affect modulation and expression in trauma-focused CBT.

Emotion regulation is one of the four modules of DBT skills which introduces the theoretical function of emotion and provides skills for self-validation and altering emotional experiences that are not justified by our environment (Linehan, 2015). Learning DBT's theory of emotion and using emotion regulation handouts in group and individual sessions significantly

improved my ability to help clients develop affective modulation and expression skills. I found that handouts on the function of emotions, as well as identifying secondary and primary emotions, were useful in many of my sessions. In addition, the handouts provided relatable examples and identification of concepts that could be used for homework and/or to practice skills in session.

Use of immediacy.

The therapeutic use of immediacy is also well represented within DBT, as an emotion processing technique and a way to generalize skills development. Therapeutic immediacy refers to attending to the moment in session (Friedberg, 2013). Therefore, therapeutic immediacy encompasses the practice of processing emotions, thoughts, behaviours and interpersonal interactions that arise during session which functions to promote immediate awareness, skill use and skills development (Linehan, 2015).

Again, I found that DBT theory and skills provided multiple avenues for me to hone my practice of immediacy in session. In DBT the tool of chain analysis often serves as a collaborative activity to observe, describe and label emotions, thoughts and behaviours, while simultaneously identifying skills used, missed opportunities for skill use, and skills that could be used in the future (Rizvi, 2019). I used chain analysis in many of my DBT sessions, either verbally or written. Chain analysis has come to be a standard tool I rely on in my practice to guide sessions because chaining is helpful to explore and process past and present emotions, thoughts and behaviours, as well as reinforce skills use and areas for skill building. In addition, immediacy is also inherently a tool of mindfulness through its emphasis on being in the present moment with a non-judgemental awareness and curiosity of our own responses and the environment. Mindfulness is the core skill of DBT, and the understanding and practice of

mindfulness is closely linked to skills development in the other three modules (Linehan, 2015; Van Dijk, 2012). The therapeutic use of immediacy also provides the opportunity for clinicians to model mindfulness, curiosity and relationship effectiveness. For example, the effectiveness of immediate repair in interpersonal relationships, or the use of mindfulness to be curious of emotional changes and urges in response to others in group as an opportunity for practicing self-validation and developing insight. Immediacy can also enhance therapeutic alliance by avoiding lengthy relationship ruptures, as well as the natural external validation that occurs when a clinician is present, engaged, curious, transparent and self-disclosing with therapeutic purpose (Linehan, 2015).

Development and maintenance of therapeutic alliance.

Therapeutic alliance is scientifically validated as integral to therapeutic outcomes (Cameron, 2014; Miller, 2012). I view the therapeutic relationship as an opportunity to model a secure attachment and reap the benefits of safety and growth inherent to secure attachments (Fitton, 2012; Johnson, 2019). I generally believe I have strong skills in building and maintaining therapeutic alliance, particularly with youth and young adults. However, I feel that this practicum enhanced my validation and immediacy skills which indirectly strengthened my therapeutic relationships with clients.

Both Linehan (2015) and Van Dijk (2012) emphasize how the development of a strong therapeutic relationship is one of the key tasks in DBT that begins during orientation to the therapeutic model and the clinician themselves. Unlike therapeutic interventions which express concerns about the safety and purpose of clinician self-disclosure, DBT emphasizes how authentic disclosure and reflection is integral to the development and maintenance of an authentic and genuine therapeutic alliance (Linehan, 2015; Van Dijk, 2012). According to

Linehan (2015) and Van Dijk (2019), human growth and safety is fostered by secure human connection, by embracing clinical fallibility and by utilizing the relationship as the ultimate tool for modeling skills use, skills development, and the ubiquity of human experience of pain. I felt more freedom in DBT practice to self-disclose as part of modeling authenticity and accepting human pain and error. I believe my openness, particularly when accepting my own errors or reflecting on my own DBT skills practice, increased clients' relatability to me, and therefore accelerated relationship building.

As I learned in this practicum through relationship building experiences with clients, discussion with my supervisors, and journal reflections, DBT appears to be most effective when the clinician has embedded themselves in their own practice of DBT and is authentic about their own reflections on their connection to theory and practice of skills. During supervision, I often reflected with my agency supervisor, Jenny, on how DBT is more than a therapeutic model; DBT is a way of being and interacting with the world that is best facilitated by using self in practice. It appears that once the world is viewed and experienced through a DBT coloured lens, it is difficult to "un-see" it from this dialectical, non-judgemental and effectiveness seeking perspective.

