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Joseph Gary Davidson

(Student first, middle, last name)

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Viann Nguyen-Feng PhD LP

(Faculty Advisor Name, degree)

Name of Faculty Advisor



Signature of Faculty Advisor

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Date

**Integration of Dialectical Behavior Therapy and Trauma Center Trauma Sensitive
Yoga: Expert Opinion Through Delphi Method**

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Committee Members:
Viann N. Nguyen-Feng, PhD, MPH
Rhea Owens, PhD
Leah Cleeland, PhD

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With gratitude and hope,

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Integration of Dialectical Behavior Therapy and Trauma Center Trauma Sensitive Yoga: Expert Opinion Through Delphi Method

The integration of different models of psychotherapeutic treatment have been emerging (e.g., Ramirez et al., 2014). Integrative therapies have been trending since the 1990s, given that research over time has demonstrated the effectiveness of multiple approaches and common factors in psychotherapy (Zarbo et al., 2016). Although this may be the case, integrative approaches often place emphasis on the psychotherapy, lacking the consideration of the mind-body connection. I suggest here the integration of dialectical behavior therapy (DBT, Linehan et al., 1993) and Trauma Center Trauma-Sensitive Yoga (TCTSY; Emerson, 2015), as this may begin to address the need for a mind-body approach in traumatized individuals.

Dialectical Behavior Therapy

Dialectical behavior therapy was originally developed in response to the need of an effective treatment for those who experience suicidality and are diagnosed with borderline personality disorder (Budak et al., 2020; Limandri, 2020; Linehan et al., 1993). Two of the main operating principles of DBT include dialectical philosophy and biosocial theory (Linehan, 2015). Dialectical philosophy consists of the idea that there are opposing truths and that situations do not necessarily occur in dichotomies (Lyons, 2020; Rizvi et al., 2013). For example, one dialectical situation that is taught in DBT is change versus acceptance, where one learns to accept both possibilities of changing an aspect of themselves and accepting who they are (Limandri, 2020; Linehan, 2015; Lyons, 2020). The other component of DBT is biosocial theory, where emotional dysregulation stems

from a maladaptive biological mechanism, which further stems from an emotionally invalidating environment (Budak et al., 2020; Linehan, 2015; Rizvi et al., 2013; Shabb, 2016; Sweezy, 2011). Because of this, DBT includes a validation component to address emotional dysregulation (Berk, 2020; Fasulo et al., 2015; Limandri, 2020; Shabb, 2016).

Another component of DBT is the chain analysis (Limandri, 2020; Linehan, 2015; Rizvi et al., 2013). This provides individuals with the skills to self-analyze their behavior (Limandri, 2020; Linehan, 2015). The goal of behavioral chain analysis is to analyze behavior that is ineffective, such as using prompts to describe the problem behavior and the factors that led up to it (Limandri, 2020; Linehan, 2015; Mattei & Sposato, 2020; Rizvi et al., 2013). This skill helps users reflect and integrate DBT skills more effectively. The same principles apply to missing links analysis, where the user reflects on skills they could have used in times of distress (Linehan, 2015).

It is important to also note that Linehan (2015) and Limandri (2020) state that there are assumptions about the client when delivering DBT. These assumptions serve the purpose of orienting the therapist and client to their roles in DBT. These include that clients are trying their best; they are wanting to improve; they strive to do better and are motivated to change; others may have caused their problems, but they have to solve them anyway; the newly learned behaviors have to apply to all contexts, all actions, thoughts, and behaviors are caused; lastly, changing the behavior is more effective than judging or blaming. With these assumptions, the therapist positively believes in and guides the client. The client has a role in engaging in skills to manage dysregulation.

