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Sometimes a Crucible: Mindfulness Art Therapy Experientials in a DBT-Oriented Residential Partial Hospitalization Program for Dually-Diagnosed Adults

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Sometimes a Crucible: Mindfulness Art Therapy Experientials in a DBT-Oriented Residential
Partial Hospitalization Program for Dually-Diagnosed Adults
Capstone Thesis (Option 1)
Lesley University

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Abstract

My thesis concerns observations made while incorporating mindfulness-oriented art therapy experientials into hour-long, didactic DBT skills-training groups at a residential partial program serving dually-diagnosed adults. For the thesis, I adapted two exercises from Clark's *DBT-Informed Art Therapy*. My research method was arts-based grounded theory, referencing Corbin's grounded theory and Wadeson and Allen's thinking on the use of art for professional processing. My data took the form of a journal, word clouds, poems, and small artworks I iteratively created to deepen my learnings. My experientials highlighted areas of confusion regarding mindfulness that I attempted to address. Through the process, I became profoundly aware of art-making's potential to evoke shame in patients. This turned my attention to relational trauma and its enduring impact on patients with addiction disorders. I saw that the work that I was doing in groups was providing a safe, contained space for patients to gently re-experience shame. The art moments, including their ability to evoke shame, were an opportunity for corrective emotional experiences. Because of their acuity, some patients benefitted from the structure of DBT and its focus on managing dysfunctional behaviors. Patients who were better stabilized and regulated had the added potential to benefit from approaches that considered maladaptive schemas. I concluded that both DBT and aspects of schema therapy could be incorporated into the setting, with benefits to many patients, as long as the overarching framework of attachment trauma was kept in the practitioner's mind.

Keywords: Dialectical behavior therapy, DBT, schema therapy, early maladaptive schemas, mindfulness, art therapy, attachment, trauma, relational therapy, grounded theory, substance-use disorders, opioid addiction, alcohol, stimulants, depression, anxiety, shame, dually-diagnosed adults

Sometimes a Crucible: Mindfulness Art Therapy Experientials in a DBT-Oriented Residential
Partial Hospitalization Program for Dually-Diagnosed Adults

This is the precariousness of magic itself, magic that arises in intimacy, in a relationship that is being found to be reliable.

- D. W. Winnicott

Dialectical behavior therapy (DBT) is a treatment of choice in many hospital settings because it is deemed to represent an evidence-based practice (Koerner, 2012; Linehan, 2015b). DBT was originally developed for use in outpatient settings, with chronically suicidal or self-harming women with borderline personality disorder (BPD; Koerner, 2012; Linehan, 2015b; Swales, Heard, & Williams, 2000). The full-fidelity DBT curriculum lasts a year and includes skills training in groups, worksheets and homework, individual therapy conducted by DBT-trained clinicians, telephone access and skills coaching for clients, and DBT-focused group supervision (Koerner, 2012; Linehan, 2015b; Swales, 2009). Four core DBT skill sets are taught, including mindfulness (a foundational skill residing at the heart of the other DBT skills), distress tolerance, emotion regulation, and interpersonal effectiveness (Clark, 2016; Koerner, 2012; Linehan, 2015a; Swales, 2009; Swales et al., 2000).

DBT as practiced in hospitals is typically adapted to a shorter, condensed curriculum in line with shorter lengths of stay. In the residential partial hospitalization program (RPHP) where I completed my clinical internship, “DBT” was limited to DBT-skills training (DBT-ST) where it was administered over a two-week curriculum/treatment window to a transdiagnostic patient population. Not all patients in the RPHP stayed for two weeks, and some patients stayed for much longer (e.g., up to two months), but no patient stayed in this treatment setting for a year. Other

components of full-fidelity DBT were also absent from this setting, including DBT-oriented weekly individual therapy, homework, and DBT-oriented group supervision.

The population in this setting was also mixed. This was a dual-diagnosis program. In addition to substance use disorders (SUD) that included alcohol, opioids, anxiolytics, and stimulants, patients within the RPHP represented a mix of psychiatric diagnoses including bipolar disorder (BD), post-traumatic stress disorder (PTSD), complex trauma histories, major depressive disorder (MDD), generalized anxiety disorder (GAD), social anxiety, schizophrenia or schizoaffective disorder, traumatic brain injury, attention deficit-hyperactivity disorder (ADHD), BPD and other DSM-5 Cluster B personality disorders, intellectual or learning disabilities, and dementia. The mix of men and women and their multiple issues took the treatment population far afield from the original conception and application of DBT.

My thesis concerns what I observed as I incorporated mindfulness-oriented art therapy experientials into my hour-long didactic DBT skills training groups. For the thesis, I adapted two drawing exercises from Susan Clark's (2016) *DBT-Informed Art Therapy*. My research method was arts-based grounded theory, referencing Corbin's (2015) grounded theory and influenced by Eisner's (2002) theories of the arts in education and suggestions from art therapists such as Harriet Wadeson (2003) and Pat Allen (1995) on the use of art for professional processing. I used a grounded theory framework to interpret my data, which took the form of a written journal, word clouds, poems, and small artworks that I created while administering these experientials and processing my thoughts, feelings, and learnings about my experiences. I used my iterative process to deepen the meanings about my learnings from the patients and the site. Following the grounded theory model, as well as suggestions from Wadeson (2003) and Allen (1995), I endeavored to keep

myself open to new possibilities and meanings that emerged as I worked my way through my thesis tasks.

My initial experientials and research highlighted areas of patient confusion about DBT skills but surfaced points of confusion that I believed could be addressed and clarified. In fact, in my second and third waves of experientials, I attempted to fine tune ideas to remedy confusion and improve patient integration of DBT-ST concepts. My research process and thinking evolved over the study period and pulled me into an intellectual confrontation between DBT and schema therapy (Bricker & Young, 1993; Young, Klosko, & Weishaar, 2003) as well as a consideration of art-making's potential to evoke shame in patients (Wilson, 2012). Ultimately, I returned to trauma (especially early relational trauma) and its impact on patients with SUDs. I thought more deeply about Herman's (1997) three stages of trauma processing. I saw that the work that I was doing in groups was providing a safe, contained space for patients to gently re-experience shame, and I saw that my work was actually about recognizing attachment wounds and preparing the ground for future trauma work. The art moments, including their ability to evoke shame, were an opportunity for corrective emotional experiences (Alexander & French, 1946; Sharpless & Barber, 2012).

While applied science in clinical settings often moves toward forcing a choice between one treatment method or another (e.g., DBT versus schema therapy), in my mind, this treatment setting presented a both/and opportunity for treatment approaches. There is a false dichotomy in pitting DBT against schema therapy. Because of their acuity, some patients will benefit from the safety and structure of DBT and its overt focus on shaping dysfunctional behaviors. Other patients will be more stabilized, and better able to begin to undertake relevant trauma processing. The latter patients may be looking for ways to "open doors" into their SUD and trauma recoveries. I have provisionally concluded that both DBT and schema therapy can be incorporated into RPHP settings,

with benefits to many of the patients, as long as the overarching framework of attachment trauma is kept in the practitioner's mind.