Balancing psychoeducation, skills development and process in individual and group sessions.

Early on in reflection of my clinical style I identified that I am comfortable with group facilitation and providing psychoeducation. This is understandable considering my academic and work experience in facilitation, as well as my training in facilitating psychoeducational groups. When I am in a facilitation-based role, my comfort with psychoeducation, leadership and problem solving is an asset. However, I find it concerning when I revert to psychoeducation as a

place of safety and avoidance of deeper processing in my clinical sessions. In fact, I frequently experienced judgemental thoughts about how I was "doing counselling wrong" in my first practicum and held an expectation that I should talk less and include less psychoeducation during sessions. While completing my practicum, I independently attended a three day intensive DBT training with Sheri Van Dijk (2019) that was mostly funded by my employer. I felt immense relief when Van Dijk (2019) announced that DBT-oriented clinicians tend to talk more and provide more psychoeducation in session because DBT is a skills-based intervention. Furthermore, Van Dijk (2019) shared how it is understandable that clinicians who are more directive are drawn to DBT as an intervention. The external validation and acceptance felt glorious to me. Therefore, in reflection on my goal to balance psychoeducation and processing in individual and group sessions, I have come to a place of acceptance of my own therapeutic comfort and style, as well as the function and intention of being more directional and including more psychoeducation in the context of using a skills-based intervention.

This realization has resulted in me being more curious about the intention and timing of my use of psychoeducation and process in individual and group sessions. My awareness has also led to increased transparency with clients during orientation about my therapeutic style and the psychoeducation and homework component inherent to skills-based approaches. Furthermore, I noticed greater skill in identifying times when I may be using direction, problem solving, or psychoeducation to avoid the discomfort of emotion processing in a session. In response, I am choosing to try to tolerate, and be curious about, this discomfort, as part of my own DBT skills use. I have also reflected on being more intentional about my use of psychoeducation or process in session. This resulted in me noticing that as I have become more comfortable with DBT psychoeducation and emotional processing I appear to be more ready and able to integrate and

transition between the two therapeutic techniques, both in group and individual sessions. In hindsight, I believe this to be one of the most impactful practices of balancing the DBT principles of acceptance and change in integrating DBT into my personal practice model.

Reflection on Specific Practicum Learning Goals

Below I reflect on my learning experiences related to the more specific learning goals I set out to complete in my practicum proposal with Walmsley and Validity Counselling.

Observe and practice individual CBT and all components of DBT.

In my literature review, I briefly discuss how it can be difficult to differentiate between CBT and DBT interventions in practice. During my practicum experience, this confluence has become more understandable to me, for two reasons. First, it is reasonable that it can become difficult to differentiate DBT theory and skills from CBT because Linehan (1993, 2015) derived DBT from CBT. In fact, Linehan's (1993) introductory text on DBT is titled *Cognitive Behavioural Treatment of Borderline Personality Disorder.* Second, as identified by Linehan (2015) and Van Dijk (2012), the integration of MABTs theory and skills into CBT practice further confuses the differentiation of DBT from CBT practice because it is these very skills that are best used to identify DBT. Therefore, I have come to my own conclusion that DBT practice, especially the more flexible and informal component practice of DBT, is essentially "CBT plus mindfulness and acceptance". As it is difficult to deny the growing popularity and scientific validation of the effectiveness of mindfulness and acceptance-based interventions, it is understandable, and likely ethical practice, that they would be integrated into existing therapeutic interventions, such as CBT (Masuda, 2014).

In reflection of the therapeutic interventions utilized during my practicum, instead of attempting to differentiate CBT from DBT, I chose to focus on honing my ability to intentionally

identify where DBT theory and skills have been directly derived from CBT and where DBT has expanded on CBT. This was accomplished through independent theoretical research, as well as discussion during supervision with Jenny. One example of this is, CBT places a significant focus on challenging or altering unhelpful ways of thinking, acting or feeling, and focuses most on identifying distorted thought patterns (Miller, 2012). Where DBT differs is that it is first and foremost emotion-focused, and therefore, begins with the emotional experience (Linehan, 2015). In addition, in the spirit of DBT's intentional balance of change and acceptance, DBT skills focus on examining if our thoughts are factual and effective prior to determining if we are in a position where changing our thoughts about a situation would be validating and helpful (Linehan, 2015). Finally, because DBT recognizes and provides psychoeducation on the adaptive, survival-based action tendencies associated with emotions, I perceive that it helps to cognitively differentiate urges from actions themselves. In my perspective, this offers clients a larger window of opportunity for intervention, as they are better able to mindfully observe emotions, thoughts and urges, prior to choosing which response would be most effective and aligned with their values and goals.

