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Moving to the other side of the desk: An examination of the practice of including peer support specialists as treatment providers within the dialectical behavior therapy paradigm

Chelsea Cawood

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Moving to the Other Side of the Desk: An Examination of the Practice of Including Peer Support Specialists as Treatment Providers within the Dialectical Behavior Therapy Paradigm.

by
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Dissertation

Submitted to the Department of Psychology
Eastern Michigan University
In partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY
In Clinical Psychology

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Abstract

Dialectical Behavior Therapy is the primary empirically supported treatment for Borderline Personality Disorder. This multi-modal treatment consists of individual therapy, group skills training, the availability of 24-hour phone coaching, and weekly consultation meetings for therapists. A recent trend in Michigan Community Mental Health has been to add an additional component to traditional DBT, the inclusion of peer-provided services. In this role, graduates of DBT programs become members of the DBT team and may function to provide services at a variety of levels. Currently, no research exists examining this potential new treatment modality. The purpose of the current qualitative and descriptive study was to investigate this new component of DBT and examine the roles and experiences of DBT peer-providers, as well as the DBT therapists who work alongside them. It was hypothesized DBT peer-providers will find their job rewarding yet have difficulty with the transition from being a client to a provider. Additionally, it was hypothesized DBT peer-providers will experience lower levels of burnout than DBT therapists. Participants were thirty-eight DBT therapists and nineteen DBT PSSs employed in Michigan Community Mental Health agencies. Results found that both DBT therapists and PSSs view the PSS position favorably. Transitions from DBT client to provider were generally nonproblematic for both samples; however, few PSSs were hired to work on DBT teams where they previously received services. Although both samples experience moderate levels of burnout, PSSs had significantly lower scores of burnout than therapists on one subscale. Although results revealed numerous positive findings, several areas of growth for the PSS movement were identified. These include inadequate training and vague ethical guidelines. The implications of these results, limitations of the present study, and directions for future research are discussed.
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Introduction

Mental health recovery is an emergent trend in work with individuals with severe mental illness (SMI), suggesting a focus on hope, support, and empowering individuals to make decisions about their own treatment goals and well-being (Anthony, 2000, 1993). Several decades ago, the focus of treatment for individuals with SMI was on managing symptoms; however, research has long since indicated that individuals with SMI are able to carry out fulfilling lives (Rodgers, Norell, Roll, & Dyck, 2007). Consequently, programs that primarily serve individuals with SMI (i.e. community mental health agencies) are shifting to promote a recovery-orientation of treatment. As part of this effort, community mental health (CMH) settings have increasingly included peer-providers of services (PSS). The literature on PSS generally focuses on individuals with schizophrenia, bipolar disorder, and substance abuse disorders. Most community mental health (CMH) settings also provide services to a large population of individuals with Borderline Personality Disorder (BPD). Due to this service need, CMH settings have widely adopted Dialectical Behavior Therapy programs, as this is the only empirically supported treatment for individuals with BPD. Recently, CMH in the state of Michigan has led a national movement to include a peer-provider on DBT treatment teams. However, how this addition of a new modality to the DBT paradigm affects treatment provision is unknown. The purpose of the present study is to investigate this new component of DBT and examine the roles and experiences of DBT peer-providers, as well as the DBT therapists who work alongside them.
Literature Review

Overview of Borderline Personality Disorder

BPD is defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association, 2000) as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (p. 710). Other symptoms include feelings of emptiness, anger, avoidance of abandonment, suicidal behaviors, and non-suicidal self-harm (NSSH). The rates of NSSH, suicide attempts, and completed suicides are alarmingly high in this population. The prevalence of NSSH among individuals with BPD ranges from 50% to 78.3% (Dubo, Zanarini, Lewis, & Williams, 1997; Dulit, Fyer, Leon, Brodsky, & Frances, 1994; Shearer, 1994; Zanarini et al., 2006a). Furthermore, over half attempt suicide (Soloff, Fabio, Kelly, Malone, & Mann, 2005; Stanley & Brodsky, 2005), and 8-10% of individuals with BPD complete suicide (*DSM-IV-TR*; American Psychiatric Association, 2000). The intentional self-injury of this population is extremely costly; inpatient hospitalizations of individuals with BPD cost the US healthcare system $150 million each year (Olfson et al., 2005).

According to the *DSM-IV-TR*, 2% of the general population in the United States suffers from BPD. In clinical samples, the disorder comprises 10% of outpatient and 20% of inpatient clients (Bateman & Fonagy, 2004; *DSM-IV-TR*; American Psychiatric Association, 2000; Torgersen, 2005). Since the publication of the *DSM-IV-TR*, rates of BPD are rising. In a recent national study of 34,653 respondents, the prevalence of BPD in the general population was 5.9% (Grant et al., 2008). Among clinical populations, seventy-five percent of individuals diagnosed with BPD are female (*DSM-IV-TR*; American Psychiatric Association, 2000).
**Course and Prognosis of Borderline Personality Disorder**

Personality disorders are by definition thought to be inflexible, pervasive, and persistent over time (*DSM-IV-TR*; American Psychiatric Association, 2000). Clinically, BPD has received a reputation of being intractable, with little hope of full recovery. Early literature documents the lack of success in psychotherapy (Waldinger & Gunderson, 1984; Wallerstein, 1986) and strong negative emotional reactions on the part of clinicians working with this population (Adler, 1993; Beck & Freeman, 1990; Linehan, 1993). However, the empirical literature paints a different picture of the stability of this disorder. An early longitudinal study of the course of BPD found that at 15-year follow-up, 75% of participants no longer met criteria for BPD (Paris, Brown, & Nowlis, 1987). More recently, Zanarini, Frankenburg, Hennen, Reich, and Silk (2006b) examined the course of BPD in 290 inpatient participants, over 10 years. Eighty-eight percent of participants no longer met diagnostic criteria after ten years, with over half reaching remission four years into the study. Research indicates that the course of specific symptoms of BPD is variable; some studies have found features such as anger, affective instability, and interpersonal dependency to be more stable than NSSH and suicidal behavior (Zanarini, Frankenburg, Reich, Silk, Hudson & McSweeney, 2007; Skodol, Gunderson, Shea, McGlashan, Morey, & Sanislow, 2005). Nonetheless, BPD is considered a serious disorder and difficult to treat.

Until recently, clinicians lacked an empirically efficacious means of treating this potentially fatal disorder. Developed by Dr. Marsha Linehan (1993), Dialectical Behavior Therapy (DBT) is the only treatment found to be efficacious with this population across several randomized controlled trials (RCT).

**Dialectical Behavior Therapy**
DBT is primarily a cognitive-behavioral treatment, with roots in Eastern and Zen mindfulness practices. The core philosophy of DBT includes its basis in mindfulness, clear prioritizing of treatment targets, and a dialectical balance between acceptance and change strategies. This foundation is applied through multiple treatment modalities, making DBT a comprehensive, intensive, and innovative treatment. The profusion of empirical support for DBT is reviewed below.

**Mindfulness.** Mindfulness is a core element of DBT and is the basis for DBT skills training. DBT teaches clients to observe, describe, and participate in the present moment in a way that is effective and nonjudgmental. DBT is not the first psychotherapy to incorporate mindfulness practices; mindfulness is a central component in various psychological treatments such as Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) and Mindfulness-Based Cognitive Therapy for Depression (Seagal, Williams, & Teasdale, 2002). Mindfulness is particularly important in DBT because clients with BPD or emotion dysregulation lack full awareness when they engage in impulsive and mood-dependent behaviors (Linehan, 1993). Increasing this awareness enables clients to make more adaptive choices.

**Treatment targets.** Clients with BPD often have multiple debilitating symptoms, in addition to chaotic environmental difficulties. This array of potential treatment foci can become overwhelming for therapists who struggle to maintain a treatment target amidst the chaos. DBT provides a much needed, hierarchical structure of treatment targets (Linehan, 1993). First, DBT aims to decrease life-threatening and NSSH behaviors. Second, any behaviors that interfere with therapy are targeted. The third target is to decrease quality of life interfering behaviors, and last, DBT aims to increase knowledge and use of skill-driven behaviors. DBT is a quality of life improving program, not a suicide prevention program. However, life-threatening behaviors are
targeted first because as Mintz (1968, cited in Linehan, 1993) states to clients, “no psychotherapy is effective with a dead patient” (p. 124).

**Dialectics: The balance of acceptance and change strategies.** A primary guiding principle behind DBT is the balance between encouraging clients to accept themselves and their life circumstances, while recognizing the need to change the way they are living. DBT uses multiple therapeutic strategies for problem-solving (i.e. change). A primary change strategy is behavioral chain analysis, which identifies, in detail, the triggers and consequences of target behaviors. Skill training is a vital change strategy in DBT; use of skills is requisite for change in DBT, and a frequent treatment target. Interestingly, skill training also teaches DBT clients to adapt an attitude of acceptance through use of mindfulness and radical acceptance skills. DBT therapists demonstrate acceptance of their clients through use of validation strategies. The “dialectic” component of DBT is the notion that opposing tensions will arise and require a synthesis, and a primary dialectic is the balance of these seemingly opposite acceptance and change strategies (Linehan, 1993).

**Treatment modalities.** DBT is an intensive, multi-modal treatment, composed of weekly individual therapy, weekly group skills training classes, access to 24-hour telephone consultation with a DBT therapist, and weekly consultation meetings for therapists. Each modality plays an integral role to DBT, and most randomized controlled trials (RCT) of DBT include all four modalities. Therapists who exclude one or more component of DBT may be doing a disservice to their clients, as dismantling studies have not demonstrated DBT is efficacious without all four components. Preliminary component studies using skills training classes outside of comprehensive DBT will be discussed later.
**Individual therapy.** All clients in DBT receive at least 50-60 minutes of weekly outpatient individual therapy. Longer sessions may occasionally be required for some clients. The goal of individual therapy is to help the client change maladaptive behaviors and promote adaptive, skillful behaviors (Linehan, 1993). Clients in DBT are required to meet with their individual therapist as well as attend weekly skills training classes. An important role of the individual therapist is to facilitate use of skills in the client’s life.

**Skills training.** The goal of group skills training is to teach skills that will enhance the clients’ capabilities. These classes are psychoeducational and didactic, with a focus on learning and practicing new skills. Part of DBT’s philosophy is that individuals with BPD lack the skills to regulate emotion. Hence, great importance is placed on skill acquisition. There are four modules focusing on different skills: mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. The last three modules are eight weeks each, with three weeks of mindfulness training beginning each module. In standard DBT, skills classes meet weekly for approximately two hours, and clients typically attend classes for one year, cycling through each module twice.

**Telephone consultation.** It may seem surprising that a treatment for individuals with BPD, who historically are considered to have poor boundaries, grant clients constant phone access to their therapist. The primary role of 24-hour phone consultation is to coach clients’ generalization of DBT skills into their daily lives. Thus, the phone consultation used in DBT is brief, typically no more than 15 minutes per call, and focuses on helping the clients identify a skill to use when under emotional duress.

**Therapist consultation meetings.** Clients with BPD present a range of difficulties that can be extremely stressful for therapists (Adler, 1993; Beck & Freeman, 1990; Linehan, 1993).
The purpose of DBT therapist consultation meetings is to reduce therapist burnout and ensure therapist adherence to the DBT protocol. These weekly meetings allow opportunities for therapists to discuss specific cases and enhance therapist skill development. Furthermore, these meetings focus on managing therapists’ emotional reactions to clients.

**Empirical support for DBT**

DBT is “well-established” for treating BPD based on the criteria set by the APA Task Force on Promotion and Dissemination of Psychological Procedures (1995). Treatments are classified as well-established or probably efficacious based on the quality of the methodology used in treatment outcome research (Chambless & Hollon, 1998). The multiple RCTs of DBT for BPD (discussed below) clearly exceed the criteria for a well-established treatment.

**Randomized controlled trials of DBT.** To date, multiple researchers have conducted six RCTs demonstrating the empirical support of DBT for BPD. In the first RCT by Linehan et al. (1991), 44 parasuicidal women with BPD were randomized into DBT or treatment as usual (TAU). After one year of treatment, the DBT group had significantly lower rates of parasuicide and suicide attempts, better treatment retention, and fewer days of inpatient hospitalization. Treatment gains were sustained at 6-month and 1-year follow-ups (Linehan, Heard, & Armstrong, 1993). Additionally, the DBT group scored significantly better than TAU on measures of anger, social adjustment, and global functioning but not on suicidal ideation, hopelessness, or depression (Linehan, Tutek, Heard & Armstrong, 1994).

In 2001, Koons et al. conducted the second RCT of DBT for BPD using twenty female veterans with BPD. Koons compared 6 months of DBT to TAU in a VA system. The ten participants assigned to DBT showed significant decreases in suicidal behaviors, NSSH, suicidal ideation, hopelessness, depression, and expression of anger over participants in TAU. The DBT
group did not differ from TAU on number of hospitalizations. However, the proportion of participants with any hospitalizations in the three months prior to treatment was 30% of the DBT group and 20% of the TAU group, indicating a low baseline for this variable. Although neither group saw significant changes, analysis of variance revealed the DBT group reduction (from 30% pretreatment to 10% posttreatment) approached significance ($p = .06$) whereas the TAU condition (20% pretreatment, 10% posttreatment) did not ($p = .72$).

The changes in suicidal ideation, hopeless, and depression in Koons et al.’s (2001) study contrast with those of the original RCT. A distinction about Koons et al. is that previous suicide attempts or NSSH was not an inclusion criterion, as in Linehan’s RCT (1991). Therefore, Koon’s sample had a lower pre-treatment rate of self-harm. Consistent with the hierarchy of treatment targets in DBT, this difference in samples may have enabled clinicians to focus on quality of life issues as opposed to life-threatening behaviors, resulting in the different findings.

Verheul et al. (2003) conducted the first international RCT of DBT in the Netherlands, randomly assigning 58 women with BPD to 12 months of either DBT or TAU. The DBT group had significantly lower treatment dropout, NSSH, and total impulsive behaviors (including alcohol consumption) than the group receiving TAU. These effects were sustained at six-month follow-up (van den Bosh, Koeter, Stijnen, Verheul, & van den Brink, 2005). Verheul did not find significant group differences for suicide attempts; however, only two out of ten DBT participants made a suicide attempt, compared to seven out of ten in the control group. Furthermore, participants in the TAU group actually increased in rates of NSSH, suggesting that a non-specialized treatment may be detrimental to this population. Interestingly, the effects on reducing NSSH were greater for participants with high baseline rates of these behaviors, suggesting DBT might be most appropriate for individuals with more severe histories of NSSH.
In 2006, Linehan et al. completed the most rigorous RCT of DBT for BPD to date, comparing 12 months of DBT to treatment by expert non-behavioral therapists in the community. Participants were 101 women diagnosed with BPD. Although participants in the DBT group received significantly more hours of therapy from study therapists, there were no significant differences in total number of hours when all services were summed (e.g. group therapy, case management, and day treatment). Additionally, the control condition received individual supervision and attended consultation groups. Results indicated that the DBT group had significantly lower rates of dropout, suicide attempts, and hospitalizations/crisis service utilization than controls. Both groups saw decreases in NSSH.

Most recently, Kliem, Kröger, and Kosfelder (2010) conducted the first meta-analysis of DBT for BPD. This study included data from eight RCTs and eight non-randomized controlled trials of DBT for BPD, including outpatient and inpatient forms of the treatment. Results indicated a moderate effect size (.37, p = .006) for both suicidal and non-suicidal self-harm behaviors. However, these effects decrease to the small range when DBT is compared to other treatments designed specifically for BPD, such as transference-focused psychotherapy.

Expansions of DBT to new populations. In the last decade, DBT has expanded for use with various clinical populations, beyond BPD. Several authors have outlined and tested adaptations of DBT with other populations of interest.

Substance abuse is a highly prevalent (and dangerous) problem among individuals with BPD, and substance abuse disorders (SAD) are comorbid in 64-72% of cases (Grant et al., 2008; Zanarini et al., 1998). Minor adaptations to DBT have been suggested to optimize DBT for comorbid SADs (McMain, Sayrs, Dimeff, & Linehan, 2007). This included the notion of “dialectical abstinence,” which consists of applying abstinence principles throughout treatment
but utilizing acceptance and problem-solving relapse prevention principles upon substance use relapse. Additionally, “attachment” strategies were added to increase client engagement and bring back “lost” clients. These include actively pursuing clients in their environment if they have been missing from treatment.

Using these adaptations, Linehan et al. (1999) conducted the first RCT of DBT for women with BPD and SADs. Twenty-eight women were randomized into a year of DBT or TAU. Participants in the experimental condition also received replacement medication pharmacotherapy (methylphenidate or methadone), which was tapered off by the end of the treatment year. After one year of treatment, the DBT group had significantly greater reductions in substance use based on both urinalysis (effect size = .63) and interview (effect size = 1.12) than TAU. Additionally, significantly fewer participants in the DBT group dropped out of treatment than in the control group. These differences were sustained at 16-month follow-up (effect sizes = .75 for urinalysis, 1.03 for interview). Furthermore, although not significant immediately post-treatment, 16-month follow-up revealed the DBT group had significantly better social ($p < .05$) and global ($p < .001$) functioning scores.

In 2002, Linehan and Dimeff, et al. (2002) conducted a randomized controlled trial comparing 23 women with BPD and opioid dependency after 12 months of DBT (n = 11) to Comprehensive Validation Therapy plus a 12-Step (CVT+12; n= 12) program. This RCT utilized a considerably more rigorous control condition than the previous. The CVT+12 was comprised of individual therapy that utilized DBT acceptance strategies (e.g. validation) and participation in a 12-step program (including weekly group meetings). Both groups were treated with opiate agonist therapy throughout the study. Participants in both treatment conditions significantly
reduced opioid use; however, in the last four months of treatment, participants in the control group increased their drug use ($p < 0.001$), whereas the DBT group sustained their reductions.

Recently, Harned et al. (2008) examined changes in co-occurring Axis 1 disorders (including SADs) using participants in Linehan et al.’s (2006) RCT of DBT vs. therapy by community experts. After one year of treatment, the DBT group had significantly higher rates of full remission from substance dependence disorders than the control group (87% and 33%, respectively; this effect was large, Cohen’s $w$ effect size = 0.55). The groups did not differ in rates of remission for any other co-occurring Axis 1 disorders.

The above research on DBT for BPD and comorbid SADs is optimistic. Given that substance use is a risk factor for suicide, and highly comorbid with BPD, an empirically validated treatment for individual’s struggling with both conditions is imperative. As mentioned, DBT is a well-established treatment for BPD. The reviewed research suggests DBT is a probably efficacious treatment for BPD with co-occurring SADS. If new research teams can replicate Linehan and colleague’s promising results, the treatment will be well established for use with individuals struggling with both BPD and SADS. Outcome studies of DBT for non-BPD individuals with SADs are nonexistent in the literature and are required to expand the use of DBT to broader substance abusing populations.

Based on the suggested underlying problem of emotion dysregulation in disordered eating behaviors, researchers have examined the efficacy of DBT in treating eating disorders. Wisniewski, Safer, and Chen (2007) delineate minor adaptations to DBT for treating disordered eating behaviors. In particular, they discuss the use of dialectical abstinence for binge and purge behaviors and focusing skills training on related urges. Safer, Telch, and Agras (2001) tested the efficacy of DBT for Bulimia Nervosa compared to a wait-list control group. After 20 weeks of
treatment, the experimental group had significantly lower rates of binge eating and purging; 28.6% of the DBT group, compared to none of the control group, were abstinent from binging and purging ($p > .05$). Significant treatment effects were especially large for binging ($d = 1.15$) and moderate for purging behaviors ($d = .61$). Thirty-six percent of the DBT group and 20% of the control group were in remission from bulimia nervosa post treatment. Other variables, such as self-esteem and depression, did not change significantly. Although the wait-list control condition makes comparisons of attrition impossible, it is notable that none of participants dropped out of DBT. Telch, Agras, and Linehan (2001) conducted a randomized controlled trial comparing the efficacy of a modified DBT skills training group to a wait-list control among 44 women with binge eating disorder. After the 20-week skills group, participants who attended group significantly decreased frequency of binge eating compared to controls (abstinence rates were 89% and 12.5%, respectively; $p < .001$). Although 89% of the DBT group was abstinent from binge eating at the end of treatment, this dropped to 56% at 6-month follow-up. At follow-up, 89% of DBT group reported continued practice of skills learned in treatment. Due to the use of a wait-list control in both of the aforementioned studies, further research is required to confirm that DBT has an effect on BN or BED beyond the additive effect of psychotherapy.

**Relevant non-randomized controlled trials.** Although randomized controlled trials are needed, expansions of DBT for suicidal adolescent and adult inpatient populations have showed promise in non-randomized controlled trials. Researchers (Miller, Rathus, & Linehan, 2007; Rathus & Miller, 2002) have proposed important adaptations to standard DBT for work with adolescent populations. The primary deviation from the DBT manual (Linehan, 1993) is emphasis on family involvement, including having a family member participate in skills training groups alongside each adolescent client. Additionally, to facilitate treatment completion, the
course of treatment is reduced from 1 year to 12 weeks. Rathus and Miller (2002) compared this adapted format of DBT to TAU in a sample of 111 suicidal adolescents. After the 12 weeks of treatment, the DBT group had fewer psychiatric hospitalizations and higher rates of treatment completion. There were no significant differences between groups in suicide attempts; however, it is notable that the TAU group had twice the suicide attempts as the DBT group, and participants in the DBT group were significantly more severe at baseline in terms of diagnosis (major depressive disorder, SADs, and BPD), suicidal ideation, and prior hospitalizations. Within the DBT group, there were significant reductions posttreatment in suicidal ideation, general psychiatric symptoms, and BPD symptoms; however, these variables were not analyzed between groups.

Katz, Gunasekara, Cox, and Miller (2004) found similar results using a sample of 62 suicidal adolescents on an inpatient unit. After 18 days, participants in the DBT group had fewer behavioral incidents than the TAU group, and both groups improved significantly on measures of depression, suicidal ideation, hopelessness, and parasuicide. After a one-year follow-up period, there were absolute differences favoring DBT between the effect sizes of the DBT and TAU groups on measures of depression (1.67 -1.05 = 0.62), suicidal ideation (2.12 – 1.36 = 0.76), and hopelessness (0.73 – 0.33 = 0.40). These findings coupled with those of the Rathus and Miller (2002) indicate promise for the efficacy of DBT with suicidal adolescents across settings.

Uncontrolled trials of DBT for adolescents have expanded to community outpatient (Woodberry & Popenoe, 2008) and bipolar specialty clinics (Goldstein, Axelson, Birmaher, & Brent, 2007) and found improvements in not only adolescent ratings of self-harm and psychiatric symptoms, but in depressive symptoms of their parents (Woodberry & Popenoe, 2008).
However, further research on DBT with various adolescent populations using randomized controlled trials is required to demonstrate that DBT is efficacious with this population.