Literature Review

When working with patients on mindfulness, I often direct them to think about the journalistic “who, what, where, when, and why” that I associate with DBT’s “observe, describe, and participate,” that is, the “what” skills of DBT (Linehan, 2015a, p. 154). My literature review represents an attempt to summarize those journalistic “W” questions about my chosen experientials, with this treatment population and clinical environment. Past life experience in research settings alerts me to the possibility and degree of “validity threat” (Shadish, Cook, & Campbell, 2002) to whatever I am reporting as well as any provisional conclusions I might draw from my experiences. I will try to address my thinking and hesitancy. First, I will address DBT-ST as a stand-alone treatment. Next, I will present information about the use of DBT (or DBT-ST) with non-BPD populations, including mixed, transdiagnostic populations and patients with SUDs. I will briefly address schema therapy (Bricker & Young, 1993; Young et al., 2003) as one alternative to DBT. I follow this with background information relevant to grounded theory (Corbin, 2015) and my arts-based method. My literature review continues with a summary of studies examining art therapy in DBT, and why mindfulness-oriented art experientials make sense in a DBT-oriented clinical context, even when full-fidelity DBT is not being practiced.

Stand-Alone DBT Skills Training (DBT-ST)

Linehan has argued that BPD symptoms stem from emotion regulation and distress tolerance skills deficits and that increased skills use is the mechanism of change in positive treatment outcomes for patients with BPD (Linehan, 2015b; Stein, Hearon, Beard, Hsu, & Björgvinsson. 2015). Regarding the concern about programs that implement DBT core skills

training alone (i.e., DBT-ST), in 2015, Linehan's team (Linehan, Korslund, Harned, Gallop, Lungu, ...& Murray-Gregory, 2015) published the results of a statistical component analysis that demonstrated the independent, positive impact of DBT-ST in reducing self injury and depression within a sample of women with BPD who received full-fidelity DBT. This publication presented the results of a post-hoc statistical analysis of data captured over seven years. Although a statistical analysis may show an independent effect of DBT-ST (when administered in the context of full-fidelity DBT, to women with BPD, over the course of twelve months, in an outpatient setting), this does not guarantee that standalone DBT-ST will be an effective treatment or remotely as effective as full-fidelity DBT, especially when administered to different populations, over shorter time frames, and in a partial hospital setting.

Recognizing the need for rigorous research-based support—and fully realizing that DBT is quite often applied outside BPD populations and over shorter timeframes—Linehan's team (Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014) published an outcome study with anxious and depressed non-BPD adults. The 2014 paper demonstrated benefits of teaching stand-alone DBT-ST, over a shortened 16-week treatment window, to adults with emotion dysregulation not related to BPD (Neacsiu et al., 2014). The study suggested that stand-alone skills can be taught to non-BPD patients, over a shortened timeframe, resulting in improved clinical outcomes.

In 2015, Valentine's team (Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015) published a systematic review of 17 trials that addressed DBT-ST as a stand-alone treatment. The 17 DBT-ST studies reviewed were administered in a variety of settings and to a variety of treatment populations, including individuals with personality disorders, MDD, eating disorders, non-suicidal self injury, intellectual disability, and ADHD (Valentine et al., 2015). The reviewed studies could not support a meta-analysis of the data because of the variability of the populations assessed and the

methods used to teach the research subjects the DBT skills. Valentine et al. (2015) pointed out that the number of skills training contact hours varied greatly across the studies, from a low of 17.5 hours to a high of 47 hours. As the authors pointed out, lack of adequate control groups and “significant deviations from standard DBT skills training content and methods” (p. 16) among other limitations, reduced the generalizability of results. The authors noted,

These studies represent the creative application of DBT skills training as a means of improving global functioning by reducing dysfunctional behaviors. The results from trials that utilize a naturalistic study design provide important data for program evaluation, but are more limited in terms of the reliability of conclusions that we can draw about treatment efficacy. (Valentine et al., 2015, p. 16)

While the studies have merit in advancing the evidence base and the “use case,” they also have limitations reflecting the state of research into DBT. The authors continued:

There is some preliminary evidence of the feasibility and acceptability of DBT skills training across a range of populations . . . ; for example, a lack of adverse effects, low dropout rates, reported reductions in mental health symptoms and behavioral problems, and improvements in overall functioning.... However, we remain unable to draw firm conclusions regarding DBT skills training as a stand-alone treatment given the wide variability in intervention content (e.g., omitted modules, non-DBT content), patient population, therapist training, and focus on mental and behavioral health problems. (Valentine et al., 2015)

In other words, in addition to diversity of treatment populations, the methods themselves were too diverse to really know what was being administered and tested and if it was comparable to treatments that were delivered in similar studies, and especially those coming out of Linehan’s

research shop. Results from studies focusing on DBT-ST are promising, the authors suggest, but demonstrations of proof of efficacy are far from conclusive at this point.

DBT-ST and SUDs

Turning to the treatment of dually-diagnosed individuals with SUDs, Stotts and Northrup (2015) highlighted that, as of their writing, the few published studies on DBT and SUD-specific DBT treatments were limited to studies of women with BPD and SUDs, and that “generalizability to a more heterogeneous SUD population is unknown” (p. 79). However, some “dandelion” studies did exist at that time. For example, Azizi, Borjali, and Golzari (2010) demonstrated the efficacy of teaching a subset of core DBT skills (namely, emotion regulation and distress tolerance) to an outpatient population of adult males with opioid addiction. Another study (Chiesa & Serretti, 2014) of mindfulness-oriented interventions (MBIs) administered to individuals with polysubstance abuse, while technically not a DBT study, noted that MBIs could lessen patients’ use of substances better than educational support groups and control groups. Maffei’s team (Maffei, Cavicchioli, Movalli, Cavallaro, & Fossati, 2018) demonstrated improvements in SUDs and emotional regulation in patients dependent on alcohol. The team noted a “partial but significant relation between improved emotional regulation and alcohol use outcomes” (Maffei et al., 2018, p. 1). These are just some examples of the application or potential utility of using DBT-ST, or subsets of the skills, with patients with SUDs. Of course, there are caveats. As Maffei et al. (2018) noted, pre-treatment motivation levels might be the actual driver of change and therefore future studies should attempt to factor this into outcome evaluations. Within the substance use and recovery field, there is evolving evidence that core skills training alone (i.e., DBT-ST) can be effective at improving symptoms in adults with SUDs, but the evidence base is still very early in development, and it is unclear whether or not DBT is better than alternative treatments, including especially other cognitive-behavioral

therapy (CBT)-based treatments such as Acceptance and Commitment Therapy (Maffei et al., 2018) or Mindfulness-based stress reduction (MBSR), which is also based on mindfulness plus CBT approaches (Kabat-Zinn, 2013).

DBT-ST and Mood Disorders

Another area where the evidence base for DBT-ST is growing but developmental is with mood disorders such as MDD or BD (Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009; Neacsiu et al., 2014; Ritschel, Cheavens, & Nelson, 2012; Valentine et al., 2015). Adding to the evidence base supporting the use of DBT-ST with mood disordered patients, Feldman's team (2009) published a study that showed decreases in depression among treatment-resistant patients with MDD who participated in an adjunctive, 16-week DBT-ST program. A more-recently published open pilot study of patients with BD by Eisner and colleagues (Eisner, Eddie, Harley, Jacobo, Nierenberg, & Deckersbach, 2017) demonstrated that DBT mindfulness-skills use was related to reductions in depression while improvements in emotion regulation were related to positive perceptions of well-being (Eisner et al., 2017). This was a rigorous study using a sharply-defined patient population (with extensive exclusion criteria for co-morbidity) and a DBT-ST "treatment" that was purposefully faithful to Linehan's model for DBT-ST administered over a 16-week treatment window.

