

**Experiences and Utilization of Certified Peer Support Specialists Employed on
Dialectical Behavior Therapy Teams**

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A DISSERTATION

in

Clinical Social Work

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2015

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Qualitative, Exploratory Study of The Experiences and Utilization of Certified Peer
Support Specialists Working on Dialectical Behavior Therapy Teams
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DEDICATION

This paper is dedicated to my wonderful son, Oliver Schutt. Thank you for your love and patience. I'm sorry that I wasn't with you every day for the last three years. You were always in my heart and I thought about you daily. I am so proud of you. I love you.

ACKNOWLEDGMENTS

I want to give a sincere and heart-felt thank you to my dissertation chair, Andrea Doyle. Your support, guidance, and belief in me did not go unnoticed. Thank you for giving me the opportunity to meet key researchers in the DBT community. Thank you, Rosie Frasso, for reading my less-than-stellar first drafts and sticking with me. Your patience and willingness to push me forward was tremendously valued. I want to thank the DBT Strategic Planning Meeting attendees of 2014 for challenging me. This paper is better for it. And I want to acknowledge Matt Ditty for helping me organize my thoughts. Thank you for your enthusiasm for my topic and the conversation on the long flight to Seattle.

A very special thank you to my parents, Marybeth and Mike Karl. I wish that you were here to share this accomplishment. I miss you every day. Your love, support, and belief in me stay with me to this day and sustain me through challenging times.

I must also thank my family and friends. A very special thank you to Paul Schutt. If it wasn't for your support and faith in me, I wouldn't have been able to accomplish this dream. Thank you to my friend and roommate, Monica Rochman. You were my daily sounding board. You supported me and kept me sane. Thank you to my sister, Lisa Jones, and my aunt, Barbara Karl, for believing in me and supporting my decisions. I am truly blessed to have such amazing people in my life; I love you all very much.

Lastly, I express my abundant gratitude to all of the Certified Peer Support Specialists who graciously allowed me to interview them. The courage, dedication, and enthusiasm you expressed were inspirational. Thank you for sharing your time and stories.

ABSTRACT

The purpose of this dissertation is to explore the experiences and utilization of Certified Peer Support Specialists employed on Dialectical Behavior Therapy teams. Trends in the literature regarding peer support include the challenges faced by Peer Support Specialists, the benefits peers gained by employment, and solutions for ongoing peer program development. There is also an abundance of studies supporting the use of Dialectical Behavior Therapy (DBT) for treating Borderline Personality Disorder and other DBT adaptations for specific populations. Currently, there is limited literature available that discusses the training of line staff in DBT and no published studies that discuss the use of Certified Peer Support Specialists (CPSS's) on DBT teams specifically. The State of Michigan mandates that DBT teams include a CPSS. Data were collected through the use of in-depth key informant interviews with thirteen CPSS's working on DBT teams throughout Michigan. A thematic analysis was completed on the resultant transcripts. The analysis identified four salient themes that include: 1) the benefits of CPSS's employment on themselves and their clients, 2) the challenges CPSS's face, 3) the responsibilities and functions of those roles being filled by the CPSS's, and 4) the supervision and support provided to CPSS's. Further research on this topic is encouraged and this study recommends how CPSS's can be used on DBT teams.

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LIST OF ABBREVIATIONS

ACT – Assertive Community Treatment

BPD – Borderline Personality Disorder

CBT – Cognitive-Behavioral Therapy

CMH – Community Mental Health

CPSS – Certified Peer Support Specialist

CPSS's- Certified Peer Supports Specialists

CVT – Comprehensive Validation Therapy

DBT – Dialectical Behavior Therapy

DBT-ACES – Dialectical Behavior Therapy-Accepting the Challenges of Exiting the System

DBT-BED – Dialectical Behavior Therapy-Binge Eating Disorder

DBT-PTSD – Dialectical Behavior Therapy-Post-Traumatic Stress Disorder

DBT-ST – Dialectical Behavior Therapy-Skills Group Only

DBT-SUD – Dialectical Behavior Therapy-Substance Use Disorder

IMR – Illness Management and Recovery

MDCH – Michigan Department of Community Health

NSSI – Non-Suicidal Self-Injury

PTSD – Post-Traumatic Stress Disorder

SAMHSA- Substance Abuse and Mental Health Service Administration

TAU – Treatment as Usual

Chapter 1

Introduction

The purpose of this paper is to explore the experiences and utilization of Certified Peer Support Specialists (CPSS's) employed on Dialectical Behavior Therapy (DBT) teams. This paper offers a review of the recent literature about the experiences and uses of CPSS's in the adult mental health system. Studies concerning efficacy of CPSS's are briefly discussed. This paper includes the definition of peer support (i.e. CPSS's), a brief history, and its CPSS conceptual framework. Literature is reviewed regarding the structure of DBT and its adaptations. Studies regarding adaptations serve as justification for modifying traditional DBT. The evidence supporting DBT modifications support the further study of utilization and efficacy of CPSS's working on DBT teams, which is proposed as an adaptation of traditionally structured DBT programs. For clarification, the terms peer support, peers and CPSS's are used interchangeably in this paper.

Purpose of the Study

The purpose of this study is to explore the experiences and utilization of CPSS's employed on adult DBT teams. Michigan employs CPSS's on Dialectical Behavior Therapy teams. This means that CPSS's work on specialized teams in the public mental health system. This is a mandated practice that has no published data to guide systems through peer integration in DBT.

The mandate states:

The Michigan Department of Community Health (MDCH) (2010), along with BehavioralTech LLC, has provided several trainings to implement DBT systematically. Since FY 2007, 35 DBT teams are in different stages of implementing this treatment modality. Approximately 350 staff from community mental health programs has been trained intensively on this modality. MDCH also issued a directive in 2008 regarding approval of the program, expectations of a DBT program, and how to report DBT to the

state's data warehouse. It is expected that all the DBT teams have a peer support specialist as part of their team. (p. 9)

A qualitative study using semi-structured interviews was undertaken of CPSS's employed on adult DBT teams in the State of Michigan. Employing peers on DBT teams is a new concept in the State of Michigan. The conceptual framework of peer support (i.e., recovery) will be integrated into the modes and functions of DBT in order to merge the two approaches and begin the investigation of this potential new component of DBT treatment.

History and Definition of Peer Support

Peer support is based on the belief that “people who have faced, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations...” (Davidson, Chinman, Sells, & Rowe 2006, p. 443). One of the first clinicians to use peer supports in his work was Harry S. Sullivan in the 1920s (Davidson et al., 2006). Reportedly, Sullivan recruited young men who “recovered” from his schizophrenia treatment at Sheppard Pratt Hospital. These men then served as aides on the schizophrenia inpatient unit (Perry, 1982). From 1935 to 1950, the peer-guided program of Alcoholics Anonymous (AA) (2015) began to develop in the United States. In the mid-1970s, large mental health hospitals closed and marked the beginning of the deinstitutionalization of the mental health system (Substance Abuse and Mental Health Service Administration (SAMHSA), 2010). No longer locked up against their will, angry ex-mental health patients organized and gained the attention of the U.S. government (Davidson et al., 2006). These ex-patients protested the inhumane treatment they received in mental health clinics and hospitals. They advocated for equal rights and fought for laws against involuntary mental health treatment (SAMHSA, 2010). Becoming a part of communities and no longer being hidden by society, consumers in the 1980s started the first form of mental health peer support, the mental health self-help group. These groups used the self-guided principles of AA but focused instead on mental illness. Between 1990 to 2000, opportunities for education and employment for consumers, those people receiving mental health

services, flourished and the definition of recovery from mental illness started to become part of the professional discussion (SAMHSA, 2010).

In a speech in September 16, 1996 at The Sixth Annual Mental Health Services Conference of Australia and New Zealand in Brisbane, Australia, Deegan (2015), presented her definition of recovery as follows:

Recovery does not refer to an end product or result. It does not mean that one is “cured” nor does [it] not mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts one’s limitations and discovers a new world of possibility.

The successes of the recovery movement and the increased integration of peer support specialists within the mental health system are credited to the national leadership of Patricia Deegan and the Mental Health Consumer Movement (Davidson et al., 2006).

According to Davidson et al. (2006), peer support in mental health is defined as “one or more people who have a history of mental illness and have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are considered to be not as far along in their own recovery” (p. 444). Peer support practices can take three forms: informal mutual support, consumer-run programs, and a consumer employed to provide-mental health services within a traditional mental health system (Solomon & Draine, 2001). The consumer employees support is differentiated from mutual support and consumer-run services by identifying it as an asymmetrical helping relationship (Davidson et al., 2006).

A national survey on peer support by Salzer et al. (2012) defines services peers provide. The survey reports that most peer supports’ time consisted of sharing personal experiences, encouraging self-determination, focusing on health and wellness, addressing hopelessness, assisting in communications with providers, illness management education, and challenging stigma in the community. Davidson et al. (2006) discuss that peer services are implemented within the treatment of many conditions, such as mental health, addictions, cancer, and trauma. Because of the peers’ liberal

use of self-disclosure, by sharing recovery stories, treatment is potentially transformed into a different environment from traditional therapy provided by professionally qualified practitioners.

The form of peer support that this paper examines is the experiences of mental health consumers employed in traditional community mental health settings, referred to as Certified Peer Support Specialists (CPSS's). These individuals are formally trained, paid employees who provide services and support typically at mental health clinics and/or rehabilitation centers. CPSS's perform duties that enhance consumers' control of their mental illness (Grant, Reinhart, Wituk, & Meissen, 2012). Grant et al. (2012) found the most common duties CPSS's perform are assisting consumers in identifying relapse triggers and teaching consumers to make independent decisions.

Certified Peer Support Specialists typically start training in an intensive two-week course. This course is followed by an examination. Continuing education courses, specifically aimed at peer interests, are completed throughout their employment. Training varies by state. In 2007, certification trainings for Peer Support Specialists started in Kansas, Georgia, and New York (Grant, Swink, Reinhart, & Wituk, 2010). Many training programs are modeled after the Georgia Peer Specialists Training Project that enabled Georgia to become the first state to provide Medicaid and Medicare reimbursement for peer-delivered services. Only after certification training completion, the peer services are reimbursable by Medicaid and Medicare. Medicaid and Medicare reimbursement of peer-delivered services is a growing trend. The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities provides a document detailing the certification standards required by different states (see Appendix A for Michigan Certified Peer Support Training requirements) (<http://tucollaborative.org>). All of the peer support trainings include teaching the Peer Support Philosophy and the skills needed for effective Certified Peer Support Specialist service delivery.

Peer Support Philosophy and Training

There are some basic principles that all of certification trainings have in common. The Recovery Philosophy is the conceptual framework that guides all peer trainings; it includes the

following beliefs: diagnosis impacts people, diagnosis limits life, changes are possible, change requires action and commitment (Grant et al., 2010). The other concept taught in certification trainings is the Strengths Model. This model recognizes that people can recover, people are the directors of their treatment, they have unique strengths, and people's relationships are essential. Both of these concepts highlight the belief in self-determination and change.

History and Definition of Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a form of cognitive-behavioral therapy that treats severe emotional dysregulation, suicidality, and non-suicidal self-injury (NSSI) in clients (Linehan, 1993; Koerner, 2013). Linehan (1993) created DBT in 1991 for severely suicidal people, and it became one of the first therapies to be proven effective in the treatment of Borderline Personality Disorder (BPD) in randomized controlled trials (Linehan, 2015). BPD is a mental illness that causes extreme instability in mood, interpersonal relationships, self-image, and behavior (Linehan, 1993). This results in people with BPD exhibiting intense anger, impulsivity, suicidality, and NSSI. These behaviors can lead to expensive costs to society, such as legal involvement, hospitalizations, and numerous emergency room visits. BPD affects about 2% of the U.S. population (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Additionally, 10% of psychiatric outpatients and 20% of inpatient populations meet the diagnostic criteria for BPD. People with BPD complete suicide at a rate ten times higher than the general population (Lieb et al., 2004). The symptoms of BPD are disabling and effect all areas of living: relationships, employment, education, and health. Since the early 1970s, with Otto Kernberg's optimistic research showing that BPD was treatable, there has been an explosion of treatment options for BPD (Gunderson, 2008). With the robust evidence that DBT is an effective treatment for BPD, it is natural that DBT is being adapted or modified to populations besides those who have BPD (Linehan, 2015). Before there is a discussion about DBT adaptations, standard DBT is reviewed in the next section so the modifications presented will be more discernable.