Adaptations of DBT for inpatient settings are cogent given the high rates of suicidality and BPD in such settings. Inpatient DBT programs use principles of mindfulness, behavioral analysis, and dialectics to develop an inpatient treatment plan, reduce behavioral dyscontrol (e.g. suicidal and NSSH behaviors), and implement a discharge plan. Given the time-limited nature of inpatient stays, inpatient DBT programs involve mindfulness activities, skills training, and homework throughout most of each day (Swenson, Witterholt, & Bohus, 2007). Barley et al. (1993) conducted the first controlled trial of inpatient DBT, comparing patient data 19 months prior to DBT implementation, during the 10-month training and development period, and for 14 months post implementation. A similar inpatient unit receiving “standard treatment” served as the control group. After the 14-month full implementation period, the unit receiving DBT had significantly less parasuicide than the control unit. Bohus et al. (2004) examined efficacy of a 3-month inpatient DBT unit compared to a non-DBT unit (mean 44 inpatient days). From pretreatment to one-month post-discharge, the DBT group significantly improved on depression, anxiety, interpersonal functioning, social adjustment, general psychopathology, and NSSH; the control group did not improve on any variable. A major limitation of this study was the lack of randomization. Additionally, the control condition received considerably fewer treatment days than the DBT group; thus, results could be due to quantity of services provided, as opposed to the specific intervention. Implementing DBT in inpatient settings is theoretically sound, and initial findings are hopeful.

Additional adaptations of DBT have been articulated, including treatment of families or couples (Fruzzetti, Santisteban, & Hoffman, 2007), incarcerated individuals (McCann, Ivanoff,
Schmidt, & Beach, 2007), and individuals with bipolar disorder (Goldstein, Axelson, Birmaher, & Brent, 2007), posttraumatic stress disorder (Becker & Zayfert, 2001), and attention deficit hyperactivity disorder (Hesslinger et al., 2002). Some of these adaptations are merely theoretical, and others have preliminary support using uncontrolled trials but require additional research to verify efficacy. These adaptations provide interesting new directions for future development of DBT.

**Effectiveness of DBT in community mental health settings.** Clearly, DBT is an efficacious treatment for BPD and is possibly efficacious with additional populations. This raises the question of whether DBT is effective and easily disseminated in community venues. A dearth of research exists examining the effectiveness of DBT in CMH settings; this is problematic as DBT is extremely common in these settings. Ben-Porath, Peterson, and Smee (2004) studied effects of 6 months of DBT on a sample of 23 clients with BPD and comorbid Axis 1 disorders in a CMH clinic. The co-morbid Axis 1 disorders included bipolar disorder, major depression, schizoaffective disorder, and schizophrenia. Additionally, 69% of the sample had been hospitalized eleven or more times. Clinicians with a range of experience and training in DBT administered the treatment. Although the study was uncontrolled, participants reported significantly lower suicidal ideation, unemployment, and psychiatric symptoms (on the Symptom-Checklist-90-R, Horowitz et al., 1988) post treatment.

Comtois, Elwood, Holdcraft, Smith, and Simpson (2007) examined effectiveness of DBT in a CMH setting among 38 clients, most of whom had a BPD diagnosis plus a co-morbid Axis 1 diagnosis. Ninety-one percent of the sample had a history of at least one suicide attempt. Comtois et al. did not include a control group. Findings indicate that after one year of DBT,
participants had significantly lower rates of self-harm, emergency room visits, and psychiatric hospitalizations.

Most recently, Blennerhassett et al. (2009) conducted an uncontrolled trial of DBT in a CMH setting in Ireland. The sample consisted of eight participants with BPD. After six months of treatment, participants reported significantly fewer psychiatric symptoms, engaged in significantly less suicidal behaviors, and used significantly fewer inpatient hospitalization days. These preliminary findings in community mental health settings indicate DBT may be effective for clients with comorbid diagnoses when administered by community clinicians. Although results are promising, these studies lack a control group, making it impossible to discern whether effects are specific to DBT or simply due to the presence of an intensive treatment.

There are multiple barriers to implementing DBT in community mental health settings. As Ben-Porath et al. (2004) and Herschell et al. (2009) discuss, clinician training in DBT and high staff turnover rates create difficulties for implementing and maintaining a comprehensive DBT program. According to one study (Aarons & Sawitzky, 2006), the annual turnover rate for a group of clinicians and case managers in community mental health was 28 percent. The standard for training in DBT is a 10-day intensive workshop; therefore, a great deal of administrative support and funding is required to train clinicians to conduct this treatment adherently. This is a risky investment for an organization, considering the high turnover rate of therapists in community mental health settings.

**Component studies: Efficacy of skills training separate from traditional DBT.** Due to the considerable resources required to run a comprehensive DBT clinic, the question arises as to whether components of DBT, such as skills training groups, are efficacious outside of the full DBT package. Furthermore, understanding the specific components that make DBT unique and
efficacious improves upon the treatment’s generalizability, effectiveness, and client outcomes. Linehan (1993) was the first to examine the efficacy of skills training groups outside of the full DBT protocol. Results revealed that of 19 participants with BPD, the group who received DBT group skills training and non-DBT individual therapy did not differ on any variable compared to participants receiving non-DBT individual therapy only. Although Linehan’s early results suggest skills training is not an effective treatment outside of a full DBT program, recent research has been promising.

Soler et al. (2009) examined outcomes in 60 participants with BPD, after completing 3 months of DBT skills training versus standard group therapy. None of the participants received individual therapy during the trial. The DBT group had significantly fewer dropouts and lower scores on scales of depression, anxiety, irritability, anger, and affective instability than the control group. However, neither group decreased significantly in number of suicide attempts or NSSH. Last, Harley, Baity, Blais, and Jacobo (2007) compared the full DBT package to DBT skills training plus non-DBT individual therapy in 49 participants with BPD. The most notable finding was that participants receiving full DBT had significantly better treatment retention; 51% of the participants receiving skills training plus a non-DBT therapist dropped out of treatment, compared to 35% of those receiving full DBT. Similar improvements in BPD symptoms, depression, and suicidal ideation occurred in both groups. In sum, these findings suggest that DBT skills groups may be an effective mode of treatment when a comprehensive DBT clinic is unavailable. However, the presence of an individual DBT therapist appears to help keep clients in treatment and may be necessary for clients with dangerous behavioral symptoms, such as suicide attempts and NSSH.
Although use of DBT skills training groups has mixed results as a stand-alone treatment for BPD, there is some speculation that adaptations of these groups may be a worthy treatment for other populations. As mentioned above, Telch, Agras, and Linehan (2001) found that a revised skills training group was beneficial for reducing binge eating among individuals with binge-eating disorder, even in the absence of individual therapy. Lynch et al. (2007) examined 28 weeks of antidepressant medication and case management alone versus with DBT skills training and telephone coaching. First, Lynch et al. examined outcomes among 34 chronically depressed older adults (60 years or older); next, he and colleagues conducted a second study examining outcomes among 35 chronically depressed older adults with a co-morbid personality disorder. In the first sample, 71% of the DBT group was in remission from MDD at post treatment, compared to 47% of the medication group. In the second sample, there were no significant post treatment differences between groups on depressive symptoms, and effect sizes were relatively small at .34. However, the DBT group reached remission more quickly and had significantly greater changes in interpersonal sensitivity and aggression than the medication group. Regarding changes in personality pathology, only seven participants in the medication group and nine in the DBT group fully remitted by the end of treatment. Feldman, Harley, Kerrigan, Jacobo, and Fava (2009) examined changes in emotional processing and depression among nineteen depressed adults who participated in either a 16-week DBT skills training group or a waitlist control. Although not statistically significant, the DBT group had large effect size for changes in emotional processing (Cohen’s $d = 1.26$) compared to the control group. Furthermore, results found a significant interaction between emotional processing and changes in depression, based on group assignment. Results suggest emotional processing may be adaptive for improving mood in individuals who receive skills training. Thus, Feldman et al.’s study
suggests that DBT skills training groups, in the absence of an individual DBT therapist, may be a sufficient format for skill acquisition. These results once again suggest that DBT skills training groups are a promising treatment for some populations, yet more severely impaired individuals will profit from the full DBT package.

Recently, Neacsiu, Rizvi, and Linehan (2010) examined client use of DBT skills as a mediator of successful treatment outcome within DBT for BPD. Data from 108 women with BPD from three different 12 month RCTs were analyzed. DBT skill use fully mediated the relationship between time in treatment and decrease in suicide attempts, depression, and ability to control anger. Use of skills partially mediated the relationship between treatment and decrease in non-suicidal self-injury. Results indicate client use of skills is integral to treatment success.

The DBT literature has not yet addressed the question of whether new components or treatment modalities could be added to DBT to improve its utility. As mentioned, a problem with the state of the DBT literature is the issue of whether the empirical support from randomized controlled trials generalizes to community clinics. This presents an opportunity to examine whether there are new treatment components that could improve the effectiveness of DBT in a community mental health setting. The current zeitgeist supports the addition of peer support specialists to existing DBT teams. Although this practice has not yet been studied, the extant literature speaks to peer-provided services in other contexts.

**Peer-Providers of Mental Health Services**

The involvement of peers as providers in mental health recovery dates back several decades and includes peer-providers in a variety of roles. Clay (2005) organizes peer-provider programs into three categories: drop-in centers, peer support and mentoring, and education and
advocacy. Additionally, the literature (Davidson et al., 2006; Paulson et al., 1999; Sells, Davidson, Jewell, Falzer, & Rowe, 2006; Solomon & Draine, 1995) documents peer-providers in case management service roles. Therefore, for the purposes of this study, a fourth category will be included: peers providers of case management.

Drop-in centers are peer-run, typically government funded facilities, which provide a variety of services to community members with mental illness. Services may include meals, recreational activities (e.g. pool tables, crafts, and card games), housing assistance, and a stigma-free environment to relax and socialize. Drop-in centers typically run independently of other mental health agencies and services; individuals who utilize the drop-in center are not required to participate in other mental health services.

Peer support and mentorship programs generally emphasize one-on-one services provided by the peer-provider to clients. The roles of peer-providers in this category may vary substantially between programs. Peer-providers may organize recreational activities for their clients, meet with clients individually to provide support or mentorship, and disclose their own experiences with recovery from mental illness and/or substance abuse. One of the first treatment models to include peers in this role is the sponsor system used in Alcoholics Anonymous and other twelve step programs. In many cases, peer-providers in supportive or mentorship roles are hired by a community mental health (or other government-funded) agency to provide these services; others are unpaid and work as mentors or sponsors to benefit their own recovery. Additionally, the level of involvement between peer-providers in supportive or mentorship roles and other mental health professionals varies. Often, they provide services as supplement to (and in collaboration with) other forms of treatment; however, others provide a stand-alone service.
The third category of peer-providers is peers serving in education and advocacy roles. Commonly, peer-providers in these roles lead psychoeducational classes or support groups for clients. These may focus on problem-solving and stress-management skills, recovery from mental illness and substance abuse, or information about relevant legal matters for individuals with mental illness (Clay, 2005).

Last, the fourth category of peer-providers is in case management roles. In these programs, mental health agencies hire individuals who are in remission from mental illness to provide services already being conducted at the agency, typically, case management. In most cases, peer-case managers work alongside non-peer case managers and in collaboration with other mental health professionals at the agency. Generally, job duties of peer case managers are not different from non-peer case managers. The empirical support for this peer-provider role is discussed below. It is important to consider, as Davidson et al. (2006) point out, that the degree to which these services are peer-based is questionable, given that the primary feature distinguishing peer from non-peer providers is disclosure of history of mental illness.

Clearly, a variety of programs exist utilizing peer-providers in multiple roles. This leads to a need for research on peer-providers across a variety of settings. In addition to raising the question of how this role benefits client outcomes, we need to understand how this role impacts the peer-providers themselves and the team of professionals they work with. The current study focuses on PSS in DBT, which may cut across roles common to peer support, education, and conventional services.

Clinical and Ethical Considerations for Peer-Providers

We know little about services provided by DBT PSSs; however, it seems DBT PSSs facilitate a unique blend of services to clients. It is important to consider relevant ethical
principles to ensure such services are sound and beneficial to clients. Given DBT PSSs may provide services that mirror those provided by DBT therapists, consultation with the American Psychological Association Ethics Code is indicated to establish treatment parameters. Nonetheless, DBT PSSs are not psychologists. Thus, the APA ethics code may serve as a guideline, but PSSs require ethical standards of their own. Such ethical standards have not yet been established. The Depression and Bipolar Support Alliance Peer-to-Peer Resource Center (DBSA PPRC), which provides training and certification for Peer Support Specialists broadly, has established a code of ethics, which is displayed in Figure 1 (R. Wolbert, personal communication, June 1, 2010).

<table>
<thead>
<tr>
<th>The primary responsibility of the Peer Specialist is to help those they serve achieve self-directed recovery, advocating for the full integration of individuals into communities of their choice. The Following principles guide Peer Specialists in their various professional roles, relationships, and areas of responsibility:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Peer specialists believe that every individual has strength and the ability to learn and grow.</td>
</tr>
<tr>
<td>2. Peer Specialists respect the rights and dignity of those they serve.</td>
</tr>
<tr>
<td>3. Peer Specialists openly share their personal recovery stories with colleagues and those they serve.</td>
</tr>
<tr>
<td>4. Peer Specialists seek to role-model recovery</td>
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<tr>
<td>5. Peer Specialists respect the privacy and confidentiality of those they serve</td>
</tr>
<tr>
<td>6. Peer Specialists never intimidate, threaten, or harass those they serve, and never make unwarranted promises of benefits to those they serve.</td>
</tr>
<tr>
<td>7. Peer Specialists do not practice, condone, facilitate, or collaborate in any form of discrimination on the basis on ethnicity, race, gender, sexual orientation, age, religions, national origin, marital status, political belief, or mental or physical disability</td>
</tr>
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*Figure 1. DBSA Peer-to-Peer Resource Center Code of Ethics*

The nature of peer-provided services creates divergence from some APA ethical standards, in particular, code 3.05 Multiple Relationships. The purpose of this code is to prevent
dual relationships between treatment providers and clients. In cases where a peer-provider is hired to work on a DBT team where they were previously a client, dual relationships are inherent. However, code 3.05 also states, “Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.” Whether a dual relationship between a peer-provider and DBT therapist, or peer-provider and DBT client, has potential for harm requires careful determination. Future research on DBT PSSs and therapist colleagues may help provide an empirical basis for making these important decisions.

Despite multiple categories of peer-provided services, one function of a peer-provider cuts across these roles: open identification as a peer. For many, including DBT PSSs, this includes speaking in various capacities about their recovery from mental illness. Several authors have written about the complexity of provider self-disclosure in clinical treatment. The benefits and consequences of self-disclosure has historically been a controversial topic. Yalom (2002) wrote extensively about self-disclosure and indicated there are various degrees of sharing. While Yalom believed therapeutic procedures should be fully disclosed, he thought therapists should use discretion when sharing their present feelings about the client, and share personal information cautiously. Certainly, a peer-provider’s recovery story falls into the latter category. Yalom described an overarching rule for self-disclosure: “Is this disclosure in the best interest of the patient?” (p. 87, Yalom, 2002). In the case of the peer-provider, the theoretical answer is yes. However, research has yet to examine the type, frequency, and benefits of self-disclosure within the relationship between DBT PSSs and clients.

Self-disclosure is not uncommon to DBT, and therapists’ disclosure of feelings during session is encouraged in many situations. Specifically, self-disclosure is considered an important therapeutic tool in DBT to validate clients, create an egalitarian relationship, and reinforce
appropriate interpersonal interactions. The use of self-disclosure for these purposes makes it an essential part of the treatment package (Filetti & Mattei, 2009) and lays a welcoming foundation for the addition of peer-provided services. However, how peer disclosure best supports these principles has yet to be articulated.

There are several issues to consider regarding effective use peer-provided services in clinical settings, such as DBT. Although the APA ethics code may inform peer-provided services, it is not designed for that purpose. Certified Peer Support Specialists are trained according to the DBSA PPRC code of ethics; however, this may not account for the multitude of roles PSSs can take, such as being a DBT PSS. One function of peer-provided services is the disclosure of the peer’s recovery story. Although careful self-disclosure is encouraged within DBT, more information is required as to how self-disclosure by PSSs may intertwine with the current DBT paradigm.

**Empirical Support for Peer-Provided Services**

Although the research is somewhat limited, studies have documented successful outcomes of peer-provider programs. Most recently, Boisvert et al. (2008) examined whether a peer-support community program reduced relapse rates and increased perceived community affiliation, supportive behaviors, self-determination, and quality of life for 18 adult clients. All participants were homeless adults in remission from substance abuse disorders who had previously completed a substance abuse treatment program. Results showed clients in the peer-support program significantly increased in emotional/informational support, tangible support, and affectionate support from pre-to post-test. Additionally, clients in the peer-support program had a significantly lower mean relapse rate than clients receiving treatment as usual. The year
prior to the study (6.16 and 18.5, respectively). Analysis of odds showed controls had a 24% chance of relapse compared to 7% for those in the PSS program.

Klein, Cnaan, and Whitecraft (1998) hypothesized that clients who receive both case management and peer support will use fewer emergency services, have fewer hospitalizations, show improvement in social functioning/use of community resources, report improved quality of life, and decline in drug use compared to clients receiving only case management. Participants were ten dually diagnosed adult clients in the Friends Connection program and 51 controls who received case management services alone.

The Friends Connection consists of peers providing one-on-one support and “clean” recreational activities to dually diagnosed consumers. Peers are meant to serve as role models and coaches in conjunction with the intensive case management services consumers receive from mental health professionals. Results indicated consumers in the Friends Connection program had significantly fewer crises and hospitalizations and significantly higher GAF scores than consumers receiving intensive case management alone. Additionally, the experimental group had significantly higher scores on the living, income, and health subscales of the Lehman’s Quality of Life Questionnaire (Lehman, 1988). Last, the experimental group reported decreases in substance abuse, whereas the control group actually had increased rates of substance abuse.

Rivera, Sullivan, and Valeni (2007) conducted a randomized-controlled trial of peer-assisted case management compared to case management without peer assistance. The role of peer-providers was to facilitate and provide social support. Participants were 203 clients with serious mental illness. The majority of participants received other services (outpatient therapy, group therapy, psychiatric care) within the CMH agency. After 12 months of treatment, each group improved similarly on measures of symptomology, health-care satisfaction, quality of life,
and social network. Not surprisingly, participants in the peer-assisted case management group were involved in more peer-organized activities. Participants receiving case management without peer assistance used more individual contact with the professional staff.

Yanos, Primavera, and Knight (2001) examined the influence of participation in consumer-run groups on social functioning outcomes among adults with schizophrenia, schizoaffective disorder, or bipolar disorder. Twenty-seven participants were in the experimental condition and received peer-run support or activity groups in addition to psychiatric services or outpatient therapy (a minority of participants in the experimental condition did not receive professional mental health services). Thirty-three participants served as controls and received psychiatric or outpatient therapy alone. Clients in consumer-run support groups had higher social functioning scores and used a higher number of coping strategies at post-treatment. No significant differences were found on measures of hopefulness or self-efficacy.

While few studies have been done, the literature that does exist documents the benefits of peer-provided services for mental health recovery. However, the conclusions that can be drawn from this body of literature are minimized by the wide variations among roles of PSS across different programs. Research on peer-providers of case management services (below) have used larger samples and compare peer and non-peer providers of the same service.

Sells, Davidson, Jewell, Falzer, and Rowe (2006) conducted a randomized controlled trial of 137 adults with serious mental illness who received either peer-based case management or regular (i.e. non-peer) case management services. After six months, clients receiving services from a peer case manager perceived significantly higher positive regard, understanding, and acceptance from their peer providers than did participants with a non-peer case manager. These differences were no longer significant at 12 months; however, positive regard and understanding
at six months predicted higher motivation for treatment at 12 months. These results suggest that when peer-providers are in conventional treatment roles, clients may receive additional benefits from a peer-provider’s ability to communicate positive regard and understanding early on in the treatment relationship.

Similar to Sells et al. (2006), Solomon and Draine (1995) examined outcomes of peer-case management among 91 participants with severe mental illness who were randomly assigned to a self-help organization for peer-provided case management or non-peer case management in a CMH setting. The two groups did not differ significantly on outcomes such as housing, employment, social network, symptomatology, or quality of life. However, participants in the peer-case manager group reported significantly lower satisfaction with their overall mental health treatment services, including case management, outpatient therapy, and psychiatric care. These results are somewhat divergent with the later work by Sells that suggests positive outcomes associated with peer-provided case management.

The Experience of Peer-Providers

In addition to client outcomes, it is important to consider the impact of the PSS position for the peers themselves. One qualitative study (Salzer, 2002) sought to identify peer-provider benefits among 14 peer-providers in the Friends Connection peer support program. An interview focused on what the peer-providers like about their job identified several common themes. Most peer-providers indicated their job was rewarding because it facilitated others’ recovery, facilitated their own recovery, and increased their professional growth. Additionally, some participants indicated they obtained social approval, job-related gains (i.e. flexible hours, opportunities for travel), and mutual support. Further, they reported that their job benefited their recovery by providing a supportive environment where they could be themselves. Although
Salzer’s study provides valuable information about the benefits of the peer-provider position, information on potential difficulties experienced by peer-providers was not examined.

Mancini and Lawson (2009) interviewed peer-providers about their experience as a peer-provider and how it impacts their own recovery. Participants were fifteen peer-providers from various agencies. Of these, six participants were working in direct peer-support roles, five in peer education or advocacy roles, three in program development or research roles, and one as a director of consumer affairs. Three themes were identified based on the interview data. The first theme related to participants’ reports of feeling overburdened, experiencing difficulties separating work from their personal lives, and difficulties transitioning from being a client to a provider. Despite these difficulties, this theme also reflected participants’ experience that their work helps others and creates meaning in their lives. The second theme captured participants’ experiences of feeling stigmatized or disrespected by non-peer co-workers. Last, a theme was identified illustrating the benefits participants’ perceived from working in networks of caring fellow peer and non-peer allies.

Mancini and Lawson’s (2009) findings provide important information about the difficulties encountered by peer-providers working in a variety of positions. Their study suggests that the relationship between peer-providers and their colleagues greatly impacts peer-providers’ experience and well-being in their position. Thus, research assessing the experience of both peer-providers and their non-peer colleagues becomes important to consider.

Chinman et al. (2008) explored the challenges of implementing peer-provider positions in the Veteran Affairs (VA) system. Participants were 59 peer-providers and 34 supervisors from VAs across the United States who attended a three-day conference. During the conference, peer-providers and supervisors attended a focus group where they were asked to speak about their
experiences (both positive and negative) working as or with a peer-provider early on in the implementation stage. Notes from the focus group were analyzed but not coded for specific themes. Findings suggested that peer-providers helped treatment teams become more patient-centered and that peer-providers facilitated patient engagement, satisfaction, and empowered patients to be more outspoken about pursuing their own goals. Participants said that the peer-provider’s perspectives are educational for staff and encourage staff and patients to be more hopeful about recovery.

Chinman et al.’s (2008) findings also illustrate the difficulties encountered by peer-providers and supervisors; some participants reported that staff initially feared peer-providers would overstep their roles; however, these fears dissipated over time. Additionally, some issues were raised with regard to developing the peer-provider’s role within the team and finding resources for them as new employees (i.e. office space, computers). Many peer-providers reported that their role felt ambiguous at first and that they would have appreciated more training or supervision. Peer-providers also discussed difficulties transitioning from patient to staff, working with a staff member who was previously their therapist, and experiencing insensitivity or stigma from other staff members.