Non-DBT Content and Competing Mechanisms of Change

Finally, I wondered about the mechanism of change of DBT-ST in my treatment setting, especially as I was implementing it. I will note that there can be a huge gap between DBT-skills training practiced by experienced clinicians and the DBT skills training that I was practicing at my site. (See Field, 2016 for information on training recent graduates in DBT skills.) Was the DBT-ST that I delivered remotely faithful to Linehan's model? Was I treatment adherent? I ran groups

independently (not in a pair as Linehan advises) and often worked other, “parallel ideas” into my classroom experiences, including exercises on attunement such as using one’s body to make sounds that are mirrored by others (Kossak, 2009; Kristel, 2013), handouts and discussions on maladaptive attachment schemas (Najavits, 2002; Wesley & Manjula, 2015; Young et al., 2003), conversations about emotional awareness, theory of mind, and mentalizing (Fonagy & Bateman, 2007; Clark, 2016) including empathy and the impact we have on each other, and ideas about reclaiming and reintegrating lost or rejected parts of self (Anderson, Sweezy, & Schwartz, 2017). I was not adherent to DBT because I was always folding in other therapeutic components that seemed to make sense given the mix of patients in the room and what was happening that week.

Art therapist Susan Clark (2016) has commented on the link between Linehan’s validation of internal emotional experience, Fonagy and Bateman’s stress on the importance of attachment in developing mentalization and empathy, and the work that happens in Winnicott’s transitional space:

Mentalization ultimately emerges from Winnicott’s transitional space (Winnicott, 1971), which is itself generated between the dynamic, playful interactions of child and adult:

“From a psychodynamic perspective, we argue that the capacity for mentalization is an intersubjective developmental achievement greatly facilitated by secure attachment (Fonagy 1997; Fonagy et al. 2002)” (2004b, p.39). (Clark, 2016, p. 69)

Along those lines, I believe that the work that I tried to shape in groups was as much about safe and contained play (Winnicott, 1971/2005) and repairing broken attachment schemas (or pointing to their need for later repair) as teaching any of the core DBT skill modules. My intuition was to provide safety to allow patients space and time to relax a bit and, when appropriate, to play.

All of this begs the question about what the “it” is that I delivered as therapy in my groups, especially as I layered even more (e.g., art experientials) on top of it. As Greenberg and Watson (2006) noted,

Demonstrating that a particular psychotherapy is effective in an RCT, even when therapist interventions are manualized, still does not specify what processes of change have taken place in the psychotherapy. For a convincing scientific argument that a treatment is effective, we need evidence that both what the therapist does (the distal variable) and the processes he or she induces in clients (the proximal variable) relate to outcome. (p. 82)

I believe I have already made the case that my “distal variable” is running in parallel to DBT-ST so it probably should not be considered DBT-ST. In research jargon, I administered too much non DBT-content and had multiple confounding factors impinging on the scope of treatment that I delivered, independent of what other clinicians at the site might have presented, or the diversity of the patient population or the shortened length of treatment in that RPHP. This was an applied clinical setting after all, not a research setting, and I was not asked to be a research purist (or even a researcher). But all of this strongly suggested steering myself toward qualitative research methods to describe and assess the impact of what I did.

Grounded Theory-Juliet Corbin

For ethical, practical, legal, or political reasons, randomized experiments are sometimes hard or impossible to implement.

- Steiner, Wroblewski, & Cook

Grounded theory, pioneered by Anslem Strauss and Barney Glaser, grew out of anthropological and ethnographic methods applied in the field of medical sociology (Corbin, 2015). Corbin, a student of Strauss', has stressed the difference between description in qualitative research

and theory building: “There are three main outcomes possible when doing qualitative research. There is description, conceptual ordering, and theory” (p. 58). Theory evolves from the creation of categories (i.e., themes and concepts) that build from description. Description in this context serves the purpose of theory building: “Descriptions may seem objective, but they are not. Even basic description involves purpose (otherwise why describe)...” (Corbin, 2015, p. 59). Knowing my own cognitive style, which is to reach into theory, I chose this research approach because I believed it would permit what Geertz (1973) referred to as “thick description,” building into a theoretical context, and thus accommodating my tendency to spin out theory about what I am observing. I will also state that I recognize that I spent very little calendar time on my “evaluation” of the effect of the art experientials. I am just approaching the work. But I believed the arts-based method employed and described below could yield a roadmap of a process to follow in future investigations. I was as much testing out my arts-based method as conducting an investigation into the effect of adding mindfulness art experientials into my DBT-ST curriculum.

Arts-Based Methods as a Bridge to Knowledge

I conducted over 12 hours per week of didactic classroom DBT-ST instruction at my site. I thought a lot about training and teaching during that year. What types of experiences and activities could make my teaching more engaging, effective, and possibly less repetitive for patients who stayed in the program beyond the typical two weeks, when my curriculum tended to repeat? I had reasons beyond “content fatigue” for spicing things up. I also had patients with a range of learning styles. I wanted to use art making to support embodied learning for the learners whose dominant style was kinesthetic or sensorimotor (Video Education Australasia, 2010).

For my own process, I believed, like John Dewey that, “The stamp of the aesthetic needed to be on any intellectual idea in order for that idea to be complete” (Eisner, 2002, p. 199). I am also

a kinesthetic learner. My arts-based method was a way to incorporate physical doing (lining up with my own learning style) and an esthetic and reflective component (Eisner, 2002). Panhofer and Payne (2011) discussed “embodied cognition” and the knowing that can “happen in the body, in an unconscious or preconscious way, and in a nonlanguage, metaphorical manner” (p. 218). Coming through my professional training, I am attendant to these multiple forms of knowing and learning. My research methods took this into consideration. More specifically within the field of art therapy, Wadeson noted that even trained art therapists could lose sight of the “great potentialities art offers us for reflection, insight, understanding, and problem solving around work with our clients” (p. 208). Time and again, I have found that art-making brings me into awareness of feelings of which I might otherwise remain ignorant. Like Pat Allen (1995), I felt I could use art making to quiet my over-thinking mind to support alternative ways of knowing: I could “extinguish my usual mode of being, thinking, analyzing, judging” (p. 43). Allen commented: “Until I began to paint, I never realized how completely those activities consume me, how little I really look at the world around me” (p. 43). I wanted to look and see—that is to truly take in what was happening around me.

I therefore used artful processes to flesh out my understanding of my experiences with patients in the RPHP. My process was similar to, but different from, Miller’s (2012) *El Duende* process (used for examining countertransference in art therapy supervision). I did not plan or want to cover over my accumulating creative products as one would in Miller’s process, but rather use each piece as a springboard into the next, while leaving it intact. My cumulative work created an audit trail for my analysis (Cruz & Tania, 2017). Leaving art products unaltered also allowed me time and capacity to review and reflect on individual contributions to my thinking. As Patricia Leavy (2009) wrote, “Qualitative researchers do not simply gather and write; they *compose*,

orchestrate, and *weave*” (p. 10). I wanted to weave together insights gleaned by using this process, but I felt I could only do that by leaving my intermediate pieces intact.

DBT and Art Therapy

Before Clark’s (2016) landmark book, there were relatively few papers addressing DBT and art therapy. In 2015, Drass published a set of experientials to consider for patients with BPD in outpatient settings. Her open-studio, art therapy interventions covered a range of DBT “coping skills ... to help establish safety, identify emotions, learn grounding techniques, and develop containment strategies in order to reduce maladaptive behaviors” (Drass, 2015, p. 168).

Experientials such as Drass’ woven distress tolerance baskets and strength medallions, while appealing, could not be implemented in the RPHP because of ligature risk. Other of Drass’ experientials were unworkable in the setting. For example, because many patients were insecurely housed and possibly discharging into shelters, bulky items such as Drass’ “save it for later boxes,” while interesting and possibly quite useful, were impractical for many patients.