In addition to these assumptions, it is important to be mindful of the inconsistent literature on DBT in terms of methodology due the several variations of dialectical

behavior therapy (Gillions et al., 2019). Variations of DBT include, but are not limited to, adaptations (e.g., Gorg et al., 2019), different populations (e.g., Justo et al., 2018), and differing lengths of treatment (e.g., Andion et al., 2012). These variations all originate from DBT principles, but affect the generalizability of the manualized therapy (Gillions et al., 2019). In the present study, references to DBT will generally include its principles and skills utilized in the four modules: (1) distress tolerance, (2) interpersonal effectiveness, (3) emotion regulation, and (4) mindfulness (Linehan, 2015):

(1) The goals of distress tolerance are to manage oneself in crisis situations, such as mental health relapse, and come to terms with reality (Linehan, 2015). An example of a skill used in this module is the STOP skill (stop, take step back, observe, and proceed mindfully; Linehan, 2015). This skill would be used to tolerate stressful events that cannot be resolved immediately. Previous literature has demonstrated that having distress tolerance skills are a mechanism of change in general psychopathology and borderline personality disorder symptoms (Zeifman et al., 2020).

(2) The goals of interpersonal effectiveness is effectively communicating your wants and needs out of interpersonal relationships, building those relationships in a healthy manner, and being able to compromise (Linehan, 2015). An example of a skill used in this module is the DEAR MAN skill (describe, express, assert, reinforce, stay mindful, appear confident, and negotiate; Linehan, 2015). This skill would be most appropriate for social situations where one wants to assert themselves to others. As a result of DBT skills training involving interpersonal effectiveness, literature has demonstrated the improvement of group relationships throughout DBT for individuals diagnosed with substance use disorders (Cavicchioli et al., 2020).

(3) Arguably, one of the most crucial modules in DBT is emotion regulation (Linehan, 2015; Mattei & Sposato, 2020; Metcalfe et al., 2017). The goal of this module is to identify emotions, reduce the frequency and suffering of unwanted emotions, and to increase tolerance for intense emotions (Linehan, 2015). A skill in this module is “Check the facts,” where individuals learn to reflect on their perceptions of their events and to further prevent catastrophizing. Literature has established that DBT improves emotion regulation in those who have borderline personality disorder diagnosis (Bohus et al., 2004; Metcalfe et al., 2017) as well as those in other various contexts. There are two pilot studies with promising results among those who are incarcerated, one that involves emotion regulation using a DBT-Corrections Modified approach (Nyamathi et al., 2018), and the other involves emotion-behavioral regulation in a jail population (Moore et al., 2018). One study further used DBT-Skills Training as an social-emotional intervention for teachers (Justo et al., 2018).

(4) The remaining module of DBT is mindfulness. DBT defines mindfulness using three components: intentional awareness of the moment, without judgment of it, and without attachment (Linehan, 2015). The main goals of mindfulness are to experience reality as is, develop control over the mind, and reduce suffering to increase happiness (Budak et al., 2020; Limandri, 2020; Linehan, 2015). A component of DBT mindfulness is “Wise Mind,” a balance between emotions and reason. An example of practicing “Wise Mind” is the skill of imagining that one is a “walking down the spiral stairs” (Linehan, 2015, pg.11). This module becomes essential to the rest of the DBT modules as there is a component of awareness and acceptance in them (Budak et al., 2020; Limandri, 2020; Linehan, 2015; Rizvi et al., 2013; Zeifman et al., 2020). This

component tends to overlap with other psychotherapies, such as acceptance and commitment therapy (Hayes et al., 2006) and mindfulness-based cognitive therapy (Teasdale et al., 2000). An intervention that mindfulness overlaps with that is relevant to this study is TCTSY (Emerson, 2009), an empirically supported form of yoga.

With growing support for transdiagnostic applications of DBT (Ritschel et al., 2015) including posttraumatic stress disorder (PTSD), it is also important to note where these might have limitations. For example, two studies demonstrated that those with comorbid PTSD and borderline personality disorder reported more symptom severity than those with borderline personality disorder alone (Barnicot et al., 2013; Boritz et al., 2016). In addition, dissociation impacts outcomes of DBT-PTSD for women with and without and comorbid PTSD diagnosis to their borderline personality disorder diagnosis (Kleindienst et al., 2016).