Paulson et al. (1999) compared the practice patterns of peer and non-peer providers of assertive community treatment case management using activity log data. Results indicated that there were not substantial differences in the amount of direct service or administrative tasks conducted by each group. However, the peer-provider group had higher staff absence and turnover rates than the non-peer group. Additionally, qualitative interviews and observations suggested differences between the groups among four themes. First, with regard to boundaries between providers and clients, it appeared the non-peer providers set firmer boundaries with
clients, identified less with clients, and self-disclosed less than the peer-providers. Second, non-peer providers demonstrated more authority over clients and rigidly followed treatment plans, which seemed to elicit negative reactions from clients. Peer-providers appeared to support clients setting their own treatment goals. Third, non-peer providers appeared more task-oriented and held a strict schedule; conversely, peer-providers valued a supportive (rather than task-oriented) role with clients and were generally flexible in their scheduling. Last, a fourth theme emerged regarding differences between the groups in burden of care. The researchers observed group meetings and noted that non-peer providers disclosed more feelings of burden and fatigue than peer-providers. Paulson et al. did not collect self-report data on burden of care or burnout, so it is unknown whether peer-providers privately experienced burnout; however, in meetings they expressed enjoyment with regard to their work.

Although based solely on observation, Paulson et al. provide some evidence that peer-providers experience a lower degree of burden of care and fatigue (i.e. burnout) than non-peer providers. This is interesting, considering mental illness is associated with increased rates of job burnout in various professions (Mohammadi, 2006; Wang & Guo, 2007; Zhang, Xu, & Jiang, 2006).

**Burnout among Mental Health Professionals**

Burnout is defined as a cognitive and emotional state characterized by “emotional exhaustion, depersonalization, and reduced personal accomplishment” (p. 90, Leiter & Harvie, 1996; Maslach, Jackson, & Leiter, 1996). Burnout is evident among a wide range of professions and is particularly relevant to human service occupations (Leiter & Harvie, 1996). Burnout among human service professionals is associated with a variety of features, such as lack of support from administrators or supervisors (O’Driscoll & Schubert, 1988; Ross, Altmaier, &
Russell, 1989) and role ambiguity (Firth, Mckeown, McIntee, & Britton, 1997). Specifically, psychologists’ level of burnout is associated with client characteristics, excessive workloads, professional self-doubt, and poor quality of management at their workplace (Hannigan, Edwards, & Burnard, 2004).

Early research suggests theoretical orientation of mental health professionals is not associated with burnout (Ackerley et al., 1988; Epstein & Silvern, 1990; Farber, 1985; and Raquepaw & Miller, 1989). Research has not examined levels of burnout among DBT clinicians. This is interesting to consider, given that DBT clinicians work with a high-risk population. BPD has historically been considered difficult to treat; theoretical literature documents the strong negative emotional reactions on part of clinicians working with this population (Adler, 1993, Beck and Freeman, 1990, Linehan, 1993). Furthermore, DBT is a multi-modal treatment that requires therapists provide various services, including taking after-hour phone calls. In summary, DBT is demanding of therapists because of both the challenging population served and intensive treatment protocol.

**Summary of the Literature**

The above review of the literature illustrates the importance of DBT’s adoption in CMH settings, as it is a well-established treatment for a frequently treated high-risk population (i.e. individuals with BPD). Although DBT’s efficacy is based on research using its four primary treatment modalities, a new component, peer-provided services, is being advocated in the Michigan CMH system. Research on peer-provided services suggests beneficial client outcomes, although it is unknown whether these outcomes are improved when peer-provided services are added to intensive treatment programs, such as DBT. Peer-providers may have an enhanced ability to build rapport, support, and empower clients with severe mental illness. Furthermore,
peer-providers may experience personal benefits to their own recovery, as well as some drawbacks and difficulties adjusting to the transition from being a client to provider. Generally, therapists working with peer-providers report positive experiences in their work together, particularly, that peer-providers instill hope in both clients and colleagues. Additional research suggests peer-providers experience less burnout than non-peer-providers.

These findings, coupled with the trend in Michigan, serve as the foundation for the purpose of the present study, which examined the benefits and drawbacks of adding a peer-provided service component to DBT for BPD.

**Methods**

**Purpose and Hypotheses**

Presently, little is known about Michigan CMH’s adoption of peer-providers (titled “Peer Support Specialists”) in DBT programs. As reviewed above, DBT is an empirically supported treatment for BPD that consists of individual therapy, group skills training, 24-hour phone coaching, and weekly consultation meetings for therapists. Adding a Peer Support Specialist (PSS) to this empirical model of care essentially adds an untested fifth mode of treatment. Research has not yet examined whether including a PSS boosts the efficacy of DBT for individuals with BPD; nor do we know how this position affects the PSS. In this model, PSSs are themselves DBT graduates, now working within the same program where they received care. The purpose of the current cross-sectional descriptive study was to improve understanding of the experiences of Peer Support Specialists working on DBT teams. More specifically, this study endeavored to understand the benefits and difficulties experienced by the PSS, the experience of the DBT therapists who work with the PSS, and therapist perceptions of this position’s added value to the traditional DBT package.
Based on the existing literature, the following hypotheses were tested:

1) The performed job duties of the DBT PSSs would vary across DBT teams.
2) DBT PSSs would report a desire for more training, supervision, guidance, or clearly defined job duties.
3) DBT PSSs would report their job is personally rewarding and beneficial to their own recovery.
4) DBT PSSs would report some difficulty transitioning from being a DBT client to provider, but that these difficulties dissipated over time in the position.
5) DBT therapists would report they value having a DBT PSS on their team and perceive that the DBT PSS increases client empowerment and hopefulness.
6) DBT therapists would report difficulty adjusting to working with a PSS in cases where they themselves knew the PSS as a DBT client (i.e. role transition).
7) PSSs would report significantly lower levels of burnout than DBT therapists. Burnout will be defined as high scores on the MBI-HSS depersonalization and emotional exhaustion subscales and low scores on the personal accomplishment subscale indicate burnout (Maslach, Jackson, & Leiter, 1996).

Last, this study will aim to examine properties of a new measure of PSS experiences, including factor analysis. Thus, the following exploratory hypothesis is proposed:

1) Responses on the DBT PSS Experience Questionnaire and DBT Therapist PSS Experience Questionnaire will negatively correlate with burnout as measured by the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996) to further understanding of how various aspects of the PSS position may relate to burnout.
Participants

Two groups form the participants for this study, DBT PSSs and Therapists. Figure 2 illustrates the recruitment process.

*Figure 2. Participant recruitment and participation.*

**DBT Peer Support Specialists.** Approximately twenty-three individuals currently employed as a DBT PSS were invited to participate in this study. The invited PSSs were employed at various CMH agencies across the state of Michigan at the start of the study period. Of these, nineteen DBT PSSs from fourteen different CMH agencies completed participation. DBT PSS participants had been in their position of employment a mean of 1.6 years ($SD = 9.34$ months). Number of months in position ranged from 1 – 36. The DBT PSS participants worked a mean 19.84 hours per week ($SD = 11.31$). The majority of DBT PSS participants were female ($n = 16, 84.2\%$); three male DBT PSSs participated (15.8%). DBT PSS participants had a mean age of 44.21 ($SD = 8.20$) and ranged from 27 to 58 years old. Seven (36.8%) DBT PSS
participants reported their marital status as single, nine (47.4%) were divorced, two (10.5%) were “living with a partner,” and one participant (5.3%) selected “other” as their marital status. None of the sample reported “married” as their marital status. Seventeen participants (89.5%) reported their race to be Caucasian. Regarding income, most participants \( (n = 15, 78.9\%) \) reported their household income as less than $30,000 per year. Four participants (21.1%) reported their income between $30,000-$39,000. Despite markedly low household incomes, most participants had some college or their bachelors degree \( (n = 9, 47.4\%, \) and \( n = 8, 42.1\%, \) respectively). One participant reported having earned a master’s degree, and another reported having a “high school degree or equivalent” as their highest level of education.

Given the nature of the PSS position, information was obtained about PSSs’ treatment history and recent symptoms of BPD. Over half of PSS participants (63.2\%, \( n = 12 \)) indicated they are currently receiving some type of mental health services. Of these, 70.6\% \( (n =12) \) are in individual therapy. Eleven PSS participants (57.9\%) indicated they have received therapy in total seven years or more. Five participants (26.3\%) reported they received therapy for 2-3 years, two (10.5\%) for 4-5 years, and one participant (5.3\%) for 5-6 years. PSS participants reported having been hospitalized for mental health reasons a mean of 4.21 \( (SD = 4.06) \) times. Number of hospitalizations ranged from zero to 18, with a mode of zero. Notably, two participants (10.5\%) reported they have been hospitalized since becoming a DBT PSS.

Participants completed the ten-item McLean Screening Instrument for BPD (MSI-BPD). Only one participant (5.2\%) met BPD criteria based on the MSI-BPD with regard to the past two months. Two additional participants (10.5\%) met BPD criteria when considering the time since beginning their position as a DBT PSS. Thus, three participants (15.7\%) likely met diagnostic criterion for BPD while simultaneously providing treatment for the disorder as a PSS.
**DBT Therapists.** To be eligible to participate, DBT therapists had to currently work on a team with a DBT PSS. Approximately 75 individuals employed as DBT therapists at Michigan CMH agencies met this criteria and were invited to participate. Of these, thirty-seven therapists from fifteen different agencies completed participation. Therapists reported having been employed as DBT therapists a mean of 2.8 years (SD = 27.15 months) and have worked with a DBT PSS a mean of 1.7 years (SD = 9.63 months). Twenty-seven (69.2%) of the DBT therapist participants completed a 10-day intensive training in DBT. The majority of DBT therapist participants were female (n = 32, 86.5%); five male DBT therapists participated (13.5%). Therapists were a mean age of 39 years old (SD = 10.0) and ranged from 27 – 65 years of age. Most (n = 23, 62.3%) DBT therapists were married, seven (18.9%) were single, four (10.8%) were divorced, and three (10.5%) selected “living with a partner,” as their marital status. DBT therapists were primarily Caucasian (91.9%). Regarding income, the majority of participants (n = 33, 89.1%) report their household income between $40,000 and $99,000 per year. One participant (2.7%) reported their income as $30,000-$39,000 and three (8.1%) were in the $100,000-150,000 income range. Nearly all therapist participants had a master’s degree (n = 35, 94.6%). One participant (2.7%) reported having earned their doctorate, and one (2.7%) reported a bachelor’s degree as their highest level of education. A small number of therapist participants (n = 4, 10.5%) indicated they currently receive some form of psychotherapy. Therapist participants were not asked any questions about treatment history.

**Procedure**

The principal investigator (PI) obtained approval from the Eastern Michigan University HSRC for all procedures, including informed consent, before beginning data collection. Informed consent documents for both samples are provided in Appendix A and B.
Potential participants were recruited in three ways. First, the PI attended a DBT PSS training event that many PSSs and DBT therapists attended. The PI described the study to attendees; potential participants provided their email address and were sent a link to participate in the study. Second, DBT therapists and PSSs were invited to participate through email on the Michigan DBT Listserve. The email contained a link to fill out informed consent and questionnaires online, via a SurveyMonkey© online database. Last, participants were given the option to complete hard copies of the questionnaires in person. One team (consisting of three therapists and one PSS) elected to do so, and the PI facilitated participation at their agency. A master’s level research assistant entered these responses into the SurveyMonkey© database.

Data obtained through SurveyMonkey© were stored online, in a password-protected database. All data were completely confidential; participants’ names were not attached to their responses.

**Measures**

Several measures were used in the present study and are described below. Each measure is provided in full in Appendices C – F.

*Demographics Questionnaire (Appendix C).* A brief demographics questionnaire was created to assess basic demographic variables such as age, gender, race, socioeconomic status, and education. The Demographics questionnaire was administered to both samples (DBT therapists and PSSs).

*DBT PSS Experience Questionnaire (PSS-EQ, Appendix D).* The PSS-EQ is a 53-item questionnaire designed for this study that was administered to participants who are DBT PSSs. The questionnaire consists of five short-answer items, seven open-ended items, seven multiple choice items, eight yes or no items, and twenty-six 5-point Likert scale items. The questionnaire
measures the DBT PSS’s job duties, relationship to the agency and DBT team prior to becoming an employee, and benefits and difficulties associated with their job. Likert scale items assessing potential benefits and drawbacks of the DBT PSS job were based on findings from three previously mentioned qualitative studies examining the experience of peer-providers of mental health services (Chinman et al., 2008; Mancini & Lawson, 2009; and Salzer & Shear, 2002).

*McLean Screening Instrument for BPD (MSI-BPD, Zanarini, Vujanovic, Parachini, Boulanger, Frankenburg, Hennen, 2003).* The MSI-BPD is a ten-item yes or no self-report measure designed to screen for symptoms of BPD. A score of seven or higher indicates a diagnosis of BPD. The MSI-BPD has good sensitivity and specificity (.81 and .85, respectively). Two week test-retest reliability indicated .78 agreement between assessments; Chronbach’s alpha internal consistency is .78 (Chanen et al., 2008). For the purposes of the present study, the MSI-BPD was administered to the DBT PSS sample twice, once with the instruction to answer based on the previous two months, and a second time based on the period of time since beginning their position as a DBT PSS. The MSI-BPD was presented to participants within the PSS-EQ and is therefore in Appendix D, items 53-72.

*DBT Therapist Experience with PSSs Questionnaire (Therapist-EQ, Appendix E).* The Therapist-EQ is a 35-item questionnaire designed for the present study. The Therapist-EQ was administered to participants who are DBT therapists. The questionnaire consists of four short-answer items, six open-ended items, three multiple-choice items, four yes or no items, and eighteen 5-point Likert scale items. The Therapist-EQ measures DBT therapists’ perceptions of the benefits and difficulties associated with working on a DBT team with a PSS. Additionally, it assesses the participant’s previous relationship with their team’s DBT PSS (i.e., was the PSS a previous client). Designed to parallel the PSS-EQ, Likert scale items assessing potential benefits
and drawbacks of working on a team that includes a DBT PSS were based on findings from Chinman et al. (2008), Mancini and Lawson (2009), and Salzer and Shear (2002).

*Maslach Burnout Inventory-Human Service Survey (MBI-HSS; Maslach, Jackson, & Leiter, 1996; Appendix F)*. The MBI-HSS was designed to measure burnout among professionals in human service fields. The MBI-HSS consists of 22 seven-point Likert scale items across three subscales: depersonalization, emotional exhaustion, and personal accomplishment. The MBI-HSS is a widely used measure of burnout and has adequate psychometric properties. The measure was normed based on psychologists, therapists, counselors, and other mental health providers, making it an appropriate choice for the proposed study. The internal consistency of the emotional exhaustion, depersonalization, and personal accomplishment subscales are .90, .79, and .71, respectively (Ackerley, Burnell, Holder, Kurdek, 1988; Hallberg & Sverke, 2004; Jackson, Schwab, & Schuler, 1986).

The sum of responses on each subscale determines the score for that subscale; scores can be categorized as a low, moderate, or high. The MBI-HSS does not include an overall burnout score; instead, moderate to high scores on the depersonalization and emotional exhaustion subscales indicate burnout, and low scores on the personal accomplishment subscale indicate burnout. A low score is considered below 16, a moderate score between 17 – 26, and high score is above 27. The MBI-HSS was administered to both PSS and DBT Therapist samples.

**Results**

**Scale Development**

As discussed previously, the present study is the first to assess the practice of including peer-provided services within DBT. To the author’s knowledge, no measures exist that empirically assess this practice. In order to answer the questions sought by this study, two
measures, the PSS-EQ and Therapist-EQ, were created and are the first designed to examine several facets and perceptions of the PSS position. To further develop these measures, internal consistency and exploratory factor analyses were conducted.

**PSS-EQ.** Cronbach’s alpha was computed to determine internal consistency among PSS-EQ items. The PSS-EQ was designed to measure both positive and negative aspects of the PSS position; thus, internal consistency was computed separately for items indicative of positive work experiences and negative work experiences. For the fourteen items depicting positive aspects of the PSS position (items 14-27), Cronbach’s alpha was .97. Cronbach’s alpha was .80 for the twelve items depicting negative work experiences (items 28-39). The internal consistency of the PSS-EQ would increase slightly (Cronbach’s alpha = .81) if item 38 (“I have experienced significant emotional distress in response to my job as a DBT PSS”) were deleted. These results suggest the PSS-EQ may have two internally consistent subscales.

The PSS sample of nineteen participants is too small for confirmatory factor analysis. However, De Winter, Doduo, and Wieringa (2009) suggest that exploratory factor analysis is valuable even with small sample sizes (i.e. samples below 50 participants). Thus, an exploratory factor analysis was performed using principal component analysis with Promax rotation. Initially, results produced six factors with eigenvalues greater than 1. However, three of these factors contained only one item loading. Therefore, factors were restricted based on a scree plot of factor loadings and reviewed. This process resulted in the proposed 2-factor model, which explains 60.4% of the variance in the PSS-EQ. The first factor includes 8 items and is defined as Job Satisfaction. Factor 2 contains 9 items and is defined as Job Discontent. Factor 1 explains 43.7% of variance in the PSS-EQ, and Factor 2, 16.6%. Appendix G provides a table with
eigenvalue and factor loading for each item. Only item loadings .40 and above were considered. Item loadings were in the expected direction and did not cross-load among factors.

Four items on the PSS-EQ did not load at .40 or higher on any factor. Item 23, “Working as a DBT PSS helps me move forward with my career goals,” loaded .39 on Factor 1 and -.082 on Factor 2. Item 30, “I am sometimes uncomfortable that my coworkers (i.e. other DBT therapists) on the DBT team know the details of my history of mental illness” loaded .22 on Factor 1 and .29 on Factor 2. Item 37, “My job as a DBT PSS is highly stressful” loaded -.14 on Factor 1 and .13 on Factor 2. Last, item 38, “I have experienced significant emotional distress in response to my job as a DBT PSS” loaded -.11 and -.12 on Factors 1 and 2, respectively. The factor structure of the PSS-EQ may improve if items 23, 30, 37, and 38 are removed.

**Therapist-EQ.** Cronbach’s alpha was computed to assess internal consistency among Therapist-EQ items. Similar to the PSS-EQ, the Therapist-EQ was designed to measure multiple facets of the PSS position. Thus, the internal-consistency of the scale was calculated separately for items indicative of positive and negative work experiences. For the ten items depicting therapists’ positive views of the PSS position (items 17-26), Cronbach’s alpha was .84. Cronbach’s alpha was .48 for the six items depicting negative work experiences (items 27-32), suggesting this subscale of the Therapist-EQ is not internally consistent and needs further development.

Although the therapist sample is considerably larger than the PSS sample, its N of 37 is smaller than the suggested N = 50 for conducting confirmatory factor analysis. Thus, exploratory factor analysis was conducted for the Therapist-EQ, based on the guidelines in Winter, Doduo, and Wieringa (2009). Initially, principal component factoring with Promax rotation was used, revealing five factors. However, three of these factors each contained three or fewer item
loadings and eleven items cross-loaded among factors. In this model, the first factor accounted for 27.4% of the variance. Based on the scree plot of this variance and theoretical understanding of the scale items, factors were restricted and reviewed. This process revealed a 2-factor model, which accounts for 43.32% of the variance. See Appendix H for a table of item factor loadings and eigenvalues. Only items with loadings above .40 were considered. Factor 1 contained 9 items and was defined as PSS Position Valued. Factor 2, with 4 items, was defined as PSS Position Unsatisfactory. Factors 1 and 2 explained 27.4% and 15.9% of variance in the Therapist-EQ, respectively.

The 2-factor model contains two cross loadings (presented in Appendix H), which indicates items that relate to both factors of the Therapist-EQ. Three items did not load in the expected direction. First, item 23, “Through working with a DBT Peer Support Specialist, I have become more sensitive to the way I talk about mental illness and Borderline Personality Disorder,” cross-loaded on both factors, indicating the item may be considered a positive or negative aspect of working with a DBT PSS. Item 31, “My job as a DBT Therapist is highly stressful,” loaded on Factor 2, which is value in the PSS position. Last, item 30, “I have felt like I had to watch what I say around our DBT Peer Support Specialist” loaded negatively on Factor 1 and positively on Factor 2, indicating the less DBT therapists feel censored by the PSS, the more they are likely to value the PSS position. Two items on the Therapist-EQ did not load at .40 or higher on any factor. Item 28, “We have struggled with getting agency funding to pay for our DBT PSS,” loaded .05 on Factor 1 and .01 on Factor 2. Item 32, “I have experienced significant emotional distress in response to my job as a DBT therapist,” loaded .15 on Factor 1 and .30 on Factor 2. The factor structure of the Therapist-EQ may improve if items 28 and 32 are removed.
Qualitative Analyses

Several open-ended items of the PSS-EQ and Therapist-EQ were analyzed using thematic analysis, organizing responses into recurrent themes (Braun & Clarke, 2006). As recommended by Firth and Gleeson (2004), themes were identified inductively based on the data. In order to analyze the data thematically, units of analysis for coding had to be determined based on each open-ended response. There are various approaches to defining units of analysis within a qualitative data set, and the available data and research questions must be considered (Snrka & Koeszegi, 2007). As recommended by Snrka and Koeszegi (2007), a unit for analysis was defined based on communication of an individual idea, regardless of sentence structure or word count (i.e. “units of meaning”). Data were coded at a semantic level based on the actual text of responses; no themes were created based on perceived underlying latent meaning of responses (Braun & Clarke, 2006). This approach was deemed most appropriate for the present study as data were in written format. Additionally, this approach eliminates researcher bias to the greatest extent possible.

Table 1 provides the mean word count and units of analysis per participant for the Therapist-EQ and PSS-EQ open-ended items. Two items (PSS-EQ item 10, “Why do you think you in particular were chosen to be a DBT Peer Support Specialist?” and Therapist-EQ item 11, “Please describe how your team went about selecting and hiring a DBT Peer Support Specialist”) were excluded from thematic analysis because the patterns of responses were not seminal to the main questions of this study. Responses from Therapist-EQ items 6 and 10 were combined for analysis due to having indistinguishable response patterns. The last items on both measures (PSS-EQ item 78 and Therapist-EQ item 45) were open-ended and asked participants to describe “anything else you think we should know.” No new themes emerged from these data; thus, they
were coded into the pre-existing themes from other items. All other open-ended items on both measures were analyzed individually for themes.