In 2009, Huckvale and Learmonth published a case study exploring DBT principles in the art therapy of a woman hospitalized with depression and anxiety. As the authors noted about the patient, “Working with chaos, deep distress, acute disturbance, and imminent life-threatening danger to the person demands containing structures” (Huckvale & Learmonth, 2009, p. 62). While not acute to the point of self-harm, patients at the RPHP were often severely dysregulated. Aiming for the proper “window-opening” size for a therapeutic window could be especially challenging in a group that contained 12 to 18 individuals with varying levels of dysregulation and experience with the distress tolerance skills that I was teaching. I had to factor that into experientials to keep things physically and emotionally safe.

As Heckwolf, Bergland, and Mouratidis (2014) noted, “art therapy facilitates the development of observing capacities, which helps individuals make more informed decisions and aids amelioration of impulsive behaviors” (p. 331). The ability of art-making to help patients mentalize and develop empathy was also noted by Clark (2016). While the patients in the program may not have had a diagnosis of BPD (most did not), many of them did struggle with impulsivity, and to a lesser degree, lack of empathy and ability to mentalize. Managing impulsivity was part of my art therapist safety plan, while teaching skills to improve patients’ capacity for mentalization and empathy was a desirable goal.

Mindfulness-Oriented Art Experientials

I come to my selection of mindfulness-oriented art experientials. Rappaport and Kalmanowitz (2014) noted that through mindfulness and expressive therapies, “the arts intrinsically provide access to two wings of the bird—experience and witness” (Mindfulness and the arts therapies). A present-moment orientation that involves “both wings of the bird,” where “one wing symbolizes our experience; [and] the other represents our ability to witness and observe our experience” (Two Wings of a Bird: Experiencing and Witnessing) maps roughly to DBT’s Emotion Mind and Reasonable Mind (Linehan, 2015a, p. 50). Our ability to use or develop reflective distance, that is, taking a step back to slow down, observe, and describe what is happening in the moment, including our thoughts and feelings and others’ thoughts and feelings, builds the skill of mentalization, which is often lacking in patients with BPD or impulsivity. Using reflective distance in mindfulness arts experientials, I believed I could help patients improve mentalization while also providing opportunities for building distress tolerance.

Although Linehan (2015b) formally places mindfulness (and distress tolerance) skills underneath the dialectical pole of “Acceptance,” in contrast to the DBT “Change” skills of emotion

regulation and interpersonal effectiveness (p. 14), others (Clark, 2016; Swales, 2009) have noted that mindfulness underlies all the DBT skills.

Mindfulness is the first module taught in DBT skills training and is considered most important because effectively practicing the other skills requires this basic ability to achieve and maintain attention. Hence, this module, also known as Core Mindfulness, is the only skill set continuously emphasized throughout DBT. (Clark, 2016, p. 85)

In truth, mindfulness sits at the core of DBT.

Methods

This section of the paper covers a more detailed description of the site, my art therapy experientials, and the arts-based method I used to reflect on and evaluate my experience.

The Clinical Setting

The clinical setting was a residentially-based partial hospital program (RPHP) that served dually-diagnosed adults (i.e., patients with a psychiatric diagnosis and SUD). About thirty-five patients were enrolled in the RPHP at any given time. Patients resided in dormitories at the site, for (on average) two to three weeks, attending treatment groups seven days a week, for about five hours per day. The thirty-five patients within the RPHP were assigned to one of two groups (“Pink” or “Purple”), and patients stayed within their assigned group for all their classes during the day. This, in combination with the dormitory-style housing, allowed group dynamics (Yalom, 2005) to develop and play out more quickly and intensely than one might see in a typical PHP (or almost any other social arrangement).

The patient population included men and women, ranging in age from 25 to 65. In addition to being diagnostically diverse, the patients represented differing ethnicities, differing levels of intellectual ability, educational attainment, English-language competency, differing career paths,

and widely differing levels of impulsivity, coping skills, and functionality. The common thread was addiction and some degree of mental health problem. Some patients were homeless and had been so for many years; some patients were recently incarcerated; others had legal problems, such as child custody issues or DUIs; some experienced intimate partner violence. Patients who successfully discharged from the RPHP moved on to intensive outpatient programs, shelters, halfway and sober houses. Patients occasionally stepped-up to an inpatient setting because of their acuity. This had implications for art materials that could safely be offered to patients. Although this was considered “outpatient treatment,” the possibility that patients could step up to inpatient care required a cautious risk-management approach to materials offered with art experientials.

I was at the site three days per week, conducting about 12 hours of DBT-ST groups per week. In addition to time spent with patients in milieu, I saw each patient in groups for about six hours per week which provided me with much data on which to gauge their status. While I had no formal training in DBT, I had been a student of Buddhism (a core component of DBT) for over thirty years. I had completed a program in MBSR (Kabat-Zinn, 2013) in 2014. Mindfulness-Based Stress Reduction, like DBT, incorporates CBT and mindfulness. Finally, a few years ago, I befriended the anxiety and depression that I have experienced since my childhood. I believe that my lived experiences helped me remain present, empathic, and empathetic to patients in the program.

Interventions: Mindfulness-Oriented Art Therapy Experientials

My two mindfulness-oriented art therapy experientials were adapted from Susan Clark’s *DBT-Informed Art Therapy* (2016). The experientials were themselves based on Betty Edwards’ *Drawing on the Right Side of the Brain* (1979/2012). The experientials I used, upside-down and contour drawings (Clark, 2016, pp. 174-177), were administered separately as part of hour-long didactic groups on mindfulness skills. There were three interventions, since I repeated the upside-

down drawings experiential with some simplifications to images and reshaping of my discussion questions. This was done in response to feedback and learning from Interventions 1 and 2. The art-making sessions occurred on three Fridays in January and February 2019. Each of the art-making sessions started with a check-in, followed by a 15-minute overview of mindfulness skills, emphasizing the DBT *what* skills (observe, describe, and participate) and *how* skills (one-mindfully, non-judgmentally, effectively; Linehan, 2015a, pp. 53-54). Art-making was followed by a discussion session.

Intervention 1: Upside-Down Geometric Animal Drawing

I walked around the table and presented each patient with a photocopied line drawing that I handed to them upside-down. The images were selected from Michelle Waldie's (2017) *Crystal Menagerie Coloring Book*. Clark (2016) suggested using images that are appropriate for adults and neither too simple nor too challenging. I selected animal images from Waldie's book because they seemed to provide a strong linear design that patients (some of whom had problems seeing) would be able to discern. I also appreciated that they were images of animals. I selected a subset of images that included a range of animals, including "strong" animals (like wolves, i.e., predators) and more meek animals such as hedgehogs and turtles. The distribution of images to individuals was random. An example of one of the images (a hummingbird) is shown in Figure 1.

On the whiteboard I wrote out some mindfulness suggestions: "Go slowly; Use distress tolerance skills; Observe and describe." I instructed patients to copy (but not trace) the image and to keep it oriented upside down while they worked. I repeatedly instructed patients to "*Go slowly*," and carefully draw what they saw and to work slowly enough to take in what was in front of them. Patients were given twenty minutes to work on their drawings. The last twenty minutes of class was

spent talking about their experience of creating the drawing: what made it hard, what made it easy, what they were surprised by, etc.