I thoroughly embedded myself in DBT during this practicum. I independently attended a *3 Day Intensive: DBT Made Simple* training course with Sheri Van Dijk (2019) and I accessed weekly supervision with my DBT trained agency supervisor Jenny DeReis. Furthermore, I attended weekly case consultations with Jenny and other clinicians for three out of six months of my practicum. I also thoroughly reviewed and revisited Linehan (2015) and Van Dijk's (2012) texts on DBT, always seeming to find new information to integrate into my practice.

What I view as most influential and rewarding during my practicum, both personally and professionally, was my attendance and co-facilitation in the weekly DBT skills group. Co-

facilitating DBT skills group with Jenny kept me accountable and fresh in learning and practicing the many DBT skills within each of the four modules. In reflection, I believe that I integrated some form of DBT theory and skills into most, if not all, of my individual sessions. I found that biosocial theory, as well as skills of self-validation, mindfulness, radical acceptance, and opposite action, were particularly useful and fitting interventions in many of my sessions. I am significantly more comfortable with DBT theory and skills, and yet I still find the number of skills and depth of theory simultaneously overwhelming and exciting. I think there is still so much to learn and integrate from DBT practice and I have accepted that this may be a profession-long pursuit.

While it does appear that Walmsley and Validity's Counselling is one of the few local counselling centers that offers telephone consultation, I did not have the opportunity to practice this component of DBT. Initially, it was because my lack of access to a confidential work number. However, towards the end of my practicum, Jenny and I figured out a confidential alternative, but the two DBT clients I offered this service to did not use it. While I did not have the opportunity to directly practice the skill of telephone coaching, the practical difficulties raised many considerations, including my limitations with being available after-hours. In supervision, I reflected on the impact of sleep-deprivation on mine and my partner's functioning and relationship. While I like the principal of offering telephone consultations as an opportunity to practice immediacy, to skills coach, and to facilitate the generalization and practice of DBT skills, it became clear to me that I had reservations regarding the level of responsibility and impact of being "on-call". If I provide after-hours professional phone coaching in the future, I now know to carefully examine both its practicality and my limitations.

Gradually build and manage a caseload of 8 to 12 clients.

My case load was smaller towards the beginning and end of this practicum, which is typical in growing and closing caseloads. During the peak of my practicum, I saw an average of eight clients per week. I enjoyed the opportunity to schedule and maintain a caseload. I noticed that my capacity for sessions is around four to five sessions per day. Furthermore, I noticed that it was also important for me to consider the type of session and presenting issue when scheduling sessions. I learned to try my best to give myself an extra half hour following family sessions and limit myself to approximately two family sessions per day. In addition, I discovered I had more energy if I did not have more than two family, crisis or intense DBT sessions back to back. Overall, I feel these scheduling and case-management reflections will be very useful in my future practice as I continue to balance meeting client needs and wants, with my own wellness and effectiveness.

Engage in observational learning by shadowing a minimum of two clinicians during my practicum.

One of the most effective forms of reflection and learning for me occurs through observing other professionals in practice. I enjoy seeing different clinical therapeutic models and styles in practice as it gives me the opportunity to try to identify them, as well as reflect on my own style. Furthermore, this practice-based exposure to the clinical techniques and styles of others introduces me to new aspects of clinical practice that I can integrate into my own practice model.

I had the opportunity to observe my agency supervisor Jenny in our weekly DBT group and was frequently left in amazement at the way she casually, yet intentionally, flowed between providing psychoeducation/skills coaching, emotional processing and facilitating discussion. It

was through observing Jenny in practice that I recognized the importance of self-disclosure in DBT skills coaching, with an emphasis on the need to have planned and appropriate examples to share during group. As DBT skills coaching can be experienced as theoretically or educationally heavy at times, Jenny showed me how the use of casual language, as well as real-world and personal examples, can lighten and personalize this experience.