Some other limitations that DBT has is that it is a demanding process for the clients in terms of time, energy, and resources, as it requires 12 weeks of twice-weekly sessions, one individual and one with a group (Reddy & Vijay, 2017). Further, clients may not find it feasible to meet the homework demands of DBT as well as the logic-based and educational style that it entails. Although some cultural adaptations of DBT are emerging, such as for Latin American individuals (Mercado & Hinojosa, 2017), this manualized therapy approach may not fully consider other cultural factors such as spirituality. Gillions and colleagues (2019) further recognize the limitations of DBT research, as literature employs inconsistent methodology. To address these limitations, and to use the strength of adaptability of DBT, integration with TCTSY is proposed as not only filling gaps, but further enhancing the treatment of traumatized individuals.

Trauma Center Trauma-Sensitive Yoga

History of the Globalization of Yoga

It is important to acknowledge the foundation of yoga as it allows one to appreciate its longstanding history and global influence. Yoga originates in Hinduism, Buddhist philosophy, and draws on mindfulness principles, which have influenced Western psychology (Neves-Pereira et al., 2018). In Buddhism, one practices mindfulness in part to reach a state of enlightenment, an experience of inner peace and wisdom (Neves-Pereira et al., 2018). As yoga began to globalize, Buddhist and mindfulness principles spread to the West and became increasingly focused on improvement of physical and mental health (Newcombe, 2009).

The origins of yogic practices date back to the 1700-1000 BCE, during the Vedic times, up to the 19th century (Hoyez, 2007). Yoga was mainly practiced in India for this time period. Hoyez (2007) provides a chrono-geographical account for the globalization of yoga, which is attributed to the spread of *bhakti yoga* by Swami Vivekananda, a yogic saint. Vivekananda connected with devotees in Asia, the United States, and Europe to spread *bhakti yoga* (Hoyez, 2007; Newcombe, 2009). Yoga further became more circulated throughout North America, Western Europe, and India. These locations became centers for yoga practice, where translators would interpret Hindu readings, and yoga practitioners began to hold yoga classes (Hoyez, 2007; Newcombe, 2009). Yoga then started to globalize to other regions of the world and started to see different practices accepted in different countries (Hoyez, 2007). This globalization then leads to how yoga has transpired in today's time, where there are individual, native forms of yoga in different countries (e.g., the Czech Republic; Hoyez, 2007).

Another important aspect in the history of yoga is not only its globalization, but also its westernization. There has been much criticism of the westernization of yoga, due to its shift in purpose. In the case of westernization, yoga has changed from a spiritual to a scientific, therapeutic practice (Lutkajtis, 2018; Newcombe, 2009). Yoga became an important topic in post-1500s America, where Christians were divided on the acceptance of yoga as a spiritual practice and where scientific investigators accepted yoga as a therapeutic practice (Newcombe, 2009). Along with yoga's establishment as a therapeutic practice, individuals (e.g., Strings et al., 2019) have criticized yoga for its westernization, increased femininity focus, and weight loss focus. Acknowledging these criticisms of the westernization of yoga and its origins are taken into account through this study as we facilitate discussion with experts on the integration of DBT and TCTSY.

What is TCTSY?

TCTSY is an empirically-supported treatment for individuals with treatment-resistant PTSD (Nolan, 2016; van der Kolk et al., 2014; West et al., 2017) and individuals who have experienced interpersonal traumas (Nguyen-Feng et al., 2019). TCTSY has further been deemed feasible as an adjunctive mental health treatment to therapy in community settings (Clark et al., 2014). Ongoing research on TCTSY continues to be promising in treating individuals with trauma-related symptoms with an embodied healing approach while providing other benefits of yoga, such as increased levels of mindfulness. This empirically supported form of yoga emphasizes several considerations including: creating a safe, welcoming environment; introducing trauma-sensitive physical forms; considering qualities of the facilitator; providing no physical assists; and using invitational language (Emerson, 2009). Some core themes

include experiencing the present moment, making choices, taking effective action, and creating rhythms (Emerson, 2009; Nolan, 2016).

TCTSY is an effective approach in reducing trauma symptomatology (e.g., van der Kolk, 2014). However, it does have its limitations, such as training requirements, accessibility to the training, and the need for integration into mental health clinics to make it reimbursable for clients. However, as mentioned before, TCTSY may also complement DBT well in addressing the need for adaptability for differing cultures and the incorporation of spirituality. As the TCTSY approach continues to grow, it may address these needs over time. In addition, some of these limitations may be addressed by DBT.

