A Peer-Clinician Approach to the Delivery of Dialectical Behaviour Therapy Targeted to Young Adults in a Community Mental Health Setting

Claudie Coulombe, Stephanie Rattelade, Miriam McLaughlin, and John Choi
Stella's Place

ABSTRACT

Stella's Place created an adapted DBT program, delivered through an integrated peer-clinician approach, to treat young adults with mental health difficulties in a community mental health setting. Evaluation findings revealed significant improvements in participants' use of coping skills, resiliency, and self-efficacy following their participation in the program.

Keywords: dialectical behavior therapy, peer support, young adults, community mental health

RÉSUMÉ

Stella's Place a développé une adaptation de la thérapie comportementale dialectique (TCD) offerte à travers une approche reposant sur le soutien par les pairs, visant à traiter des jeunes adultes aux prises avec des problèmes de santé mentale, et ce, dans un contexte de santé mentale communautaire. Une évaluation a révélé des améliorations significatives quant à la capacité d'adaptation, la résilience et l'autoefficacité des participants après avoir suivi le programme.

Claudie Coulombe; Stephanie Rattelade; Miriam McLaughlin; and John Choi, Stella's Place, Toronto, Ontario.

Claudie Coulombe, Stephanie Rattelade, and John Choi were formally with Stella's Place. Stephanie Rattelade is now with The Ottawa Mission, Ottawa, Ontario. John Choi is now at Sheena's Place, Toronto, Ontario. Claudie Coulombe is at Department of Psychology, University of Guelph, Ontario.

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Correspondence concerning this article should be addressed to Claudie Coulombe, 18 Camden Street, Toronto, ON, M5V 1V1. Email: claudie.coulombe@mail.mcgill.ca

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Mots clés : thérapie comportementale dialectique, soutien par les pairs, jeunes adultes, santé mentale communautaire

BACKGROUND

Dialectical behavior therapy (DBT) is an empirically supported cognitive-behavioral treatment originally developed to treat borderline personality disorder (BPD). Considered the gold standard treatment for this diagnosis, it has also been successfully adapted for other forms of mental illness and age groups (MacPherson, Cheavens, & Fristad, 2013). Research has namely demonstrated the effectiveness of young adult-adapted DBT programs (YA-DBT) for treating young adults (YAs) presenting with various mental health difficulties (Miller, Rathus, & Linehan, 2007). Studies also suggest that YA-DBT can be successfully held in community mental health (CMH) settings, revealing improvements in YAs' depression, hopelessness, non-suicidal self-injury (NSSI), anger, dissociation, suicidal ideation, overall psychiatric symptoms, and functional difficulties (MacPherson et al., 2013). However, YA-DBT adaptations have yet to incorporate a peer support component, despite evidence documenting its benefits on YA mental health outcomes (Gopalan, Jung, Harris, Acri, & Munson, 2017).

Incorporating the best practices of peer support and YA-DBT programs, Stella's Place (SP) developed an effective adaptation of YA-DBT featuring an integrated peer-clinician approach to its delivery. A community-based mental health organization in Toronto, SP provides low-barrier services to YAs aged 16–29. Typically featuring an integrated peer-clinician model, its programs are designed using a participatory approach, incorporating the expertise of YAs and professionals in program planning, development, and delivery.

RATIONALE

DBT is typically facilitated by a trained therapist who helps patients develop skills in four areas: emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness (Linehan, 1993). It features a multi-modal approach involving weekly group and individual therapy sessions, 24-hour access to phone support, and therapist consultation team meetings. Inspired by the demonstrated benefits of DBT for adults, Miller and colleagues developed an adaptation of this program targeted to adolescents with suicidal ideations and BPD features (Miller et al., 2007). It brought several modifications to standard DBT: a shorter length of treatment, fewer skills taught, the inclusion of family members in treatment, modified handouts featuring developmentally appropriate language, and the addition of a fifth skills training module, "Walking the Middle Path."

Since then, Miller and colleagues' (2007) YA-DBT has been modified, successfully targeting other disorders and symptoms (MacPherson et al., 2013). Versions of YA-DBT have shown promise especially in treating BPD, bipolar disorder, suicide ideation and behavior, NSSI, eating disorders, oppositional defiant disorder, and trichotillomania (MacPherson et al., 2013).

While many adaptations have been developed, none have included a peer support component. In fact, only a few studies have examined the effects of peer support specifically in YA mental health programs. These studies suggest positive impacts of peer support on social, emotional, and behavioral functioning among YAs, as well as on their reported program satisfaction and engagement, hope, empowerment, and self-determination (Gopalan et al., 2017). As these effects could have important implications for YAs' recovery and well-being, further research examining the incorporation of peer support in youth mental health care is needed. Moreover, integrating the insight of peer supporters with the trained expertise of clinicians in program delivery may prove particularly effective for DBT. As a program, DBT relies on the therapeutic alliance between service providers and patients, which can be strengthened by provider self-disclosure (Kohler et al., 2017). By disclosing their shared experience, peer supporters may act as successful role models, teaching problem-solving and coping skills needed to improve functioning and potentially enhancing the benefits of DBT. An integrated peer-clinician approach to program delivery is a natural fit for DBT, and an investigation into this approach is warranted.