I also had the privilege of shadowing Ida, who was privately contracted to Walmsley and Validity Counselling. Ida has over twenty years experience working with children, youth, couples and families in northern British Columbia and describes herself as an Adlerian Therapist. Observing her gathering information during an orientation session, it was incredible to see how she used strength-based questioning, validation and body language to build relationship while simultaneously conducting her assessment. Her style and confidence appeared casual and natural, and her presence was warm, compassionate and inviting. I specifically appreciated her curious, non-judgemental, and casual phrasing of questions. I recognized the intentionality behind her assessment, and yet it felt like a conversation amongst friends. As I also view the therapeutic relationship as the foundation of clinical work, I hope that with intentionality and experience, I too can build towards conducting such a thorough assessment, while building connection, warmth and highlighting strengths of the client.

Conduct formal clinical reports and assessments, as well as complete regular clinical documentation.

As per Walmsley and Validity Counselling's policy and practice, I documented progress notes following all my individual sessions and my notes were occasionally reviewed by co-owner Tracy. I noticed in my previous practice that my clinical documentation could be unnecessarily lengthy, and I wished to reduce the length of my session notes. As summarized in

the Canadian Association of Social Worker's (CASW, 2005), the maintenance and handling of client records, client documentation must be impartial, accurate, and written with consideration that the records could legally be read by the courts or the clients themselves. Therefore, the more information included in notation, the more information accessible for disclosure. In daily practice clinical documentation often serves as a reminder of session content and progress for clinicians, however, I wanted to ensure I was documenting my sessions as ethically and concisely as possible.

Walmsley and Validity Counselling did not provide a standardized format for clinical documentation; however, I had previously encountered multiple templates to draw from to develop my own format. I found that the more headings in a template, the more I tended to write, and the more likely I was to repeat information. Furthermore, I also noticed that I prefer to write out comments and assessments myself rather than complete checklists or fill-in-the-blanks. Therefore, I used the following headings for first session documentation: presenting issue, brief mental status examination, summary, and plan. In all following sessions, I used the headings: focus, summary, and plan. If there were concerns for safety, I also included this as a separate heading. I found this process helped me to write concise and professional clinical documentation that included all pertinent information, followed CASW ethical guidelines, and aided my memory. Tracy provided the feedback that my clinical documentation was thorough and professional.

Complete a weekly mindfulness journal to hone my mindfulness skills and reflect on its impact on my professional practice.

Linehan (2015) states that "Mindfulness skills are as essential for therapists and skills trainers to practice as they are for participants. Indeed, clinicians' practice of mindfulness has

been found to be associated with a better therapeutic course and better outcomes" (p. 151). I am a firm believer that clinicians should "practice what they preach", to the best of their ability, with all the struggles and fallibility of the human experience of new and healthy habit forming. Since I received training in Acceptance and Commitment Therapy-based group facilitation two years ago, I have increasingly focused on incorporating informal mindfulness practices into my day. Van Dijk (2012) differentiates formal from informal practices of mindfulness, with formal mindfulness practices being those that we set aside specific time and may use guiding tools, such as in meditation. On the other hand, informal mindfulness is the practice of awareness in the present moment without judgement and with acceptance that we can do virtually anywhere (Van Dijk, 2012). Informal mindfulness can be practiced while doing household chores, driving, snuggling your dog, going for a walk, listening to music, stretching, etc. Prior to entering this practicum, I found myself practicing informal mindfulness at least a couple times a day, and that it was easiest for me when I was in or observing nature or with my dog.

During my practicum, I desired to at least continue, if not increase, my informal mindfulness practice, while also developing a formal mindfulness practice. I hoped that journaling this process would increase accountability and opportunities for reflection, both of which I found to be true. Admittedly, I struggled to journal twice a week, and I often missed my phone alarm to practice formal guided mindfulness. As has been my previous experience, because of the variability of my schedule, I find setting specific times for things a challenge as what is opportune and feasible on one day, may not be for the rest of the week. The flip side of this, is that if I do not schedule and set alarms for formal mindfulness I forget! Therefore, I learned to view my alarm as a reminder and tool of accountability.