Interventions for Posttraumatic Stress Disorder

Relevant to this study are the DBT and TCTSY as interventions for PTSD. The criteria for PTSD as detailed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition–Text Revision (DSM-5-TR; American Psychiatric Association, 2022)* include exposure to traumatic events resulting in intrusion symptoms, avoidance of similar stimuli to traumatic events, negative alterations in cognition and mood, and alterations in arousal. Literature on the definition of trauma has indicated that outcomes of trauma are more severe when index trauma is defined as having multiple traumas, as opposed to the worst single traumatic experience (Priebe et al., 2018).

DBT has been used for those who have been diagnosed with PTSD (Bohus et al., 2013, 2019, 2020; Fasulo et al., 2015). Literature has demonstrated that DBT for PTSD is effective in the PTSD population (Bohus et al., 2013, 2019, 2020; Gorg et al., 2019; Lee et al., 2021; Steil et al., 2018). TCTSY has also been demonstrated to be effective for

those who have been diagnosed with PTSD (Nolan, 2016; van der Kolk et al., 2014; West et al., 2017). Given that these approaches effectively reduce PTSD symptoms, DBT and TCTSY may be able to complement each other well and enhance outcomes in PTSD symptomatology.

With growing support for transdiagnostic applications of DBT (Ritschel et al., 2015) including PTSD, it is also important to note where these might have limitations. For example, two studies demonstrated that those with comorbid PTSD and borderline personality disorder reported more symptom severity than those with borderline personality disorder alone (Barnicot et al., 2013; Boritz et al., 2016). In addition, dissociation impacts outcomes of DBT-PTSD for women with and without and comorbid PTSD diagnosis to their borderline personality disorder diagnosis (Kleindienst et al., 2016). DBT integrated with an embodied approach, such as TCTSY, has the potential to address these limitations.

DBT-TCTSY Integration

In the integration of DBT-TCTSY, it is important to address its overlapping components and how they complement each other. One great example of this is the combination of DBT's emphasis on the qualities of the therapist (Linehan, 2015; Limandri, 2020), whereas TCTSY has a focus towards the environment to reduce triggers (Emerson et al., 2009). DBT places an emphasis on therapist qualities through the use of dialectics. These include orientation to acceptance versus orientation to change, benevolent demanding versus nurturing, and unwavering centeredness versus compassionate flexibility (Linehan, 2015; Limandri, 2020). TCTSY provides a focus on the environment that reduces triggers, where choice is emphasized (Emerson et al., 2009).

The complementary qualities of these therapeutic techniques may suggest theoretical rationale for such an integration.

Literature has indicated inconsistent results with DBT and the outcome of aggression (Gillions et al., 2019). A component of this that TCTSY may account for is the physiological arousal associated with aggression (Barrett, 2017; Frank et al., 2014; Gard et al., 2014; Mocanu et al., 2018). Thus, TCTSY may complement DBT by utilizing a “body” approach, where DBT may focus more on the cognitive “mind” approach in aggression and emotion regulation. In addition, dissociation impacts the outcomes of DBT for individuals with PTSD (Kleindienst et al., 2016). Although DBT includes a mindfulness component, integrating an embodied approach may help manage dissociation, as TCTSY is geared towards individuals with treatment-resistant PTSD. In terms of PTSD symptomatology, integrating DBT principles in TCTSY may enhance treatment outcomes.

Study Aims

Considering the ways in which DBT and TCTSY complement each other and the promising outcomes of each therapeutic technique, this integrative approach has potential in enhancing outcomes related to mental health symptoms. Because this integrative approach has not been empirically developed or tested, it is important to obtain expert opinions of said integration. In this study, I aim to facilitate expert discussion on the proposed DBT-TCTSY integration through the use of the Delphi method, a sequential forecasting survey method used to detect consensus. With this in mind, the development of this study involves expert discussion of DBT-TCTSY integration on those who experience treatment-resistant PTSD with multiple traumas and the intended receivers of

DBT—those who experience suicidal-related symptoms and borderline personality disorder (see e.g., Bohus et al., 2004; Courtney-Seidler et al., 2014).