Intervention 2: Contour drawing of fresh tulips

I conducted this intervention two weeks after Intervention 1, and I had already begun to comprehend the difficulty patients had generalizing their DBT skills into a task such as working on a drawing. I had noted after Intervention 1 that the many patients thought “coloring” (i.e., filling in coloring sheets) was relaxing and soothing but most could not see that drawing freehand could be distress tolerance-skill building. I started this class with a twenty-minute interactive lecture on mindfulness skills in DBT, stressing that “*certain activities such as mindfulness meditation, or even drawing something challenging, could be used to build their mindfulness (and distress tolerance) muscles.*” I discussed how mindful awareness could be broken apart into two areas corresponding to Wise Mind’s Emotion Mind and Reasonable Mind (Linehan, 2015b, p. 50): On the emotional mind side, they could use self-soothing and distress tolerance skills in the moment (e.g., breathing), and pay watchful attention to their impulsivity (i.e., save a comment for the discussion later; don’t blurt out in the moment). On the rational mind side, I suggested “*seeing things as they are, going slower to improve your ability to see things as they are, and really focusing on observing and describing.*”

I gave a brief demonstration of how to do a contour drawing, using a thick marker so that when I held up my drawing for patients to see, they could see it and how little I drew over a 30-second period of looking and drawing. As with Intervention 1, I wrote out key suggestions on the whiteboard: “Go slowly; Use distress tolerance skills; Observe and describe; Breathe!” I repeatedly instructed patients to “*Go slowly,*” and carefully draw what they saw, and to work slowly enough to take in what was in front of them. Patients were given twenty minutes to work on their drawings.

As with Intervention 1, the last twenty minutes of class were spent talking about their experience of creating the drawing: what made it hard, what made it easy, what were they surprised by, etc.

Intervention 3: Upside-Down Geometric Animal Drawing (Simpler Images)

I ran the upside-down drawings experiential a second time, four weeks after the first implementation. I wanted to see if, by using some of Waldie's (2017) simpler drawings, and emphasizing distress tolerance skills, the patients could stay focused on their drawings longer since many tended to finish within ten minutes. In the discussion following this experiential, I raised the issues of shame and embarrassment, talked about drawings as being relatively "low stakes" activities (since a drawing could be thrown away, they did not have to share their drawing with the group, etc.) I wanted to continue to probe and start to member check on what I thought I had heard from patients after the first two interventions.

All experientials groups were run with 13-18 patients per group. I ran two groups for each experiential for a total of about 33 patients per each of the three interventions. This equated to about 100 patient-hours of mindfulness art interventions in total, in the context of about 1,250 patient-hours of group and milieu observations made during my 5-week study period.

Arts-Based Grounded Theory Research Method

I kept a written journal and made periodic entries during the study period. From this journal, I selected out entries and then generated two "word clouds" (using Google Docs' Word Cloud Generator; see Figure 2 for the word cloud that I created from my journal following Intervention 1). The word clouds were intended to be a way for me to cull down my writing (which was sometimes copious and disjointed) into a visual presentation for my personal reflection. I had not planned to incorporate my dreams into my data, but I had a number of dreams about my hospital experiences as I was working on my data collection, and I realized that they were influencing my thinking about

patients and what I was doing in groups, so I incorporated them into my journal. The word clouds led to a poem that I included here (Figure 3) and two collages (Figures 4 and 5) that I created.

Results

Several themes emerged for me that I will address in more detail below but summarize as the following. First, patients had a very hard time generalizing mindfulness and distress tolerance skills but one (I) could work at “selling the benefits,” which could improve the uptake of skills. Second, and more importantly, the possibility to accidentally induce shame with this patient population was ever present. However, I found that I could gently work with that shame to contextualize it, which ended up being soothing and comforting. Third, the ability to hold a space for both shame and play led, I felt, to much deeper conversations in the groups and perhaps to laying the groundwork for future trauma healing and recovery.

Difficulty Generalizing Skills, Selling the Benefits

Patients could readily accept and appreciate that art-making could be soothing or distracting, and that when it was so, it could help them manage distress. What was hard to communicate to patients was the usefulness of taking on purposefully challenging art-making tasks with the aim of building mindfulness skills, including increasing their capacity for distress tolerance or mentalization. In my lecture before Intervention 2, I explicitly linked the contour drawing task to both sides of Wise Mind: On the emotion mind side, patients could maintain mindfulness of their emotional responses and use deep breathing or other personally-effective distress tolerance skills to manage their anxiety. They could stay in the moment, and keep a mindful eye on their impulsivity, saving their comments for the group discussion to follow. They could also use tasks to build the “*distress tolerance muscles through practice.*” On the rational mind side of Wise Mind, I emphasized the skills of slowing down the moment to be able to “*see things as they are,*” to observe

and describe. They could jot down how they were feeling or what they were thinking as they were working (to develop reflective distance and mentalization). I re-iterated that this level of mindfulness was “*a skill that required practice.*” I repeated these instructions before and after Intervention 3, but I still got puzzled looks from many patients. Using drawing to build distress tolerance skills, like many meditative skills, is hard to put in words, and the more I talked about it, the more confused the patients became. Patients were still having difficulty generalizing their mindfulness skills (especially distress tolerance) when extended out of the lecture context, which Clark (2016) had also noted.

Between Interventions 2 and 3, I altered my approach (not just with these mindfulness art experientials but with all my lectures) to place more emphasis on “benefits to the consumer.” I sensed that the benefits needed to be “sold in,” (Video Education Australasia, 2010) to these adult learners, so I started being more explicit about my “sales pitch” in groups: “*This is helpful for....*” “*You can use this when you need to ...*” I also continued to work at finding the right words to describe what I was trying to get patients to do with mindfulness. I have found that DBT-ST teaching (by the book) is too abstract for most patients (even when using engaging classroom activities) and this leads to an inability of patients to generalize to real-world situations. I could have very engaged students who enjoyed the group hour we spent together, but if they didn’t take away skills they could use, it really wouldn’t do them any good in their life after discharge, which was frustrating for me as a teacher to contemplate.

Shame, Vulnerability, and Deepening Conversations

At baseline, many patients in the program were hyperaroused. After my initial run of Intervention 1, my first group (Pink) was so dysregulated, I was worried about containing them for their next group hour. During the art-making period, about half of the patients left and rejoined the

room in small groups while other patients continued to work on their drawings. One patient repeatedly exclaimed during Intervention 1, “*You’re trying to ***** with us!*” He said it in a good-humored way, but he became more dysregulated as the hour went on. I attempted to maintain a stable, accepting presence: “*No, no. It’s okay. Just do what you can. You’re good.*” (This patient did have a particularly difficult drawing. His reaction led to my culling down images for Intervention 3.) I kept to the 20-minute window for art-making as I felt there was a therapeutic benefit in setting the time, which I wrote on the board, and sticking to it. I was demonstrating my steadiness and reliability.

In the group discussions after Intervention 1, some patients talked about their shame regarding their drawing abilities. This patient population is acutely aware of shame (past and present). When I asked what made Intervention 1 difficult, one patient in the second group stated, he wanted to have more control over what he produced, especially since he viewed himself as artistic. Even for self-described artists, the public nature of the task created a sense of competition where one could be compared to peers, humiliated, and shamed.

At noon I returned to run a group with Pink before their lunch, and we had a very intense conversation about group process (Yalom, 2005), including feelings about loss (since some key group members had discharged earlier in the week). We talked about the impact we have on each other and the difficulty of loss. I think the intensity of that particular noon group stemmed from the degree of decentering and subsequent vulnerability patients experienced (Kossak, 2009) while making their upside-down drawings. I reminded them that it was perfectly normal to feel sadness at members leaving the group. “*It’s okay to feel your feelings. It’s okay to feel a sense of loss and mourn when people you care about leave.*” This conversation had a calming effect on the group. I

continued to weave thoughts about “*the impact we have on each other*” into my lectures in the days that followed.

Pressure Cooker or Crucible?