In reflection of my journal and experience with formal mindfulness practice, I found that all mindfulness was beneficial in increasing a feeling of being calm and grounded, as well as reducing my overall feelings of stress. However, this effect was increased significantly when I was practicing informal mindfulness at least three times a week. Furthermore, the positive impacts of formal mindfulness practice were most significant when I was practicing at home and at work. For example, I found guided mindfulness practices that focused on the transition of work-to-home particularly soothing and re-orienting. I was better able to practice letting go of work-based thoughts and attuning myself to being present at home for the rest of the evening. I also found timed breathing practices with nature sounds effective at work, particularly when transitioning between sessions or while debriefing difficult sessions. Knowing this, I plan to incorporate mindfulness time blocks into my work schedule and maintain my work-to-home mindfulness alarm. Aside from the benefits of formal mindfulness practice more generally influencing my work, this activity also provided anecdotal evidence and examples for me regarding the importance of "practice" in developing mindfulness skills, as well as finding what works for you individually in a non-judgemental way.

Video tape and review a minimum of three sessions during clinical supervision.

No sessions were videotaped as planned predominately because of barriers related to scheduling and access to equipment that I could ensure was confidential. It is more difficult to obtain legal consent to record minors from their guardians and I thought that recording sessions with minors might interrupt the session more than with adults. Therefore, I decided to only arrange video recording with adult clients. Unfortunately, the clients I had planned to record either cancelled sessions or it seemed inappropriate to record due to high emotionality or abuse disclosures. The purpose of videotaping sessions was for myself and my supervisor to be able to

observe and reflect on my skills use, skills development, and body language in session. While I was unable to fulfill this function personally, my supervisor Jenny was able to observe my practice in group and provide feedback.

Participate in weekly-bimonthly supervision with my agency DBT trained supervisor.

I am extremely grateful for the extensive supervision I had access to during my practicum placement. I met weekly to every second week, for separate supervision with my agency supervisor Jenny, as well as co-owner Tracy. Tracy's therapeutic approach incorporates more CBT and solution focused therapy, however, she also has training in DBT, so we were able to engage in regular discussions comparing different therapeutic models and styles. Furthermore, while Jenny and I more regularly engaged in supervision regarding managing my caseload and DBT practice, Tracy and I were able to explore other presenting issues that arose during my practicum, including grief, loss, trauma and abuse disclosures. I was also able to have structural conversations in supervision with both Jenny and Tracy regarding gaps in care and access to services in the north, dual relationships in community but also when working with multiple family members, e-health, telehealth, and setting limits in practice. Finally, early on my practicum we frequently discussed the topic of private versus non-profit organizational models.

Access twice monthly supervision from an external MSW Consultant.

The function of having external consultation, or supervision, with someone with an MSW degree is to ensure that my practicum is completed from a social work lens. Therefore, the focus of our supervision included examining my practicum experience from a structural and anti-oppressive social work perspective and discussing potential professional drift. My external social work supervision was provided by Clarie, approximately twice a month with the option for

an as-needed consultation. We often processed structural and policy concerns as related to more micro-level clinical practice issues, and how best to consider the impact of larger structural issues on the micro-level presenting problems. For example, we discussed the role of gender in clinical professions, including topics such as attire, professional growth and development, and safety issues from both critical feminist and anti-oppressive perspectives. Together, we noticed how my scope of practice and willingness to engage in supportive or social service interventions was associated with my identity as a social worker.

Fittingly, the most impactful learning and reflection that occurred in my supervision with Clarie had to do with my identity as a social worker. Having completed my undergraduate degree in psychology, and now accessing a practicum where my agency supervisor's graduate degree was in psychology, there were concerns about professional drift. Professional drift refers to the neglect of the ethical guidelines and values of one's own profession in favor of another professional discipline. According to Sheafor and Horejsi (2015), professional drift most frequently occurs in interdisciplinary settings, particularly when "in clinical settings social workers align themselves too closely with models and theories used in medicine, psychology, and other disciplines, which tend to minimize social policy and social justice issues" (p. 4). Having completed most of my work experience in interdisciplinary settings with medical professionals or at academic institutions, I wanted to ensure that I was cautious about professional drift. However, the most fulfilling moment of my supervision with Clarie was when I realized that I have long held the values, beliefs and critical lens that aligns with social work. Understandably, this is why I experienced discomfort in many of my previous work settings. As I noted in my journal on May 28th:

> …it is clear that I have been practicing from a critical social work lens since I started working in mental health, with lots of learning along the way. The values and observations that led me to pursue graduate studies in social work, as opposed to an MEd or Psych degree, have long been entrenched, and aren't going anywhere. I instinctually consider social determinants of health, take a wider lens when working with clients, and apply a broader scope of practice in supporting them. It is comforting to know that this isn't going anywhere. I still feel it is important for me to consider possible professional drift, however, I think it is more important for me to be curious about how my practice as a social worker can impact the other professionals around me. For example, I often bring into sessions socio-cultural and colonial impacts on our thoughts, feelings, behaviours, and development of self (ie., discussing alcohol as a social norm for coping with stress, consider the role of gender norms and socialization when working with father and daughter, discussing societal responses to fear and the happiness trap when talking about emotional growth and development). These are the ways that I bring critical social work and anti-oppressive practice into my micro-level clinical practice. Critical social work does not need to be activism always, but professionally for me it is bringing that informed critical lens into sessions with clients to frame understanding and empower. It is also stepping into an advocacy role and considering social determinants of health in my interventions. I have always felt the need to DO MORE to be a "good social worker", but I am finding comfort in recognizing how my practice is already social work. (para. 2)

During this practicum I have had the opportunity to discard my feelings of being an imposter and began to feel worthy of defining myself as a social worker. The confidence and security that

resulted from this has been tremendously settling for me, which I believed has translated to increased effectiveness in my practice.

Reflect on private vs. non-profit service models.

This practicum was my first experience working with self-pay clients whom I needed to accept payment from at the end of the session. Accepting payment felt uncomfortable, and upon reflection of my journal notes, most of this discomfort appeared to be reduced when I took a more dialectical stance and recognized my socially democratic bias. I am a firm believer that mental health care should be publicly funded as a health service offered under the umbrella of our national health care program. Therefore, I think my professional values better align with non-profit agencies. Yet, I also find that due to lack of funding the wages of mental health services providers in non-profits can be significantly low when you consider costs of a graduate level education, as well as psychotherapeutic and professional development training. Conversely, completing my practicum in a private agency has enabled me with the opportunity to review the extensive overhead costs associated with running a private agency that are included within session fees. Again, my DBT skills enabled me to better process a complex issue, from a non-judgemental distance with acceptance of dialectical truths of two seemingly opposing clinical organization models.

Reflect on the cultural safety of DBT in practice, particularly with Indigenous clients if there is opportunity.

Prior to engaging in this practicum, I was curious about the claims that MABT, and particularly DBT, are culturally safe and appropriate interventions for Indigenous peoples. I am critical of the generalization of western and urban-developed interventions as evidence-based interventions for use with marginalized peoples residing in rural, remote and northern

geographical regions (Anderson, Lewis, Johnson, Morgan, & Street, 2014; Christ, 2014; Graham, Brownlee, Shier, & Doucette, 2008). I believe that this skepticism and curiosity is integral to the anti-oppressive and structural elements of my personal practice model. That being said, my heart warmed when I witnessed an Indigenous participant in DBT group achieve significant validation from learning about DBT's biosocial theory of emotion dysregulation. In her discussion of invalidating environments, Jenny reviewed how the very existence of marginalized and colonized individuals in our society results in their chronic experience of invalidation. As a group we went on to discuss how residential schools, intergenerational trauma, and the tragic rates of Indigenous suicides are in many ways products of invalidation. During these groups, a lesbian participant also reflected on their chronic experience of invalidation as resulting from merely existing outside of our society's dominant sexual orientation. As multiple females in the group, together we reflected on the life-long invalidating experience of living in a patriarchal society. We were united and collectively validated in our experience of oppression and the impact that it has had on our ability to self-validate, to regulate our emotions and behaviours, and to develop and maintain healthy communication styles and relationships. The structural and anti-oppressive content of our sessions initially took me by surprise, particularly because I get excited about the impact of validation and unity in empowerment and allyship.

I also found it fascinating how spirituality was integrated into our skills-based discussions of mindfulness, from Indigenous and Christian participants. Masuda (2014) and Linehan (2015) describe how mindfulness practices are generally adaptable to diverse spiritual practices. In fact, Linehan (2015) provides relatively inclusive mindfulness-based handouts specifically for a more spiritual approach to learning and practicing mindfulness in individual or advanced DBT group sessions. While Jenny did not avoid the topic of spirituality, her practice appears to align with the

teachings of Van Dijk (2019) who leaves it to participants themselves to breach the topic of spirituality. Christian participants gave examples of mindfulness as prayer, while an Indigenous participant referred to the representation of acceptance and non-judgemental stance within Indigenous wisdom.