Standard DBT Structure

As stated previously, DBT is a form of cognitive-behavioral therapy (CBT) that is used to treat clients with severe emotional dysregulation, suicidality, and non-suicidal self-injury (NSSI) (Linehan, 1993; Koerner, 2013). In some instances, traditional CBT was viewed as overly focused on change and as being inherently invalidating to some populations (Linehan, 1993). To bring balance to CBT change focus, validation strategies, Linehan (1993) dialectics and Zen Buddhists' thought were added. Dialectics form the foundation for DBT strategies. Dialectics in treatment perceive the interconnectedness of behavior to the whole of reality; reality is made up of opposing forces (i.e., accepting who you are and needing to change) and reality is change and process (Linehan, 2015). Zen thought is added to DBT through the teaching of mindfulness and acceptance strategies. Mindfulness is the unattached, nonjudgmental observation of the self and the world around us. Mindfulness is the one skill in DBT that both supersedes and is imbedded in all of the other skills. Linehan (1993) explains that when an individual is predisposed to emotional sensitivity and experiences an invalidating environment from a caregiver, this can lead to emotion dysregulation. This theory is called the Biosocial Theory and it explains how extreme emotion dysregulation occurs (Linehan, 2015). To summarize, dialectics, mindfulness and biosocial theory are the conceptual framework or worldview that inform DBT.

DBT Stages of Change

DBT is a highly structured treatment organized in stages. These stages are fluid and clients may not go through the stages in a linear manner. Linehan (1993) outlines four stages of treatment. In the first stage, individuals stop behavioral dyscontrol, such as life-threatening and treatment-interfering behaviors. Second, the individual learns to experience emotion. If the consumer requires treatment for Post-Traumatic Stress Disorder (PTSD). It is usually completed after some first stage emotional control is obtained. PTSD treatment is considered a second stage treatment. The third stage is described as experiencing "ordinary" levels of happiness. The fourth and final stage is developing meaning in one's life.

DBT Modes and Functions

The structure of DBT consists of five modes of treatment: individual, group-skills training, telephone skills coaching, case management, and team consultation meeting. Each of these modes of treatment describes what role the clinician assumes on the DBT team and the functions that define the purpose the mode completes (Linehan, 2015). The mode of individual treatment functions to improve client motivation, group-skills training functions to enhance capabilities, telephone-skills coaching helps to ensure skill generalization to the natural environment, case management enhances the environment, and the therapist consultation meeting enhances therapist motivation.

DBT Treatment Hierarchy

Because a client in DBT can experience a multitude of problems, individual therapy is arranged in a specific hierarchy to keep the therapist organized in addressing issues in treatment. The first behaviors to address are life-threatening behaviors or those that could lead to the client's death, for example, suicidal behaviors and non-suicidal self-injury. The second behavior addressed in therapy is any kind of therapy-interfering behavior or behavior that interrupts therapy, for example, arriving late and not completing the homework. Next are quality-of-life behaviors. These and any other problematic behaviors include relationship issues, homelessness, and financial problems. The fourth behaviors addressed are skills acquisition (Linehan, 1993).

According to Linehan (2015), there are four main skills taught in DBT Group Skills Training that are reinforced in individual therapy. These include:

1. Mindfulness is observing in an unattached and nonjudgmental way with focus on the moment.
2. Interpersonal effectiveness is making a request or saying no, getting or keeping a good relationship, and maintaining one's self-respect.
3. Emotion regulation is understanding and naming emotions, changing unwanted emotions, reducing vulnerability to emotions, and managing extreme emotions.
4. Distress tolerance is tolerating and surviving a crisis and accepting life as it is, in the moment.

Current Knowledge of CPSS's Working on DBT Teams

Although there is anecdotal evidence of DBT teams using peer support, to date, there are no published studies examining the use of peer support on DBT teams. By reviewing the effectiveness of DBT modifications, this provides support for the use of peers in DBT as a modification and justifies further research. The next section of the literature review discusses the current literature on DBT modifications and the effectiveness of those modifications. Only studies that are consistent with the functions of DBT are included in this literature review.

Chapter 2

Literature Review

This literature review was conducted by using Psychinfo, Social Work Abstracts, Cochrane Database of Systematic Reviews, and Medline in a top-down search. Key words used in the search included peer support, certified peer support specialist, peer support and mental health, dialectical behavior therapy, and dialectical behavior therapy and peers. A bottom-up search for relevant literature was also conducted. This literature review is organized into three sections. The first section is a review of the literature that pertains to peer supports involved in mental health and the effectiveness of these peers. The second section is a review regarding DBT modifications and the effectiveness. The third section is a literature summary. Because there are no published studies that argue for peer involvement in DBT, the summary attempts to make the case.

Literature Review of Peers in the Mental Health System

There are numerous studies that discuss peer support employment involvement in a variety of settings, such as health care, mental health and veteran services. This literature review is concerned with peer employment in the community mental health system. One identifiable trend in the peer literature is the challenges that peers experience in their work. This section organizes the challenges within the literature as personal, structural, and relational challenges.

Challenges for peers.

Personal. Moran et al (2013) and Mowbray et al (1998) found that among the personal struggles that peer supports encounter is the uncertainty about their competence to help. This finding relates to what Moll et al (2009) describe as struggles peer supports face in mastering the learning curve of their new jobs. Mowbray et al. (1996) found that it was especially difficult for peers when trying to help someone fight stigma. Peers were also challenged when they helped someone with similar issues to themselves (Kemp & Henderson, 2012; Moran et al., 2013; Mowbray et al., 1996). Job stress was another concern of peers. Moran et al. (2013) found conflicts with recipients was a trigger for stress. Some peers were the only consumers employed at their agency. Moran et al. also found this led to feelings of isolation. When feeling isolated, Mowbray et al. (1998) described peers interpreting this as a lack of support from their employer.

In a meta-analysis of qualitative articles, Walker and Bryant (2013) compared and critically analyzed twenty-seven articles from four countries between 1993 and 2010. Of the articles reviewed in the meta-synthesis, the most frequent concern of the peers was low pay and limited hours. Similar to the findings reported in the Walker and Bryant article, Mowbray et al. (1996) found that peers expressed frustrations with low pay, unpredictable hours, and lack of opportunity for advancement. Not only were peer supports concerned with low pay, advancement opportunities and dual relationships but they also struggled with handling relapse. Walker and Bryant (2013) noted that when the peer support person called in sick, it was often due to a relapse in psychiatric symptoms. In separate studies, Kemp and Henderson (2012) and Manning and Suire (1996) found that peers were concerned about their readiness to return to the work of supporting others, after they themselves suffered a relapse of mental illness.

Relational. Peer support persons The transition from consumer to staff member can be challenging (Carlson, Rapp, & McDiarmid, 2001; Moll et al., 2009; Walker & Bryant, 2013). Walker and Bryant (2013) found that the peer support was often treated as a “patient,” instead of a colleague, by non-peer staff. Some peers reported that they did not feel fully integrated as staff in mental health centers. This was in line with studies conducted by Manning and Suire (1996) and Mowbray et al.

(1996) that found that peers felt stigmatized within their treatment team. Barret, Pratt, and Gill (2000) reported that dealing with non-consumer providers' comfort levels with peer support specialists was a challenge for the respondents in their study. In contrast to earlier studies, Grant et al. (2012) reported very different findings with respect to the workplace integration, job satisfaction and organizational support of CPPS. Their subjects reported being well received and supported by other non-peer staff. ,

Receiving appropriate supervision is essential to providing services within the mental health system. Mowbray et al. (1998) reported that the "supervisory recognition and attention to boundary issues, which were so critical to these new employees' position and performance, were almost completely absent" (p. 409). Monitoring boundary issues in supervision can help assure ethical behavior on the part of the CPSS. Support for peers was also lacking by non-consumer staff members in studies by Barrett et al. (2000), Moll et al. (2009), Moran et al. (2013), and Walker and Bryant (2012).

The very nature of the CPSS profession potentially places workers in dual-relationships. Kagle and Giebelhausen (1994) defines a dual role occurring when "a professional enters into a dual-relationship whenever he or she assumes a second role with a client becoming a social worker and a friend, employer, teacher, business associate, family member, or sexual partner" (p.213). In this new role, peer supports are confronted with issues, such as self-disclosure, confidentiality, as well as dual relationships (Barrett et al., 2000; Carlson et al., 2001; Kemp & Henderson, 2012; Moll et al., 2009; Mowbray et al., 1998). In an article by Carlson et al. (2001), she reports that within forums conducted with five mental health agencies in Kansas, managing dual-relationships and confidentiality was among primary concerns of peers. Kemp and Henderson (2012) found that peers were concerned with receiving appropriate supervision. They also found that peers were concerned with using self-disclosure as a therapeutic tool. The therapeutic use of self-disclosure is a cornerstone of the peer philosophy; as such, it is a topic that should be included in comprehensive supervision. Lack of appropriate supervision is a concern that relates to the overall structure of an agency. Agency structure is the focus of the next area of concern for peers.

Structural. Human service agencies have the responsibility of providing adequate structure, guidance and support to employees so that they are best equipped to provide effective services. Clear roles and responsibilities is one aspect of providing appropriate structure and guidance for workers. Walker and Bryant (2012) reported peer-employee role confusion from non-peer colleagues. Similarly, Kemp and Henderson (2012) also found that peers were troubled by the lack of role clarity both within their job roles and their relationships with consumers. Job clarity concerns were also prevalent in studies by Manning and Suire (1996), Moll et al. (2009), Moran et al. (2013), and Mowbray et al. (1998). , With respect to the support agencies provide to their employees, Mowbray and Kemp (1998) reported that peers questioned how much autonomy they had on the job and what level of decision-making was allowed to be able to best perform their work responsibilities as they understood them. Mowbray (1998) also noted the lack of initial orientation the agency provided to the peer. Paulson et al.(1999) found that consumer staff were treated unprofessionally and were less likely to be trusted, as compared to staff at non-mental health agencies. More recently, Moran (2013) described how some peers were not even given a desk or work space. This contributed to the peer feeling like a second-class worker.

Benefits to CPSS's. Although there are numerous challenges faced by peer supports, there are also benefits for the peers who provide this type of support. Walker and Bryant (2012) found that peers reported the following benefits: increased self-esteem, increased fellowship with other peers, and increased social networks. The peers in this study viewed their work as a peer support specialist as first steps towards reintegration into the workforce. Similarly, Mowbray et al. (1996) reported the areas of personal growth reported by peers as becoming more emotionally attuned to others, learning from mistakes, improving communication skills, and fulfilling commitments. Salzer and Shear (2002) described benefits to peers in a qualitative study as increasing interpersonal competence by giving back to others and facilitating their recovery. In addition, peers reported increased social approval, which led to greater self-esteem. Armstrong, Korba, and Emard (1995) reported that peers developed positive self-perceptions, a sense of identity, and a quality of life. Slazer and Shear (2002) reported that peers reported a feeling of being trusted. Both Slazer and Shear (2002) and Armstrong et al. (1995) described

peers as experiencing professional growth and benefits from the mutual, reciprocal nature of the peer-client dyad. Grant et al. (2012) supported Slazer and Shear's (2002) findings that peers generally felt supported by their organizations and felt integrated into the organization and its culture. Armstrong et al. (1995) reported that the peers in their study experienced high job satisfaction. Solomon (2004) reports that there appears to be strong support for peers as employees due to the benefits they provide to the people they serve, themselves and the mental health system. Along with the peer reports of high job satisfaction, personal growth and increased self-esteem, it is important to consider the effectiveness of peer support interventions.

Peer Effectiveness. The effectiveness of peer support is well documented in the literature. In 1995, Solomon and Draine conducted a randomized controlled trial over a two-year period. This study compared case management services for chronically mentally ill consumers provided by a consumer-peer staff and non-consumer staff. These researchers found that services delivered by consumers were as effective as services delivered by non-consumers regarding psychosocial and clinical outcomes. Similarly, Chinman, Rosenheck, Lam, and Davidson (2000) studied the differences in service provision between consumer and non-consumer case managers working with the mentally ill homeless population. They found that, regardless of who provided the treatment, there were no differences in the degree of change or the therapeutic alliance between the consumer and non-consumer treatment groups.

Other studies have explored the benefits of employing consumers on intensive case management teams. Rivera, Sullivan, and Valenti (2007) conducted a randomized trial comparing consumer-assisted case management, non-consumer-assisted case management, and standard clinic care on intensive case management teams. Rivera et al. (2007) found no difference between groups for symptoms, health care satisfaction, and quality of life. They additionally found no evidence that adding a consumer to treatment improved case management services. These studies are in sharp contrast to a quasi-experimental design conducted by Felton, Stastny, Shern, Blanch, Donague, Knight, and Brown (1995). This study also compared the addition of non-consumer paraprofessionals, peers, and no additional support to case management teams. Felton et al. (1995) found little difference between the

non-consumer paraprofessional assistant compared to the no-assist case-management conditions. In the peer assistance condition, Felton et al. reported improvements in satisfaction with the client's living situation, quality-of-life, finances, personal safety, self-esteem, and social support. In contrast, they reported improvements in satisfaction with the client's living situation, quality-of-life, finances, personal safety, self-esteem, and social support in the case management with peer assistance condition.