Table 1

*Word Count and Units Analyzed for PSS-EQ and Therapist-EQ Open-Ended responses.*

<table>
<thead>
<tr>
<th>Measure, item number, and topic</th>
<th>Word Count per response $M$ ($SD$)</th>
<th>Units analyzed per response $M$ ($SD$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All responses (both measures)</td>
<td>36.7 (16.1)</td>
<td>2.7 (1.1)</td>
</tr>
<tr>
<td>PSS-EQ all responses</td>
<td>41.6 (18.8)</td>
<td>2.9 (1.1)</td>
</tr>
<tr>
<td>PSS-EQ item 9 – Positive aspects of position</td>
<td>65.9 (53.7)</td>
<td>4.4 (2.5)</td>
</tr>
<tr>
<td>PSS-EQ item 10 – Negative aspects of position</td>
<td>44.9 (50.2)</td>
<td>2.6 (2.8)</td>
</tr>
<tr>
<td>PSS-EQ item 45 – Transition from being a client to a PSS</td>
<td>21.6 (22.7)</td>
<td>1.8 (1.3)</td>
</tr>
<tr>
<td>PSS-EQ item 13 – Training experiences</td>
<td>34.1 (20.8)</td>
<td>2.8 (1.2)</td>
</tr>
<tr>
<td>Therapist-EQ all responses</td>
<td>30.1 (11.7)</td>
<td>2.4 (1.4)</td>
</tr>
<tr>
<td>Therapist-EQ items 6 and 10 – Positive aspects of working with a PSS</td>
<td>42.7 (27.5)</td>
<td>3.9 (1.8)</td>
</tr>
<tr>
<td>Therapist-EQ item 8 – Negative aspects of working with a PSS</td>
<td>28.2 (29.6)</td>
<td>2.1 (1.6)</td>
</tr>
<tr>
<td>Therapist-EQ item 16 – PSS’s transition from client to peer</td>
<td>19.5 (18.8)</td>
<td>1.2 (0.4)</td>
</tr>
</tbody>
</table>

One hundred thirty-six response units were analyzed from the PSS sample; only one response unit was excluded because it was too vague to be understood. From the therapist sample, 298 response units were analyzed. An additional five therapist response units were excluded from analysis because they were either vague, did not relate to the topic of PSSs, or had grammatical errors that made the comment incomprehensible.

**Inter-rater Reliability.** After themes were developed, codebooks were created for each sample, listing and defining each theme (and are provided in Appendices I and J). Inter-rater
reliability was conducted between the PI and one of two trained coders for 10.5% of the therapist sample and 21% of the PSS sample. Data used to calculate inter-rater reliability were selected using a random number generator. Two master’s level research assistants performed the ratings after receiving 90 minutes of coding training. Inter-rater reliability agreement was 90% for the therapist sample and 89.8% for the PSS sample.

Emerging Themes. Twenty-eight distinct themes emerged from the open-ended data in total, which were evenly divided among the samples. These themes create a robust understanding of the addition of the PSS position to the DBT treatment package. Themes capture interpersonal considerations relevant to the team’s functioning as a unit, perceived benefits to clients, and impact of the position on the PSS employee.

PSS data. Fourteen themes emerged from the 136 response units provided by the PSS participants. Table 2 provides all themes identified from PSS’s open-ended responses.

Table 2

Themes revealed based on DBT PSS’s experiences in their position

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoy being a source of inspiration and role model for others</td>
<td>20</td>
</tr>
<tr>
<td>Recognizing the meaningful nature of the work</td>
<td>17</td>
</tr>
<tr>
<td>Enjoy providing validation and making interpersonal connections</td>
<td>14</td>
</tr>
<tr>
<td>Dislike a specific characteristic associated with the position (not related to DBT frame)</td>
<td>13</td>
</tr>
<tr>
<td>Enjoy a specific characteristics or task associated with the position</td>
<td>13</td>
</tr>
<tr>
<td>Transition from being a DBT client to provider was nonproblematic</td>
<td>12</td>
</tr>
<tr>
<td>Desire more job duties or responsibilities</td>
<td>8</td>
</tr>
<tr>
<td>Emotional or stressful nature of the work</td>
<td>8</td>
</tr>
<tr>
<td>Desire formal training specific to DBT PSS role</td>
<td>8</td>
</tr>
<tr>
<td>Empowering work that assists in my own recovery</td>
<td>5</td>
</tr>
<tr>
<td>Position deepens my understanding and appreciation for DBT</td>
<td>5</td>
</tr>
<tr>
<td>Difficulties maintaining boundaries</td>
<td>5</td>
</tr>
<tr>
<td>Difficulties related to the DBT team</td>
<td>4</td>
</tr>
<tr>
<td>Discomfort with dual relationships</td>
<td>4</td>
</tr>
</tbody>
</table>
These themes reflect seven positive and seven negative aspects of the PSS position. Overall, the negative themes were less prominent than positive themes, suggesting that in general, PSS’s view their position favorably. Of the 136 response units analyzed, 86 units were categorized into one of the positive themes and 50 units were categorized into negative themes.

**Therapist data.** Fourteen themes emerged from the Therapist’s responses to open-ended items, which are displayed in Table 3.

Table 3

Themes revealed based on DBT Therapists’ experiences working with a PSS

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS is an effective DBT service provider and team member</td>
<td>84</td>
</tr>
<tr>
<td>PSS is a role model and provides a valuable perspective</td>
<td>67</td>
</tr>
<tr>
<td>PSSs have unique ability to relate to clients</td>
<td>26</td>
</tr>
<tr>
<td>PSS facilitates client engagement and commitment to treatment</td>
<td>23</td>
</tr>
<tr>
<td>No difficulties working with a PSS</td>
<td>16</td>
</tr>
<tr>
<td>Concerns with PSS’s mental health stability and emotional vulnerability</td>
<td>15</td>
</tr>
<tr>
<td>PSS lacks clinical education and work experience</td>
<td>14</td>
</tr>
<tr>
<td>PSS’s transition from being a DBT client to provider was nonproblematic</td>
<td>11</td>
</tr>
<tr>
<td>PSS reduces therapist burnout or workload</td>
<td>10</td>
</tr>
<tr>
<td>PSS struggles to maintaining boundaries with clients or team members</td>
<td>9</td>
</tr>
<tr>
<td>PSS is an ineffective DBT service provider or team member</td>
<td>7</td>
</tr>
<tr>
<td>Problems with administrative issues not specific to DBT model</td>
<td>7</td>
</tr>
<tr>
<td>Discomfort with dual relationships</td>
<td>5</td>
</tr>
<tr>
<td>PSS role or job description is underdeveloped</td>
<td>4</td>
</tr>
</tbody>
</table>

Similar to the PSS sample, seven themes emerged related to therapists’ positive views of the PSS position, and seven themes are indicative of therapists’ negative experiences working with a PSS. Of the 298 response units, 61 were categorized into negative themes and 237 into positive themes. Furthermore, when asked to describe things that have been difficult about
working with a PSS (Therapist-EQ item 8), sixteen responses were categorized into the theme, “No difficulties working with a PSS.”

Thematic analysis of both samples’ open-ended responses on the PSS-EQ and Therapist-EQ helps shed some light on this new practice within DBT. A larger proportion of responses from both samples emerged into favorable themes, suggesting that in general both PSSs and therapists affirm the practice. That said, responses highlighted several difficulties associated with the inclusion of the PSS position. These results provide a foundational understanding to the DBT PSS position and will be further elaborated on with respect to the study hypotheses.

Tests of Hypotheses

Descriptive statistics on the PSS-EQ were calculated to test hypotheses 1-4, pertaining to the experience of DBT PSSs. Similarly, descriptive statistics on the Therapist-EQ were used to test hypotheses related to the experience of DBT Therapists who work with PSSs (Hypotheses 5-6). As discussed above, open-ended items on the Therapist-EQ and PSS-EQ were analyzed using thematic analysis. These qualitative analyses will provide additional evidence to aid discernment of the study hypotheses.

Hypothesis 1. Hypothesis 1 stated that the performed job duties of the DBT PSSs will vary across DBT teams. Descriptive statistics were calculated for PSS-EQ multiple-choice item 6, which is provided in Table 4.

Table 4

<table>
<thead>
<tr>
<th>Testing Hypothesis 1 (Job Duties): PSS-EQ items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multiple-option item</strong></td>
</tr>
<tr>
<td>6a. We would like to understand more about your current job duties or role as a DBT Peer Support Specialist. Please check as many boxes below as apply to your job responsibilities.</td>
</tr>
<tr>
<td><strong>Open-ended items</strong></td>
</tr>
<tr>
<td>6b. Please describe if you lead a different type of group for DBT clients (graduate group, etc).</td>
</tr>
<tr>
<td>6c. Please describe if you have other job duties or roles not listed above.</td>
</tr>
</tbody>
</table>
PSS participants endorsed thirteen job duties in all, which are illustrated in Table 5. All PSS participants reported that they take part in the weekly case-consultation meetings, and a majority meet with clients individually for skill coaching, do administrative tasks related to DBT, make phone calls to clients, and co-lead DBT skills groups. However, several tasks were endorsed by less than half of the sample, such as providing phone coaching and leading DBT orientations. Although there are several job responsibilities shared by the majority of DBT PSS’s, there appears to be just one task universal to the PSS role: participating in case consultation meetings. It seems that overall, the duties performed by DBT PSSs may vary considerably; thus, evidence supports Hypothesis 1.

Table 5

*Job Duties Performed by DBT Peer Support Specialists*

<table>
<thead>
<tr>
<th>Job Duty</th>
<th>Percentage</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I attend weekly DBT team case consultation meetings</td>
<td>100.0</td>
<td>19</td>
</tr>
<tr>
<td>I meet with clients individually to help with skills coaching and understanding skills</td>
<td>89.5</td>
<td>17</td>
</tr>
<tr>
<td>I do administrative work such as making copies of DBT handouts, etc.</td>
<td>78.9</td>
<td>15</td>
</tr>
<tr>
<td>I co-lead one or more DBT skills training classes on a weekly basis</td>
<td>63.2</td>
<td>12</td>
</tr>
<tr>
<td>I make phone calls to remind clients about sessions.</td>
<td>57.9</td>
<td>11</td>
</tr>
<tr>
<td>I give DBT clients rides to skills classes and appointments as needed.</td>
<td>41.2</td>
<td>8</td>
</tr>
<tr>
<td>I am sometimes on-call for the DBT phone coaching line.</td>
<td>36.8</td>
<td>7</td>
</tr>
<tr>
<td>I sit in on DBT skills training classes (or have some other role in the class) but am not one of the two co-leaders.</td>
<td>36.8</td>
<td>7</td>
</tr>
<tr>
<td>Orient new clients to DBT*</td>
<td>31.5</td>
<td>6</td>
</tr>
<tr>
<td>I co-lead DBT skills training classes occasionally, but not on a regular basis</td>
<td>15.8</td>
<td>3</td>
</tr>
<tr>
<td>Lead or co-facilitate graduate group*</td>
<td>15.6</td>
<td>3</td>
</tr>
<tr>
<td>Lead or co-facilitate a different type of DBT-based group (i.e. substance abuse, special needs)*</td>
<td>10.5</td>
<td>2</td>
</tr>
<tr>
<td>Help clients find resources/Case management*</td>
<td>10.5</td>
<td>2</td>
</tr>
</tbody>
</table>

*Descriptive statistics for these items calculated based on open-ended responses to PSS-EQ items 6b and 6c. All other items based on PSS-EQ multiple-choice item 6a.
**Hypothesis 2.** Hypothesis 2 was that DBT PSSs will report a desire for more training, supervision, guidance, or clearly defined job duties. PSS-EQ items relevant to Hypothesis 2 are provided in Table 6.

Table 6

*Testing Hypothesis 2 (Training): PSS-EQ items*

<table>
<thead>
<tr>
<th>Likert-scale items</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>28. I have experienced confusion about my role within the DBT team, or confusion/uncertainty about what my job duties consist of.</td>
<td></td>
</tr>
<tr>
<td>29. I have wanted more guidance, supervision, or training in my work as a DBT Peer Support Specialist.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multiple-option item</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Please indicate how much training on DBT you have had (check as many boxes as apply)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Open-ended item</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Please describe the training, guidance, and supervision you receive for your role as a DBT Peer Support Specialist. Include things like formal trainings as well as individual supervision or training with a supervisor/colleague. What additional training or guidance would be helpful for you to best perform your job?</td>
<td></td>
</tr>
</tbody>
</table>

Descriptive statistics were calculated for responses from PSS-EQ items 28 and 29, which were Likert scale items about concerns related to job responsibilities and training. PSS-EQ multiple-option item 4 provides information on the type of training experiences the PSS sample received. Last, thematic analysis of PSS-EQ open-ended item 13 helped to inform this hypothesis.

Frequency counts for types of training PSS’s received for their position is provided in Table 7. Over half of participants reported engaging in individual study, 2-day DBT trainings, 5-day PSS trainings, and learning DBT through personal experience as a client. Slightly under half of PSSs have completed 10-day intensive DBT training, which is the standard for DBT therapists.
Table 7

Training activities completed by DBT PSSs

<table>
<thead>
<tr>
<th>Training experience</th>
<th>Percentage</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual study (reading DBT manuals, etc)</td>
<td>84.2</td>
<td>16</td>
</tr>
<tr>
<td>2-Day DBT training workshop</td>
<td>63.2</td>
<td>12</td>
</tr>
<tr>
<td>5-Day Certified Peer Support Specialist training</td>
<td>63.2</td>
<td>12</td>
</tr>
<tr>
<td>Personal experience as a DBT client</td>
<td>57.9</td>
<td>11</td>
</tr>
<tr>
<td>10-Day intensive DBT training</td>
<td>47.4</td>
<td>9</td>
</tr>
<tr>
<td>5-Day foundational DBT training</td>
<td>36.8</td>
<td>7</td>
</tr>
<tr>
<td>DBT Peer Support Specialist training event</td>
<td>36.8</td>
<td>7</td>
</tr>
<tr>
<td>Plan to complete 5 or 10-Day DBT training in the next year</td>
<td>10.5</td>
<td>2</td>
</tr>
<tr>
<td>Half-day DBT training event</td>
<td>10.5</td>
<td>2</td>
</tr>
<tr>
<td>Completed online DBT training</td>
<td>5.3</td>
<td>1</td>
</tr>
</tbody>
</table>

Part 1: Desire for training and guidance. On PSS-EQ item 29 (“I have wanted more guidance, supervision, or training in my work as a DBT Peer Support Specialist”), five participants (26.3%) indicated a desire for more training, guidance, or supervision. Seven (36.8%) participants did not report a desire for more guidance, supervision, or training in their position, and another seven participants indicated they feel “neutral” about this issue. Analysis of the PSS-EQ open-ended item #24 revealed five themes; two of these were training experiences in concordance with those listed in the PSS-EQ item 4 (“Attending formal DBT and PSS trainings,” and “studying DBT materials on their own”). Additionally, responses were coded into the themes “Regular meetings with a supervisor,” “Consultation with DBT team,” and, “Desire more DBT PSS specific training.” Virtually all responses that suggested a desire for more training fit into this last category. For example, one peer wrote, “I’d like workshops on how to share our recovery story, and what not to share.”
Although the DBT therapist sample was not directly asked about their opinion of PSS training, when open-ended responses were analyzed thematically, the theme “PSS lacks clinical education and work experience” was revealed, describing therapists concerns that PSSs do not have sufficient training. One therapist stated, “I cannot rely on her to educate the members in group as well as I would another trained therapist. She continues to have insecurities, and does not offer input as much as she could. Her lack of therapy experience hinders her from understanding certain things on a deeper level.” Another therapist reported, “Her clinical skills are very limited and that at times causes misunderstandings in the application of DBT.” As illustrated in Table 3, the theme “PSS lacks clinical education and work experience” was one of the most significant concerns revealed by the open-ended data.

**Part 2: Confusion about role within DBT.** Hypothesis 2 also questioned whether DBT PSSs experience confusion about their role within the DBT team or with regard to their specific job duties. This was assessed based on PSS-EQ item 28 (“I have experienced confusion about my role within the DBT team or confusion/uncertainty about what my job duties consist of”). Responses indicated PSSs were divided on this issue. Nine participants (47.4%) reported they have experienced confusion about their role or job duties and six participants (31.6%) denied that this has been a concern for them. Four participants (21.1%) were neutral on this issue.

**Hypothesis 2: Summary of results.** Based on these results, it seems that training among PSSs is inconsistent and below the training standards expected of DBT therapists. The majority of PSSs do not report lack of training as a concern despite the finding that less than half have received 5-10 days of DBT training. Qualitative analyses suggested some PSSs desire more training specific to the DBT PSS position. Approximately half feel confusion about their position and job responsibilities. Thus, there is insufficient evidence to support Hypothesis 2, as the
majority of PSSs do not report concern with training or job definition. Trends in the data on training are worrisome.

**Hypothesis 3.** Hypothesis 3 stated that DBT PSSs will report their job is personally rewarding and beneficial to their own recovery. Descriptive statistics of PSS-EQ items 28-29 and 31-34 were calculated to test this hypothesis. Additional information related to this hypothesis was obtained through thematic analysis of PSS-EQ item 18, which was an open-ended question inquiring about positive aspects of PSS’s position. See Table 8 for the PSS-EQ items relevant to Hypothesis 3.

Table 8

**Testing Hypothesis 3 (Personal Benefits): PSS-EQ items**

<table>
<thead>
<tr>
<th>Likert Scale Items</th>
<th>Open-ended Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. It is rewarding to watch DBT clients get better.</td>
<td></td>
</tr>
<tr>
<td>18. I like being able to use my experience with mental illness and DBT to help others.*</td>
<td>In your own words, please describe the things you like about being a DBT Peer Support Specialist. Please take your time and include as much detail as possible.</td>
</tr>
<tr>
<td>20. Working as a Peer Support Specialist has benefited my own recovery from mental illness.*</td>
<td></td>
</tr>
<tr>
<td>21. Working as a DBT Peer Support Specialist has encouraged me to continue using DBT skills.</td>
<td></td>
</tr>
<tr>
<td>22. Working as a Peer Support Specialist improves my self-esteem or self-confidence.*</td>
<td></td>
</tr>
<tr>
<td>23. Working as a Peer Support Specialist helps me move forward with my career goals.</td>
<td></td>
</tr>
</tbody>
</table>

Note. *One participant did not completed PSS-EQ items 18, 20, and 22; the total N for these items is 18.

The majority of the sample agreed with the relevant PSS-EQ items (listed above) pertaining to the rewarding nature of the work and benefits to personal well-being or mental health. In particular, 94.5% (n = 17) of the PSSs reported they like being able to use their experience with mental illness and DBT to help others. Eighty-nine percent (n = 19) of PSSs indicated it is rewarding to watch DBT clients get better and that the position benefits their own mental health, improves their self-esteem or self-confidence, and encourages them to continue using their DBT skills. Over half of participants (n = 15, 78.9%) reported that their position as a
PSS helps them move forward with their career goals. However, three participants (15.8%) were neutral on this item and one (5.3%) disagreed.

Several positive themes were identified through thematic analysis of PSS-EQ item 9 and are provided in Table 2 (p. 45). The most prominent theme reported by PSSs was “Enjoy being a source of inspiration and role model for others.” For example, one participant stated, “I like giving examples of my personal experiences to try and help support consumers, and to help therapists increase their empathy toward the clients they work with.” Another participant stated, “I enjoy being a peer support because I feel I offer a glimmer of hope and the reality of BPD before, during, and after DBT.”

Several responses were categorized as “Recognizing the meaningful nature of the work.” One participant reported, “I am passionate about what I do because these skills have worked for me. It's like teaching someone to fish instead of handing him a fish - he can eat forever if he learns to fish. If I pass on the skills, a peer can take ownership of her own recovery and be empowered.” Clearly, the altruistic nature of the work is cherished by many DBT PSSs.

Last, the theme “Empowering work that assists in my own recovery,” was identified and particularly relates to Hypothesis 3. For example, one participant wrote, “I like that I can use what I thought was a ‘bad thing...having a mental illness’ to my and others’ benefit. This has led me to accept my mental illness and know there was a reason for what I went through in my life.” Overall, Hypothesis 3 was well supported by both quantitative and qualitative results; the PSS position is generally reported to be rewarding and beneficial to PSSs’ recovery.
**Hypothesis 4.** Hypothesis 4 indicated that DBT PSSs will report some difficulty transitioning from being a DBT client to provider, but that these difficulties would dissipate over time in the position. To help inform this hypothesis, descriptive statistics for PSS-EQ items 40-44 were calculated to determine PSSs’ previous relationships with their agency of employment. Over half the PSSs (57.9%, n = 11) work in the same agency/facility where they previously received or currently receive mental health services. Four PSSs (22.2%) work on a DBT team where they previously received services and currently work with one of their previous DBT group skills-trainers. Six PSSs (33.3%) currently work with their previous individual therapist. The majority of PSS participants (83.3%, n = 15) reported they do not currently provide services to clients they used to be in skills classes with; however, three (16.7%) PSSs do provide services to such clients. Percentages for several PSS-EQ items (43-50) were calculated to determine difficulties related to role transitions and dual relationships. These items are provided in Table 9.

Table 9  

**Testing Hypothesis 4 (Dual Relationships): PSS-EQ items**

<table>
<thead>
<tr>
<th>Likert Scale Items</th>
<th>Open-ended Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. I am sometimes uncomfortable that my coworkers (i.e. other DBT therapists) on the DBT team know the details of my history of mental illness.</td>
<td>45. If you responded yes to one or more of items 40-44, have any of these changes in roles been problematic or uncomfortable? Please explain in as much detail as possible.</td>
</tr>
<tr>
<td>31. I am unsure how much I should disclose to DBT clients about my history of mental illness.</td>
<td></td>
</tr>
<tr>
<td>32. I found the transition from being a DBT client to DBT staff challenging in some way or another.*</td>
<td></td>
</tr>
<tr>
<td>33. Working as a service provider for clients I used to be in skills classes with has been difficult.*</td>
<td></td>
</tr>
<tr>
<td>34. Being a co-worker with people who used to be my DBT therapist(s) has been difficult.*</td>
<td></td>
</tr>
<tr>
<td>35. My DBT team members treat me as fragile or patronize me because of my history of mental illness.</td>
<td></td>
</tr>
<tr>
<td>36. My DBT team members have made insensitive or inappropriate comments about mental illness.</td>
<td></td>
</tr>
<tr>
<td>39. My job as a DBT Peer Support Specialist would make it more difficult to seek treatment (i.e. therapy) if I desired it.</td>
<td></td>
</tr>
</tbody>
</table>

Note. N = 19. *One participant did not completed PSS-EQ items 32, 33, and 34; the total N for these items is 18.
Figure 3 illustrates participants’ endorsement of these items. Fifty percent of PSSs (n = 9), reported they did not have difficulty with the transition from being a DBT client to DBT staff. Four participants (22.3%) agreed this transition had been difficult, and five (27.8%) were neutral. No participants indicated they experienced difficulty working with a previous therapist (PSS-EQ item 47), although half (50.0%, n = 9) responded “neutral” to this issue. Additionally, no participants reported difficulty with providing services to clients they were previously in skills classes with (PSS-EQ item 46).

![Figure 3. PSS’s Report of Discomfort with Dual Relationships.](image)

Additional information related to this hypothesis was obtained through thematic analysis of PSS-EQ item 45, which was open-ended. Fourteen participants responded to this item, with sixteen comments. Comments were coded into two themes: “transition from being a DBT client to provider was nonproblematic” and “discomfort with dual relationships,” both of which are listed above in Table 2. Of the four comments placed in the “discomfort with dual relationships” theme, discomfort was described as generally mild and resolved over time. For example, one participate wrote, “Working with my previous individual therapist took more getting used to, as
it was a pretty dramatic change in our relationship.” One participant described beginning work as a PSS while continuing to receive individual therapy with a colleague: “When I first became a Peer almost 2 years ago, my therapist was on the team with me. She still is but I have now changed companies in which I get therapy. This was an uncomfortable situation for both of us, that is why the change. Now everything is good.”