I learned from these experiences that mindfulness skills, and DBT-informed practice overall, can be facilitated in a way that is culturally adaptable and particularly validating of some of the more micro-level outcomes of structural oppression. However, I also recognize that I see these outcomes because I questioned them in the first place. Therefore, it is equally important that I do not abandon my critical lens in regard to the practice of Western, Eurocentric, urban-developed, evidence-based interventions with marginalized peoples in diverse settings.

Engage in reflexivity regarding localized northern practice considerations.

Group facilitation texts, and professional experience, tell me that one of the biggest barriers to conducting groups is that it is difficult to recruit and maintain a functional number of group participants (Corey, Corey, Callahan, & Russel, 2015). During my practicum experience, this continued to be the most problematic concern with the facilitation of DBT groups. However, unlike high population centers that may have similar rates of attrition and challenges with recruitment, Prince George overall has fewer potential participants due to its smaller population. Furthermore, participants in Walmsley and Validity's Counselling DBT group must also either have access to means to self-pay, even though it can be significantly more affordable than paying for individual sessions, or they must have access to EFAP/extended benefits. While many of the group participants who stopped attending group did not discuss their reasons for discontinuing service, I am aware of one participant who found the travel difficult from a rural outlying community. Other participants attended more irregularly due to work schedules, or because they

worked in an industry that required frequent travel. Therefore, it appears that northern factors can increase recruitment challenges and rates of participant attrition. The response to this was increased flexibility through offering an open-group structure, ongoing referral and recruitment, as well as pushing through participant attendance lulls.

Chapter Summary

This chapter consists of reflections on my learning experiences and implications for future practice. During my 450-hour practicum placement at Walmsley and Validity Counselling I had conducted 115 individual sessions, I co-facilitated 19 DBT groups, and I accessed weekly supervision from three highly skilled clinicians from different professional and clinical backgrounds. In this chapter, I explored the outcomes of the general and specific learning goals I set for myself prior to beginning my practicum placement which includes topics such as: recognition of general clinical skill goals in the DBT therapeutic model, practice of all DBT components, differentiating CBT from DBT, caseload management, clinical documentation, insights from supervision, personal mindfulness practice, cultural safety of DBT in practice, and northern practice considerations.

Chapter Six: Concluding Integration of Practicum Experience into Personal Practice

The process of obtaining an MSW at the University of Northern British Columbia has felt like coming home to me. In the literal sense, I returned home to my place of birth, a land and a community that I intend to settle into and plant my roots. In the figurative sense, this program, and particularly my practicum experiences, facilitated a discovery of personal, professional and localized self. Reflection and reflexivity of interests, values, beliefs, world views, politics, and the development of my personal practice model have left me feeling secure and grounded in my identification as a social worker, as well as my intentional use of theory and therapeutic models in practice. Furthermore, I have gained a sense of confidence and flexibility that I believe stems primarily from more thoroughly understanding how I have integrated therapeutic models into my clinical practice as a social worker.

In conversation with my external MSW consultant Clarie, I reflected on how strongly I experienced imposter syndrome during my foundation year social work practicum. Gallagher (2019) describes how a lack of confidence in existing skills and the fear of being exposed as a fraud is a common experience for students in health care professions. Furthermore, that while a greater experience of imposter syndrome was linked to burnout for nursing students, the negative impacts of imposter syndrome on practice and personal wellness can be mitigated by supervision and critical reflection on professional interests (Gallagher, 2019). Beginning my foundation year social work practicum, I felt that I was starting over with an empty toolbox of skills and knowledge. Through access to supervision, as well as regular reflection and self-care, I discovered that my clinical skills toolbox actually had a false bottom, full of many clinical and communication tools that were transferable from previous academic and professional experiences. At the end of my final year practicum with Walmsley and Validity Counselling, I

feel like my skills toolbox is overflowing. This plethora of skills is directly associated with the abundance of skills taught in DBT (Linehan, 2015). However, what I am most pleased about my skills is not how many I now carry, but the knowledge and intentionality that I can now confidently practice skills with. This includes how I can connect therapeutic models, such as DBT, to my personal practice model.

At the beginning of this report, I described my personal practice model as a house. My personal practice model is built on a foundation of Rogerian person-centered practice (Coggins, 2016) , with walls made of strength-based practice (Payne, 2014), a roof of made from trauma-informed care (Levenson, 2017), windows designed for the use of anti-oppressive practice (Bishop, 2015) which links to the view of structural social work theory on the horizon (Mullaly, 2010). Warming my practice model from the inside out, is my value of attachment theory. I now can more clearly identify how attachment theory's biopsychosocial tenets and emphasis on relationship are reflected within DBT (Fitton, 2012; Linehan, 2003), for example, the shared importance of relationship, the roles of caregivers as emotional and behavioural co-regulators, and the destigmatization of maladaptive behaviours (Coggins, 2016; Fitton, 2012; Linehan, 2015; Linehan, 2003).