THE PROGRAM

SP's modified program incorporated peer support in the delivery of YA-DBT in a CMH setting. Assisted by the Toronto Urban Health Fund and the Ministry of Health & Long-Term Care, SP offered this program to eight cohorts spanning two years and evaluated its effectiveness.

SP's YA-DBT program followed Miller et al.'s (2007) adolescent-adapted curriculum. It was divided into the same five modules, within which participants were taught the corresponding skills. The program was delivered through weekly group and individual therapy sessions, excluding 24-hour phone support given limited resources. It featured a shorter length of treatment compared to standard DBT, ranging from 10 to 14 weeks depending on the intensity of the program. SP's workbook was based on Miller and Rathus' *DBT Skills Manual for Adolescents*. It was modified by staff, based on participant feedback, to enhance its modern-day relevance. Experiential exercises were used throughout the program to increase participant engagement.

While remaining consistent with the content of Miller et al.'s (2007) YA-DBT, SP's program deviated from it in its delivery. The program was co-led by two trained clinical social workers and one peer support person. This peer supporter was a trained individual who had successfully completed a DBT program as a participant and who, by virtue of their lived experience, brought a unique perspective and sense of authenticity to the program's delivery. The tasks carried out by facilitators were differentiated based upon their role. Clinical social workers organized and delivered the program in a way accessible to YAs, and peer supporters supplemented this delivery and increased participant engagement and hope by sharing their personal experience applying skills to daily living. The facilitators were also in a similar age group to participants and trained to foster a sense of community and safe space. Other modifications included larger-than-typical cohorts, an emphasis on collecting evaluative feedback from participants weekly to incorporate into program planning and implementation, and the exclusion of participants' family based on participant feedback.

To assess program effectiveness, outcome measures were collected at the first and last session. The DBT Ways of Coping Checklist was used to evaluate participants' self-reported use of coping skills. The Core Self-Evaluation Scale was also administered to assess their self-efficacy, and the Connor-Davidson

10-Item Resilience Scale was used to measure their resiliency. Data from all cohorts were combined and paired-sample t-tests were conducted to examine differences in these outcomes before and after participation in SP's YA-DBT.

RESULTS

In total, 130 individuals enrolled in eight cohorts of SP's YA-DBT program from 2017–2018, with an average of 16.3 participants per cohort. Demographic information from 123 participants was available (68.3% female, mean age of approximately 24.7 years) and pre-measure and post-measure data were collected for 76 participants.

Prior to conducting analyses, normality assumptions were examined and considered satisfied. Paired t-tests revealed significant mean differences for all outcomes before and after the program. As shown in Table 1, participation in the program was associated with a significant decrease in the use of harmful coping skills, and significant increases in the use of effective coping skills, self-efficacy, and resiliency.

Table 1

Pre-Post Data Results

Measure	N	Pre		Post		t	Cohen's d	*p*
		M	SD	M	SD			
Harmful coping skills	76	2.15	0.38	1.65	0.48	-8.96	1.14	$p<.001$*
Effective coping skills	76	1.71	0.44	2.22	0.38	11.20	1.23	$p<.001$*
Self-efficacy	75	35.37	7.63	38.19	6.52	4.30	0.40	$p<.001$*
Resiliency	75	29.99	5.58	35.93	5.98	8.01	1.03	$p<.001$*

Note. $\alpha = .05$

IMPLICATIONS AND FUTURE DIRECTIONS

This evaluation constitutes a promising first step in assessing the benefits of an integrated peer-clinician approach to YA-DBT in a CMH setting. This model was associated with improvements in participants' coping skills, resiliency, and self-efficacy, contributing to growing evidence supporting peer support models of mental health care and YA-DBT programs in CMH settings. Participant feedback also revealed their satisfaction with the program. Ongoing evaluation efforts continue to collect feedback and evidence of effectiveness to drive program improvements.

Without a control group, it was impossible to identify the specific impact of peer support on participant experiences. Further evaluation into integrated peer-clinician delivery models will provide more evidence for peer support approaches and integration. This evaluation was also limited by its sample size and by the dynamic nature of the program, which was continuously updated based on participant feedback, potentially introducing variation in each cohort's experience. While enhancing accessibility, the lack of exclusion criteria and limited demographics information collected prevented the control of certain variables (i.e., simultaneous involvement in other SP programs, mental illness diagnoses), limiting predictive analyses.

Given this evaluation's encouraging results, continued examination of this model is justified. A larger-scale, better-controlled, longitudinal investigation would help determine the added value of incorporating peer support in YA-DBT and its long-term effects. A successful component of this program was the YA feedback integration and ongoing improvements; future evaluations should examine this approach's impact on participant engagement. Examining the integration model itself, the balance of peer supporters and clinicians, and the added benefit of peer-clinician delivery to other CMH programs could prove informative. This model could be adapted and evaluated for various treatments, age groups, and mental health challenges, integrating peer support benefits with clinical approaches to care.

These findings regarding an integrated peer-clinician approach to YA-DBT delivery are promising. As successful role models, peer supporters may introduce a sense of hope and authenticity, facilitating YAs' mental health recovery alongside clinicians through this adapted YA-DBT program. Altogether, further research, program development, and exploration of this approach to CMH care is warranted.

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