Based on both qualitative and quantitative findings, it appears that the transition from being a DBT client to service provider is generally nonproblematic. Although some concerns arise when working with a previous therapist, it appears this discomfort is resolved over time; thus, results supported Hypothesis 4.

**Hypothesis 5.** Hypothesis 5 stated that DBT therapists will report they value having a DBT PSS on their team and that the DBT PSS increases client empowerment and hopefulness. Descriptive statistics of Therapist-EQ Likert Scale items 22-23, 25-26, and 28-30 were calculated to test this hypothesis. Thematic analysis of Therapist-EQ open-ended items 6 and 12 provided additional information related to Hypothesis 5. All items used to test Hypothesis 5 are presented in Table 10.
**Table 10**

*Testing Hypothesis 5 (Therapist Value): Therapist-EQ items*

<table>
<thead>
<tr>
<th>Likert Scale Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Our DBT PSS facilitates client satisfaction and/or engagement.</td>
</tr>
<tr>
<td>19. Our DBT PSS empowers clients to be more outspoken about pursuing their own goals.</td>
</tr>
<tr>
<td>21. I am very glad to have a DBT PSS on our team.</td>
</tr>
<tr>
<td>22. If I were to transfer to another CMH DBT team, whether or not the team had a DBT PSS would</td>
</tr>
<tr>
<td>influence my decision, as I would want to work on a team with a PSS.*</td>
</tr>
<tr>
<td>24. Our DBT PSS helps clients be more hopeful that recovery from mental illness is possible.±</td>
</tr>
<tr>
<td>25. Our DBT PSS helps me be more hopeful that my clients can recover from mental illness.</td>
</tr>
<tr>
<td>26. Having a DBT PSS on our team makes my job easier and/or less stressful.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Open-ended Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. In your own words, please describe the things you like about having a DBT Peer Support Specialist on</td>
</tr>
<tr>
<td>your DBT team. Please take your time and provide as many details as possible.</td>
</tr>
<tr>
<td>10. In your opinion, what added value does the Peer Support Specialist position add to the DBT</td>
</tr>
<tr>
<td>treatment package? In other words, how does including a Peer Support Specialist on DBT teams improve DBT</td>
</tr>
<tr>
<td>service delivery? Please take your time and provide as many details as possible.</td>
</tr>
</tbody>
</table>

Note. Total N = 37. *Two participants did not complete Therapist-EQ item 22. The total N for this item is 35. ± One participant did not complete Therapist-EQ item 24. The total N for this item is 36.

**Part 1: Therapist value of PSS position.** Most therapist participants (91.9%, n = 34) either “agreed” or “strongly agreed” that they were very glad to have a PSS on their team.

Eighty-one percent of therapists (n = 30) indicated the DBT PSS on their team increases therapist hopefulness that their clients may recover from mental illness. Therapists’ responses were more divided on other items. Although over half of participants believed having a DBT PSS made their jobs easier or less stressful, 13.1% disagreed and 26.3% were neutral. When asked whether a DBT team’s inclusion of a DBT PSS would influence a therapist’s decision to transfer agencies, 51.4% indicated this would be a factor, as they would want to work on a DBT team.
with a PSS. The remaining therapists responded “neutral” (28.6%, \( n = 10 \)) or “disagree” (20%, \( n = 7 \)).

As shown in Table 3, the vast majority of therapist’s open-ended responses were categorized by the theme, “PSS is an effective DBT service provider and team member.” This theme included general praise for DBT PSS’s, such as “PSS is an asset to our team,” and “helpful in every aspect of DBT program.” Other responses included in this category were positive comments about the PSS’s job performance in DBT-related tasks. These included statements such as “Helps with client’s understanding and generalization of skills,” “Instrumental in skills group and orientations,” and “Helps clients with diary cards and homework.”

**Part 2: PSS position increases client hopefulness and empowerment.** All of the therapist participants responded that they believe the DBT PSS helps clients be hopeful that recovery from mental illness is possible (100%, \( n = 36 \)). Over eighty percent of therapist participants believed the DBT PSS facilitates client satisfaction and engagement in treatment (\( n = 32 \)) and empowers clients to pursue their goals (\( n = 31 \)).

A second prominent theme revealed by the therapist open-ended responses was “PSS is a role model and provides a valuable perspective.” This theme included comments about the PSS’s ability to model recovery, share a unique perspective, and facilitate hope and inspiration for both DBT clients and therapists. For example, one therapist participant wrote, “It is helpful to have someone that can provide hope from their own experiences and can be supportive in a different way. The peer can offer a different perspective.” Another stated, “She often gives ‘pearls of wisdom,’ I call them. They are unique perspectives. She is open about how far she's come and ways that DBT skills and philosophy have impacted her life positively.” Similarly, a therapist
described, “Our peer has provided hope and inspiration to members of the group as they see how she has overcome her struggles to become successful. She helps therapists with seeing the consumers’ point of view. She helps keep us in check when we become judgmental.”

Additionally, the theme “PSS facilitates client engagement and commitment to treatment” emerged from the open-ended data. This theme included responses such as “the peer helps keep clients engaged in treatment,” “Our peer gets new client’s [sic] committed to DBT,” and “the PSS keeps clients’ motivations high.”

**Hypothesis 5: Summary of results.** Approximately half of the therapist participants reported they “Agree” or “Strongly Agree” with all of the items relevant to Hypothesis 5. Of these, some items were endorsed by all, or nearly all, therapist participants. The themes, “PSS is an effective DBT service provider and team member,” “PSS is a role model and provides a valuable perspective,” and “PSS facilitates client engagement and commitment to treatment,” further illustrate the perceived value of this position. Thus, extensive support was found for Hypothesis 5.

**Hypothesis 6.** Hypothesis 6 stated that DBT therapists will report difficulty adjusting to working with a PSS in cases where they themselves knew the PSS as a DBT client. All items used to test Hypothesis 6 are presented in Table 11.

**Table 11**

**Testing Hypothesis 6 (Dual Relationships): Therapist-EQ items**

<table>
<thead>
<tr>
<th>Yes or No Items</th>
<th>Open-ended Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. The Peer Support Specialist on our DBT team used to be my individual therapy client.</td>
<td>16. If you responded yes to one or more of items 15-19, have any of these changes in roles been problematic or uncomfortable? Please explain:</td>
</tr>
<tr>
<td>14. I was at one point a skills trainer for the Peer Support Specialist on our DBT team</td>
<td></td>
</tr>
<tr>
<td>15. Our DBT Peer Support Specialist provides services to clients who she or he used to be in a skills class with.</td>
<td></td>
</tr>
</tbody>
</table>
Descriptive statistics for three items (13-15) on the Therapist-EQ provide information on therapists’ previous relationships with their PSS. The majority of therapist participants (89.5%, $n = 34$) reported they have never provided individual therapy to their team’s DBT PSS. Each of the four participants who served in this role reported they provided individual therapy to their current PSS for 2 years. Twenty percent ($n = 7$) of therapist participants had previously been a skills trainer for their current PSS. Thus, there were eleven therapist participants in total (29.7%) who provided services to their current PSS. Last, the majority of therapists (81.1%, $n = 30$) indicated their team’s DBT PSS does not provide services to clients they used to be in a skills class with; this is consistent with PSS data.

Thematic analysis of Therapist-EQ open-ended item 16 was utilized to provide information about potential challenges therapists face with regard to role transition. Fifteen therapists responded to item 16, with a total of sixteen comments. These comments were coded into two themes: “PSSs transition from being a client to provider was nonproblematic” and “Discomfort with dual relationships.” These themes parallel the themes revealed by PSS’s data on role transitions in Hypothesis 4: “Transition from being a DBT client to provider was nonproblematic” and “Discomfort with dual relationships.” Figure 4 illustrates these emerging themes for both samples.
Eleven therapist comments were categorized as “No problems with transition.” Five comments fell into the “Discomfort with dual relationships” theme. Of these, three comments raised concerns about dual relationships but indicated the discomfort occurred initially and was resolved. For example, one participant stated, “PSS was a consumer of mine ... It was an adjustment for us but he really has led the way and we have worked out any issues by being open, honest. It’s really great and it IS related to the person's maturity and professionalism.”

Based on these findings, it appears that DBT therapists in general do not experience difficulty adjusting to working with a PSS, even when they have had a previous therapeutic relationship. Thus, Hypothesis 6 was not supported.

**Hypothesis 7.** Hypothesis 7 stated that DBT PSSs will report lower levels of burnout than DBT Therapists. For the present study, burnout is defined as moderate to high scores on the MBI-HSS depersonalization and emotional exhaustion scales and low scores on the personal accomplishment scale. Figure 5 provides an illustration of mean scores on the MBI-HSS subscales for both samples.
This hypothesis was tested using independent samples t-tests to compare DBT therapists and PSSs on each MBI-HSS subscale. Significant differences were found on the depersonalization scale \( (t = -2.79, p = .007) \); PSSs obtained a mean score in the low range \( (M = 6.89, SD = 2.47) \) and therapists in the moderate range \( (M = 9.40, SD = 4.25) \). There were no significant differences between groups on the emotional exhaustion or personal accomplishment subscales. PSSs mean score for the emotional exhaustion subscale was 23.83 \( (SD = 10.22) \) and therapists 26.73 \( (SD = 8.01) \), both of which fall in the moderate range of burnout. On the personal accomplishment subscale, both PSSs and therapists had high scores, indicating low burnout \( (M = 48.11, SD = 5.90, \text{ and } M = 47.88, SD = 5.52, \text{ respectively}) \).

In addition to t-tests, Pearson’s correlations were computed between the MBI-HSS subscales and items on the PSS-EQ and Therapist-EQ. Several significant correlations were found between
the PSS-EQ and MBI-HSS subscales; these are provided in Appendix K. The Emotional Exhaustion subscale correlated significantly with PSS-EQ items: “I have wanted more guidance, supervision, or training in my work as a DBT PSS” (.74, p < .001), “My job as a DBT PSS is highly stressful” (.62, p < .001), and “I have experienced significant emotional distress in response to my job as a DBT PSS” (.68, p < .001). Notably, the last item also correlated significantly and positively with the Depersonalization (.72, p < .001) and Personal Accomplishment (.65, p < .001) scales. Thus, PSSs’ experience of emotional distress relates to an increase in certain aspects of burnout but does not appear to indicate reductions in feelings of accomplishment with respect to their work. The Personal Accomplishment scale correlated with several additional PSS-EQ items, such as: “It is rewarding to watch DBT clients get better” (.67, p < .001), “I like being able to use my experience with mental illness and DBT to help others” (.63, p < .001), and “I like the opportunities for learning, training, or obtaining work experience” (.64, p < .001).

A significant correlation was found between Emotional Exhaustion and the Therapist-EQ item “I have experienced significant emotional distress in response to my job as a DBT Therapist” (.43, p < .01), indicating that higher degrees of emotional distress at work relate to emotional aspects of burnout. No other Therapist-EQ items significantly correlated with the MBI-HSS subscales.

**Hypothesis 7: Summary of results.** Both therapist and PSS participant groups seem to experience moderate levels of the Emotional Exhaustion domain of burnout and have a high sense of Personal Accomplishment with respect to their work. However, one statistically significant difference existed between the groups, in that DBT PSSs levels of Depersonalization
were not indicative of burnout, but therapists were. Thus, Hypothesis 7 is partially supported by these results.

**Unanticipated Themes**

Several themes emerged through thematic analysis that were not hypothesized. Each of these related to negative aspects of the PSS position and included administration, interpersonal, and emotional issues. Although initially presented in Tables 2 and 3, these unexpected themes are illustrated in Table 12.

Table 12

*Emerging themes not anticipated by study hypotheses*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapist Sample</strong></td>
<td></td>
</tr>
<tr>
<td>Concerns with PSS’s mental health stability and emotional vulnerability</td>
<td>15</td>
</tr>
<tr>
<td><strong>PSS Sample</strong></td>
<td></td>
</tr>
<tr>
<td>Dislike a specific characteristic associated with the position (not related to DBT frame)</td>
<td>13</td>
</tr>
<tr>
<td>Emotional or stressful nature of the work</td>
<td>8</td>
</tr>
<tr>
<td>Difficulties maintaining boundaries</td>
<td>5</td>
</tr>
<tr>
<td>Difficulties related to the DBT team</td>
<td>4</td>
</tr>
<tr>
<td>Discomfort with dual relationships</td>
<td>4</td>
</tr>
</tbody>
</table>

Thirteen PSS responses were categorized by the theme “Dislike a specific characteristic associated with the position,” which included problems related to limited resources, pay, or job responsibilities outside of their role as a DBT PSS. For example, one participant stated she disliked “only being able to work 15 hours a week or it will jeopardize my Social Security Disability. I would love to work more hours in a week. I have to share my desk, computer, and
office space with others. I don’t have my own copy of the Skills Training Manual and Treatment book, a photocopy was made."

Three themes emerged describing difficulties that are more interpersonal in nature. These were “Difficulties maintaining boundaries,” “Difficulties related to the DBT team,” and “Discomfort with dual relationships.” However, these themes were created based on a small number of responses (5, 4, and 4, respectively), indicating they are concerns experienced by a minority of PSSs. For example, one PSS wrote “The biggest challenge I have had is learning to set firm boundaries and limits with the consumers I work with. I try to not get caught up in the drama of their lives or validate unhealthy behaviors, while still letting them know that I understand where they are coming from (as I have had similar experiences).” Another described difficulties related to working with her DBT team: “Depending on the leader of the skills group, sometimes I feel as if my skills as a Peer are not appreciated. I was told, ‘You don't understand, you are just a Peer, I have my masters degree’.”

PSS participants also reported struggling emotionally with being a DBT provider. Eight responses were categorized by the theme “Emotional and stressful nature of the work.” One participant wrote, “I find it stressful when people engage in target behaviors on site and I have to address them and intervene.” Another stated, “Witnessing the suffering and fragile/aggressive states of folks seeking treatment is difficult. It is sometimes hard to shake off the nightmarish things we hear on any given work day.”

Interestingly, thematic analysis of DBT therapist data revealed a similar concern about PSSs emotional well-being. Fifteen responses created the theme “Concerns with PSS’s mental health stability and emotional vulnerability.” For example, one therapist wrote, “I worry about how our peer manages the demands of her job in relation to staying in recovery of her mental
illness.” Similarly, a therapist reported, “There is concern about relapse in symptoms due to the stress of the job and the intensive training schedule. At times attendance concerns have come up because of stress.” Another explained, “The PSS at times acts as though she needs to be treated fragile. I fear insulting her when it would not other therapists (i.e. someone not wanting a peer, explaining a diagnosis, etc.).”

Discussion

Participants

**DBT Peer Support Specialists.** PSSs participants were primarily middle-aged single women with relatively low incomes and limited educational attainment. The low income bracket of the PSS sample makes sense given most PSSs do not work full-time and may receive Social Security Disability for mental illness. Given 75% of individuals diagnosed with BPD are female and relatively few males have been documented in DBT treatment outcome literature, it was somewhat surprising that three male PSSs participated in the present study (15.7% of the PSS sample). No studies have compared gender differences with respect to DBT, as most RCTs of the treatment have only included female samples. Because of the very small number of male participants in the current study, no trends about their experience can be seen; however, if there is an increasing number of males participating in DBT at all levels, including becoming PSSs, more research clearly needs to be done to better understand how their experiences may differ from that of women. For example, are men perceived as more competent graduates of DBT programs and therefore more likely to be chosen for a PSS position? Do female DBT clients perceive male PSSs differently than female PSSs? Answers to these questions may help inform how to best meet the needs of both male and female DBT clients and PSSs. However, it is plausible that the number of men in this sample is due to pure chance. A larger scale study of
DBT PSSs would reveal whether the proportion of male PSSs is truly greater than expected given demographics of the diagnosis.

Beyond basic demographics, participants in the present PSS sample reported extensive histories with hospitalization and psychotherapy, validating that this is a group who has indeed experienced serious mental illness. Regarding current recovery status, most PSSs continue to receive psychotherapy. A small number of the PSS sample had been hospitalized since beginning their position and continue to meet criteria for BPD based on the screening instrument used in this study. According to the American Psychological Association (APA) ethics code, “Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner” (APA, 2002). While peers are not psychologists and therefore do not fall under the APA ethics code, the principle behind this particular code would appear to be relevant to any treatment provider, including PSSs.

As mentioned previously, DBT peer-providers currently do not have a widespread published code of ethics. The ethics code of Certified Peer Support Specialists includes a statement on maintenance of healthy behaviors; however, it fails to include standards related to competence and personal problems. Given the de facto mental health history of PSSs, it is problematic that this concern has not been more carefully considered and written about. It is not known whether the PSSs who reported exacerbation of illness during the time they have been a PSS reported their condition to their employers and/or if their condition impaired their ability to work. It would be very useful to understand more about how these situations were dealt with to better inform policy making as the practice the inclusion of DBT PSSs becomes more widespread. We would like to assume during the time frame that PSSs were symptomatic (e.g.
psychiatrically hospitalized) they were relieved of their duties; however, there is no evidence of such. Moreover, given that some participants still met criteria for BPD, it would be useful to understand whether or not being in the clinical range of functioning is considered in the process of being discharged from DBT treatment and being considered for the role of PSS.

At the same time, there is a delicate balance between individual rights and protection of the public that must be observed. For example, the Americans with Disabilities Act prohibits discrimination based on mental illness. Mental health workers are not routinely questioned with regard to their own mental health history. Yet, once a history is known, there is a duty of supervisors to ensure that therapists and by extension, paraprofessionals, are competent to provide care to vulnerable populations. Even in the case of this study, DBT therapists were not asked to complete the same mental health inventories as the PSSs, primarily for fear of offending this population. With all of these complexities noted, there is much about the interplay between the job demands, mental health history, and present psychological functioning of PSSs that needs to be researched and articulated.

**DBT Therapists.** Therapist participants were primarily middle-aged married women with income in the $40,000-$90,000 range. Therapists reported a much higher household income than PSSs, which was expected given they were on average highly educated, married, and employed full time. The lower end of this income range is surprisingly minimal for a married household, especially considering most therapists had earned their master’s degree. We do not know the mental health histories of the DBT therapist sample and this would be an interesting question for future research when comparing these groups.

**Rate of participation.** Although the sample of DBT therapists was much larger than PSSs, the rate of participation by PSSs was much higher. Nearly all PSSs invited to participate
did so, compared to approximately half of therapists recruited. One reason for the higher rate of completion among PSSs might be a difference in the value of the position. Although overall it seems both PSSs and therapists view the PSS position as a positive addition to DBT, perhaps the position is particularly meaningful for the individuals who hold the PSS position. Given the DBT PSS movement is in its youth, there is motivation to participate in research that could potentially further the development of this new approach to treatment. Thus, PSSs likely felt compelled to do so, perhaps more so than DBT therapists. Additionally, PSSs are aware that they are a small group and may have felt less diffusion of responsibility than therapists.

As previously discussed, individuals with severe mental illness face stigma and discrimination. While this stigma underlies the need for peer-provided services, peer-providers also experience differential treatment in their agencies. Individuals with BPD have historically been viewed negatively by clinicians (Adler, 1993; Beck & Freeman, 1990; Linehan, 1993); thus, DBT PSSs may be an especially likely to experience marginalization from their colleagues. The broad PSS movement addresses this stigma by emphasizing the importance of vocalization. Some PSSs authors (outside of DBT) have gone so far as to say, “Nothing written about us, without us” (Clay, 2005). This spirit may carry to the DBT PSSs in the present study, who perhaps viewed participation as an important opportunity to have their voice heard.

In addition to the above intrinsic motivators, this study provided extrinsic incentives to participate in the form of a drawing for gift cards. This opportunity could have been more appealing to the PSS sample than the therapist sample for several reasons. First, a drawing for two $120 gift cards was awarded in each sample. Potential participants were notified of the odds of winning, which were considerably higher for the small PSS sample. Additionally, the amount of money rewarded is likely more significant to the PSS sample, who are of considerably lower
incomes than DBT therapists. Finally, most PSSs are employed part-time, and as revealed in this study, have inconsistent job duties. Full-time DBT therapists may simply have had less time during their workday to complete the online questionnaires.

**Workplace dynamics.** It is important to consider how the above demographics influence the workplace dynamic between therapists and PSSs. On all teams, therapists outnumber PSSs, and most DBT teams include only one PSS. Therapists and PSSs are both primarily female and are similar in age. However, therapists are likely to be married, more educated, and earn higher incomes than PSSs. These factors could create a difference in lifestyle between therapists and PSSs that hinders sense of equality. Furthermore, therapists know about the PSS’s history of mental illness simply by function of their position, and in some cases because they had previous clinical relationships with the PSS employee. It is often assumed DBT therapists are mentally healthy; their current and past mental health status is generally considered private information. That the therapists and PSSs in this sample were similar in other ways, such as age and sex, may help create a sense of camaraderie and mutual understanding. DBT promotes egalitarian relationships between therapists and clients; thus, therapists practicing DBT may be less likely to create a power differential when working individuals different from them in SES and history of mental illness.

**Scale Development**

Two measures were created for the present study, the PSS-EQ and Therapist-EQ. The primary purpose of these measures was to provide descriptive data to inform study hypotheses. To the author’s knowledge, these are the first measures created to examine the DBT PSS position. As this is a new and emerging area of research, it is possible the PSS-EQ and Therapist-EQ could be adapted for use in future studies on the provision of peer-provided services within
DBT. Thus, exploratory analyses were conducted to examine the internal consistency and factor structure of these new measures.

**PSS-EQ.** Exploratory factor analysis revealed a 2-factor model for the PSS-EQ. Internal consistency of each factor was good. It appears the PSS-EQ consists of two subscales, one which examines positive aspects of DBT PSS’s position, and one that examines negative aspects of the job. These subscales were named Job Satisfaction and Job Discontent, respectively. Future development of the PSS-EQ may include removing items that load below .40 and re-examining the measure’s factor structure. Additionally, a scoring system could be created so that researchers may obtain and interpret subscale total scores for each participant.

**Therapist-EQ.** Exploratory factor analysis of the Therapist-EQ revealed a 2-factor model; however, this model explained less than half of variance in the measure. These factors were named PSS Position Valued and PSS Position Unsatisfactory. The first factor, PSS Position Valued, demonstrated good internal consistency; however, the second factor, PSS Position Unsatisfactory, was not internally consistent. This may be due to three items on the Therapist-EQ that did not load in the expected direction.

The item “Through working with a DBT Peer Support Specialist, I have become more sensitive to the way I talk about mental illness and Borderline Personality Disorder” cross-loaded on both factors. Hence, the item may be considered a positive or negative aspect of working with a DBT PSS. Results of the present study found working with a PSS helps DBT therapists recognize biases and maintain a nonjudgmental stance. Many DBT therapists may view this as indicative of personal growth. However, it is also possible that DBT therapists who endorsed this item view their censorship as related to the PSS being sensitive or easily offended. In fact, results of the present study revealed this is one concern DBT therapists have in working with a PSS.
Similarly, the item “I have felt like I had to watch what I say around our DBT Peer Support Specialist” loaded negatively on Factor 1 and positively on Factor 2, indicating the less DBT therapists feel censored by the PSS, the more they are likely to value the PSS position. Last, the item “My job as a DBT Therapist is highly stressful,” loaded on PSS Position Valued, which was unexpected. This may indicate that DBT therapists who feel overburdened appreciate having the additional help of a peer-provider, more so than therapists who feel less job-related stress. Future development of the Therapist-EQ may include removing items that load below .40 and re-examining the measure’s factor structure.