I aim to provide direction in answering the following question: What is the likelihood that the integration of DBT-TCTSY is feasible (Bowen et al., 2009), has integrity (Leff et al., 2009), and is clinically relevant (Lenz, 2021)? In providing this direction, I hypothesize that there will be consensus among ratings of DBT therapists and TCTSY facilitators that indicate DBT-TCTSY is likely to be feasible, clinically relevant, and to have integrity.

Method

The research members for this study who contributed to analysis of qualitative and quantitative research include two graduate students in a clinical counseling psychology program, one of which who participates in a DBT program, a postdoctoral fellow who has conducted previous research on the integration of DBT-TCTSY, two undergraduate research assistants, and a supervising researcher who is a registered yoga teacher and is working towards certification in TCTSY. The following study protocol was registered with the Center for Open Science and is available at <https://osf.io/jzfpr/>.

Participants

Per Beiderbeck and colleagues' (2021) recommendation, I recruited at least 15 participants per expert group. In this study, there were two expert groups: certified DBT therapists and certified TCTSY facilitators. DBT experts were recruited through the DBT-Linehan Board of Certification therapist directory (<https://dbt-lbc.org/>), emailing local organizations with DBT programs, and word of mouth. TCTSY facilitators were recruited through a TCTSY facilitator listserv. Generally, research has demonstrated that

response rates are increased with the use of phone calls in comparison to postal and internet surveys (Sinclair et al., 2012). However, internet surveys are more cost-effective in terms of the proportion of software costs and response rates (Sinclair et al., 2012). Given the cost-effectiveness of internet surveys, and that the sample consists of international and specialized experts (e.g., DBT and TCTSY), this is the most appropriate method of data collection.

There were participants in this study who were both certified in DBT and TCTSY ($n = 7$). These participants were subsumed under the DBT expert category due to the need for this category to meet the minimum of 15 participants. Furthermore, new DBT therapists were recruited in Rounds 2 ($n = 11$) and 3 ($n = 12$) to further meet the minimum recruitment recommendation of 15 (Beiderbeck et al., 2021). DBT therapists were recruited via direct email. TCTSY facilitators were recruited through the TCTSY-Facilitators listserv. For a depiction of the recruitment process and the corresponding sample size for each round, see the CONSORT diagram in Figure 1.

Experts were asked to report sociodemographic information such as employment status, years of certification, level of certification, scope of practice, race/ethnicity, location, age, gender identity/expression, sexual orientation, income status, and formal education background. Participants who reside in the United States originate from 20 different states. The demographic information was included only for respondents of the first round. Resultantly, Table 1 represents Round 1 demographics, which might not be fully representative of the sample of later rounds.

For compensation, participants were entered into a drawing each round upon completion of the survey. Rounds 1 and 2 included a drawing for three \$25 prepaid debit

cards, and Round 3 included a drawing for three \$50 prepaid debit cards. No participants were excluded from the study.

Measures

Quantitative

The Delphi method used here is quantitative and qualitative in nature. Following Rayens and Hahn (2000) model for Delphi statements, the quantitative measures in this study involve Likert-scale ratings of the likelihood of a statement of a corresponding construct, where 1 = *very unlikely*, 2 = *unlikely*, 3 = *neither unlikely or likely*, 4 = *likely*, and 5 = *very likely*. A Delphi statement is what one rates based on their expertise and are used in forecasting studies (Beiderbeck et al., 2021).

For example, an item in the feasibility (Bowen et al., 2009) states: “How likely... is DBT-TCTSY to be a successful integration?” These items arose from Brown et al.’s (2009) definition of feasibility, which includes consideration of the following factors: the demand for this integration, the implementation, the acceptability, the practicality, adaptability, the ability to integrate DBT-TCTSY into existing programs, and ability to expand to other populations than the target population.