Other studies reported positive outcomes related to peer involvement. Dixon, Hackman, and Lehman (1997) reported that employing a consumer on an Assertive Community Treatment (ACT) team showed an increase in positive staff attitudes toward homeless people with mental illness. Another study looked at an ACT team that included a fully integrated consumer (Salyers, Hicks, & McGuire, 2009), where the consumer provided an evidence-based recovery group, Illness Management and Recovery (IMR). This study found that clients' knowledge about their illness and their perceived recovery improved. In this mixed-method design, the researchers determined that clients reported hope and motivation as their greatest changes (Salyers et al., 2009). Paulson et al. conducted a study regarding practice patterns among consumer and non-consumer ACT staff. They found no differences between the two groups regarding the activities performed and the amount of time it took to perform them. The difference between the groups occurred during the qualitative portion of the study. The researchers discovered differences in practice "culture" between the groups (Paulson et al. 1999). The consumer staff was more likely to self-disclose and relax boundaries. They exercised less authority over the client. And because of unique vulnerabilities, peers experienced a greater burden of care. Due to this increased burden of care, the consumer staff spent twice as much time in supervision than non-consumer staff. Paulson et al. (1999) summarized the findings by stating, "...both teams had similar patterns in *what* they did...there were observable differences in how the teams carried out these same activities. In other words, there were differences in the practice 'cultures' operating in the two teams" (p. 259).

Literature Review of DBT Modification Effectiveness

The employment of CPSS's on a DBT teams is not part of the standard DBT treatment protocol. This would be considered a modification of standard DBT; therefore a literature review of DBT modifications follows. The literature on the effectiveness of DBT modifications falls into two categories: modifications for specific populations and modifications for specific disorders.

DBT Modifications for specific populations. Many researchers have worked on modifications to standard DBT to serve the unique needs of various populations. The modifications to specific populations in the next section include adolescents, college students and older adults. Community Mental Health recipients can encompass any person along the life span continuum but those included in this section pose unique challenges for treatment providers.

Adolescents. In 2000, Miller et al. studied the adolescent DBT model. These researchers performed a pre-post self-report design with adolescents who experienced BPD symptoms. The study showed reductions in confusion related to self, impulsivity, emotional instability, and interpersonal problems. In 2007, Miller, Rathus, and Linehan pioneered and refined the use of DBT with adolescents. In addition to standard DBT (described previously), changes included adolescent caregivers involvement in individual therapy. DBT for adolescents also included adolescent accessible skills material, a simplified and shortened skills group, and an additional module targeted at adolescents' concerns (Miller et al., 2007). Similar to the Miller et al. (2000) study, Woodberry and Popenoe (2008) performed a pre-post design using DBT statistical measures with adolescents experiencing BPD symptoms. The researchers found reductions in anger, depressive symptoms, impulsivity and dissociation, and increases in overall functioning.

Uliaszek, Wilson, Mayberry, Cox and Maslar (2013) tested a pilot program using Miller's DBT for adolescent concepts but created a multifamily group-only treatment. In this study, the authors also found reductions in anger, including reductions in rule breaking and attention problems. In 2002, Rathus and Miller conducted a quasi-experimental study that showed reductions in hospitalizations, treatment dropout, and suicidal ideation. Katz, Cox, Gunasekara and Miller (2004) also conducted a quasi-experimental design, but this study population involved suicidal adolescents admitted to one inpatient unit. Katz et al. showed no between-group differences in the DBT versus treatment-as-usual

(TAU) groups. The study did show, however, reductions in behavior problems for the DBT group. Even though there were no differences between the groups, the reductions in parasuicide behaviors, which were maintained at the one-year follow-up for both groups, showed that brief DBT in an inpatient setting is feasible for adolescents. The researchers reported that the reductions in behavior problems on the inpatient ward are still witnessed today.

Goldstein, Axelson, Birmaher, and Brent (2007) demonstrated the feasibility of DBT for adolescents experiencing bipolar symptoms. This study reported improvements in suicidal ideations, NSSI, emotion dysregulations, and depressive symptoms. In 2008, James, Taylor, Winmill and Alfoadari tested the use of standard DBT with a group of older female adolescents with histories of NSSI. Similar to Goldstein et al., the researchers reported decreases in NSSI, depressive symptoms, and hopelessness, and they noted increases in emotional control and overall functioning. James, Winmill, Anderson and Alfoadari (2011) corroborated these findings by providing standard DBT to a group of self-harming adolescents and also reported decreases in NSSI, depressive symptoms, and hopelessness, and increases in emotional control and overall functioning.

College students. Another population where DBT was modified was college students (Engle, Gadichkie, & Nunziato, 2013; Chugani, Ghali, & Brunner, 2013). Staff at Sarah Lawrence College produced an article describing their DBT program for college students; although there was no data accompanying this description, it is worth noting that Sarah Lawrence College demonstrated the feasibility of providing a comprehensive DBT program without any modifications of DBT modes or functions (Engle et al., 2013). Chugani et al. (2013) described a modified DBT program in a college setting. This DBT program followed an eleven-week skills training protocol that coincided with academic activities (Chugani et al., 2013). Other modifications in Chaguni et al.'s version of DBT were that individual therapists did not necessarily practice DBT-informed individual therapy and no after-hours phone consultation was available. However, unlike the descriptive Sarah Lawrence article, a study accompanied this program description of a DBT program aimed at treating college students who exhibited BPD traits. Chaguni et al. compared college students receiving DBT vs. college students receiving TAU; researchers found that the group receiving DBT had significant decreases in

dysfunctional coping and difficulty regulating emotions. This study also demonstrated that the feasibility of a short-term DBT skills training program in a college setting can meet the needs of highly troubled students.

Older adults. On the other end of the age spectrum, DBT was modified for an older, depressed population (Lynch, Morse, Mendelson and Robins, 2003). In 2003, Lynch et al. led a study for a group with a mean age of 66 who experienced at least one episode of depression. Participants were assigned to a medication-only treatment or a medication plus modified DBT plan. The modification program included a 28-week skills group and 30-minute telephone contact with a therapist once a week. At the end of this study, and compared to the medication-only treatment condition, the medication plus DBT condition showed an improvement in self-rated depression, adaptive coping, and relationships (Lynch et al., 2003).

Community Mental Health recipients. Another population identified in the literature is outpatient community mental health (CMH) recipients (Ben-Porath, Peterson, & Smee, 2004; Blackford & Love, 2011; Comtois, Elwood, Holdcraft, Smith, & Simpson, 2007). The co-occurrence of a major mental illness, traits of BPD, and low socio-economic status make the CMH population unique to other populations in the DBT literature. With the multiple disciplines involved in CMH client treatment, such as psychologists, social workers, psychiatrists, case management, and nursing, DBT consultation team interventions are well-suited to a CMH treatment center (Ben-Porath et al., 2004). In 2007, Comtois et al. initiated a modified version of DBT similar to the standard DBT but it included one additional skills training group a week, case management, administrative support, and a quality-of-life interfering target that was structured for consumers of CMH. Comtois et al. found in their one-year study a reduction in medically-treated self-injury, psychiatric emergency room visits, and psychiatric admissions. When participants in this study were hospitalized, they spent shorter amounts of time in the psychiatric hospital. Similar to the Comtois findings, Ben-Porath et al. (2004), measuring the same behaviors, found a reduction in quality-of-life interfering behaviors, therapy-interfering behaviors, and life-threatening behaviors. Ben-Porath et al. had differing modifications from the modified DBT used by Comtois et al. (2007). Ben-Porath et al.'s modifications included enhanced

commitment strategies, diary cards tailored to the CMH population, and a skills training group limited to one and one-half hours.

Blackford and Love (2011) also modified DBT skills groups to one and one-half hours and provided DBT skills group-only treatment. The clients in their study could receive non-DBT individual therapy and /or pharmacotherapy. Despite high dropout rates, Blackford and Love found that increased attendance in a skills group correlated to improvements in community functioning, quality of life, and decreased depressive symptoms. In conclusion, the evidence supports DBT modifications aimed at treating various populations. The next section addresses the effectiveness of DBT modifications for specific disorders.

Modifications for specific disorders. Not only are DBT modifications developed to treat people across the life span but researchers make modifications to DBT to treat specific disorders. The disorders reviewed in this section include specific behavioral disorders and affective disorders. The behavioral disorders reviewed include substance use and problem eating. The affective disorders reviewed include Bipolar disorder, PTSD and mixed diagnostic presentations. Finally, a study is reviewed that modifies DBT for those in recovery from Borderline Personality Disorder.

Eating disorders. When applied to eating disorders, DBT treatment includes eating related material and discussion. DBT for eating disorder modifications vary in the different studies. The eating disorder literature spans many different forms of eating difficulties, including anorexia nervosa, binge eating, and emotional overeating (Ben-Porath, Wisniewski, & Warren, 2009; Federici & Wisniewski, 2013; Federici, Wisniewski, & Ben-Porath, 2012; Hill, Craighead, & Safer, 2011; Klein, Skinner, & Hawley, 2012; Kröger, Schweiger, Sipos, Kliem, Arnold, Schunert, & Reinecker, 2010; Masson, Von Ranson, Wallace, & Safer, 2013; Safer, Robinson, & Jo, 2010, Safer, Telch, & Agras, 2001; Salbach-Andrae, Bohnekamp, Pfeiffer, Lehmkuhl, & Miller, 2008; Telch, Agras, & Linehan, 2001). Some DBT modifications include 20-week group-only treatment that omits the interpersonal effectiveness module and uses an eating behavior context for the mindfulness, emotion regulation, and distress tolerance module (Klein et al., 2012; Safer et al., 2010, 2001; Telch et al., 2001).

Klein et al. (2012), Safer et al. (2010, 2001) and Telch et al. (2001) found that DBT for Binge Eating Disorder (DBT-BED) reduced binge-eating episodes. However, Safer et al. (2010) discovered that, compared to a different treatment condition, the DBT-BED condition achieved abstinence faster, but at the twelve-month follow-up, there was no between-group differences. Safer also found that emotion regulation skills alone did not moderate DBT-BED effectiveness.

Federici and Wisniewski (2013), Federici et al. (2012), and Ben-Porath et al. (2009) completed studies applying DBT and eating-disorder education to a partial hospitalization setting. This DBT modification followed standard DBT practices and included additional disordered eating groups. Ben-Porath (2009) found decreases in depression and anxiety. Federici and Winiewski (2013) reported increases in treatment retention, medical stability, and decreases in eating-disorder symptoms, as well as decreases in suicidal ideation and NSSI. Hill et al. (2011) applied the 20-week DBT-BED training to a twelve-week session and included appetite awareness within the mindfulness module. The researchers found decreases in bulimic episodes and in depression.

Kroger et al. (2010) conducted a three-month standard DBT model that focused on eating-disordered behaviors on a hospital inpatient unit. This study yielded decreases in binge-eating episodes and increases in global functioning. Masson et al. (2013) applied a very different form of treatment as compared to the rest of the researchers. These investigators randomly disseminated a DBT-focused self-help manual to a group of participants and compared them to a wait list condition. The participants working on the self-help manual received six biweekly twenty-minute support phone calls over the thirteen-week study. Masson et al. reported decreased binge eating episodes and increases in quality of life compared to the wait list. However, during the six-month follow-up, binge-eating episodes tended to increase compared to the reports submitted at the end of the study. To summarize, DBT modifications for binge eating disorder have shown to be effective.

Substance Use Disorder. Another modification of DBT is for Substance Use Disorder (DBT-SUD) (Courbasson, Nishikawa, & Dixon, 2012; Dimeff, Rizvi, Brown, & Linehan, 2000; Linehan, Dimeff, Reynolds, Comtois, Welch, Heagerty, & Kivlahan, 2002; Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999; Wagner, Miller, Greene, & Winiarski, 2004). Dimeff et al. (2000) describes the treatment as mirroring DBT modes and functions with the addition of substance use viewed as an impulsive dysfunctional behavior. New and relevant skills aimed at substance use, increasing the clients' attachment to a therapist, finding "lost" clients, and the concept of "Dialectical Abstinence" were also added. In 1999, Linehan et al. conducted one of the first randomized controlled designs using this modified version of DBT compared to TAU. This study found reduced substance abuse, increased treatment retention, and increased social and global adjustment. In a small uncontrolled pilot study in 2000, Dimeff et al. recruited 3 women with multiple suicide attempts, NSSI and methamphetamine use. Dimeff et al. found that abstinence from substances was achieved for two of the participants after six months of treatment and it was maintained at twelve months. Both of these studies coincide with a 2002 study by Linehan et al., in which a randomized control design compared DBT-SUD with another manualized treatment, Comprehensive Validation Therapy (CVT) plus twelve-step. These authors found that both conditions had a decrease in opiate use, but in the DBT-SUD group, reduction was maintained through the follow-up period. While both conditions showed a reduction in psychopathology, the Linehan et al. (2002) study reported the DBT-SUD group self-reported drug use more accurately. In terms of treatment retention, the CVT plus twelve-step group reported higher rates.

Courbasson et al. (2012) conducted a randomized controlled study with a mentally ill population with substance use disorder and binge eating disorder. Standard DBT was administered, as well as psycho education about the interplay between eating disorders and substance use. Courbasson et al. found that the adapted DBT group reported a reduction in binge eating episodes, a reduction in substance use and severity, and an increase in coping and emotion regulation compared to TAU. The researchers also reported higher retention rates in the DBT condition.