**Training**

The amount and type of training received by DBT PSSs is quite variable. For DBT therapists the standard training is a ten-day intensive course, which is completed as a team. Therapists who join a previously trained team often complete a 5-day training course plus additional homework assignments. The training standard for DBT PSSs is the same 5-10 day training course as expected of therapists. Less than half of PSSs in the present study had completed a 5 or 10-day DBT training, suggesting that a large number of practicing PSS’s have received inadequate training in provision of DBT services. Furthermore, many DBT PSSs do not have a background in mental health services; this was one critique voiced by DBT therapists. PSSs lack of clinical background and education makes the formal clinical DBT training course even more pertinent to success as a treatment provider. There is an obvious chasm between the preparation PSSs received and expectations of competence and professionalism; thus, it is surprising there were not more concerns expressed by both therapists and PSSs with regard to training.
DBT PSSs are in a special position in that they may use their experience as a DBT client as a learning tool. However, this in no way makes up for a lack of formal training. For example, knowing how to practice a skill oneself does not necessarily translate into being able to teach that skill in a group setting, which requires understanding of the skill at a principle level. Additionally, co-facilitating a DBT skills-training class involves more than responsibilities as an educator. Co-facilitators must manage group dynamics, client therapy-interfering behaviors, and clients who become emotionally dysregulated. To date, only one DBT training has been offered focusing on the PSS role specifically. Although DBT PSSs are presumably well-versed in DBT from their history as a client, the lack of training related to their role as a peer-provider of DBT may create confusion about their position and place within the DBT treatment paradigm. Likely, this type of training on the addition of the PSS modality to DBT could be extended beyond PSSs and made available for all DBT team members.

An important next step in the development of the DBT PSS position is to develop formal training programs and literature specific to this role. Administrators considering the addition of a PSS to their DBT treatment package must be committed to training their PSS to the same extent they would a DBT therapist. While PSSs should receive parallel training to DBT clinicians, PSSs special role within the team must be emphasized and trained accordingly, to maximize the value of this additional treatment component.

Despite the hypothesis that DBT PSSs would desire more training, the majority of the sample did not endorse this need. This is concerning given half of DBT PSSs have not received the standard training to provide treatment, suggesting they may be unaware of their limitations as service providers. This is mirrored in the therapist sample’s concern with lack of training and boundary maintenance. The APA ethics code emphasizes the importance of providers
understanding the limits of their training and competence in order to practice within one’s scope. This ethical standard is not included in the DBSA PPRC code of ethics (Depression and Bipolar Support Alliance Peer-to-Peer Resource Center – Appalachian Consulting Group, Inc., 2010), which certified Peer Support Specialists are trained to follow. Although DBT PSSs are not psychologists, they do provide clinical and psychoeducational services. Perhaps PSSs working on DBT teams provide more therapeutic services than is typical for peer-providers and the ethical training currently in place reflects this role differential. This creates a need for a more expansive code of ethics, including attention to recognition of competence and personal limits.

**Job Responsibilities**

The DBT PSS position is a new addition to the DBT treatment package; thus, we knew little prior to this study about the job duties performed by DBT PSSs at various agencies. Results in the present study confirmed there is great variability among the role of a PSS on different DBT teams. That said, all of the DBT PSS participants in our study reported engaging in weekly therapist consultation meetings. This is ideal and expected, given that the consultation meeting is a core component of DBT and suggested as being pertinent to therapist effectiveness (Linehan, 1993). The findings of the present study indicate that PSSs can function to help therapists better understand their client’s perspective and remain nonjudgmental towards clients. In fact, this benefit of the PSS role was voiced by the majority of DBT therapists, both quantitatively and qualitatively. The PSSs attendance at weekly consultation meetings is vital to their ability to aid the DBT team in this way.

An interesting finding was that nearly all DBT PSSs reported meeting with clients individually to aid in learning and generalizing DBT skills. Clients in traditional DBT learn skills primarily in a group format; thus, the individual meetings being provided by DBT PSSs adds a
new mechanism for learning DBT skills beyond the traditional treatment package. Future research should consider whether such individual skill training sessions aid client success in treatment. Recent research has found client use of DBT skills mediate treatment outcomes (Neacsiu, Rizvi, & Linehan, 2010); hence, an additional mechanism for learning skills, such as the individual sessions provided by PSSs, may aid treatment success.

Although the present study suggests this practice is common among DBT PSSs, there are no standardized protocols for performing such sessions. Formal training and guidelines for conducting individual skills training is an important next step. Seasoned DBT therapists often struggle with how to limit the scope of their individual treatment sessions to skill generalization. Linehan (1993) writes about the common difficulty therapists experience to maintain focus in session, especially when clients with BPD become emotionally dysregulated. It would be interesting to know whether PSSs experience a similar problem of “scope creep” within their individual skills training sessions, given these meetings topographically resemble individual therapy. PSSs, who lack formal clinical training, may experience more difficulty than seasoned clinicians at maintaining focus during sessions. If so, this is problematic because PSSs are not trained or licensed to provide psychotherapy. Thus, the issue of “scope creep” becomes infidelity to the treatment model, and at worst, harm to clients. This is one example of an important issue that could be addressed formally in DBT PSSs trainings or service protocols. In fact, continuing this practice without formalized training violates the APA ethics code: 2.01 Boundaries of Competence. Research on the efficacy of DBT is based on the traditional treatment package; thus, although individual skills training meetings with a PSS may enhance skill acquisition, this provision of treatment should in no way replace skill classes.
Valued Addition to the DBT Treatment Package

Given the overwhelming number of therapist responses indicating that the “PSS is an effective DBT service provider and team member;” it is clear that in general, therapists feel PSSs are competent to provide a number of services within DBT and function as equal team members. The theme “PSS is a role model and provides a valuable perspective” further elaborates therapists’ value of the PSS position, suggesting an important piece that goes beyond what DBT therapists are able to provide for clients. This theme is mirrored in the PSS participant data, where PSSs reported “Being a source of inspiration and role model for others” as an enjoyable part of their position. For both PSS and Therapist samples, these were two of the most robust themes. The PSS’s ability to serve as a role model for recovery and provide a perspective that parallels that of DBT clients is truly unique.

The present study did not examine current DBT’s clients’ experience with PSSs. However, a substantial theme revealed by the therapist data suggested that “PSSs facilitate client engagement and commitment to treatment.” It seems that part of what therapists appreciate about working with a PSS is the perceived benefits incurred by clients. These findings are in concordance with previous research by Chinman et al. (2008) who assessed clinician and peer-providers’ views of newly implemented peer-provided services within a VA system. Similarly, clinicians in Chinman’s study reported feeling peer-providers improve client engagement, satisfaction, and empowerment. Future research should seek to examine whether the PSS role aids client treatment adherence or outcomes. If the role truly benefits clients in this way, it raises the question of what type and quality of contact with a DBT PSS is the active ingredient. Many aspects of the PSS role could have this effect, such as receiving individual skill coaching sessions, help with diary cards or homework, rides to appointments, or exposure to a role model.
Additionally, PSSs effect on DBT therapists, such as helping them to better understand the perspective of clients, could positively influence client commitment and engagement in treatment.

**Dual Relationships**

A general critique of the PSS movement is the potential for dual relationships. Both the APA ethics code and DBSA PPRC code of ethics include standards preventing dual relationships. Within the DBT PSS model, dual relationships are probable when PSSs are hired to work on DBT teams where they currently receive or previously have received services. In addition to violating ethics codes, such dual relationships may make for uncomfortable working environments. The DBT paradigm highlights the importance of supportive and collaborative treatment teams. This emphasis serves to prevent therapist burnout and maintain effective client services. Thus, it is imperative that the addition of peer-provided services does not jeopardize relationships among the treatment team by placing either the PSSs or therapists in an ethical quagmire.

It is strongly recommended that to the extent possible, DBT PSSs be hired from outside of the agency where they received services. Under no circumstances should DBT PSSs be hired to work on a team alongside their current treatment providers. To help ensure a comfortable working environment and the well-being of the PSS, all therapeutic relationships between the peer and DBT therapists must be terminated prior to their beginning work. Preferably, DBT PSSs should not be receiving services at the agency where they are employed. Given geographical limitations, it will of course not always be feasible for a DBT treatment team to hire a PSS from outside their own agency. Although it seems there are benefits to adding a PSS to existing treatment teams, a multitude of research shows that DBT is effective in its current form, without
such services. Thus, the benefits of peer-provided services may not outweigh the ethical risks associated with a DBT team hiring their previous client.

Virtually all of the PSS and therapist comments related to difficult transitions focused on discomfort centered on the PSS working with their previous individual therapist. In the case of one participant, they struggled to adjust to working on a team with their current therapist. This is not at all surprising and may even have been iatrogenic to that client/PSS, and for those reasons, should never be permitted. Difficulty with the transition from client to service provider has been noted in previous research on the PSS movement (Mancini & Lawson, 2009; Chinman et al., 2008). In a focus group study by Chinman et al. (2008), many peer-providers described difficulties related to working with their previous and current mental health providers. Mancini and Lawson (2009) revealed a theme related to difficulty transitioning from a client to provider. Somewhat different from the present results, Mancini and Lawson found qualitative evidence that this transition is challenging regardless of previous involvement with the agency of employment. In their study, participants cited concerns that colleagues would view them differently than other providers. While our recommendations to diminish dual relationships are not exclusive to peer-provided services within DBT, it is especially pertinent for this treatment model given the aforementioned focus on therapist support, as well as the nature of BPD symptomology. PSSs that have or are in recovery from BPD will likely have a history of difficulties maintaining social boundaries, as this is diagnostic criterion. This indicates DBT PSSs may have unique struggles to manage dual relationships, both with individuals on the DBT team, as well as with clients in the DBT program.

Somewhat surprisingly, the results of the present study demonstrated that few dual relationships existed, and the transition from client to service provider was generally smooth.
Results revealed “Discomfort with Dual Relationships” was an emerging theme in both samples; however, for both therapists and PSSs, it was one of the least prominent themes reported. Furthermore, the themes “Transition from being a DBT client to provider was nonproblematic” and “PSS’s transition from being a DBT client to provider was nonproblematic” were mirrored in both samples and contained more responses than the themes suggesting discomfort with relationship transitions.

The majority of DBT therapists had not had a previous therapeutic relationship with their PSS. This is ideal and likely influenced the occurrence of smooth working relationships reported by the samples. Had the number of previous therapeutic relationships between PSSs and therapists been greater, it is possible that both samples would have reported more difficulty with dual relationships.

**Burnout**

DBT providers are part of an intensive treatment program and implement a range of services to a high-risk population. This is the first study to examine burnout among DBT treatment providers, as well as the first to compare burnout among clinicians and peer-providers quantitatively. Both DBT therapists and PSSs reported moderate levels of emotional exhaustion, indicating burnout. The MBI-HSS manual describes emotional exhaustion as “feelings of being emotionally overextended and exhausted by one’s work” (p. 4). Therapists additionally experienced moderate levels of depersonalization, which was significantly different from PSS’s low level of burnout in this domain. The MBI-HSS defines depersonalization as a feature of burnout measuring “an unfeeling and impersonal response toward recipients of one’s service care, treatment, or instruction” (p 4). Despite therapists reporting emotional exhaustion and depersonalization, they had high scores of personal accomplishment with respect to their job.
High scores in personal accomplishment suggest the lowest range of burnout defined as “feelings of competence and successful achievement in one’s work with people” (MBI-HSS manual, p. 4). Similarly, PSSs also scored high in personal accomplishment.

Based on a previous qualitative study (Paulson et al., 1999), it was hypothesized PSSs would have lower levels of burnout than therapists. The PSSs’ significantly lower depersonalization scores in part confirm this hypothesis. It may seem surprising that PSSs, a group with history of severe mental illness, would score lower on a domain of burnout. Furthermore, previous research has found a positive association between mental illness and burnout for a variety of professions (Mohammadi, 2006; Wang & Guo, 2007; Zhang, Xu, & Jiang, 2006). However, given their history it is understandable that PSSs would easily relate to clients, which may decrease depersonalization. This ability to feel connected to clients may protect against burnout. Conversely, PSSs may experience lower levels of burnout than therapists as a function of working part-time and being new employees. Although therapists and PSS samples were both relatively new to their positions, therapists had been employed approximately twice as long as peers and work full-time. Additionally, results indicated therapists have concerns with PSSs emotional stability and some noticed a tendency to treat the peer employee as fragile. If PSSs are being treated as such, it is possible that being protected from workplace stressors because of perceived fragility could also create lower levels of burnout.

The results indicated that both PSSs and therapists experience emotional exhaustion with respect to their work. This is likely because both groups are working with a population characterized by high suicidality, impulsivity, emotional dysregulation, and lack of resources. Furthermore, DBT providers are responsible for several service provisions, including a 24-hour telephone coaching and crisis line. All of these factors may relate to feeling exhausted.
emotionally. It would be beneficial to know more about whether a relationship exists between extended periods of clinical availability (i.e. carrying a pager or being on-call) and sense of emotional exhaustion. Despite having similar levels of emotional exhaustion to therapists, most PSSs in this sample do not perform this task. Thus, different factors may contribute to emotional exhaustion for PSSs compared to therapists. These findings are also interesting in light of the fact that DBT is considered a therapeutic modality that promotes less therapist burnout than traditional psychotherapies for clients with personality disorders. As such, it would be fruitful to compare levels of emotional exhaustion among DBT providers with those of therapists working with the same population using different techniques.

Although burnout existed in other domains, scores for both groups indicated a high sense of personal accomplishment with respect to their work. As discussed in the literature review, DBT is a highly effective treatment for BPD. Thus, even though individuals with BPD are a high-risk population, seeing clients make vast treatment gains, commit to living, and recover from severe mental illness is inspiring work and these data support that conclusion. It is possible that there is a correlation between treatment success and provider’s sense of personal accomplishment. This would be interesting to attempt to measure in future studies that include client outcome data. It is unknown how these rates of personal accomplishment would compare to CMH providers outside of DBT treatment teams. Additionally, previous researchers have not addressed how having a peer-provider may influence therapists’ level of burnout, and vice versa. This is an additional question for future research. It is possible that for therapists, working alongside a peer-provider further demonstrates the power of the DBT treatment by providing a model for recovery. This may serve to strengthen DBT therapists’ sense of personal accomplishment.
Clinical Implications

The results of the present study provide a first look at a clinical practice currently being used in several agencies throughout the state of Michigan; considerable discussion exists about the practice becoming a national trend. Although preliminary, these findings allow some observations to be made about the current and future use of the practice of peer-provided services with DBT.

Initial support for the DBT PSS movement. Overall, the present study found considerable support for the addition of the DBT PSS role on treatment teams. This implies Michigan CMH’s trend towards including peer-provided services within DBT is generally sound. Further expansion of this practice, for example to CMH agencies in other states, could be an advantageous future direction that may offer both clinical and economic benefit. However, much additional research is required to further our understanding of how the position affects clients. Thus, although the use of peer-provided services within DBT is supported, these data should be considered preliminary and used cautiously. The DBT PSS trend clearly promotes client empowerment, inspiration, and support, which are central to the recovery movement in CMH settings. However, the present study did not endeavor to measure any true clinical outcomes, either for PSSs or current DBT clients. It is critical to understand these important variables before more definitive conclusions can be drawn with regard to this practice. Should the trend continue to prove empirically sound it could become a routine part of DBT within CMH settings, and perhaps be considered a fifth module within the DBT treatment package. Peer-provided services could theoretically be a mechanism to improve the utility and generalizability of DBT to community clinical settings.
Growth edge for the DBT PSS movement. Although the PSS position was viewed as highly favorable by both groups surveyed, several areas of growth were suggested and are illustrated in Figure 6.

**Figure 6. Areas of growth within the DBT PSS movement.**

First, findings indicate several areas where PSSs could benefit from further training. In particular, increasing the availability of training materials and experiences, such as service manuals and workshops specific to the DBT PSS position are an important next step. Some services provided by DBT PSSs are unique to the role, such as individual skills coaching sessions and helping clients with their diary card or homework. Formalized training on these components of the position may enhance the effectiveness of such services. The DBT training standard for members of the treatment team are 5 to 10-day training courses. It is vital for DBT PSSs to participate in these intensive trainings; especially given PSSs typically have limited
clinical education or work experience. However, it does a disservice to the PSS role and to professional therapists if the roles become synonymous. Training opportunities and materials that emphasize, rather than minimize, the uniqueness of the DBT PSS role will best facilitate the benefits of the position for clients, PSS employees, and DBT treatment teams at large.

Second, the findings of this study demonstrate the importance of minimizing dual relationships between DBT therapists and PSSs. Few therapists in the present study had been a service provider for their PSSs, and both samples reported relatively smooth adjustments as the PSS began employment. As discussed previously, having a collegial relationship with a former therapist (or client, in the case of therapists) may create uncomfortable work environments, and potentially hinder previous therapeutic gains.

Last, it seems that working in the PSS role could potentially help maintain a DBT graduate’s recovery, create a sense of empowerment, and encourage them to continue using DBT skills. Although the benefits of the position seem to outweigh the drawbacks, participants from both samples noted concerns about stress of the position and impact on emotional well-being and maintenance of recovery. Because control data were not collected on a sample of DBT graduates in other employment settings, we cannot fully assume that the benefits, stressors, or threats to recovery are unique to being a PSS. Additionally, both samples stated concerns with PSSs' ability to maintain boundaries within the team and with clients. The PSS position is a special opportunity that may enhance the well-being of the individual in this role, as long as these benefits are cultivated. Certain drawbacks of the position, such as lack of resources for proper training, DBT materials, etc., can and should be addressed. The function of the PSS position as assisting in recovery of the PSS themselves must be considered and job duties designed to facilitate that. As mentioned previously, the DBSA PPRC code of ethics does not include
standards for recognizing areas of competence and personal limits. The development and adherence to such a standard is imperative to the well-being of PSSs and the clients they serve.

**Directions for Future Research**

The present study served to provide an initial look at the role of PSSs within the DBT paradigm. These findings imply several directions for future research on this new component of DBT. Most importantly, the next step in research on peer-provided services within DBT is to examine how the position affects DBT clients. This should be conducted using both quantitative and qualitative methodology. A controlled trial comparing teams with and without PSSs on variables such as clinical outcomes and adherence to treatment (i.e. diary card completion, skill use, attendance, etc) would be especially valuable. Qualitative analysis of DBT clients’ reported experiences with peer-provided services could aid understanding of the position further. Special attention should be given to examining the potential for dual relationships and boundary concerns with current DBT clients. If it were found that this addition to the DBT package is empirically advantageous, it raises the question of what aspects of peer-provided services are the active agents facilitating client change? For example, could the addition of a paraprofessional treatment team member who is not a DBT graduate, and therefore not a peer, help achieve the same outcomes? Or is it the case that the unique nature of peer provision of services is, in and of itself, important to the change process? The present study identified several components of DBT peer-provided services that are viewed admirably, such as the PSS’s ability to inspire both clients and therapists, serve as a role model, and relate to clients. Additionally, the position provides DBT clients increased access to a service provider, help with DBT homework, and may make for less judgmental and burnt-out clinicians. Each of these components could be examined individually in future research.
Limitations of the present study

The present study is the first to examine the addition of peer-provided services to DBT and the results provide important information on the value and limitations of this potential additional treatment component. That said, there are several limitations to the present study that limit the conclusions drawn and generalizability of the findings. Most importantly, this first examination of the DBT PSS practice did not include DBT client data. Thus, questions remain unanswered with regard to how the PSS position and services might influence client outcomes or treatment adherence. Although the present study included qualitative analysis of therapist and PSSs perspectives, client perspectives were not examined and would be useful to know.

This study provided insight into the mental health history and current BPD symptoms of DBT PSSs. However, this is limited by the absence of data on other forms of psychopathology. BPD is typically comorbid with multiple Axis I disorders (Zanarini et al., 1998); thus, this information would be valuable. Even less data was collected with regard to therapist mental health status. Although therapists were asked about emotional distress, burnout, and whether they receive psychotherapy, no information was gathered about Axis I or II psychopathology. This information would be interesting alone as well as in comparison to PSSs.

Some limitations exist in the methods used to recruit participants in this study. First, many participants were recruited from a DBT PSS training event. This was the first event of its kind and much of the content discussed was inspirational. That this study was associated with such a positive event may have influenced the way in which participants recruited at the event responded. Similarly, because the DBT PSS position is in its developmental stages, there may be some pressure to describe the position favorably, or minimize negative aspects, in order to further the DBT PSS movement. Alternatively, although the study was confidential, Michigan
CMH DBT providers are a small community and may have felt uncertain about the extent to which results would be anonymous, especially given a summary of results was promised to be posted on the DBT Listserve in the future. Although most data were collected online, three therapists and one PSS completed participation in person. It is uncertain whether obtaining data in this alternate method could have influenced results for these participants.

The design of the present study is somewhat limited. In particular, some study hypotheses inferred change over time in the position. This was a cross-sectional study that used retrospective report; the only way to accurately examine change across time would be to use a longitudinal design. Additionally, with the exception of the Maslach Burnout Measure and the McLean BPD Screening Instrument, hypotheses were primarily tested using instruments created for the present study, which had not previously been standardized or tested. Results did reveal the PSS-EQ as a consistent measure. However, the Therapist-EQ was less reliable, calling into question conclusions drawn from data gathered using this measure. Both the PSS-EQ and Therapist-EQ included a final open-ended item asking whether there is anything else the participant feels the researchers should know. No new themes emerged from responses to these items, suggesting all relevant questions were asked within the measures.

Both samples used in the present study were limited. The PSS sample was particularly small with only nineteen participants. That said, the pool of potential participants for both samples was restricted and the rate of participation was high. Nonetheless, the limited sample sizes created difficulty with respect to statistical power. It is unclear whether the sample of DBT therapists and PSSs in CMH agencies would generalize to other types of DBT clinics, such as free-standing DBT agencies, DBT private practices, and DBT teams that treat nontraditional populations (i.e., forensic and inpatient settings, adolescent populations, etc).
Conclusions

The present study sought to examine the practice of including peer-provided services within the DBT treatment model. This research was timely and important as it focused on a currently untested trend within an empirically-supported treatment. Overall findings provided much support for this mode of treatment. Peer-provided services were viewed by PSSs and therapists as effective, inspirational, and beneficial to clients. The primary concerns sited by both samples related to PSSs’ lack of training, emotional well-being, and administrative issues.

Several directions for future research were identified, including gathering data with regard to the impact of this practice on client outcomes. Although the DBT PSS movement appears beneficial, it is still in its youth; thus, continued development, both empirically and practically, is required. If such efforts are made, peer-provided services within DBT have the potential to become an invaluable treatment modality.
References


APPEDICES
Appendix A: Informed Consent Peer Support Specialist Sample *administered online via Surveymonkey.com©

Project Title: DBT Peer Support Specialist Study

Principle Investigator: Chelsea Cawood, M.S., Doctoral Fellow
Co-Investigator: Dr. Michelle Byrd, Ph.D., L.P., Associate Professor

Purpose of the Study: The purpose of this research study is to better understand the experience and role of DBT Peer Support Specialists, both from their perspective as well as from the perspective of DBT therapists they work with. You are being asked to participate because you work as a DBT Peer Support Specialist, are over the age of eighteen, and can read and write in English.