For integrity (Leff et al., 2009), an example item states: “How likely... are facilitators able to effectively implement DBT-TCTSY?” These items arose from Leff et al.’s definition of integrity, which includes consideration of the following factors: effective implementation, ability for evaluation and comparison to other interventions, clients’ response, expert (i.e., DBT therapist and TCTSY facilitator) ability to collaborate, and expert ability to understand the integration of DBT-TCTSY.

For clinical relevance (Lenz, 2021), an example item states: “How likely... will DBT-TCTSY be meaningful for your target population?” These items arose from Lenz’s definition of clinical relevance, which includes consideration of the following factors: DBT-TCTSY as a meaningful approach and being worthwhile considering the expected costs and inconveniences.

There are five existing items for integrity, seven for feasibility, and two for clinical relevance for the first round with subsequent additions in the following two rounds. Given the exploratory and sequential nature of the Delphi method, experts were encouraged to add Delphi statements and rate them on the same scale of likelihood. Because of its sequential nature, the Delphi method occurred in multiple rounds, with three rounds in this study. See Appendix for the full measures with newer Delphi statements in the later two rounds.

Qualitative

A qualitative component was added to the Delphi method survey due to the exploratory nature of this study. For each area of interest (integrity, feasibility, and clinical relevance), participants were encouraged to leave commentary by using this prompt: “If you would like to add comments about the [insert area of interest] of the integration of DBT-TCTSY, please do so here: [text box].” This occurred for all three rounds of the study.

Procedures

The Delphi method, following the Beiderbeck et al. (2021) model, is a survey that occurs in rounds. The Delphi method was used in this survey through three rounds. Before the survey, the experts were asked to view an infographic containing background

information on DBT and TCTSY themselves and then the proposed integrated DBT-TCTSY skills card deck created by content experts. In the first round of the survey, experts were asked to complete a demographic questionnaire and the Delphi survey involving the three constructs: integrity (Leff et al., 2009), feasibility (Bowen et al., 2009), and clinical relevance (Lenz, 2021). The consensus analysis was then conducted for the first round. In the second round, the experts were informed of where consensus occurred in Round 1. Then, the experts were asked to re-rate each Delphi statement, including new statements added from Round 1. Another analysis for consensus was conducted afterward. The third round was the same as the second round, with the final analysis of consensus occurring afterward. Qualitative analyses were ongoing throughout the course of the study and were analyzed thematically.

Data Analysis

Consensus Analysis

Consensus was determined through the use of an interquartile range (IQR) of less than 1 per recommendation of Rayens and Hahn (2000). This is an appropriate cutoff given the proposed small sample size, as this specific range of IQR allows for detection of both consensus and non-consensus (i.e., dissent) among 30-40 experts. Following Beiderbeck and associates' (2021) recommendation, the calculated IQR was to determine consensus among each expert group. The IQR was calculated based on the responses given per Delphi statement. The responses were used to calculate the IQR among the overall sample, DBT therapists, and TCTSY facilitators. If the calculated IQR was less than 1 for the Delphi statements, then consensus was considered to be reached.

Qualitative Analysis

Continuing to model after Beiderbeck and colleagues' (2021) Delphi method, a simple thematic analysis approach was utilized to detect themes and frequencies in the qualitative comments of the experts. All research members of this study contributed to coding themes across the qualitative comments in each round. In each round, each member coded their own themes and then the research team agreed upon and edited coded themes to better represent the qualitative comments. This coding process is iterative in nature as DBT experts and TCTSY facilitators were asked to answer qualitative items each round.

Given the continuous nature of the Delphi method in this study, inductive approaches were used for all rounds. This approach was selected given the novelty in integrating DBT and TCTSY and thus the lack of literature to create deductive codes. Cross-impact analysis, which involves establishing relationships between certain events and areas of interest (Beiderbeck et al., 2021), was not utilized due to the lack of specific, hypothetical events, but rather qualities of an emerging therapeutic approach.