Wagner et al. (2004) reported on a program description for mentally ill individuals with substance use disorders and who were HIV positive. Although this article included a case study and did not report on the program's effectiveness, it was included in this literature review because of its unique modifications to DBT. In this program, consumers received the standard DBT-SUD treatment; adjustments were made to treatment targets, skills, and modes. Added to the *therapy interfering behavior* target was HIV-treatment adherence. In addition to the skills taught in the group was the use of mindfulness in the methadone dosing line in order to reduce the potentially triggering environment. Within the mode of the therapist consultation group, DBT therapists were working towards the "Path to HIV Competence" (Wagner et al., 2004). This study shows a unique combination of combining DBT-SUD with HIV positive adults.

Mixed-diagnostic presentation. DBT has been adapted for a mixed-diagnostic population (Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014). This population is described as experiencing depression, anxiety, and difficulty regulating their emotions. The modification administered was DBT skills group only (DBT-ST), as compared to a supportive treatment. The researchers found that participants in the DBT-ST condition experienced reductions in emotion dysregulation, increased skills use, and decreased anxiety. Recovery from depression was twice as high in the DBT-ST group as compared to the supportive therapy group. These gains were maintained at follow-up.

Bipolar Disorder. Van Dijk, Jeffrey and Katz (2013) used a twelve-week group format that combined psychoeducation about bipolar disorder, mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance skills modules. The researchers reported reduced depressive symptoms, increased emotional control, and increased self-efficacy. Goldstein, Fersch-Podrat, Rivera, Axelson, Merranko, and Birmaher (2014) conducted a randomized controlled trial comparing DBT and TAU with 20 adolescents diagnosed with Bipolar Disorder. The treatment condition included the use of standard DBT with modifications for adolescents. These modifications were based on Miller, Rathus, and Linehan (2007) therapy using DBT to treat suicidal adolescents. The Goldstein et al. (2014) study found compared to TAU, participants had greater treatment adherence and improvements

in manic symptoms, suicidal ideation and emotion dysregulation. Although the Goldstein et al. and Van Dijk et al. both report improvements in emotional control, the Goldstein et al. study was completed in 12 months compared to 12 weeks. Goldstein et al. also included standard DBT compared to Van Dijk et al. who used a shorten group format. Both studies however, show the effectiveness of DBT in treating bipolar disorder.

Post-traumatic Stress Disorder. It is important to note that in standard DBT practice, treatment for PTSD is not initiated until stage two of DBT treatment, when clients have gained behavior control, and are diagnosed with PTSD. Both of the studies in this section use a combination of standard DBT and prolonged exposure protocols in an attempt to treat post-traumatic stress disorder (PTSD) (Bohus, Dyer, Priebe, Kruger, Kleindienst, Schmahl, Niedtfeld, & Steil, 2013; Harned, Korslund, & Linehan, 2013). The results of these studies included decreased PTSD symptoms, decreased depression, and increased global social functioning. Although the treatment outcomes were similar, the treatment delivery was quite different. Bohus et al. (2013) conducted a randomized control trial comparing what they called DBT-PTSD to TAU. Standard DBT with the inclusion of prolonged exposure was administered in a twelve-week residential treatment program. To the contrary, Harned et al. (2013) compared one year of standard DBT to one year of standard DBT plus prolonged exposure treatment in an outpatient setting.

Recovering from BPD. Comtois et al. (2011) developed a unique program for consumers who were recovering from symptoms of BPD. This program is called DBT-ACES (Accepting the Challenges of Exiting the System). The consumers involved in the program, who were enrolled in Comtois et al.'s feasibility study, were required to complete one year of standard DBT and achieve behavioral control of their BPD symptoms. These consumers, like those in the DBT plus prolonged exposure program, were considered to be in *Stage 2* of DBT treatment. Also, in order to participate in this program, consumers needed the desire to work or go to school and exit the public mental health system. In the feasibility trial, Comtois et al. found that participants' had increased productivity, employment, and quality of life. Although there are currently no published articles that report CPSS's

working on DBT teams, these are promising results that recovery, employment, and exiting the mental health system are possible and desired by graduates of standard DBT. This population is most similar to the participants in this study.

Literature Summary

Within this literature review, thirty-one studies on DBT modifications were reviewed. Of the thirty studies that were reviewed, 29 of them reported positive effects for populations, including adolescents, college students, older adults, and community mental health recipients. Modifications for specific disorders, such as eating disorders, substance use, bipolar, mixed diagnostic presentations, PTSD, and those in recovery from BPD, also showed positive effects. Overall, the modifications in DBT occurred in the modes of treatment and not the functions, meaning that all of the DBT concepts were taught but changes occurred in how the material was presented and for what length of time.

A DBT team that includes CPSS's would not need to make adjustments to program functions and the DBT team would need to determine in which mode to include CPSS's participation. Creating a modification of DBT by using a CPSS would not require drastic changes to a standard DBT program. As with all of the DBT modifications in this literature review, the modes of DBT treatment can be adjusted without affecting the integrity and overall effectiveness of the intervention. Moreover the goals of recovery, gaining meaningful employment, and increased quality of life are not only possible, but desired by DBT participants (Comtois et al., 2011). As Linehan (1993) argued, the ultimate goal of DBT is "creating a life worth living." Becoming a CPSS in a DBT program is one way of fulfilling that aspiration

In addition to the potential benefits to the CPSS worker involved in DBT, a solid case must be made for the benefit of CPSS involvement to the consumer who is undergoing the DBT treatment. A related question is whether the DBT protocol is too complicated for a layperson to be able to learn, understand and apply. In a study by Hawkins and Sinha (1998), researchers showed that knowledge of DBT-trained mental health workers was relatively the same regardless of education, role, and

disciplinary affiliation. This study showed that line staff could acquire sophisticated DBT knowledge. This supports the position that CPSS's can learn and provide effective DBT through adequate training.

The lived experience CPSS's have with their own DBT treatment can be viewed as a tool for incorporating the CPSS philosophy of self-disclosure, while providing a valuable insider perspective on DBT treatment. Furthermore, Dixon, Hackman, and Lehman (1997) showed that having a peer on staff improved staff attitudes about the consumers. It is reasonable to expect that having a CPSS working on a DBT team could create more sensitivity and/or mindful staff reaction towards DBT consumers.

Chapter 3

Methodology

This chapter introduces the methods used in this study. The methods section includes an explanation of the study design, study setting, participants, recruitment procedures, ethics, data collection, and analysis procedures. This section also addresses study rigor.

Study Design

Qualitative research allows for the exploration of meaning and a rich description of the human experience (Rubin and Babbie, 2011). This study allowed the researcher the opportunity to engage directly with key informants, that is CPSS's employed on DBT teams. In-depth qualitative interviews were completed.

Setting

This study was conducted in the State of Michigan. Michigan CMH centers provide medication management, case management, and other specialty programs, such as, Assertive Community Treatment (ACT), Supported Employment to adults and children with serious mental illness and/or developmental disabilities and DBT. As of 2013, there were 45 known DBT teams housed in CMH centers (Michigan Department of Community Health, 2013). Michigan mandates all CMH teams employ a CPSS. To date Michigan has certified 1,392 consumers to be employed as CPSS's (Dinsmore, personal communication, April 7, 2015). However, it is unknown how many certified peers were employed on DBT teams at the time of this study.

Participants Recruitment

The State of Michigan DBT Consortium committee members and DBT team supervisors were asked, via email, to disseminate recruitment information to potential participants (see Appendix B for Recruitment Email). The State of Michigan DBT Consortium committee members forwarded the recruitment email to teams that might be interested. Potential participants were asked to contact the

researcher and were invited to participate if they met inclusion and exclusion criteria. Inclusion criteria were past or present employment as a CPSS on a DBT team. Participants also needed to be past, or present consumers of DBT, or have had training in DBT and a working knowledge of DBT skills. CPSS were also excluded if they did not complete the State of Michigan CPSS training. Participants worked on DBT teams in urban, suburban, and rural locations.

Interviews occurred in the place of employment of the CPSS's, his or her home, or a community location based on participant preference (see Figure 1).

Ethics

The University of Pennsylvania Institutional Review Board approved this study. The researcher explained the study in detail to each participant and reviewed the consent documents. Participants were then asked to sign an informed consent document (see Appendix C for Informed Consent). Participants were given a \$10 gift card after the interview was complete.

Instrument

The qualitative interview guide was comprised of open-ended questions informed by the researcher's 15 years of work in DBT, professional contact with the population, and an extensive literature review exploring the CPSS's role in DBT, the Recovery Philosophy. The guide included questions that addressed the CPSS's role on the DBT team, the duties performed and their personal experiences being employed on a DBT team (see Appendix D for CPSS Interview Guide). Care was taken to avoid confusing and leading questions (Padgett, 2008).

Data Collection

All interviews were conducted face-to-face, audio recorded and transcribed verbatim by a professional transcribing company working under a confidentiality agreement (see Appendix E for GMR Transcription Services, Inc. Confidentiality Agreement). Transcripts were entered into NVivo10, a qualitative software program used to facilitate systematic analysis. All study documents were stored

on a password protected computer. A sample of transcriptions were verified with the audio recordings to check for accuracy.

Content Analysis

The researcher, in consultation with mentors, developed a comprehensive codebook. The codebook included a priori codes which reflected DBT activities and codes that were generated following line-by-line coding of initial interview transcripts. Miles and Huberman (1994) define a code as a phrase used to give a chunk of data meaning. Using NVivo software, subsequent transcripts were coded throughout the data collection process. After coding was complete, using a clustering tactic described by Miles and Huberman (1994) codes were analyzed for commonalities and refined into 17 categories. The a priori DBT codes included individual therapy, group skills training, therapist consultation meeting, telephone consultation and case management. Additional DBT a priori codes also included engagement activities and DBT graduate activities. The DBT functions, identified in the transcripts, were organized into DBT modes or DBT a priori codes described above. To convey nuance to the themes, thick descriptions and sub themes were then created. Thick descriptions inform the data by giving it a richer context. Lincoln and Guba (1990) explain that thick descriptions assist in determining the degree of transferability of all, or part of a study, by others to different contexts. Figure 2 illustrates the theming process.

Quality and Rigor

Reflexivity. During the last fifteen years of my professional life, I worked on a DBT team at a community mental health center in Michigan. My therapeutic approach has been heavily influenced by DBT practice and theory. This influence is observable in my case formulations, interventions and worldview. As a supervisor of a DBT team, I was fortunate to employ a CPSS as part of the DBT Therapy Team. I have positive experiences with supervising a CPSS.

Before I started the interview process, I was not in a state of “equipoise” (Freedman, 1987). Freedman (1987) explains equipoise as the researcher not having a preference between treatment

conditions in a study. I personally witnessed the benefits to peer involvement in DBT and positive effects on their client interactions. This positive experience potentially biased the questions asked and created a risk to equipoise because I favored CPSS involvement in DBT rather than no CPSS involvement. To control for this bias, the interviewer attempted to balance interview questions and explored both the benefits and challenges faced by teams that employ CPSS's.

CPSS Perspective. In order to understand the CPSS responses this investigator used the critical perspective. The critical perspective suggest we live in a power-rich context. These approaches seek to reflexively step outside of the dominant ideology (insofar as possible) to create a space for resistive, counterhegemonic knowledge production that destabilizes oppressive material and symbolic relations of dominance” (Hesse-Biber and Leavy, 2011, p.27). The critical perspective also suggests that our experiences occur in a socio-historical context (Ponterotto, 2005). In this study, the perspective allows for attention to the history of the recovery movement and the egregious treatment of people with mental illness. It ensures that the power differential between people who have a mental illness and those that don't are respected. I continually tried to remain **egalitarian** in my relationships with the participants.

Controlling for bias. Without close examination of the study process, the researcher risks bias that might influence observations and inferences (Miles and Huberman, 1994). In order to ensure study rigor the researcher employed a tactic, “checking for representativeness,” described by Miles and Huberman (1994), when selecting quotes to share in the result section of this document. Checking for representativeness, assured that quotes represent the data and are not too similar.

Chapter 4

Results

In this chapter, findings from the interviews and participant characteristics are reported. The findings are arranged in themes and subthemes that emerged from the data and representative quotes are used to provide meaning and clarification of the themes.

Participant Characteristics

Recruitment continued until the pool of potential participants was exhausted. Thirteen participants completed interviews. All participants were asked to fill out a demographic face sheet (see Appendix F). In Table 1, the characteristics of 12 participants are reported, note one participant refused to share demographic information.

The average age of the participants was 47 years and the majority were Caucasian females. Most of the sample were married or had been married at some point. Three-quarters of the sample were previous DBT consumers. The majority of participants (11), worked in the southern and middle regions of Michigan and one participant reported working in the northern region of the state. The mean number of years worked on DBT teams was three years and six months. The average number of hours they worked per week was 30 and half of the participants earned less than \$25,000 a year. The majority of participants earned income solely from employment on the DBT team and all of the participants had some university education.