Given this, I feel that my personal model of a house has been painted with a brilliant hue of DBT. I choose DBT as the paint of my house because DBT captures many of the components of my practice model, and it is the most striking way that I present my practice model to clients and other service providers. In my practicum experience and during my DBT training with Van Dijk (2019), I embraced the universality and flexibility of DBT-informed, or DBT component practice. Emotion dysregulation is a common experience within our society, which is reflected in the prevalence of mental illness, suicidal behaviours, and self-injurious behaviours, especially

among young people (Centre for Addiction and Mental Health, 2019). Furthermore, systems of oppression, emotional avoidance, and social media ruled by vanity and privilege comparisons each can contribute to a more generalized experience of invalidation within our society, particularly for marginalized and systemically oppressed peoples. From this perspective, I see great utility in the teaching of DBT skills in general, and particularly with school age children. Pilot studies integrating DBT skills training into schools with adolescents has reported a reduction in risky behaviours and increase in positive mental health indicators, as well as increase inter-agency collaboration (Flynn, Joyce, Weihrauch, & O'Malley, 2017; Mazza, Dexter-Mazza, Miller, Rathus, & Murphey, 2016; Zapolski & Smith, 2017). I hope one day to have the opportunity to facilitate DBT skills-based programming in mainstream and alternative schools in Prince George.

The final integration into my personal practice model was unplanned but welcomed. The same month that I started my practicum placement with Walmsley and Validity Counselling I completed advanced EFFT training through my employer (Institute for Emotion-Focused Family Therapy, 2017). This practicum provided me with the opportunity to also work with families and hone my EFFT skills. During my practicum I worked with six families and held EFFT sessions with five caregivers. EFFT's primary focus is on providing emotion coaching and behavioural skills to caregivers in an effort to reduce their loved one's symptoms, while empowering and supporting caregivers in their role (Johnson, 2019; Mental Health Foundations, 2019). In line with my holistic approach to wellness and the importance of attachment theory in my personal practice model, I believe strongly in the effectiveness of working with families and it feels like a natural evolvement from my practice with youth. During my placement, I enjoyed reflecting on how seamlessly I was able to integrate DBT-informed and EFFT practice when working with

families. Furthermore, my experience with helpful session outcomes, client goal attainment and reviews from caregivers and youth that I worked with appeared to support the effectiveness of DBT and EFFT integrated practice. I was unable to find specific literature on an integrative practice of DBT and EFFT, however, I engaged in extensive reflection on their practice and theoretical similarities in my preparation of a guest lecture for Clarie's College of New Caledonia course "Human Behaviour Techniques". I titled this presentation *My Journey Towards Emotion and Family Focused Social Work Practice* which accurately summarized my professional journey and integration of self into my personal practice model at the end of my practicum placement with Walmsley and Validity Counselling (Seida, 2019). In discussion with all my supervisors, I reflected on how DBT and EFFT are both emotion-focused, skills-based, psychoeducational, transdiagnostically effective interventions, that feature concepts of validation, self-compassion, relationship repair and a balance of acceptance and change (Institute for Emotion-Focused Family Therapy, 2017; Johnson, 2019; Linehan, 2015; Van Dijk, 2012).

I look forward to more opportunities to practice emotion and family focused social work in the community of Prince George for years to come. There is a contentment within me that has bloomed from discovering my place on land, in community, in profession and in clinical practice. When I applied to the MSW program at the University of Northern British Columbia I quoted my favourite saying from Carl Roger's (1961), "The good life is a process, not a state of being. It is a direction, not a destination" (p. 187). I find this quote meaningful because it signifies the importance of the process, the value of the journey itself, while acknowledging the need for individualization, flexibility and localization; concepts I find important within my personal life, as well as within the general therapeutic process. The completion of this practicum and security within a well-intentioned and thoughtful development of my personal practice

model is a major milestone in my journey. That being said, I am excited about all the people I have yet to talk to, the relationships I have yet to build, the supervision I have yet to receive, the books I have yet to read, the trainings I have yet to attend, and the wisdom I have yet to learn.

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