Procedure: If you decide to participate in this study, you will be asked to fill out online questionnaires asking you information about yourself (education level, ethnicity, experience in treatment, including DBT, current mental health, etc.), and your likes and dislikes about your job as a DBT Peer Support Specialist. It is estimated it will take you 50-60 minutes to fill out the questionnaires.

Confidentiality: All answers you give on the questionnaires will remain private and will only be seen by the principle investigator and members of the research team. At no time will your name be associated with your responses to the questionnaires. Information you give will not and cannot be used for any reason other than research. Your individual responses will not be shared with your co-workers, supervisors, or DBT trainers. All data will be stored in a password protected database online.

Expected Risks: As far as we know, there are no risks to you by completing this survey. However, you may feel uncomfortable answering questions about yourself and your job.
Expected Benefits: There are no known personal benefits to you; however, no research currently exists about DBT Peer Support Specialists. Thus, this research may help to create better understanding about the best way in which Peer Support Specialists can be included on DBT teams.

Incentive: After completing the questionnaires, you will be given the opportunity to enter a drawing for one of two $120 Visa giftcards, which will be awarded to two Peer Support Specialist participants at the end of the study period. To enter, you will be asked to provide your first name, phone number, and email address. Your name and contact information will be stored separate from and will never be connected to your responses.

Voluntary Participation: Participation in this study is voluntary. If you decide to participate, you can change your mind at any time and take yourself out of the study. Whether or not you choose to participate, your decision will not affect your employment and you will not be penalized in any way. If significant new findings develop during the course of research that may relate to your willingness to continue participation, you will be notified and may take yourself out of the study.

Use of Research Results: No names or information that could let others know who you are will be shared. Information gained from this study may be presented at research meetings and conferences, in scientific publications, and as part of a doctoral dissertation being conducted by the principal investigator. No person will be identified by name in any work that is disseminated; however, direct quotes from open-ended questions may be used.

Questions: If you have any questions, please ask the principle investigator. If you have any future questions concerning your participation in this study, you can contact the principal investigator, Chelsea Cawood, at (734)-487-4987 or via e-mail at cdean2@emich.edu, or her supervisor, Michelle Byrd, at 734-487-4919 or mbyrd@emich.edu.

Human Subjects Review Board: This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee (UHSRC) for use from 7-31-
2010 to 7-30-2011. If you have any questions about the approval process, please contact Dr. Deb de Laski-Smith (734-487-0042).

Consent to Participate: I have read all of the above information about this research study, including the research procedures, possible risks, and the likelihood of any benefit to me. All my questions, at this time, have been answered. By checking the box below I understand that I agree to take part in this study. If you do not wish to participate, please exit out of this survey or close your internet browser.

☐☐I hereby consent to participate in this study.
Appendix B: Informed Consent Therapist Sample *administered online via Surveymonkey.com®

Project Title: DBT Peer Support Specialist Study

Principle Investigator: Chelsea Cawood, M.S., Doctoral Fellow
Co-Investigator: Dr. Michelle Byrd, Ph.D., L.P., Associate Professor

Purpose of the Study: The purpose of this research study is to better understand the experience and role of DBT Peer Support Specialists, both from their perspective as well as from the perspective of DBT therapists they work with. You are being asked to participate because you work as a DBT Therapist on a team that includes a Peer Support Specialist, are over the age of eighteen, and can read and write in English.

Procedure: If you decide to participate in this study, you will be asked to fill out some questionnaires asking you information about yourself (education level, ethnicity, involvement in psychotherapy), your experience working with a DBT Peer Support Specialist, and personal feelings about your own job. It is estimated it will take you 30-40 minutes to fill out the questionnaires. All the questionnaires will be administered to you online.

Confidentiality: All answers you give on the questionnaires will remain private and will only be seen by the principle investigator and members of the research team. At no time will your name be associated with your responses to the questionnaires. Information you give will not and cannot be used for any reason other than research. Your individual responses will not be shared with your co-workers, supervisors, or DBT trainers. All data will be stored in a password-protected database online.

Expected Risks: As far as we know, there are no risks to you by completing this survey. However, you may feel uncomfortable answering questions about yourself and your job.
Expected Benefits: There are no known personal benefits to you; however, no research currently exists about DBT Peer Support Specialists. Thus, this research may help to create better understanding about the best way in which Peer Support Specialists can be included on DBT teams.

Incentive: After completing the questionnaires, you will be given the opportunity to enter a drawing for one of two $120 Visa giftcards, which will be awarded to two DBT Therapist participants at the end of the study period. To enter, you will be asked to provide your first name, phone number, and email address. Your name and contact information will be stored separate from and will never be connected to your responses.

Voluntary Participation: Participation in this study is voluntary. If you decide to participate, you can change your mind at any time and take yourself out of the study. Whether or not you choose to participate, your decision will not affect your employment and you will not be penalized in any way. If significant new findings develop during the course of research that may relate to your willingness to continue participation, you will be notified and may take yourself out of the study.

Use of Research Results: No names or information that could let others know who you are will be shared. Information gained from this study may be presented at research meetings and conferences, in scientific publications, and as part of a doctoral dissertation being conducted by the principal investigator. No person will be identified by name in any work that is disseminated; however, direct quotes from open-ended questions may be used.

Questions: If you have any questions concerning your participation in this study, you can contact the principal investigator, Chelsea Cawood, at (734)-487-4987 or via e-mail at cdean2@emich.edu or her supervisor, Michelle Byrd, at 734-487-4919 or mbyrd@emich.edu.

Human Subjects Review Board: This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee (UHSRC) for use from 7-31-
2010 to 7-30-2011. If you have any questions about the approval process please contact Dr. Deb de Laski-Smith (734-487-0042).

Consent to Participate: I have read all of the above information about this research study, including the research procedures, possible risks, and the likelihood of any benefit to me. All my questions, at this time, have been answered. By checking the box below I understand that I agree to take part in this study. If you do not wish to participate, please exit out of this survey or close your internet browser.

☐ ☐ I hereby consent to participate in this study.
Appendix C: Demographics Questionnaire (Both samples) *administered online via Surveymonkey.com©

Demographics

1. What is your current age? ______

2. Please select your gender:
   - Male
   - Female

3. Please select your marital status:
   - Single
   - Married
   - Separated
   - Divorced
   - Living with a partner
   - Other

4. Please select your race:
   - African American
   - Caucasian/White
   - Asian/Pacific Islander
   - Hispanic
   - Native American
   - Multiracial
   - Other

5. What is your current household income in U.S. dollars?
   - Under $10,000
   - $10,000 - $19,999
   - $20,000 - $29,999
   - $30,000 - $39,999
   - $40,000 - $49,999
   - $50,000 - $74,999
6. What is the highest level of education you have completed?

- Elementary School
- High school or equivalent
- Vocational/technical school (2 year)
- Some college
- Bachelor's degree
- Master's degree
- Doctoral degree
- Professional degree (MD, JD, etc.)
- Other

7. Please list (and spell out) any special certifications (for example Licensed Psychologist or Licensed Social Worker) you may have obtained:

_____________________________________________________________________________________________

_____________________________________________________________________________________________
Appendix D: Peer Support Specialist Experience Questionnaire (PSS-EQ)

**Dialectical Behavior Therapy Peer Support Specialist Experience Questionnaire**

1. Please write the number of months you have been employed as a DBT Peer Support Specialist: ___________.

2. Please indicate the agency you work for:
   Agency: _________________________ City where agency is located: _______________

3. Please list any previous experience you have had working in the mental health field (ex. case manager, social worker, etc) and how long you held that position. Please write n/a if you did not work in the mental health field prior to becoming a DBT Peer Support Specialist:
   Position: ______________________  Months employed in that position _________________
   Position: ______________________  Months employed in that position _________________
   Position: ______________________  Months employed in that position _________________

4. Please indicate how much training on DBT you have had (check as many boxes as apply):
   - □ I have attended a 5-day foundational training on DBT
   - □ I have attended a 10-day intensive training on DBT
   - □ I have attended a 2-day workshop/training on DBT
   - □ I have attended a 1-day workshop/training on DBT
   - □ I have attended DBT workshops or trainings that were shorter than one full day (half-day training, etc)
   - □ I have completed online training(s) on DBT
   - □ I have studied DBT on my own, through reading, etc.
   - □ I have attended training(s) specific to the DBT Peer Support Specialist position
   - □ I have attended other training(s) on becoming a Peer Support Specialist. Please describe:
     ______________________________________________________________________________
   - □ I have had other DBT training, not listed above. Please describe:
     ______________________________________________________________________________

   □ Please indicate here if you plan to complete a 5 or 10-day DBT training in the next year, but have not yet done so.

5a. Please describe your history as a client in a DBT program. Check all that apply:
   - □ I graduated from a year-long DBT program.
   - □ I graduated after less than one year in a DBT program. If yes, how many months _________.


☐ I graduated after more than one year in a DBT program. If yes, please write how many months (total) were you in DBT before graduating: __________.

☐ I have never been a client in a DBT program.

☐ Other; please describe if your history as a client in DBT is not characterized by the above options:
__________________________________________________

5b. Please list how long ago (in months) you graduated from your DBT program: ________.

5c. Please list how many months after completing your DBT program you became a DBT Peer Support Specialist: __________.

6a. We would like to understand more about your current job duties or role as a DBT Peer Support Specialist.

Please check as many boxes below as apply to your job responsibilities:

☐ I attend weekly DBT team case consultation meetings

☐ I give DBT clients rides to skills classes and appointments as needed.

☐ I do administrative work such as making copies of DBT handouts, etc.

☐ I make phone calls to remind clients about sessions

☐ I am sometimes on-call for the DBT phone coaching line

☐ I meet with clients individually to help with skills coaching and understanding skills

☐ I meet with clients individually for some other purpose. If yes, please describe:
________________________________________________________________________

☐ I co-lead one or more DBT skills training classes on a weekly basis

☐ I co-lead DBT skills training classes occasionally, but not on a regular basis

☐ I sit in on DBT skills training classes (or have some other role in the class) but am not one of the two co-leaders.

If you have another role in the class, please describe:
____________________________________________________________________________

6b. I lead a different type of group for DBT clients (graduate group, etc). Please describe:
____________________________________________________________________________
6c. I have other job duties or roles not listed above. Please describe:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

7. Please write the number of hours per week (on average) you work as a DBT Peer Support Specialist:

______________.

8a. Are you paid for your work as a DBT Peer Support Specialist (please check Yes or No)?

☐ Yes          ☐ No, I volunteer.

8b. If Yes (you are paid for your work), please check whichever box is most true for you:

☐ I feel I am paid appropriately for what my job consists of.

☐ I feel underpaid for what my job consists of.

☐ I feel overpaid for what my job consists of.

☐ Not Applicable. Check this box if you are not paid, and work as a DBT Peer Support Specialist on a volunteer basis.

9. In your own words, please describe the things you like about being a DBT Peer Support Specialist. Please take your time and include as much detail as possible:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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_____________________________________________________________________________________________
10a. In your own words, please describe things you don’t like about being a DBT Peer Support Specialist, or, things that have been difficult about your job. Please take your time and include as much detail as possible:

_____________________________________________________________________________________________
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10b. Which (if any) of the difficulties you wrote about above are current problems?

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

10c. Which (if any) of the difficulties you wrote about above used to be a problem but have been resolved?

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

11. How have your likes and dislikes about your job as a DBT Peer Support Specialist changed over your time in this position. For example, has there been anything you initially disliked but now enjoy?

_____________________________________________________________________________________________
_____________________________________________________________________________________________
12. Why do you think you in particular were chosen to be a DBT Peer Support Specialist?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

13. Please describe the training, guidance, and supervision you receive for your role as a DBT Peer Support Specialist. Include things like formal trainings as well as individual supervision or training with a supervisor/colleague. What additional training or guidance would be helpful for you to best perform your job?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Please indicate how much you agree with the following statements about the benefits of your job as a DBT Peer Support Specialist:

14. I like assisting in the recovery of the clients in DBT

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree

15. I like giving back to others

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree

16. I like helping people in the community

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree

17. It is rewarding to watch DBT clients get better.

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree
18. I like being able to use my experience with mental illness and DBT to help others.

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19. I am comfortable talking about my history of mental illness, and my history as a client in DBT, to clients in the DBT program.

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20. Working as a Peer Support Specialist has benefited my own recovery from mental illness.

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21. Working as a Peer Support Specialist has encouraged me to continue using DBT skills.

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22. Working as a Peer Support Specialist improves my self-esteem or self-confidence.

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23. Working as a Peer Support Specialist helps me move forward with my career goals.

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24. I am happy to have a job.

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25. I like the opportunities for learning, education/training, or obtaining work experience.

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26. My co-workers on the DBT team (i.e. other DBT therapists) have been supportive.

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27. I feel my co-workers (i.e. other DBT Therapists) on the DBT team value my role on the team.

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Some individuals working as peer support specialists have experienced various difficulties. Please indicate how much you agree with the following statements about your struggles with your job as a DBT Peer Support Specialist.

28a. I have experienced confusion about my role within the DBT team, or confusion/uncertainty about what my job duties consist of:

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

- Were a problem initially but have been resolved.
- Have improved, but still remain somewhat problematic.
- Are a current problem
- Not applicable – The issue described in item 28a was never a problem for me.

29a. I have wanted more guidance, supervision, or training in my work as a DBT Peer Support Specialist.

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

- Were a problem initially but have been resolved.
30a. I am sometimes uncomfortable that my coworkers on the DBT team know the details of my history of mental illness.

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:
- □ Were a problem initially but have been resolved.
- □ Have improved, but still remain somewhat problematic.
- □ Are a current problem
- □ Not applicable – The issue described in item 30a was never a problem for me.

31a. I am unsure how much I should disclose to DBT clients about my history of mental illness.

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:
- □ Were a problem initially but have been resolved.
- □ Have improved, but still remain somewhat problematic.
- □ Are a current problem
- □ Not applicable – The issue described in item 31a was never a problem for me.

32a. I found the transition from being a DBT client to DBT staff challenging in some way or another.

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:
- □ Were a problem initially but have been resolved.
- □ Have improved, but still remain somewhat problematic.
- □ Are a current problem
- □ Not applicable – The issue described in item 32a was never a problem for me.
33a. Working as a service provider for clients I used to be in skills classes with has been difficult.

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

- [ ] Were a problem initially but have been resolved.
- [ ] Have improved, but still remain somewhat problematic.
- [ ] Are a current problem
- [ ] Not applicable – The issue described in item 33a was never a problem for me.

34a. Being a co-worker with people who used to be my DBT therapist(s) has been difficult.

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b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

- [ ] Were a problem initially but have been resolved.
- [ ] Have improved, but still remain somewhat problematic.
- [ ] Are a current problem
- [ ] Not applicable – The issue described in item 34a was never a problem for me.

35a. My DBT team members treat me as fragile or patronize me because of my history of mental illness.

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<th>Strongly Agree</th>
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</thead>
</table>

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

- [ ] Were a problem initially but have been resolved.
- [ ] Have improved, but still remain somewhat problematic.
- [ ] Are a current problem
- [ ] Not applicable – The issue described in item 35a was never a problem for me.

36a. My DBT team members have made insensitive or inappropriate comments about mental illness.
37a. My job as a DBT Peer Support Specialist is highly stressful.

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<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

☐ Were a problem initially but have been resolved.
☐ Have improved, but still remain somewhat problematic.
☐ Are a current problem
☐ Not applicable – The issue described in item 36a was never a problem for me.

38a. I have experienced significant emotional distress in response to my job as a DBT Peer Support Specialist.

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<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

☐ Were a problem initially but have been resolved.
☐ Have improved, but still remain somewhat problematic.
☐ Are a current problem
☐ Not applicable – The issue described in item 37a was never a problem for me.

39. My job as a DBT Peer Support Specialist would make it more difficult to seek treatment (i.e. therapy), if I desired it.
Please circle Yes or No for the following statements about your past involvement with the agency where you work and your DBT co-workers:

40. I work in the same agency/facility where I used to or currently receive mental health services
   Yes or No

41. I work on the same DBT team where I used to receive DBT services
   Yes or No

42. One or more of my DBT team coworkers used to be my individual therapist.
   Yes or No

43. One or more of my DBT team coworkers used to be my DBT skills trainers.
   Yes or No

44. As a DBT Peer Support Specialist, I now provide services for a client(s) who used to be in skills training classes with me when I was a DBT client.
   Yes or No

45. If you responded yes to one or more of items 40-44, have any of these changes in roles been problematic or uncomfortable? Please explain:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

46. Please indicate which of the following is most true:

☐ It seems like all of the people (therapists, etc) on our DBT team take *about the same* amount of time off.
It seems most people on our team take less time off than I do. 

It seems like most people on our team take more time off than I do.

We understand that for most DBT Peer Support Specialists, you have come to this position after years of working hard to improve oneself. Please answer the following questions about your treatment history.

47. Please indicate approximately how many different therapists you worked with prior to starting DBT:

- 0-2
- 3-5
- 6-9
- 10 or more

48. Please indicate approximately how many years you were in therapy (not including breaks from therapy), prior to starting DBT:

- 0-1
- 2-3
- 4-5
- 5-6
- 7 or more

49. Please indicate how many times you have been hospitalized (including the time you were a client in a DBT program) for mental health reasons: __________.

50. Please indicate whether you have been hospitalized for mental health reasons after becoming a DBT Peer Support Specialist:

- Yes, I have been hospitalized since becoming a DBT Peer Support Specialist
- No, I have NOT been hospitalized since becoming a DBT Peer Support Specialist.

51. Are you currently receiving therapy?

- Yes
- No

52. If you are currently receiving therapy, check if you are in:

- Individual therapy
- Group therapy
- Not applicable – I am not currently receiving therapy.

The following questions assess symptoms DBT is designed to treat; we are asking these questions because you participated in a DBT program in the past. Please indicate whether you have experienced the following difficulties, in the PAST TWO MONTHS.

53. Have any of your close relationships been troubled by a lot of arguments or repeated breakups?

- Yes
- No
54. Have you deliberately hurt yourself physically (e.g. punched yourself, cut yourself, burned yourself) or made a suicide attempt?
   □ Yes    □ No

55. Have you had at least two other problems with impulsivity (e.g. eating binges, spending sprees, drinking too much, verbal outbursts)?
   □ Yes    □ No

56. Have you been extremely moody?
   □ Yes    □ No

57. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?
   □ Yes    □ No

58. Have you often been distrustful of other people?
   □ Yes    □ No

59. Have you frequently felt unreal or as if things around you were unreal?
   □ Yes    □ No

60. Have you felt chronically empty?
   □ Yes    □ No

61. Have you often felt that you had no idea of who you are or that you have no identity?
   □ Yes    □ No

62. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g. repeatedly calling someone to reassure yourself that he or she still cared, begging them not to leave you, clung to them physically)?
   □ Yes    □ No

*Please indicate whether you have experienced the following difficulties, SINCE BEGINNING YOUR WORK AS A DBT PEER SUPPORT SPECIALIST.*

63. Have any of your close relationships been troubled by a lot of arguments or repeated breakups?
   □ Yes    □ No
64. Have you deliberately hurt yourself physically (e.g. punched yourself, cut yourself, burned yourself) or made a suicide attempt?
☐ Yes    ☐ No

65. Have you had at least two other problems with impulsivity (e.g. eating binges, spending sprees, drinking too much, verbal outbursts)?
☐ Yes    ☐ No

66. Have you been extremely moody?
☐ Yes    ☐ No

67. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?
☐ Yes    ☐ No

68. Have you often been distrustful of other people?
☐ Yes    ☐ No

69. Have you frequently felt unreal or as if things around you were unreal?
☐ Yes    ☐ No

70. Have you felt chronically empty?
☐ Yes    ☐ No

71. Have you often felt that you had no idea of who you are or that you have no identity?
☐ Yes    ☐ No

72. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g. repeatedly calling someone to reassure yourself that he or she still cared, begging them not to leave you, clung to them physically)?
☐ Yes    ☐ No

73. Please tell us anything else you think we should know to help us understand your experience working as a DBT Peer Support Specialist:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Appendix E: Therapist Experience Questionnaire (Therapist-EQ) *Administered online via Surveymonkey.com©

1. Please indicate how long you have worked at the CMH agency where you are currently employed: ____________________.

2. Please indicate the agency you work for:
   Agency: _________________________ City where agency is located: _______________

3. Please indicate the number of months you have been employed as a DBT therapist: ___________.

4. Please indicate the number of months you have worked on a DBT team with a Peer Support Specialist: __________.

5. Please indicate how much training in DBT you have had (check as many boxes as apply):
   □ I have attended a 5-day foundational training on DBT
   □ I have attended a 10-day intensive training on DBT
   □ I have attended a 2-day workshop/training on DBT
   □ I have attended a 1-day workshop/training on DBT
   □ I have attended DBT workshops or trainings that were shorter than one full day (half-day training, etc)
   □ I have completed online training(s) on DBT
   □ I have studied DBT on my own, through reading, etc.
   □ I have attended training(s) specific to the DBT Peer Support Specialist position
   □ I have had other DBT training, not listed above. Please describe:
   ____________________________________________________________________________

   □ Please indicate here if you plan to complete a 5 or 10-day DBT training in the next year, but have not yet done so.

6. In your own words, please describe the things you like about having a DBT Peer Support Specialist on your DBT team. Please take your time and include as much detail as possible:

   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
7. Of the things you wrote above, how much do you attribute these positive qualities to the Peer Support Specialist position in general compared to the individual person working in that position.

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<tbody>
<tr>
<td>Due to the position</td>
<td>Neutral</td>
<td>Due to the person in general</td>
<td></td>
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</tbody>
</table>

8a. In your own words, please describe things that have been difficult about having this additional position on your DBT team. Please take your time and include as much detail as possible:

_____________________________________________________________________________________________
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8b. Which (if any) of the difficulties you wrote about above are current problems?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

8c. Which (if any) of the difficulties you wrote about above used to be a problem but have been resolved?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
9. Of the things you wrote above, how much do you attribute these difficulties to the Peer Support Specialist position in general compared to the individual person working in that position.

<table>
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<th>1</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Due to the position</td>
<td>Neutral</td>
<td>Due to the person</td>
<td></td>
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</tbody>
</table>

in general

10. In your opinion, what added value does the Peer Support Specialist position add to the DBT treatment package? In other words, how does including a Peer Support Specialist on DBT teams improve DBT service delivery? Please take your time and provide as much detail as possible:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

11. Please describe how your team went about selecting and hiring a DBT Peer Support Specialist. If you were not on the DBT team during this process (i.e. your team already had a Peer Support Specialist when you were hired), please indicate so.

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

12. Please indicate which of the following is most true:

☐ It seems like the DBT PSS on our team takes as much time off as most people on our team.

☐ It seems like the DBT PSS on our team takes less time off than most people on our team.

☐ It seems like the DBT PSS on our team takes more time off than most people on our team.