Table 1

Participant Characteristics (n=13)
 (Data missing for 1 participant)

Characteristic	<i>N</i>	% of Sample
Average Age	47	
Gender		
Male	2	17
Female	10	83
Other	0	0
Ethnicity		
Caucasian	11	92
African-American	1	8
Other	0	0
Marital Status		
Single	2	17
Married	5	42
Divorced	3	25
Separated	2	17
Previous DBT Consumer		
Yes	9	75
No	3	25
Average Number of Years Employed on a DBT Team	3.6	
Average Weekly Hours Worked	30	
Annual Salary		
<\$5,000	0	0
\$5,000-\$15,000	4	33
\$15,000-\$25,000	2	17
\$25,000-\$30,000	3	25
>\$30,000	3	25
Income Source		
Employment + SSDI	3	25
Employment	9	75
Michigan Location		
North East	0	0
North West	1	8
Middle	3	25
South East	4	33
South West	4	33
Highest Education Completed		
High School	0	0
Some College	5	42
College Graduate	7	58

Note. SSDI = Social Security Disability Income.

Themes

Codes were arranged into 17 thematic categories. The categories presented here are: 1) topics challenging to the CPSS's, 2) gains for the CPSS and his or her clients, 3) DBT modes, functions, and other DBT-modified functions, and 4) receiving supervision and support of the CPSS working on DBT Teams. Subthemes are shared to provide context (see figure 3). Direct quotes illustrate the thematic categories and subthemes.

Topics challenging for CPSS's

The topics challenging for CPSS's are organized into subthemes. They illustrate areas within the challenges that were of concern and not of concern to CPSS's. Subthemes include self-care, relapse risk, stigma, and job description. Another subtheme addressed was the risk relapse. The quotes below illustrate these challenges.

Self-care. One challenge CPSS's reported was the need for self care. The seriousness of their self-care was illuminated by specific care plans they had for themselves.

I have to watch my sleep, I have to watch my eating, um, because I deal with so much emotional stuff between DBT and trauma—working with trauma stuff, I have to take care of myself above every other thing. P10

Not only did participants acknowledge their own plans for self-care but they described the support they received. Participants expressed appreciation for the support.

I've seen, at least here, [the people] are doing a very good job at trying to support Peers and make sure that they're practicing self-care, as well. They look out for those types of things and, somehow, I think that's been a strong point, all together here. P3

Relapse. Another challenge discussed by the participants was relapse. Relapse risk was included in the interview guide but CPSS's did not report that their employment directly had an impact the risk of relapsing. This respondent summarized relapse as a unique experience for anyone, regardless of whether they worked on a DBT team or not.

I mean, you could get triggered anywhere. And what is a relapse? I mean, that's just different for everybody. P5

The participants expressed their gratitude for being involved in a DBT team and reported feeling more confident in their ability to prevent relapse by being involved in a DBT team. They even expressed that they felt that their recovery was stronger and more certain because of DBT team participation.

I feel like I am at a lot lower risk for relapse or for, um, you know—relapse is a part of recovery, but I feel like I am much more supported because I'm on the DBT team, and I feel like my recovery is stronger because I'm on the DBT team, absolutely. P1

Stigma. An important part of peer support training is combatting stigma. Stigma exists for CPSS's clients but they also personally experience stigma. This participant described his/her experience with stigma and its complexity.

I wouldn't say it's so much—maybe like the DBT team, but just like coming up against the stigma within the agency. Um, we learned in a, you know, anti-stigma training that, that has happened with peers, that people who receive services report that the second highest place that they feel they receive stigma is from within the agency itself. So like, you know, the people who are supposed to be helping them are the ones who are like stigmatizing them, without even

knowing it. I think most of the time, they're not even realizing they're being stigmatizing. P1

Job description. The final challenge that CPSS's faced was a general job description that did not outline their unique role on the DBT team. Participants reported that their job description was a general description created by either the agency or it was taken from the State of Michigan Peer Guidelines. The lack of a clear job descriptions caused problems within the agencies. It also caused frustration for the participants.

I've had a couple of run-ins with case managers through my career.

There's been a couple of them, you know like somebody wanted me to take their person to (city name) that I don't even know, I haven't even worked with, and like, no. That was my boss, he said no, too. So I think that, obviously, would be the biggest one. P7

...And like connecting back to the job description thing again, it's just really broad and it pretty much says, it's generic I would say. P7

Gains for the CPSS and his or her clients. Even though CPSS's expressed challenges that occurred in their work, they also identified gains for themselves and their clients. Subthemes about gains to the consumers who were served included hope, supporting recovery, and a unique peer perspective. Subthemes where the CPSS personally benefited included witnessing consumer achievements and continuing their immersion in DBT skills.

Hope. All CPSS's identified hope as the one thing that clients benefited from most by working with the peer. All of the peers were passionate about providing hope to their clients. The CPSS's in the quotes below both encourage clients to be more hopeful about recovery and serve as a personification of hope.

Offering hope. I mean, people with borderline personality disorder are so confused. They don't know why they're doing what they're doing, half the time. And to be able to explain what they're doing, that there's purpose to why they have these emotions, that there's things they can actually do to, to curb the emotions, to control their behaviors, to not affect everyone around them. They might actually have a normal relationship. It's hope to be able to tell someone, "I don't have this diagnosis anymore." P5

And that you can, um, tell people, "Don't be scared to, uh, continue to walk through the doors of recovery. Just believe in yourself." And, as a peer, my job is to instill hope in a person and encourage a person that they can do it. P9

Peer perspective. Some participants mentioned that the peer perspective gives the peer an insight that makes the peer role valuable to clients. The peers expressed their insight. This gave peers something unique to contribute to treatment.

I've had a client tell me that, um, they trust me more than they trust their case manager. I think that is because we share a little bit of ourselves with them. To let them know that we have been, sometimes, where you are. And we understand and we know what we're talking about. We're not just learning from a book... I'm book smart and I'm street smart. They (the clients) say. P6

I was like you can learn anything out of a book, you can learn all these skills, you can see all these people go through skills, but to actually live it and experience it and breathe it, you really can't say you know what they're going through. P7

Recovery Support. Although participants reported that relapse is always a risk, they also commented on how their work supported their recovery. The participants described finding a sense of meaning in their work.

It gives me a sense of myself and my recovery and how far I've come, and I mean my family is just amazed because they saw me way back when and they see me now and it's just like (name omitted) this job's perfect for you. P11

Definitely it enhances my own recovery; it gives me a sense of self I guess, I don't know if that's the right word. I've always had passion so I can't say it gives me passion, it kind of amplifies it, but it gives me more hope to feel like I can make [a] difference in people's lives, and that my voice is heard here. It is possible to work in this setting because it's, before I even found out about peers I

was like I'm "gonna" need years and years of school before I can even get in somewhere like that. P7

Pride and accomplishment. Another benefit that participants reported was positive feelings by witnessing clients learning, giving the CPSS a sense of pride and accomplishment. The participants expressed excitement about not only witnessing a client learn but the excitement they felt for being a part of it.

I'm not saying it's about me when I work with people, but like I said, the satisfaction of being able to help someone realize or have that light bulb, and remember when I did it and kind of get that feeling [all] over again. That's awesome... I think that it's unique to peers everywhere to get that feeling of that sense of accomplishment or pride from helping someone. P7

DBT skill immersion. Participants expressed gratitude for being immersed in the DBT skills in their employment. They felt whether they were teaching a skill in a DBT group or helping someone with homework, this DBT skill immersion reminded them of their own continual need for skill use.

I do think that as a co-facilitator, I get so much from being able to like co-facilitate. Like it keeps me immersed in the skills, and that sort of goes back to that like symbiotic relationship I mentioned of like, like helping and sharing my experience, but also still receiving, like reaping the benefits of being immersed in that every week. P1

DBT Modes and Functions of CPSS's. The modes of DBT are the roles the CPSS perform on the DBT team. The CPSS's reported that the modes of DBT treatment most commonly performed were group skills training, telephone skills coaching, therapist consultation team meetings, and case management. It is worth noting that the CPSS's reported not doing individual therapy tasks. There are other roles outside of standard DBT that CPSS's executed, which included individual and group DBT engagement and graduate group leaders.

Individual treatment. Although peers occasionally met with clients individually, none of the CPSS's interviewed identified doing individual therapy activities at any time. They voiced deep respect for the individual therapist role. They actually reported and observed individual treatment as a limit to their current role.

What they've been through (the clients), you know, just pieces of what they've been through as a child, and then they'll tell me some things. And then I'll explain, you know, after you learn skills then you can go on to exploring therapy. And I kinda don't go there. P11

At the same time, it would be—I think it would be unethical and very irresponsible for me to perform certain types of therapy that I'm not certified and not trained in, um, that's outside of what my scope is. P3

Group skills training. Group skills training is one of the modes that CPSS's reported as their most beloved activity. They shared their enjoyment of teaching clients DBT skills. They were able to provide their unique experiences using the skills in their lives.

DEAR MAN is a huge one. I know for me, personally, I love to tell people the story. I used to have really bad road rage. And I don't know how I fit this in with DEAR MAN, but I used to have really bad road rage. And running through the interpersonal skills and a little bit of distress skills, but mostly the interpersonal skills, I was able to cut that down and not care. Like, okay, this guy's gonna try to pass me, you know like they could be rushing to the hospital or something. P7

We sort of take turns, like just co-facilitating the group. It, it kind of rotates what we're doing, like homework review or, um, you know, mindfulness. A lot of times I'll lead mindfulness exercises, uh, I – I think my biggest part comes in sort of expanding on some of the skills, like as we're presenting the material, being able to say, you know, so this is what it says, and, and sort of here's my additional experience on how the skill works, and maybe why it doesn't work sometimes, and how you can get around that. P1

Telephone skills coaching. CPSS's reported providing telephone skills coaching but not crisis telephone intervention, because they did not feel equipped to do this activity. One participant nervously described his/her experiences taking crisis calls. The participants recognized taking crisis calls was out of their job scope. Instead they preferred doing activities like homework help and individual contacts.

So on one phone, I'm talking to you and trying to get you back to using skills. And on my other phone, I'm talking to the police and dispatching the police... And I just totally – that night, the urge to cut was so great... And say, "I can't do this anymore because I'm being

triggered.” ... So it was a matter of being able to know what the triggers were. Know where to set the boundaries. And using it to overcome that guilt that I’m not there like I said I was. P4

A lot of the skill coaching I do is in-group. You know, I help them go through homework. I was doing some weekly stuff with people face-to-face when I did the internship, and it’s obviously been getting more now which I love, but it’s kind of supposed to be [on an] as-needed basis. It’s all face-to-face, you know I might talk to them a little bit on the phone if they’re upset, but I don’t get the DBT phones. Some of them I see every week, some every other week. P7

Therapist consultation meeting. All CPSS’s reported involvement in the DBT Consultation Meeting. The participants reported a sense of pride that their contribution was acknowledged by the DBT team.

Sort of the acceptance into the, the therapy team and the DBT team by the therapists, and them, you know, approaching me and saying, like, “Wow, I never thought about the skill in that way.” Or like, you know, telling me, you know, “You’re really helping the group.” And like you know, “I, I appreciate what you said and added to that.” And then also, um, seeing the growth and change happen in the people receiving services in, in the group. For me, that is so gratifying because to – it’s like – so – it’s nostalgic in a way because, um, it’s like seeing – it’s like watching yourself, but like, you know, it’s not you. P1

...they appreciate what I say, and how my work goes – and sometimes they – they see that we’re on the same wavelength, you know, when we talk about a

consumer they're like, oh, yeah, that's what we're working on. It seems like you're really connecting and – P11

Participants discussed how their unique perspective and anti-stigma message had a significant impact on the DBT Consultation Team meetings.

I think part of my role is to sort of stand as a constant reminder that people receiving services are real human beings, and have the potential to be just as intelligent, perceptive, uh, you know, as anyone else, and that we're all just human beings, and having a master's degree doesn't [laughs] make you any better than someone, you know, coming in to receive services. I think that's a huge function of peers, is to sort of be a walking, talking, anti-stigma ad within an agency. P1

Case management. Frequently, the participants did not report handling case management activities. The participants were concerned that they would be used as case management support or asked to do menial jobs. However, the following quote describes how a CPSS helped a client use DBT skills *in vivo*.

I took somebody to the post office before to help them learn DEAR MAN, and we ended up growing, it was successful. But by the time we got to the last post office this person was a lot more patient and using more of their DEAR MAN, just kind of helping them integrate into real life instead of okay you're in this room this is what you're gonna do when you leave. No, we're out here right now and there's this person right here and you're gonna practice your skills type thing. P7

One participant strongly expressed resentment about being viewed as a case manager and described the feeling of doing work outside the scope of peer support.

I hate to use the term, like workhorses, but it's like therapists who don't want to do [laughs] – they're almost being used for like case management. And I feel like that's not appropriate. Like case managers should do their job. Like they're being used to do like yearly health reviews, and like the stuff like case managers like don't want to do. Like that's what it feels like – P1

Other modified DBT functions. In addition to the modes and functions in standard DBT that participants were involved in, they were also involved in engagement activities that assisted clients who were admitted to DBT programs. And, they were involved in “Advanced” DBT groups or DBT “Graduate” groups, which enforce DBT skills use when clients are discharged from DBT programs.