It was after Intervention 1 that I first thought of “pressure cooker” as a metaphor for the group dynamics and program environment, generally. Pressure cookers are good for cooking things quickly, which was happening in the program as we were literally often stuffing large numbers of adults into small conference rooms. However, in my own thinking, I quickly altered the metaphor to “crucible,” i.e., an alchemical vessel in which materials change properties, from base metals to precious metals. I liked crucible better as a working metaphor to guide and inspire me since for one, it provided me with a greater sense of agency: I could see myself standing outside the crucible, as witness and guide (and sometimes magician). The alternative was me being thrown into the pressure cooker along with the patients, and I was uncomfortable with that image. I wanted more reflective distance and control over the process.

Working with the Opportunities for Play and Shame

In the short lectures I gave before Intervention 2 (Contour drawing of fresh tulips), I emphasized “*maintaining intentional awareness without judging or without expectation.*” I also stated playfully, in response to the refrain, “I can’t draw,” “*Oh, I hear that so often I don’t even pay attention to it!*” I was purposefully breezy, attempting to lighten the mood. I attempted to make a playful game of it. (“*And no, you are not supposed to trace it!*”) In the discussion that followed Intervention 2, I realized that patients were doing better with shame which we laughed about quite openly. The laughter seemed to deflect and defuse any tension related to performance anxiety. And I was fascinated by the patients’ fascination with the fresh flowers. The flowers were experienced as a “breath of fresh air” in our stuffy rooms. Many patients wanted to touch and smell the flowers,

so we handed them around the table after our group discussion. The flowers became a transitional object.

After Intervention 2 (and also Intervention 3), our group discussions about shame, awkwardness, vulnerability, and fear of appraisal turned to issues of appropriate trust, who we can trust and how we love, including our expectations about how we are treated in relationships. (See Figures 4 and 5, Tulips collages, that I created in my reflections about these interactions.) In our group discussions, I wove conversational threads about relational schemas into the debriefings following Interventions 2 and 3, primarily to member check with the patients. Based on the nodding heads, and also the downward-turned heads of people who seemed to be experiencing shame about their past behaviors in relationships, I felt that I was approaching core issues for many patients.

Discussion

The three biggest surprises for me revolved around working with shame, the potential utility of schema therapy as an adjunct to DBT skills training, and my feelings about the attachment work that I found myself doing with my groups. I will discuss these below.

Normalizing and Decentering Shame

I was a bit surprised by how much shame took a central role in my debriefing conversations with patients. Especially following Intervention 1, I found myself working to contain a range of potent emotions, deflect and defuse the shame, make light of the shame that art-making stimulated, all while continuing to hold and support a space for making mistakes and remaining playful. As Wilson (2012) noted, addressing shame is a prominent issue in SUD-oriented art therapy work. The art experientials became opportunities for my groups to initiate processing shame, and the conversations with patients about shame went much deeper than conversations about “looking and seeing without attachment or judgment.” As Wilson (2012) noted,

Shame is characterized as a particularly intense, painful, and often incapacitating experience that involves critical self-judgment and feelings of inferiority. When shamed, the self turns on itself, imparting judgment, criticism, and negative self-evaluation, resulting in a pervasive damaged self-image. This damaged self-image interferes with many aspects of life to include the individual's relationships with others, his or her aspirations, and his or her worldview. (p. 302)

I found that I had to be especially careful about the capability of art-making to trigger shame within my patients. I also realized that art-making could, perhaps paradoxically, be used to decenter this sense of shame, and to normalize it, and thereby make it somewhat more approachable. I had to open that therapeutic window very carefully so as not to overwhelm patients.

Schema Therapy for Patients with SUDs

In Fall 2018 I introduced maladaptive schemas into my groups, based partly on my clinical intuition and partly on serendipity. As I listened to conversations in groups and milieu, it made sense to talk about maladaptive relational schemas and put that onto patients' radar screens. I typically tied this back to DBT and "*all or nothing thinking*" as a dialectic and suggested that patients with the habit of making statements beginning with, "Things never (turn out for me)..." or "This always (happens to me)..." might take a step back from those all-or-nothing statements and re-appraise the facts of a situation. In preparing my literature review, I realized that I had been incorporating a schema therapy worksheet (Bricker & Young, 1993) since early Fall. That realization led me in the direction of exploring schema therapy for use with patients with SUDs.

Regarding substance abuse and maladaptive schemas, McDonnell's team (McDonnell, Hevey, McCauley, & Ducray, 2018) published a study on early maladaptive schemas (EMS) in opioid users that linked EMS to "high emotional dysregulation, maladaptive coping, adaptive

coping and resilience” (p. 2320). The authors concluded that “EMS should be addressed when treating opioid dependent polydrug users” (p. 2320). That rang true with my experience. An Indian study (Zamirinejad, Hojjat, Moslem, MoghaddamHosseini, & Akaberi, 2018) led to similar conclusions about the link from EMS to opioid dependence in adulthood. Wesley and Manjula (2015) have also written about early trauma, EMS, and depression in adults citing the links from severity of abuse to severity of depression and dysfunctional coping, which often includes drug use.

There are points of overlap between schema therapy and DBT (Montgomery-Graham, 2016), since both are grounded in CBT. Regarding the overlap, Montgomery-Graham (2016) has posited that it is linked to mentalization (also noted by Clark, 2016): mentalization is the “common factor underlying successful therapeutic intervention in BPD” (p. 53). I had hoped my mindfulness art experientials would be useful to build patients’ mentalization capacities, but building this skill is not something that one is going to achieve over a few very short sessions. Mentalization, like distress tolerance, is hard to teach and hard for patients to learn, even when underscoring the benefits.

On more than one occasion while running groups, I thought that the “chairwork” of schema therapy (Kellogg, 2004) would be beneficial in the moment. Sometimes I mentioned it in response to a patient (usually a sex abuse survivor) expressing interest in talking to a perpetrator. The Gestalt chair (Kellogg, 2004) would allow patients an opportunity to work through pent up resentment and anger. This couldn’t happen in the context of that RPHP but I can imagine it being productive for some patients as they moved through recovery.

Others in the SUD field are also advocating for the utility of a schema therapy approach. A prospective study on schema therapy (Fassbinder, Assman, Schaich, Heinecke, Wagner, ... & Schweiger, 2018) will specifically target a comparison of the effectiveness of DBT versus schema

therapy when used to treat individuals with SUDs. This study will track patients over time and is intended to explicitly compare the effectiveness of the two somewhat similar treatment approaches, both based in CBT, using a rigorous scientific methodology (i.e., a randomized clinical trial) designed to tease apart the mechanisms of action.

Re-centering Relational Trauma Recovery

Perhaps most important to me after doing this work was and remains my desire to re-center trauma. I looked around the classrooms at the RPHP, and I saw many trauma survivors. Some had acute (and recent) trauma, and many also had complex trauma histories, including early relational trauma. I repeatedly member-checked to support my clinical intuition that under-reported developmental/early-relational trauma was sitting underneath the maladaptive schemas and emotion dysregulation of the patients that I encountered. This led me to thinking about corrective emotional experiences (Alexander & French, 1946; Sharpless & Barber, 2012) and preparing the ground for the work of repairing those attachment difficulties that led to emotion dysregulation (Kravitz, 2008). I had these realizations as I was still implementing my interventions, and I believe my growing insight affected how consciously and carefully I attempted to hold the space through Interventions 2 and 3 (Winnicott, 1971/2005).