Please circle Yes or No for the following statements about your past involvement with your DBT team’s Peer Support Specialist:

13a. The Peer Support Specialist on our DBT team used to be my individual therapy client.

Yes or No

b. If Yes, approximately how many months did you work as the clients individual therapist: ____________.

c. If Yes, how comfortable/confident were you that this person should become a DBT Peer Support Specialist?
14. I was at one point a skills trainer for the Peer Support Specialist on our DBT team.  
Yes or No

15. Our DBT Peer Support Specialist provides services to clients who she or he used to be in a skills class with.  
Yes or No

16. If you responded yes to one or more of items 13-15, have any of these changes in roles been problematic or uncomfortable? Please explain:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Please select how much you agree with the following statements, based on your experiences working with a DBT Peer Support Specialist.

17. Clients seem like they relate to and trust the DBT Peer Support Specialist more readily than the traditional DBT therapists/staff.
1  2  3  4  5
Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

18. Our DBT Peer Support Specialist facilitates client satisfaction and/or engagement.
1  2  3  4  5
Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

19. Our DBT Peer Support Specialist empowers clients to be more outspoken about pursuing their own goals.
1  2  3  4  5
Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
20. Working with a DBT Peer Support Specialist has helped me evolve even further the way I view people with mental illness. More specifically, working with a DBT Peer Support Specialist has helped me to embrace the reality that individuals with mental illness are more capable than they are often perceived.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

21. I am very glad to have a Peer Support Specialist on our DBT team.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

22. If I were to consider transferring to another CMH DBT team, whether or not the team had a DBT Peer Support Specialist would influence my decision, as I would want to work on a team with a Peer Support Specialist.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

23. Through working with a DBT Peer Support Specialist, I have become more sensitive to the way I talk about mental illness and Borderline Personality Disorder.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

24. Our DBT Peer Support Specialist helps clients be more hopeful that recovery from mental illness is possible.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

25. Our DBT Peer Support Specialist helps me be more hopeful that my clients can recover from mental illness.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

26. Having a DBT Peer Support Specialist on our team makes my job easier and/or less stressful.

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree
27a. We have had problems finding resources (for example, a workspace, telephone, or computer) for our DBT Peer Support Specialist.

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:
   □ Were a problem initially but have been resolved.
   □ Have improved, but still remain somewhat problematic.
   □ Are a current problem
   □ Not applicable – The issue described in item 27a was never a problem for me.

28a. We have struggled with getting agency funding to pay for our DBT Peer Support Specialist.

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:
   □ Were a problem initially but have been resolved.
   □ Have improved, but still remain somewhat problematic.
   □ Are a current problem
   □ Not applicable – The issue described in item 28a was never a problem for me.

29a. I was at some point concerned that the DBT Peer Support Specialist would overstep their role or intrude upon my professional ground.

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:
   □ Were a problem initially but have been resolved.
   □ Have improved, but still remain somewhat problematic.
   □ Are a current problem
   □ Not applicable – The issue described in item 29a was never a problem for me.
30a. I have felt like I had to watch what I say around our DBT Peer Support Specialist.

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

☐ Were a problem initially but have been resolved.

☐ Have improved, but still remain somewhat problematic.

☐ Are a current problem

☐ Not applicable – The issue described in item 30a was never a problem for me.

31a. My job as a DBT therapist is highly stressful

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

☐ Were a problem initially but have been resolved.

☐ Have improved, but still remain somewhat problematic.

☐ Are a current problem

☐ Not applicable – The issue described in item 31a was never a problem for me.

32a. I have experienced significant emotional distress in response to my job as a DBT therapist.

1 Strongly Disagree  2 Disagree  3 Neutral  4 Agree  5 Strongly Agree

b. If you rated this item a 3, 4, or 5, please indicate whether your difficulties:

☐ Were a problem initially but have been resolved.

☐ Have improved, but still remain somewhat problematic.

☐ Are a current problem

☐ Not applicable – The issue described in item 32a was never a problem for me.

33. Are you currently receiving therapy?

☐ Yes

☐ No
34. If you are currently receiving therapy, are you in:
☐ Individual therapy
☐ Group therapy
☐ Not applicable – I am not receiving therapy.

35. Please tell us anything else you think we should know to help us understand your experience working with a DBT Peer Support Specialist:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
Appendix F: Maslach Burnout Inventory – Human Service Survey (MBI-HSS) *Administered online via Surveymonkey.com©

CHRISTINA MASLACH • SUSAN E. JACKSON

MBI–Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professionals view their jobs and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a “0” (zero) in the space before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example

How often: 0 1 2 3 4 5 6
Never A few times a year or less Once a month or less A few times a month Once a week A few times a week Every day

How Often 0–6 Statements:

1. __________ I feel depressed at work.

If you never feel depressed at work, you would write the number “0” (zero) under then heading “How often.” If you rarely feel depressed at work (a few times a year or less), you would write the number “1.” If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a “5.”
# MBI–Human Services Survey

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<th>How often:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td>Never</td>
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<td>A few times a year or less</td>
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<td>Once a month or less</td>
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<td>A few times a month</td>
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<td>Once a week</td>
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<tr>
<td>A few times times a week</td>
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<td>Every day</td>
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### How Often 0–6

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<td>21. ________</td>
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<td>22. ________</td>
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</table>

(Administrative use only)

Appendix G: Factor loadings for the Peer Support Specialist Experience Questionnaire (PSS-EQ)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item loadings</th>
<th>Factor (eigenvalue)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.</td>
<td>I like assisting in the recovery of the clients in DBT.</td>
<td>.93</td>
</tr>
<tr>
<td>26.</td>
<td>I like giving back to others.</td>
<td>.95</td>
</tr>
<tr>
<td>27.</td>
<td>I like helping people in the community.</td>
<td>.86</td>
</tr>
<tr>
<td>28.</td>
<td>It is rewarding to watch DBT clients get better.</td>
<td>.79</td>
</tr>
<tr>
<td>29.</td>
<td>I like being able to use my experience with mental illness and DBT to help others.</td>
<td>.98</td>
</tr>
<tr>
<td>30.</td>
<td>I am comfortable talking about my history of mental illness, and my history as a client in DBT, to clients in the DBT program.</td>
<td>.94</td>
</tr>
<tr>
<td>31.</td>
<td>Working as a Peer Support Specialist has benefited my own recovery from mental illness.</td>
<td>.90</td>
</tr>
<tr>
<td>32.</td>
<td>Working as a DBT Peer Support Specialist has encouraged me to continue using DBT skills.</td>
<td>.91</td>
</tr>
<tr>
<td>33.</td>
<td>Working as a Peer Support Specialist improves my self-esteem or self-confidence.</td>
<td>.88</td>
</tr>
<tr>
<td>35.</td>
<td>I am happy to have a job.</td>
<td>.97</td>
</tr>
<tr>
<td>36.</td>
<td>I like the opportunities for learning, education/training, or obtaining work experience.</td>
<td>.92</td>
</tr>
<tr>
<td>37.</td>
<td>My co-workers (i.e. other DBT therapists) on the DBT team have been supportive.</td>
<td>.89</td>
</tr>
<tr>
<td>38.</td>
<td>I feel my co-workers (i.e. other DBT therapists) value my role on the team.</td>
<td>.80</td>
</tr>
<tr>
<td>39.</td>
<td>I have experienced confusion about my role within the DBT team, or confusion/uncertainty about what my job duties consist of.</td>
<td>.50</td>
</tr>
<tr>
<td>41.</td>
<td>I have wanted more guidance, supervision, or training in my work as a DBT Peer Support Specialist.</td>
<td>.43</td>
</tr>
<tr>
<td>45.</td>
<td>I am unsure how much I should disclose to DBT clients about my history of mental illness.</td>
<td>.59</td>
</tr>
<tr>
<td>47.</td>
<td>I found the transition from being a DBT client to DBT staff challenging in some way or another.</td>
<td>.74</td>
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<tr>
<td>49</td>
<td>Working as a service provider for clients I used to be in skills classes with has been difficult.</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Being a co-worker with people who used to be my DBT therapist(s) has been difficult.</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>My DBT team members treat me as fragile or patronize me because of my history of mental illness.</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>My DBT team members have made insensitive or inappropriate comments about mental illness.</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>My job as a DBT Peer Support Specialist would make it more difficult to seek treatment (i.e. therapy), if I desired it.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix H: Factor Loadings for the Therapist Experience Questionnaire (Therapist-EQ)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item loadings</th>
<th>Factor (eigenvalue)</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Our DBT PSS empowers clients to be more outspoken about pursuing their goals</td>
<td></td>
<td>1 (4.4)</td>
</tr>
<tr>
<td>24. Working with a DBT PSS has helped me evolve further in the way I view people with mental illness. More specifically, working with a DBT PSS has helped me to embrace the reality that individuals with mental illness are more capable than they are often perceived.</td>
<td></td>
<td>2 (2.5)</td>
</tr>
<tr>
<td>25. I am very glad to have a Peer Support Specialist on our DBT team.</td>
<td></td>
<td>.72</td>
</tr>
<tr>
<td>26. If I were to consider transferring to another CMH DBT team, whether or not the team had a DBT Peer Support Specialist would influence my decision, as I would want to work on a team with a Peer Support Specialist.</td>
<td></td>
<td>.76</td>
</tr>
<tr>
<td>27. Through working with a DBT Peer Support Specialist, I have become more sensitive to the way I talk about mental illness and Borderline Personality Disorder.</td>
<td></td>
<td>.61 .48</td>
</tr>
<tr>
<td>28. Our DBT Peer Support Specialist helps clients be more hopeful that recovery from mental illness is possible.</td>
<td></td>
<td>.68</td>
</tr>
<tr>
<td>29. Our DBT Peer Support Specialist helps me be more hopeful that my clients can recover from mental illness.</td>
<td></td>
<td>.71</td>
</tr>
<tr>
<td>30. Having a DBT Peer Support Specialist on our team makes my job easier and/or less stressful.</td>
<td></td>
<td>.78</td>
</tr>
<tr>
<td>31. We have had problems finding resources (for example, a workspace, telephone, or computer) for our DBT Peer Support Specialist.</td>
<td></td>
<td>.61</td>
</tr>
<tr>
<td>35. I was at some point concerned that the DBT Peer Support Specialist would overstep their role or intrude upon my professional ground.</td>
<td></td>
<td>.66</td>
</tr>
<tr>
<td>37. I have felt like I had to watch what I say around our DBT Peer Support Specialist.</td>
<td></td>
<td>-.44 .58</td>
</tr>
</tbody>
</table>

Clients seem like they relate to and trust the DBT PSS more readily than the traditional DBT therapists/staff.

Our DBT Peer Support Specialist facilitates client satisfaction and/or engagement.

We have had problems finding resources (for example, a workspace, telephone, or computer) for our DBT Peer Support Specialist.

I was at some point concerned that the DBT Peer Support Specialist would overstep their role or intrude upon my professional ground.

I have felt like I had to watch what I say around our DBT Peer Support Specialist.
Appendix I: Codebook – Peer Support Specialist Sample

CODEBOOK - PEER SUPPORT SPECIALIST SAMPLE

1. Difficulties maintaining boundaries
States difficulties setting or maintaining appropriate professional boundaries and limits.
Identifying/maintaining boundaries with clients in a traditional clinical sense.

2. Desire more duties or responsibility
States they dislike that they cannot perform a certain DBT task/role (i.e. groups, phone coaching),
would like more DBT responsibilities (may be broad or specific), or desire more hours.

3. Emotional and stressful nature of the work
Reports difficulties dealing with an emotional or stressful aspect of the position. Examples may
include stressful job components (dealing with dysregulated clients, etc) or coping with their own
emotional responses to the work.

4. Difficulties related to the DBT team
Problems or difficulties regarding working with the DBT team. Issues related to feeling
disconnected or different from other team members. May include identifying more with clients than
DBT therapists and/or viewing clients in a different way than the rest of the team.

5. Dislike a specific characteristics associated with this position of employment (not specific
to the DBT frame)
This category includes administrative issues, tasks, and other characteristics of the position that are
disliked. May include problems with resources (i.e. no office space, limited funds to attend trainings,
low pay), struggling to balance additional work responsibilities outside of their role in DBT, or issues associated with having a part-time job and receiving social security disability.

6. Enjoy being a source of inspiration and role model for others
States they enjoy using and/or sharing their personal experiences and stories with recovery and DBT to inspire or facilitate hope in others (this may include being a source of inspiration or hope without mention of personal experiences). Describes being a role model for recovery and/or proof that DBT (and its components) can work.

7. Empowering work that assists in my own recovery
States their position in some way helps them with their personal recovery from mental illness. May include changes to the way they perceive their mental illness history. May also include empowerment, pride, or personal accomplishment more broadly.

8. Recognizing the meaningful nature of the work
Describes they like seeing clients progress, reach their goals, recover, etc. May include general statements about helping others, making a difference, or advocating for clients.

9. Position deepens my understanding and appreciation for DBT
State they enjoy learning more about DBT (for example, through trainings). Also includes deepening belief in DBT as an effective treatment.
10. **Enjoy providing validation and making interpersonal connections**

State aspects of position related to providing validation and/or relating to clients. May also include working with people more broadly (i.e. “working on a team,” “meeting great people,” interacting with clients.”)

11. **Enjoy specific characteristics or tasks associated with the position**

Mention specific job tasks or duties they enjoy (for example, leading groups, running orientations, etc). May also include aspects of the position (i.e. pay). This category relates to content of the position, not process statements.

12. **Transition from being a DBT client to provider was nonproblematic**

The transition from being a client in the DBT program to a service provider was not problematic in any way. Adjusting to working with previous individual therapist, skills trainer, or previous skills class-classmates was not problematic. Include general comments such as "No" or “n/a” in this category.

13. **Indicators of discomfort with dual relationships**

Describe some challenge or discomfort with the transition from being a client to service provider in the DBT program. May include challenges with providing services to clients who the PSS was in skills training group with, or working with previous therapist or skills trainers. Include any problems, challenges, or discomfort in this section, even if the comment indicates the problem was resolved. May include the PSS’s comments about their own discomfort or challenge, or a statement about challenges or discomfort experienced by another DBT team member.
14. Desire formal training specific to DBT PSS role

States they feel DBT training has not related specifically to their position as a DBT PSS. Indicates they would like trainings that focus specifically on their unique role as a DBT PSS (as opposed to general PSS training or DBT trainings designed for clinicians).
Appendix J: Codebook Therapist sample

CODEBOOK – THERAPIST SAMPLE

1. **PSS role or job description is underdeveloped**

Report the Peer Support Specialist position is not clearly defined in terms of job duties or role within the team.

2. **Concerns with PSS's mental health stability and emotional vulnerability**

States concerns with upsetting, insulting, or offending the PSS when discussing job performance or potential treatment interfering behaviors. Include general statements about treating PSS as sensitive, fragile, or emotionally vulnerable in this category. Responses describe concerns about how the position might influence the PSS's mental health stability, stress level, or recovery status (or concerns about mental health and stress in general). Only include statements about poor job performance (absences, doesn't complete tasks, etc) if it is directly stated as relating to mental health or emotional concerns.

3. **PSS struggles to maintain boundaries with clients or team members**

Reports PSS has problems maintaining boundaries with clients or team members. This category includes general statements about boundaries, or specific problems that relate to clinical boundaries (i.e. “secret-keeping” or forming friendships with consumers).

4. **PSS lacks clinical education or work experience**

Describes problems related to PSS's lack of previous clinical training or work experience in the mental health field. This category includes statements about PSS's lack of knowledge or skill in clinical areas (therapy concepts, diagnosis, leading skills training groups, etc). States Peer lacks confidence, assertiveness, or is insecure (in general, or with relation to clinical work).

5. **PSS is an ineffective DBT service provider or team member**

Response describes poor job performance in general, or with relation to a specific task (not completing tasks, several absences, etc). Only include statements in this category if the problem is not directly attributed to specific causal factors (i.e. poor boundaries, lack of clinical training, etc).
6. **Problems with administrative issues not specific to DBT model**

Specific issues associated with the PSS position, but not related to the DBT treatment package or PSS employee performance. May include administrative level issues such as funding, scheduling, retention rates, or lack of support from administrative personnel.

7. **No difficulties working with a PSS**

Response directly states there have not been difficulties with the PSS position or person in that position.

8. **PSS is a role model and provides a valuable perspective**

Improves therapists’ understanding of clients’ perspective and helps therapists maintain a nonjudgmental stance toward clients. States PSS’s point of view is unique and an important contribution the team. May include statements about the PSS’s perspective more generally. PSS serves as a source of hope, inspiration and is a role model for recovery through appropriately sharing their personal experiences and story. May include statements about sharing their experiences with mental illness or DBT services, or facilitating hope and inspiration more broadly.

9. **PSSs have a unique ability to relate to clients**

Describes PSS as having strong ability to relate to and understand clients because they have previously been a client themselves. This includes statements related to clients’ trusting, connecting, or feeling at ease with the PSS. May go beyond the rapport therapists can achieve and foster an inherently empathetic relationship (while maintaining appropriate boundaries).

10. **PSS facilitates client engagement and commitment to treatment**

Reports PSS encourages clients and increases their motivation and engagement in treatment. PSS helps reduce clients’ barriers at treatment onset and throughout treatment. PSS helps commit new clients to the DBT program as well as improves commitment in current clients.

11. **PSS reduces therapist burnout or workload**

PSS helps reduce therapist workload or burnout. May state a specific reason PSS reduce workload (i.e. “Makes copies so therapist doesn’t have to”) or a general statement about reducing amount of work, burnout, or stress. Only include comments in this category if they directly indicate the performed task reduces workload or burnout. Do not include statements that simply list a task the PSS does (i.e. “PSS helps lead orientation to DBT”).
12. **PSS is an effective DBT service provider and team member**

Peer provides effective DBT services to clients (may be a general statement or comment about specific tasks, such as running groups, helping with diary cards, etc). This category also includes general positive statements about the PSS position or employee ("good team member," "helpful," etc). Only include statements in this category that are not directly attributed to specific causal factors (i.e. role mode, unique ability to relate to clients, etc).

13. **No problems with transition:**

Indicates the Peer’s transition from being a client in the DBT program to a service provider was not problematic in any way. Adjusting to working as a colleague with a previous client (individual or skills group) was not uncomfortable or challenging. Include general comments such as "No" or "n/a" in this category. Do not include any comments that suggest a challenge in this category, even if the comment indicates the problem was resolved.

14. **Indicators of discomfort with dual relationships:**

Describe some challenge or discomfort with the transition from the Peer Support Specialist being a client to service provider in the DBT program. May include the Therapist’s statements about their own discomfort or challenge, or a statement about challenges or discomfort experienced by the PSS.

Providing services to clients who the PSS was in skills training group with, or working with previous therapist or skills trainers. Include any problems, challenges, or discomfort in this section, even if the comment indicates the problem was resolved.
Appendix K: Pearson’s Correlations between the PSS-EQ and MBI-HSS Subscales

<table>
<thead>
<tr>
<th>PSS-EQ item</th>
<th>MBI-HSS Subscale</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>25. I like assisting in the recovery of the clients in DBT.</td>
<td></td>
<td>.41</td>
<td>.19</td>
<td>.46</td>
</tr>
<tr>
<td>26. I like giving back to others.</td>
<td></td>
<td>.39</td>
<td>.20</td>
<td>.54*</td>
</tr>
<tr>
<td>27. I like helping people in the community.</td>
<td></td>
<td>.52*</td>
<td>.28</td>
<td>.33</td>
</tr>
<tr>
<td>28. It is rewarding to watch DBT clients get better.</td>
<td></td>
<td>.23</td>
<td>.27</td>
<td>.67**</td>
</tr>
<tr>
<td>29. I like being able to use my experience with mental illness and DBT to help others.</td>
<td></td>
<td>.21</td>
<td>.10</td>
<td>.63**</td>
</tr>
<tr>
<td>30. I am comfortable talking about my history of mental illness, and my history as a client in DBT, to clients in the DBT program.</td>
<td></td>
<td>.16</td>
<td>.03</td>
<td>.61**</td>
</tr>
<tr>
<td>31. Working as a Peer Support Specialist has benefited my own recovery from mental illness.</td>
<td></td>
<td>.19</td>
<td>.07</td>
<td>.56*</td>
</tr>
<tr>
<td>32. Working as a DBT Peer Support Specialist has encouraged me to continue using DBT skills.</td>
<td></td>
<td>.19</td>
<td>-.15</td>
<td>.62*</td>
</tr>
<tr>
<td>33. Working as a Peer Support Specialist improves my self-esteem or self-confidence.</td>
<td></td>
<td>.21</td>
<td>-.06</td>
<td>.54*</td>
</tr>
<tr>
<td>34. Working as a Peer Support Specialist helps me move forward with my career goals.</td>
<td></td>
<td>-.04</td>
<td>-.35</td>
<td>.46</td>
</tr>
<tr>
<td>35. I am happy to have a job.</td>
<td></td>
<td>.35</td>
<td>.18</td>
<td>.57*</td>
</tr>
<tr>
<td>36. I like the opportunities for learning, education/training, or obtaining work experience.</td>
<td>.19</td>
<td>.08</td>
<td>.64**</td>
<td></td>
</tr>
<tr>
<td>37. My co-workers (i.e. other DBT therapists) on the DBT team have been supportive.</td>
<td>.11</td>
<td>-.07</td>
<td>.56*</td>
<td></td>
</tr>
<tr>
<td>38. I feel my co-workers (i.e. other DBT therapists) value my role on the team.</td>
<td>.25</td>
<td>.04</td>
<td>.28</td>
<td></td>
</tr>
<tr>
<td>39. I have experienced confusion about my role within the DBT team, or confusion/uncertainty about what my job duties consist of.</td>
<td>.42</td>
<td>.24</td>
<td>-.38</td>
<td></td>
</tr>
<tr>
<td>41. I have wanted more guidance, supervision, or training in my work as a DBT Peer Support Specialist.</td>
<td>.74**</td>
<td>.38</td>
<td>-.23</td>
<td></td>
</tr>
<tr>
<td>43. I am sometimes uncomfortable that my coworkers (i.e. other DBT therapists) on the DBT team know the details of my history of mental illness.</td>
<td>.38</td>
<td>.34</td>
<td>.03</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .001. EE = Emotional Exhaustion, DP = Depersonalization, PA = Personal Accomplishment.
45. I am unsure how much I should disclose to DBT clients about my history of mental illness. .19 .09 .37

49. Working as a service provider for clients I used to be in skills classes with has been difficult. -.04 -.15 .36

51. Being a co-worker with people who used to be my DBT therapist(s) has been difficult. -.07 -.34 .29

53. My DBT team members treat me as fragile or patronize me because of my history of mental illness. .36 .01 .21

55. My DBT team members have made insensitive or inappropriate comments about mental illness. -.01 -.24 .46

57. My job as a DBT Peer Support Specialist is highly stressful. .62** .35 -.46

59. I have experienced significant emotional distress in response to my job as a DBT Peer Support Specialist. .68** .72** .65**

61. My job as a DBT Peer Support Specialist would make it more difficult to seek treatment (i.e. therapy), if I desired it. .11 -.03 .38

*p < .05, **p < .001. EE = Emotional Exhaustion, DP = Depersonalization, PA = Personal Accomplishment.