Engagement. One activity that the participants described was engaging new clients in DBT. They engaged new clients in individual and group activities. The participants felt reported feeling pride knowing that sharing their hope and experience with DBT skills had a positive impact on the clients' first steps in DBT.

Um, I go over what it's like to be in group, what happens in group. We go over, um, [clears throat] the diagnosis of borderline, kind of what that means, the diagnostic criteria, um, the biosocial theory of kind of how borderline personality theory – how that develops. Um, we go over the modules. So I'll tell them kind of, you know, what the modules are, what type of issues it addresses.... We go over rules for the group. Uh, we have phone coaching, so we go over phone

coaching guidelines and how to use it... Um, and then just some other educational things on DBT. P12

...who sort of bridges that gap and is able to engage with people who have been recommended for DBT. Because the format of DBT is, if you, if you come in and they're in the middle of a module, you have to wait until, you know, a new module starts, to enter into DBT.... So what happens in the meantime? You know, this person's in crisis. This person needs skills. And here you're being told hurry up and wait. Um, and, and maybe we're missing an opportunity to really engage that person and to let them know, okay, you know, you do still have to wait, but there is some hope... there's a lot of people coming in for intakes. There's a lot of people being recommended for DBT. And there's a lot of people waiting for it. And you know, I think sometimes they fall through the cracks. P1

Advanced or graduate groups. CPSS's also provided services for clients who had completed the DBT program to help maintain the gains made in the program and continue their skillful behavior. Groups have been formed formally and informally in the community. The CPSS viewed these groups more about mutual support in DBT skill use than the one-sided helping relationship of their jobs. One participant described a group held for family members and loved ones who had someone involved in DBT by the advanced groups.

The advanced groups were good because we could support each other. I wasn't always giving support. P5

...we created our own, um, DBT skills group, so there were like uh, four or five of us that met, personally, at – out in the community. P2

...the advanced group would get together and put a seminar together for the families of people currently going through. P5

Receiving supervision and support. The CPSS's reported working on supportive DBT teams. They reported receiving supervision and support from team members, especially when they were struggling. They reported feeling guilty for asking for their busy supervisor's time. When asked if the CPSS's had individual supervision scheduled, they all said no. Supervision of the CPSS's was more unintentional and informal. The quotes below demonstrate these experiences.

Like when group is finished, clients leave, I'll say you know, um, like I was concerned about this client. You know or whatever, and what's going on with this? So, they're responsive, but it's like all of three minutes. P2

It is unique because I can – I feel comfortable turning to my team and saying, "I'm not in a head space where I can be recovery focused right now. I need to take care of myself," and they are supportive of that. P1

And that's what I like about the DBT team is that we do the behavior check in – every week, and if my-mine's high, my supervisor and my team will sit there and say, "How can we help you?" P10

The next and final chapter includes a discussion of these findings and how they are supported by the literature on CPSS's and DBT. The limitations and opportunities are also discussed.

Chapter 5

Discussion

The purpose of this study was to explore the utilization and experiences of CPSS's employed on adult DBT teams. Using a thematic analysis approach, significant themes emerged from the reports of thirteen participants. These themes provided insight into their roles on DBT teams, their personal perceptions about the negatives and positives of being a peer, and the level of support they receive at their jobs.

The themes include the benefits to CPSS's and their clients, challenges faced by CPSS's, utilization of CPSS's on DBT teams, and the supervision and support the DBT team provides the CPSS's. This discussion utilizes information from the literature review to support the themes discovered.

The CPSS's reported an overall positive experience. When considering that one of the goals of DBT is to create a life worth living, the CPSS's reported creating meaning in their lives through employment as a CPSS. This would have been unheard of in the past if not for the pioneers and advocates of the recovery movement in the 1990s. We do know from the work by Comtois, Kerbrat, Atkins, Harned and Elwood (2010), Quality of Life measures significantly improve when past DBT consumers are engaged in some form of vocational activity. This literature supports the positive effects of the vocational activity of previous DBT consumers and non-previous DBT consumers employed on DBT teams.

Not only did employment as CPSS's create meaning for past consumers, but their employment allowed them to utilize their strengths. The strengths perspective, core to social work training, is defined by Weick, Rapp, Sullivan, & Kisthardt (1989) as focusing

on a person's talents, abilities, and skills, rather his or her deficits or pathology. CPSS's have first-hand experience navigating the mental health system. This study confirms that employment as a CPSS enhances recovery. This study finding is supported by the research of Salzer and Shear (2002). These researchers described benefits to peers as increasing interpersonal competence by giving back to others and facilitating their recovery. This enabled the CPSS's to utilize a unique set of skills, strengths, and experience that a DBT clinician may not possess. Not only did these skills contribute to a new facet of DBT treatment worthy of further study, it defined a new motivation and future possibility for current DBT consumers.

Challenges described by the CPSS's more likely occurred within the context of the agency as a whole, rather than on the DBT team. The peers described these challenges as stigma. When probed further for how they experienced the stigma, participants described the general non-belief that peers could perform the tasks required. They experienced the stigma as overt statements or as having a diminished their role at the agency. Examples of diminishing their role or abilities included providing transportation, making photocopies, or making coffee. For the peers who were interviewed, when these requests were made, a team member or supervisor corrected staff making the request and pointed out that it was inappropriate. It is unfortunate that the peer's objection was not credible and a supervisor or team member needed to validate their concerns.

Stigma is defined by the Centers for Disease Control and Prevention (2012) as a group of attitudes and beliefs that discredit someone based on a personal trait, such as mental illness. Stigma can lead to discrimination and micro-aggression that can damage

self-worth and quality of life. Quality of life, which peer employment is trying to enhance, is thwarted by stigma. Goffman (2009) discusses stigma and the social interaction between the non-stigmatized and the stigmatized, or “a mixed social situation.” (p. 17). Goffman describes stigma as an attribute socially assigned to another that discredits them and views them as a non-person. Stigmatization is supported in the literature review by Grant et al. (2012), Manning and Suire (1996), and Mowbray et al. (1996).

Mowbray et al. (1996) found that individual supervisory support was absent, so it could not serve as a protection against stigma. However, according to Goffman (2009), supervision may not be a protective factor against stigma. He reports that the stigmatized person often experiences cowering and/or bravado in the presence of non-stigmatized people (the supervisor in this case). Therefore this potentially anxious interaction has more of a social context than just availability of the supervisor. This study confirmed the existence of stigma but showed that it did not occur within DBT teams. The support provided by immediate team members and supervisors in DBT Consultation Teams improved stigma for participants

Another challenge expressed by the CPSS’s in this study was a general job description that did not outline their specific duties working on the DBT team. Diminishing the role of the CPSS could be caused by stigmatization; but in addition, it could be caused by a lack of role clarity and understanding among agency staff. General job descriptions included duties that the peers were performing in their work, such as advocacy, inspiring hope, and facilitating recovery, to name a few. Job descriptions lacked ways these duties were to be defined from a DBT context and integrated within

the DBT delivery. This researcher recommends either rewording the general job descriptions or providing an addendum to the current job descriptions to define the role of the CPSS within the DBT team. This would provide peers with the support and empowerment they need to stand up to stigma and counter misunderstandings among the staff regarding their role on the DBT team. It would also separate the CPSS function working on DBT teams as being unique from other CPSS's who work with other teams.

A final challenge that peers, and many people in the helping professions face, is self-care. Self-care regarding the CPSS is even more critical. Lack of self-care could lead the peer to experience a reoccurrence of psychiatric symptoms and possible shame and self-deprecation, which can accompany a relapse. The DBT team environment is conducive to enhancing self-care through attendance at regular DBT Consultation Meetings and the support that is inherent within a supportive DBT team.

With regard to the roles CPSS's perform on DBT teams, the data illustrate participation in DBT Group Skills Training, the DBT Consultation Team, Telephone/Skills Coaching, and Case Management. A new potential use for CPSS's working on DBT teams is client engagement activities. CPSS's demonstrated their ability to serve as ambassadors to new clients in DBT and they assisted in the continuation of client skills use in after-care programming.

Because of a lack of literature regarding the utilization of CPSS's on DBT teams, this section summarizes the findings and makes recommendations for DBT teams that are interested in incorporating peers into their delivery of DBT programming. It is also important to adhere to the fidelity of the DBT model if a CPSS is employed on a team. The favorite DBT activity performed by the CPSS's was co-facilitating DBT Skills

Groups. Some peers reported co-facilitating the DBT Skills Group, while others reported being involved as an adjunct in the group. When a CPSS is a previous DBT consumer, it is reasonable to believe that he or she possesses the knowledge to teach clients about DBT skills. If a peer is confident in his or her ability to teach DBT skills, this could potentially bring credibility and a first-hand understanding of how to apply DBT skills to everyday living. This potentially is an added value to the traditional lecture style of teaching DBT skills. Involving CPSS's in DBT skills groups not only fulfills the goal of DBT Skills Training by enhancing the clients' learning of the DBT skill, but it also enhances the peer's self-efficacy.

As stated in the literature review, the literature regarding peer support reported that peers who are involved in team meetings are capable of creating more sensitivity and/or mindful staff reactions towards consumers (Dixon et al., 1997). It was clear based on the findings in this study that the DBT Consultation Team was a supportive, learning environment for CPSS's. They reported positive relationships with their respective DBT Teams and felt that their contributions were valued. The relationships between the clinicians and CPSS's were viewed as reciprocal. The CPSS's learned and developed clinical skill applications and the clinicians benefited from the consumer perspective and it kept the team recovery-focused. It would seem that this would cultivate a more nonjudgmental stance within the DBT Team; however, without further study of the DBT clinician attitudes, this cannot be verified. According to reports from the CPSS, the DBT Consultation Team served its function of keeping the CPSS motivated to treat this challenging population. If having a CPSS creates a nonjudgmental environment and

increases the mindfulness of the staff, as the literature suggests, it is definitely worth including a CPSS in a DBT Consultation Meeting.

Among the different DBT teams, having a CPSS involved in individual skills coaching and telephone coaching was one of the main variances presented in this study. All the CPSS's agreed that they did not have the skills or training to assist with a DBT crisis line. This activity could be a potentially triggering event for some CPSS's and is not recommended. The CPSS's successfully reported non-triggering interaction with clients individually. CPSS's assisted with skill use or skill explanation. This enabled the CPSS to impart his or her unique perspective in skill application. This is an area where a more detailed job description would help to ensure that CPSS's were not put into situations that undermine their recovery.

Individual skills coaching could somewhat accomplish the function of individual therapy by improving client motivation. However, the CPSS's understood that his or her role was not that of an individual therapist, but merely to serve as an assistant to skill acquisition. It was clear in this study that the CPSS's had no intention of replacing the individual therapist. Because of this distinction, individual therapy was not a coded mode in any of the transcripts.

CPSS's approached case management activities with caution. If detailed job descriptions included DBT language regarding case management activities, peers might feel more relaxed about conducting case management activities and having the potential to facilitate a consumer's skillful practice in the community. It was not that they were unwilling to do case management; it was more about not wanting to be perceived as case managers and not being recognized as serving in a unique role. This again conveys the

necessity of a clear job description. In DBT, case management is defined as a balance between advocating for the consumer and offering consultation to the consumer (Linehan, 1993). One quote that illustrated a case management activity described the peer as assisting the consumer with skill use in the community. This demonstrates not only the use of consultation to the consumer regarding skill use but also *in vivo* practice.

CPSS's have carved out a niche in DBT practice that is not part of the standard DBT modes and functions. The first niche is engagement activities. These activities are described as occurring both in a group and individual format. In DBT, clients potentially have to wait to begin DBT Skills Training. Depending on the program format, new clients coming into DBT might have to wait until a new module of the skills training group begins before they can start DBT. The peers serve as a contact for consumers during this waiting period. Without this contact, consumers are at risk for dropping out of treatment. Given the role CPSS's have in providing hope and encouragement, this dropout risk is potentially diminished. These peers serve as ambassadors of hope to newly admitted DBT consumers by telling their own story about how DBT changed their lives. The next niche developed by CPSS's in DBT is formulation of a DBT Graduate or Advanced Group, which is open to consumers who have completed DBT. It serves as a reminder of the DBT and problem-solving skills that can reinforce past DBT skills learning. Because of the supportive nature of these groups compared to the lecture style of standard DBT Skills Training, not only do consumers benefit from the additional support, but CPSS's who participate do as well. One CPSS also described a project that an Advanced DBT Group organized for families of new DBT consumers. This project conducted psychoeducation for family members of those living with Borderline

Personality Disorder, what DBT is, and how DBT addresses these difficulties. These are new functions of DBT added on to the standard DBT and provide a potentially value-added component to the continuum of DBT programming. See Table 2 for a summary of the CPSS's reports of DBT team roles.