In a held environment, especially for trauma survivors, I was trying to model “survivability of feelings and impulses that have never been effectively modelled or internalised” (Huckvale & Learmonth, 2009, p. 53). As I held a safe space for patients to make drawings over which they could, perhaps paradoxically, feel both pride and shame, I thought about corrective emotional experiences. The mindfulness drawings created an opportunity for shame re-exposure under “more favorable circumstances” where patients could learn to handle this stress in new and better adapted ways (Sharpless & Barber, 2012, p. 34).

Magic Markers and Relational Work

Early in my tenure at this site, I started the practice of bookending my didactic handouts with hand-illustrated cover sheets announcing the theme of the day, often including a final page with a question or quote designed to internalize and improve patient retention of the information presented that day. (See Figure 6 for an example of a cover sheet for a day focused on distress tolerance.) Patients consistently responded positively to this practice which represented (it seemed to me) a caring and personal touch that made them feel special and nurtured. Even though I told them I recycled my artwork, they still appreciated the gesture, which seemed to provide some comfort. I also noted that patients seemed to regress a bit after a few days in the program. For example, many took on pet names that they had as children. I viewed both of these phenomena as a version of Ernst Kris' "healthy regression in service of the ego" (Knafo, 2002). How can I quantify the impact of my book-ending practice, or even address it qualitatively? For now, I have linked it into attachment and trauma recovery. I keep including the hand-drawn covers on my handouts. It's a form of relational work.

Stages of Trauma Recovery: Attending to Relational Repair Work

As Briere noted in his Foreword to Courtois and Ford's (2013) *Treatment of Complex Trauma*, "the use of relational principles and techniques is not yet common in cognitive-behavioral trauma therapy, nor are therapist attunement and empathy always highly valued" (para. 10). But my sense about being effective at this work is that effective group therapy was about relational repair and preparing the ground for future trauma work as much as transmitting teachings about DBT skills. I have thought about attachment trauma, and the potential healing of my appropriate attunement to patients and patients' attunement to each other (Kristel, 2013; Yalom, 2005) as they

started to work on building healthier attachment schemas. Siporin (2010) noted the importance of corrective attunement in the SUD clinic:

If chemical dependence is an attachment disorder, then recovery requires repair of insecure or avoidant attachment patterns. This is a subtle process and includes the therapist's unconscious mirroring or attunement (Beebe, Knobluch, Rustin, & Sorter, 2005). (p. 324)

Siporin also noted, as I observed, that corrective work also happens in the group: "Reparative attachment is implicit in 12-step programmes or group psychotherapy wherein members function as 'family' (p. 324). Following the reparative attachment model, my discussions of shame and loss demonstrated that we had, together, built a "good-enough" holding environment so that patients could express potent emotions that otherwise might have been overwhelming. In short, patients benefited from their group as much as from my group stewardship.

DBT is a third-wave form of cognitive therapy that directly addresses emotion dysregulation, working at shaping behaviors, but it does not necessarily focus on the underlying causes of behaviors (Linehan, 2015b). This is what makes it a behavioral approach: focusing the therapy on changing the dysfunctional behaviors rather than addressing causes. In a hospital setting, because patients get to the hospital because of their acuity (i.e., their lack of safety), focusing on behaviors is the appropriate approach to maintain safety. I appreciated that much of the work that I did at the site was helping patients learn how to calm hyperarousal of the limbic system (Goldin & Gross, 2010; Kravitz, 2008) that led to their emotion dysregulation and unsafe behaviors. Sometimes, in the moment, my work was about literally calming people down through deep breathing so that they could stay in group, think clearly about a problem, or "lower the flame" on their anxiety.

Courtois (2008) described Herman's three stages of trauma recovery in the treatment of complex trauma. As Judith Herman (1997) noted in her landmark work, *Trauma and Recovery*,

The central task of the first stage is the reestablishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life. Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. They are an attempt to impose simplicity and order upon a process that is inherently turbulent and complex. (Herman, 1997, p. 155)

Stage 1 tasks center around safety, stabilization, affect regulation, alliance building, and education (Courtois, 2008). Most of a DBT therapy program, even a year-long program, centers around Stage 1 trauma work corresponding to Stage 1 DBT work (Clark, 2016). In Stage 2 trauma work, processing of traumatic material can lead to mourning, resolution, and integration (Courtois, 2008). In Stage 3, clients are better equipped to address relational-developmental issues (e.g., building trustworthy relationships and intimacy; Courtois, 2008). While DBT holds the promise of turning to this later-stage recovery work, which is done in Stages 3 and 4 of DBT (Linehan, 2016b), its use and success isn't well-documented via controlled studies (Koerner, 2012). This doesn't imply to me that DBT in later stages wouldn't or couldn't be useful (or documented), but more that hospital environments, which support the research studies, are understandably focused on safety and crisis management rather than the spiritual and personal healing that occurs in the later stages of trauma recovery.

My assessment is that the patients in the RPHP where I worked represented a mix of trauma recovery stages, including readiness to enter deeper stages of trauma and SUD recovery. Teaching mindfulness, mentalization, and distress tolerance skills was a good framework for establishing

safety in Stage 1 trauma work. However, like Maffei et al. (2018), I realized that some patients were able to dive a bit deeper into their recovery work.

I mentioned above that I member checked throughout my study period. When I mentioned trauma in my classrooms, and I contextualized their treatment into Herman's three stages of recovery (situating the patients in their here and now at Stage 1), I saw lightbulbs popping on. I could often register who in the room was aware of their trauma, who could consider their trauma, and possibly those that had never experienced relational trauma. If one considers the initial target population of DBT (i.e., women with BPD), and one believes that BPD (like SUDs) are driven by problems with early-relational attachment trauma (Courtois & Ford, 2013; Maffei et al. 2018), then a role for attachment repair in the treatment mix becomes quite compelling. I witnessed many patients (not all of course) go into deeper levels of awareness of themselves while in the program. It wasn't expected, but I witnessed "awakening" with some of the patients.

Furthermore, I found that "selling in" Herman's stages of trauma recovery, especially for stabilized patients who were not dealing with overt emotion dysregulation, gave those patients a way to consider how to handle their grief and move forward. It opened a doorway for them, or at least allowed them to realize there was a doorway. There is no way to "build a life worth living" (one of DBT's Stage 3 injunctions; Clark, 2016, p. 37; Linehan, 2015a) if the grief work doesn't happen at some point. The lights came on. The patients saw a doorway. My sense was that "turning on the lights" was helpful to patients.

Conclusion

This paper has had a few working titles. At one point, very early on, I thought about entitling it, "The Twelfth Step," a reference to the final step in Alcoholics' Anonymous 12-step program (AAWSI, 1952/2013). There was a period in which I was calling the paper, "*Del dicho al*

hecho,” which roughly translates from Spanish into “Easier said than done.” This was intended to refer to the difficulty of delivering DBT-ST in an applied setting. It also seemed relevant to my difficulty explaining mindfulness practices. At one point I also considered calling this thesis, “Both/And” because I came to realize there is a place for behavioral safety skills training (at which DBT and CBT work well) and a place for awakening patients to the need for deeper trauma repair work.

I intended to have my thesis be “do-able” and contained, exploring mindfulness-oriented art experientials. It was indeed do-able and contained, but it also became an intellectual journey that surprised me and deepened my thinking about relational attachment trauma and how to approach it and hold it safely when one is only working with patients for two or three or four weeks. How do I safely turn on the lights, point out the door, and then prod patients safely out the door?