Deviations from Original Protocol

Due to differing limitations of the study, some deviations from the original protocol occurred. For one, given the iterative nature of the research method, it was originally intended to use a grounded theory approach to analyzing qualitative data. Given the low number of qualitative comments, I opted for a simple thematic analysis to detect themes across all qualitative comments. Although Beiderbeck and colleagues (2021) do not recommend a specific timeline of the completion of surveys, they gave the example of nine to fifteen weeks including first round of surveys to the final round of surveys. The original intention was to follow this similar timeline given the relatively

small sample size, but then deviated to a month-to-month basis due to lack of response from expert groups. Lastly, a dissent analysis (see Beiderbeck et al., 2021) was not conducted due to an inconsistent amount of responses and time constraints of participation in a graduate program.

Results

Qualitative

Across the three rounds where qualitative comments were fielded regarding the integrity, feasibility, and clinical relevance of the integration of DBT-TCTSY, some themes were identified. The number of qualitative comments per round ranged from 4 to 22. In the skills template included for expert review in each round, themes were summarized by subject matter experts and were noted at the top of the skills template in Rounds 2 and 3 (based on the qualitative comments from the preceding round).

Comments included in Round 1 involved curiosity about the specific aspects of DBT-TCTSY (e.g., traditional DBT versus DBT skills-only integrated into yoga), concerns with required expertise and related power dynamics, and consumer perspectives on receiving DBT. For instance, one of the main themes across comments was concerns with training and collaboration among DBT therapists and TCTSY facilitators. These include having specialized training of TCTSY principles for DBT therapists, and of TCTSY facilitators with DBT Skills. Another qualitative comment demonstrated concern with power dynamics among each expert group in the administration of DBT-TCTSY. Relatedly, another identified theme was clarifying that DBT-TCTSY is the integration of DBT skills and TCTSY principles, as opposed to the traditional DBT package (Linehan, 2015) and the protocol of TCTSY.

Comments in Round 2 included seeing potential in incorporating more embodied practices with DBT, more curiosity with the specific aspects of DBT-TCTSY, and concerns with insurance coverage. Specifically, an overarching theme among qualitative comments involved practical considerations with DBT-TCTSY. One of these was providing ongoing support and consultation between DBT therapists and TCTSY facilitators. Another consideration was providing strategies to incorporate TCTSY into existing DBT programs.

Comments in Round 3 mainly included concerns with accessibility to the deaf population and excitement about this integrated approach. That is, a consideration that was present related to providing accommodations for participants with disabilities, such as members of the deaf population and with physical limitations. A suggestion included in the comments was inviting DBT therapists to participate in TCTSY to gain firsthand experience.

Lastly, although there were some concerns regarding the integration of DBT-TCTSY, participants expressed excitement about this integration. Some participants who were a part of existing DBT programs expressed wishes about integration of TCTSY into their DBT program. Other experts expressed the lack of yoga at their worksite and mentioned how yoga can be introduced through the integration of TCTSY.

Quantitative

The consensus analysis findings of each round of this study is depicted through Figures 2-4 and Tables 2-10. Newer questions in later rounds reflect additional Delphi statements added in the corresponding previous round pulled from participant input. In cases where consensus was met, the point where consensus on each scale of likelihood is

reflective of the mean. For example, if the mean of an item is 3.89, I rounded it to the nearest whole number. In this case, consensus would have been considered met at point “4” on the Likert-type scale, indicating that consensus is on attributing “Likely” to the corresponding Delphi statement.

Round 1

In Round 1, there were several Delphi statements where consensus was reached among the overall sample due to an IQR of less than 1 ($n = 7$ of 14 items; 50%). The items within integrity included: “are facilitators able to effectively implement DBT-TCTSY” ($M = 3.96, SD = 0.67, IQR = 0$), “is the ability to evaluate and compare DBT-TCTSY’s effectiveness to interventions” ($M = 3.89, SD = 0.61, IQR = 0$), “are participants to respond positively to DBT-TCTSY” ($M = 4.09, SD = 0.63, IQR = 0$).

Items within feasibility included: “is DBT-TCTSY to be a successful integration” ($M = 4.00, SD = 0.60, IQR = 0$), “is it that intended recipients will accept DBT-TCTSY” ($M = 3.98, SD = 0.54, IQR = 0$), “is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)” ($M = 4.00, SD = 0.56, IQR = 0$), “is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs” ($M = 3.87, SD = 0.74, IQR = 0$).