Table 2

CPSS report of DBT Team Roles

DBT Modes	Therapist	CPSS
Individual Therapy	Yes	No
Group Therapy	Yes	Yes
Team Consultation	Yes	Yes
Telephone Skills Coaching	Yes	No
Case Management	Yes	Yes
Engagement	No	Yes
Graduate Groups	No	Yes

The final finding related to the experiences CPSS's is supervision and support from their team. Of concern, no CPSS discussed receiving scheduled, regular individual supervision. This is a concern, because there are volumes of material written on the benefit and necessity of individual supervision for people in the helping professions. In most helping professions individual supervision is a requirement for securing and maintaining licensure. CPSS's have specific needs, including self-care, work/life balance, boundary issues, and managing reactions to consumers who would benefit from regularly scheduled individual supervision. This continues to be an issue that Mowbray

et al. found in 1998: "...supervisory recognition and attention to boundary issues, which were so critical to these new employees' position and performance, were almost completely absent" p. 409). Providing individual supervision could deliver a safe space for confidential disclosure to process their fears, stigma, and reactions to clients.

Although CPSS's reported the DBT Consultation Team and impromptu team support helped them in their work, this should not be viewed as a replacement for individual supervision. Fruzzetti, A., Waltz, J. & Linehan, M. (1997) report that individual supervision should not be used on an as needed basis like many other therapies, but is an integral part of "treating the therapist". "Treating" the therapist helps the therapist to continue providing effective therapy and preventing burnout. This is an area of growth and opportunity for DBT teams that employ CPSS's.

Limitations and Opportunities

Limitations. When interpreting the results, some limitations of this study need to be considered. Although the sample included CPSS's from various demographic regions in Michigan, the sample only included CPSS's in the State of Michigan and thus limits generalizability to that particular state. It is possible that the CPSS's feared the information they shared would have an impact on their employment. Although confidentiality of the study was communicated to the CPSS's, this could have created a bias in their self-report responses. Another limitation of this study relates to qualitative rigor. The data was only collected through individual interviews. Triangulation was not performed in this study, which impacted internal validity. By collecting data through multiple means, such as additional stakeholder interviews and focus groups, internal validity would be improved. Due to time constraints, member checking, or participant's

verifying their responses, was not done. Agreement regarding the codebook was reached between multiple researchers, but only one researcher performed the coding, which had the potential for coder bias.

Opportunities. Despite the limitations of this study, it is an important first step to beginning the discussion of CPSS's being employed on DBT teams, and there are opportunities to consider. This study can inform future research on utilizing CPSS's on DBT teams. Study formats could be qualitative or quantitative in nature. A further study could explore the attitudes of consumers and DBT team members who work with a CPSS. Another important question to consider is whether consumer outcomes change for consumers who receive services from DBT teams that include a CPSS, compared to DBT teams that do not.

Among the outcome changes could be an effect on DBT drop out rate. A future study informed by this research could inquire if CPSS's have a positive impact on preventing DBT treatment dropout. Perroud, N., Uher, R., Dieben, K., Nicastro, R. & Huguelet, P. (2010) conducted a study of 447 participants between 1998 and 2008 completing an intensive four week DBT program and reported the predictors of drop out in DBT. They reported a drop out rate of 89 participants. The most significant predictor of dropout was low education level of the consumer. Potentially, CPSS's could tutor consumers with lower education levels and have a positive effect on drop-out rates. Future studies would add to the formulation of an evidence base for the use of CPSS's employed on DBT teams and potentially transforming how we currently deliver DBT. It would be beneficial to include a more national sample in future studies. In another study by Wnuk, S., McMains, S., Links, P., Habinski, L., Murray, J., and Guimond, T. (2013),

DBT drop out was compared to General Psychiatric Management (GPM) drop out. The study found the strongest predictor of drop out was the therapeutic alliance. This could potentially create a role for CPSS's employed on DBT teams to serve as a reinforcement to the therapeutic alliance with the individual therapist and the DBT team as a whole.

If evidence is established, this would could outline a path to employment and exiting the mental health system for current DBT consumers. Another possibility is integration into DBT-ACES, as previously discussed in the literature review, which is an already established program for moving consumers into independence from the mental health system. There is also an opportunity for DBT educators to incorporate the recovery philosophy into DBT by educating about CPSS and promoting the CPSS role on the team.

Future study in this area could include which DBT treatment stage, modes, and functions are ideal for CPSS involvement. It is worth inquiring whether engagement activities by CPSS's improve dropout rates from DBT. It is also worth studying the impact that an after-care curriculum would have on the retention of gains that consumers have achieved in DBT.

Recommendations. In addition to future research, this study could guide the practical implementation of CPSS's working on DBT teams. One of the recommendations from this study is the development of a DBT-specific job description for peers working on DBT teams. Development of a specific job description could conceivably diminish peer and staff confusion and frustration regarding the peer role on the DBT team. The job description would orient staff to the CPSS role on the team and aid in an agency culture shift towards understanding peer support. Finally, this study

shows individual supervision of CPSS's as being deficient. Individual supervision is an ideal format to discuss challenges, such as self-care and role confusion. This study encouraged DBT teams implementing a more robust individual supervision strategy for CPSS's.

Interrelation of CPSS and DBT Philosophies

The recovery philosophy, the foundation of certified peer support, corresponds well with the teachings of DBT. The recovery philosophy states that people with mental illness can and do recover (Deegan, 2015). Frese and Davis (1997) state that one of the key factors in recovery is self-determination and self-actualization. Recovery is self-directed and relies on the consumer being an expert of his or her own mental illness (Starnino, 2009). Self-actualization is similar to the concept in DBT called "building a life worth living".

One of the DBT techniques that coincide with the recovery philosophy is called "validation". In DBT, validation is the non-judgmental belief that consumers' experiences are understandable and important (Linehan, 2015). By respecting the DBT consumer's self-knowledge, the CPSS is practicing validation. A validation strategy used in DBT is called "radical genuineness". Linehan (2015) describes radical genuineness, as recognizing the client is more than a disorder. It is the belief in the client's strengths and capacity for change. Similarly, the CPSS uses self-disclosure to present an authentic self to a consumer (Salzer, 2010). Another value of DBT and peer support philosophy is collaboration. The CPSS views collaboration as a process "to arrive at a mutually acceptable plan for moving forward in the treatment process" (Deegan & Drake, 2006,

p.1638). Collaboration in DBT is viewed as a strategy that strengthens the working relationship (Linehan, 2015).

Implications for Social Work Practice

As stated earlier, the central tenet of CPSS's is the recovery philosophy. Social workers can find similarities between the values of social work and CPSS's. One value in social work practice is self-determination. Through transparent communication about treatment and the option of CPSS services, the clinician creates an environment of choice for consumers. It also provides a path to recovery that empowers the consumer to utilize a less formal mental health system. This study supports the creation of a less formal DBT treatment deliver through CPSS's. Exposure to a CPSS's unique insight into struggling with issues of stigma and discrimination gives the practitioner an opportunity to reflect on their own struggles. This reflection can promote greater empathy for their consumers (Carpenter, 2002). In this study, the CPSS insight is demonstrated not only with clients but with the DBT team as well.

Social workers in supervisory roles could assist peers in navigating dual relationships because of their professionally familiarity education about dual relationships. The National Association of Social Workers Code of Ethics sets standards for ethical relationships. In the code's conflict of interest section, 1.06, it states:

c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to

clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutive. (National Association of Social Workers, 1996)

There are also opportunities for social work administrators to support the employment of CPSS's in mental health agencies. As demonstrated in this study, the CPSS's felt supported by their administrators. This coincides with the National Association of Social Worker's (1996) responsibility to the larger society by "expanding choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups". Administrators could use the information is this study to demonstrate the positive impact CPSS's have on teams and support the hiring of CPSS's. On a policy level, social workers can advocate to promote Medicaid, Medicare and Managed Care reimbursement practices for CPSS services. Some states do reimburse for CPSS services but most implementation is slow.

Social work educators can support and teach recovery by including the recovery philosophy within social work curriculum. By including recovery in curriculums, the educators actively facilitate the students' paradigm shift away from the medical model to the belief that people with mental illness can and do recover. Educators can use the information in this study to demonstrate to students the impact of recovery systems of care. Teaching recovery principles corresponds with the NASW (1996) core value of social justice which states, "social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people" (Code 6.04).

Conclusion

The purpose of this study was to explore the utilization and experiences of CPSS's employed on adult DBT teams. Based on this study and the review of the DBT and peer literature, future research and exploration on the implementation of CPSS's on DBT teams is warranted. The literature review concluded that peers, consumers, and staff benefit from CPSS involvement in the mental health system. If CPSS involvement is considered a DBT modification, the research discussed in the literature review demonstrates that DBT modifications are possible and effective. This study's findings confirmed the benefits and challenges described in the literature. The unique findings in this study outlined the DBT modes and functions that can incorporate a CPSS.

Another unique concept of involving CPSS's in engagement and after-care programming was also introduced in this study. This study's findings can guide future research and implementation of CPSS's employed on DBT teams. Another important finding is the condition of the supervision and support provided to those CPSS's working in this challenging population. Considering the limitations of this study, a mindful integration of CPSS's into DBT teams is recommended.

Despite these limitations, this study initiated the discussion of consumer inclusion in DBT treatment. The benefits of consumer inclusion in general have been demonstrated for consumers, staff, and peers. It is now time that DBT treatment focuses on consumer inclusion and creates a recovery-oriented system of care for the consumers it treats. The NASW values support the use of CPSS involvement in mental health. With

diverse social work activities such as direct practice, administration, policymaking and education, social work is in a unique position to help advance CPSS involvement in DBT.

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Appendix A

Michigan Certified Peer Support Training Requirements

Peer Specialist Training Program in Michigan

Description of the training program

Five days of training plus an additional two days of an applied group training program and one day of follow-up training. Total of eight days. In the process of creating a continuing education program.

Competencies covered in the training

In all, there are twenty-four modules/competencies including:

- Wellness Recovery Action Plan (WRAP)
- Effective Listening
- Effects of Diagnosis on Self-Image
- Role of Peer Support in the Recovery Process
- Using One's Recovery Story as a Tool
- Shifting from Maintenance to Recovery
- Description of the Recovery Process
- Person-Centered Planning
- Self-Determination
- Employment and Housing

Eligibility Criteria

- Self-reported consumer in Michigan.
- Must have ten hours of work as a peer before training.
- Must be willing to tell one's recovery story.

Certification Process

There is a three-hour exam to certify peers.

Evaluations of Initiative

None as of yet.

Is training generic or geared towards particular jobs?

Training, as a whole, is designed for the peer specialist position, although there are the subtopics of housing, homelessness, and unemployment.

Extent to which the initiative is consumer-directed.

- Almost entirely consumer-directed
- Statewide coordinator and trainers are consumers

Supervision

Supervision is provided by the jobs peers take.

Willing to share curriculum with others?

N/A

Number of people who have completed training.

- 92 certified peers
- 120 have completed the training

Key contact information

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http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/peer_support_consumer_run_services_peer_specialists/Certified_Peer_Specialist_Training_Program_Descriptions.pdf

Appendix B

Recruitment Email

Dear CPSS or DBT Supervisor:

I am currently receiving my Doctorate in Social Work and I am interested in Certified Peer Support Specialists working on Dialectical Behavior Therapy teams. I'm contacting you to ask if you would like to consider participating in this research. Your involvement would include a 60-minute interview at a confidential place of your choosing. As a token of appreciation, a \$10 gift card will be provided for your participation. If you are interested or have any questions, please feel free to email or call me at 734-883-7830.

Thank you,

Megan Schutt, LMSW, ACSW
Doctoral Candidate
University of Pennsylvania

Appendix C

Informed Consent Form

Dissertation: Qualitative, Exploratory Study of The Utilization of Certified Peer Support Specialists in DBT

Introduction and Purpose of Study

I am a graduate student in the DSW program at the School of Social Policy and Practice at the University of Pennsylvania. I am conducting interviews for the purpose of gathering information for my dissertation. I am inviting you to participate in this interview.

What is involved?

The interview itself will last about an hour or less, but we should allow one and one-half hours total, so that we can get settled and go over the consent. I will make an audio recording of the interview and may take written notes.

I will ask you questions about your experiences being a Certified Peer Support Specialist working on a DBT team.

Confidentiality:

The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personal information, or information about where you live or work in my write-up of the interview.

Any identifying information will be kept in a locked file with only my access to it. I will blot out your name on this consent form. For purposes of transcription, I will send by secured network to GMR Transcriptionists (a copy of GMR's confidentiality statement is available to you at your request). Once I have analyzed the interview and written my final class paper for this project, I will destroy the audio recording and interview notes. I will remove anything from the transcript that will appear in the final paper, which might serve to identify you, including geographic locations and names of particular individuals you might mention.

Risks of participating: There are no foreseeable risks in participating in this interview. The ways that your confidentiality will be protected have already been described.

Benefits of participating:

Although being interviewed will not help you directly, it is also possible that having a chance to share your story will be an interesting and possibly even a rewarding experience for you.

Payment

If you decide to participate, you will be given a \$10 Visa gift card when the interview is completed. You will also be reimbursed for any money you spend to travel to the interview site.