From a practical standpoint (i.e., from the perspective of improving my teaching of DBT skills), I surfaced areas of patient confusion, but they were points of confusion that I attempted to clarify for patients. Selling the benefits of whatever you are teaching is a step in the right direction. My research process and thinking evolved over the study period, pulling me into a critique of DBT, and leading me to a comparison of DBT and schema therapy, especially for dually-diagnosed patients with SUDs. A “wild card” for me in my experience and analysis, however, was the consideration of art-making’s potential to evoke shame in patients. This led me squarely back to attempt to integrate learnings about attachment trauma and corrective emotional experiences that could be part of our group therapy.

As of this writing, I consider that the fit of the therapeutic approach (for example DBT versus schema therapy) lies in the patient’s readiness and ability to undertake trauma processing, following Herman’s (1997) stages. While applied science (and the clinical environment) often

seems to force a choice between one treatment method or another (and the treatment method isn't usually relational), in my mind, this treatment setting could productively offer and hold multiple treatment approaches, including relational ones. Some patients might benefit from DBT; some patients might benefit from schema therapy; some might benefit from aspects of either. Both the therapies, plus more relationally-oriented therapies, could be incorporated into the RPHP setting, with benefits to many of the patients. For me, the overarching framework that made the most sense, and held them all, was re-centering the work around and into trauma-recovery using approaches such as Herman's three-stage model. Once that was done, I was able to "embrace the dialectic" of apparently contradictory, and yet not at all contradictory, treatment approaches.

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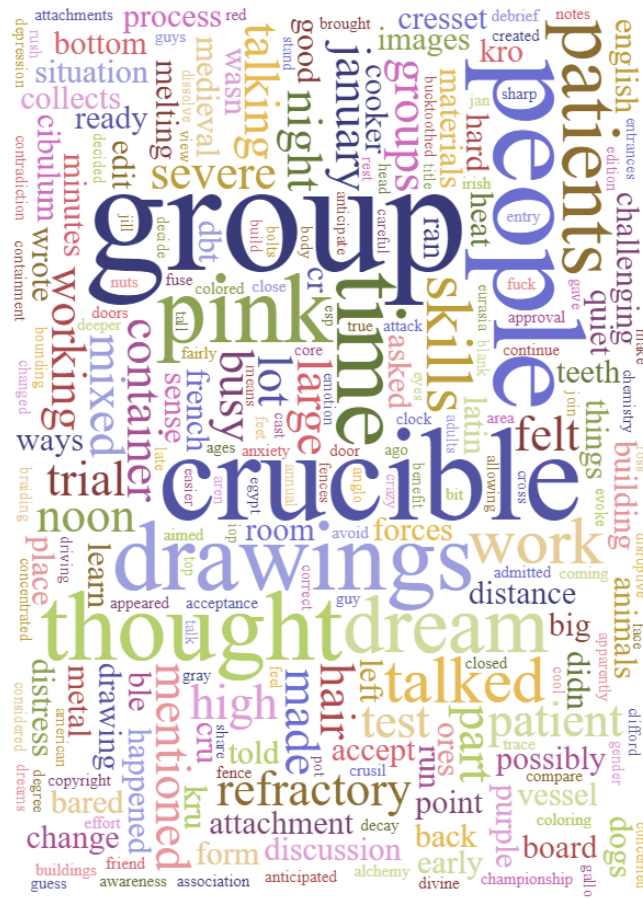
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Appendix



Figure 1. Hummingbird image from Waldie (2017) - Upright



Poem for Pink

Bottom situation collects readily
Rooms that work
People as patients
Forces admitted
Refractory attachment
Distressed metal

Part trace
....Test ores

Thoughts and dreams
And trial by noon
Withstands talking
And containment

Figure 3. Poem for Pink



Figure 4. Tulips in a landscape



Figure 5. Tulips in a glass vase, with a butterfly

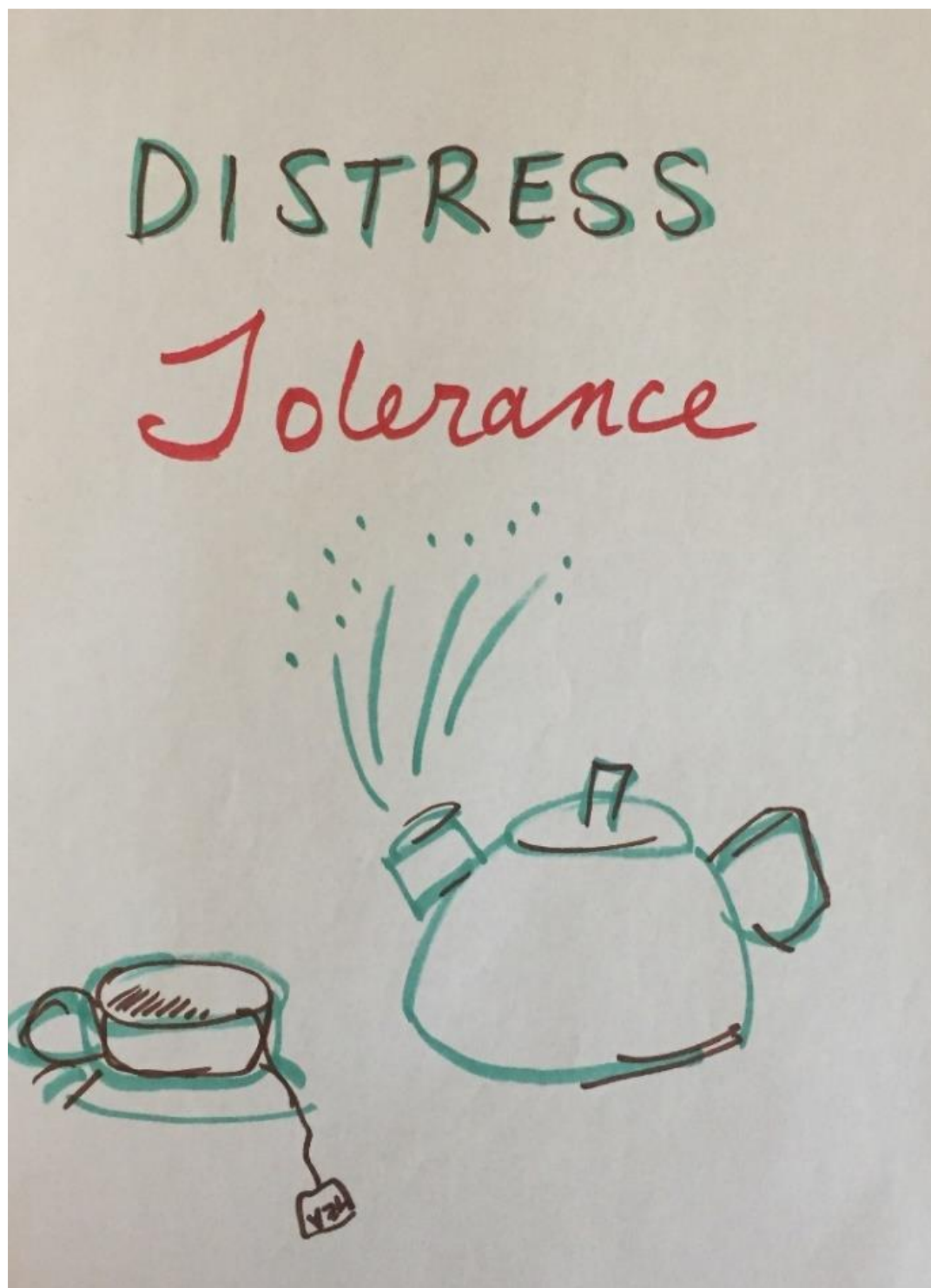


Figure 6. Cover sheet for a day focused on distress tolerance skills

THESIS APPROVAL FORM

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Expressive Therapies Division
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Type of Project: Thesis

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: _____Raquel Stephenson_____