If you have questions about the project after the interview is over, please feel free to contact me:

Megan Schutt at (734)-883-7830 or megankarlschutt@gmail.com

If after talking with me, you still have concerns, you can contact my dissertation chair:

**Andrea Doyle, PhD, LCSW
Assistant Professor
3701 Locust Walk, Caster Building Philadelphia, PA 19104-6214
doylea@sp2.upenn.edu**

Your participation is completely voluntary:

You do not have to participate in this project. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know whether you participate or not. If you don't participate, it will not affect your job or anything else.

If you do decide to be interviewed today, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer.

By signing this consent form, you are indicating that you have had all of your questions about the interview answered to your satisfaction and that you have been given a copy of this consent form.

Participant signature: _____

Participant printed name: _____

Date: _____

Interviewer signature: _____

Interviewer printed name: _____

Date: _____

Appendix D

CPSS Interview Guide

Certified Peer Support Specialist Interview Guide: (this is a question guide and outline of the categories of inquiry. Depending on the information gained from these questions, the interviewer may ask other probing questions.)

CPSS questions

Are you working as a certified peer support specialist on a DBT team?

Did you receive Michigan peer certification training?

When?

What did that training involve?

What is your understanding of the peer support philosophy?

What is your understanding of the role of CPSS?

What should CPSS not do?

DBT questions

What training did you receive in DBT?

Are you a current/previous DBT client?

Are you intensively trained in DBT?

Is your team intensively trained?

Have you received informal training from staff?

Do you participate on a DBT consultation team?

What are your duties on the DBT team?

What is the best part about working as a peer on a DBT team?

What is the most challenging part about working as a peer on a DBT team?

Who supervises you?

How often?

Are they trained in DBT? On the DBT team?

What is the quality of your supervision?

Is there something that you wish your supervisor did more of/less of?

CPSS and DBT integration

- Based on the peer philosophy you learned in your certification training, do you think it complements DBT? In what way?
- Based on your peer certification training, do you think your peer skills are being used in your current role on the DBT?
- Do you think there are any particular skills that benefit from a CPSS perspective?

- What are the DBT skills that are most helpful for CPSS to teach?

Impact

- What have you gained personally working on the DBT team? Do you think that is unique to DBT?
- Have there been any negative consequences to working on the DBT team? Do you think that is specific to DBT?
- If someone were thinking about becoming a peer on a DBT team, what would you advise them about?
- Are there any risks to relapse working with DBT clients?
- What is the future of DBT?

Appendix E

GMR Transcription Services, Inc. Confidentiality Agreement

GMR TRANSCRIPTION SERVICES, INC.

CONFIDENTIALITY AGREEMENT

This Agreement is made between GMR Transcription Services, Inc., a California Client (“GMR”) and _____ (Client) on _____.

Covenants of the Parties: GMR agrees to do the following, and the Client agrees to do the following. GMR and the Client both have made these commitments in reliance on the promises of the other as listed below.

1. Nondisclosure of Transactional Information: At all times, both during GMR’s services and after the cessation of GMR’s service, whether the cessation is voluntary or involuntary GMR shall:
 - a. Keep in the strictest confidence and trust all Transactional Information of the Client, which includes client information, production techniques, technical operations, recording information, transcription information, etc., from any source whatsoever (“Transactional Information”), which is disclosed to GMR in the course of negotiating, discussing the implementation of, or following hiring of GMR’s service with the Client; and
 - b. Not knowingly disclose, use, or induce or assist in the use or disclosure of any Transactional Information, or anything related to any Transactional Information, without the Client’s prior express written consent, except as may be necessary in the ordinary course of performing GMR’s duties as a service to the Client.
 - c. Delete all uploaded audio within one (1) week after GMR’s completion of the service.
 - d. Take all precautionary measures to ensure that GMR’s computers used for all services are protected from unauthorized personnel by obtaining and properly running an antivirus software, obtaining and properly running proper firewall protections, not allowing any other person to access GMR’s computers, not allowing any documentation relating to any project of the Client to be backed-up by an unrelated source, not allowing any documentation relating to any project of the Client to be backed-up onto any device that is not handed over to the Client upon completion of the project, and any other precautionary measures needed to protect the Transactional Information from being released to unauthorized personnel.
- 2.

e. At all times during GMR's service, promptly advise the Client of any knowledge that GMR may have of any unauthorized release or use of the Client's Transactional Information, and reasonable measures shall be taken to prevent unauthorized persons or entities from having access to, obtaining, or being furnished with any Transactional Information.

This Agreement is entered into on the date recited above by the undersigned parties in consideration of the foregoing mutual commitments.

GMR Transcription Services, Inc.
2512 Chambers Rd., Suite 206
Tustin, CA 92780
(714) 731-9000

BY:

BETH WORTHY, DIRECTOR OF OPERATIONS

Client

SIGNATURE

Appendix F

Demographic Face Sheet

CPSS Face Sheet

Participant ID:

Age:

Ethnicity:

Marital status:

Location of team:

Agency working at:

Job title:

Income source or sources (employment, Social Security, family member...):

Income per year:

- a. <\$5,000
- b. \$5,000-\$10,000
- c. \$10,000-\$15,000
- d. \$15,000-\$20,000
- e. \$20,000- \$25,000
- f. \$25,000- \$30,000
- g. \$30,000 +

Average hours worked:

Number of years on a DBT team:

Years of education:

Appendix G

Figures

Figure 1

County location of interviews

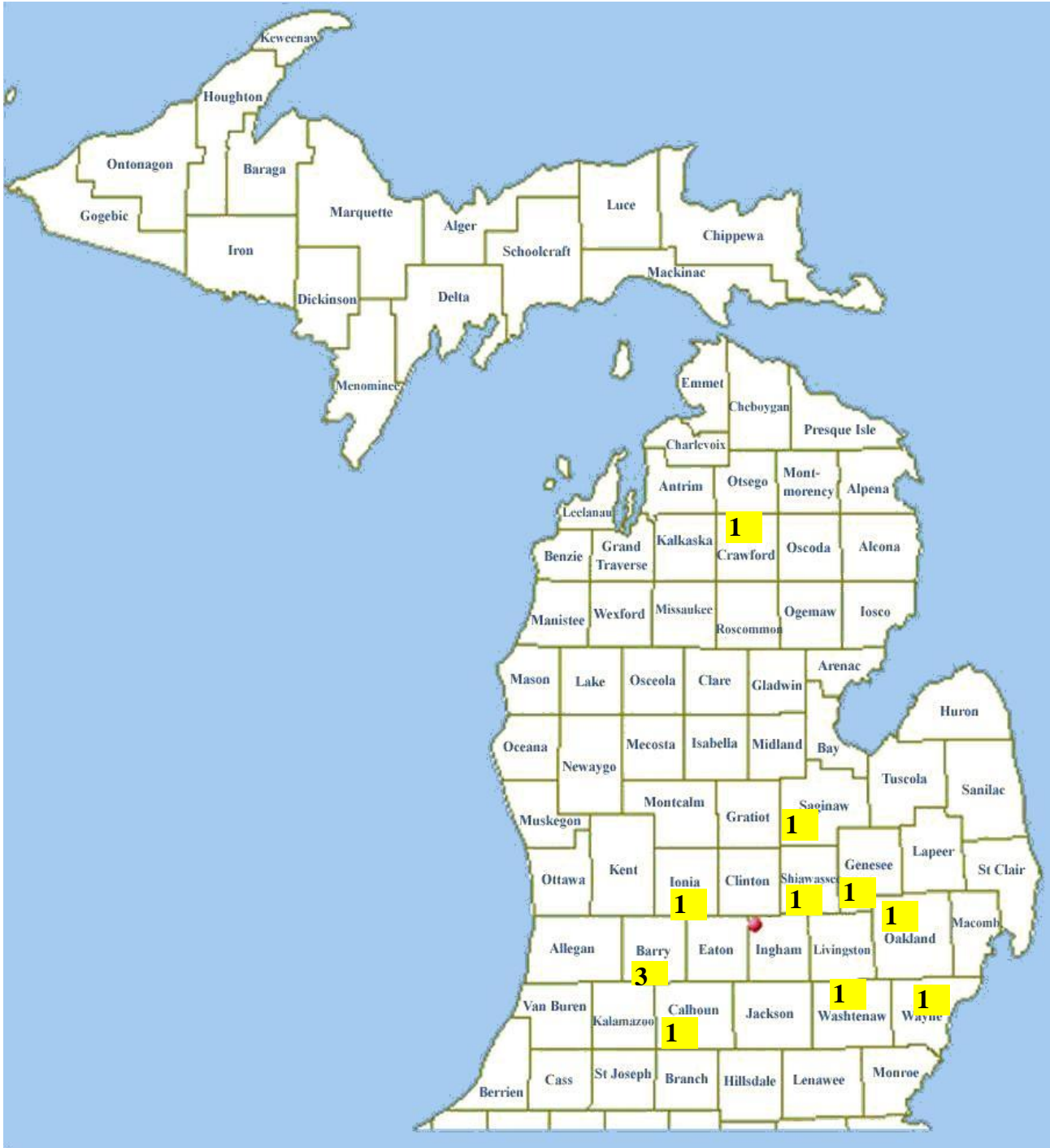


Figure 2

Thematic Process

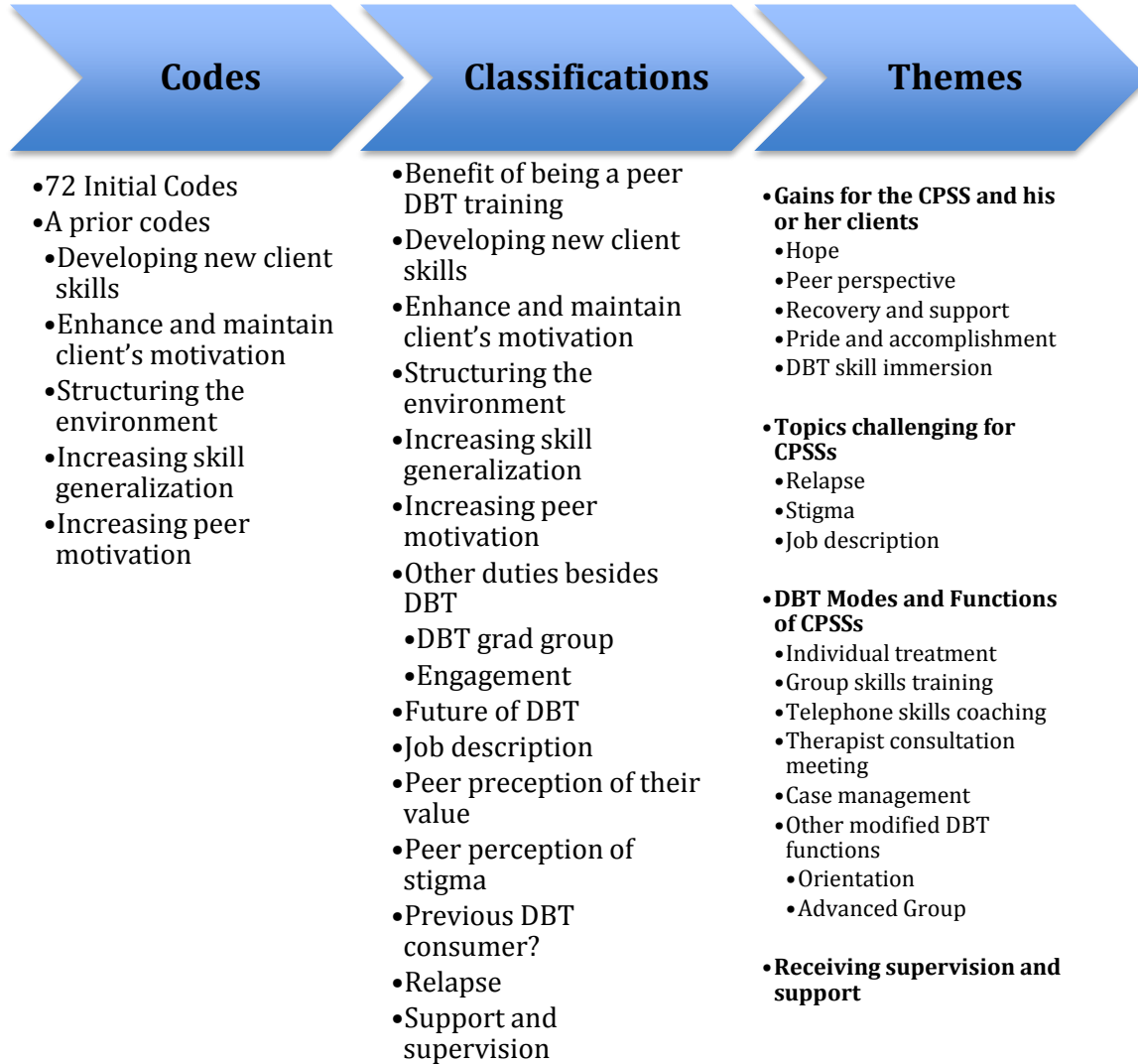


Figure 3

Themes and subthemes