No items within clinical relevance met or exceeded the IQR threshold. The other integrity and feasibility Delphi statements included in the Round 1 survey had an IQR of 1 or more, indicating that the consensus threshold was not met for these statements. These statements of non-consensus included the ability for each expert group to collaborate, the demand for DBT-TCTSY, is able to be implemented considering resources, and DBT-TCTSY as a meaningful approach. See Table 2 for a depiction of

Round 1 results for the overall sample. See Tables 3-4 and Figure 2 for results separated by DBT and TCTSY experts.

Round 2

In Round 2, there were also several Delphi statements where the consensus threshold was met ($n = 10$ of 18 items; 55.56%). The items within integrity included: “are facilitators able to effectively implement DBT-TCTSY” ($M = 4.03$, $SD = 0.32$, $IQR = 0$), “is the ability to evaluate and compare DBT-TCTSY’s effectiveness to interventions” ($M = 4.00$, $SD = 0.45$, $IQR = 0$), “are participants to respond positively to DBT-TCTSY” ($M = 4.06$, $SD = 0.37$, $IQR = 0$), “are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implement in their work” ($M = 3.87$, $SD = 0.57$, $IQR = 0.25$)

The items within feasibility included: “is there to be a demand for DBT-TCTSY” ($M = 4.03$, $SD = 0.76$, $IQR = 0$), “is DBT-TCTSY to be a successful integration” ($M = 4.17$, $SD = 0.53$, $IQR = 0.25$), “is that intended recipients will accept DBT-TCTSY” ($M = 3.93$, $SD = 0.52$, $IQR = 0$), “is DBT-TCTSY able to be integrated into existing infrastructures of treatment programs” ($M = 3.90$, $SD = 0.66$, $IQR = 0$), “is DBT-TCTSY able to expand to other populations other than the target population” ($M = 3.93$, $SD = 0.74$, $IQR = 0.25$).

The items within clinical relevance included: “is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm” ($M = 4.10$, $SD = 0.61$, $IQR = 0.25$). See Table 5 for more details on results for the overall sample. See Tables 6-7 and Figure 3 for results separated by DBT and TCTSY experts.

The other integrity, feasibility, and clinical relevance Delphi statements included in the Round 2 survey had an IQR of 1 or more, indicating that the consensus threshold was not met for these statements. The statements of non-consensus regard collaboration between expert groups, dialectics of DBT and TCTSY, resource considerations, adaptability, accessibility, ability to be empirically tested, and insurance coverage.

Round 3

In Round 3, there were more Delphi statements where consensus was reached ($n = 14$ of 20 items; 56%). Items within integrity included: “are facilitators able to effectively implement DBT-TCTSY” ($M = 4.07$, $SD = 0.27$, $IQR = 0$), “is the ability to evaluate and compare DBT-TCTSY’s effectiveness to interventions” ($M = 3.93$, $SD = 0.47$, $IQR = 0$), “are participants to respond positively to DBT-TCTSY” ($M = 4.19$, $SD = 0.40$, $IQR = 0$), “are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY” ($M = 4.00$, $SD = 0.68$, $IQR = 0$), “are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work” ($M = 4.15$, $SD = 0.53$, $IQR = 0$), “are TCTSY facilitators and DBT therapists able to balance the dialectics of TCTSY and DBT when implementing DBT-TCTSY” ($M = 3.93$, $SD = 0.55$, $IQR = 0$).

Items within feasibility included: “is there to be a demand for DBT-TCTSY” ($M = 4.07$, $SD = 0.38$, $IQR = 0$), “is DBT-TCTSY to be a successful integration” ($M = 4.11$, $SD = 0.42$, $IQR = 0$), “is that the intended recipients will accept DBT-TCTSY” ($M = 4.00$, $SD = 0.55$, $IQR = 0$), is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs ($M = 3.89$, $SD = 0.58$, $IQR = 0$), “is DBT-TCTSY able to expand to other populations other than the target population” ($M = 4.00$, $SD = 0.55$, $IQR = 0$), “is

DBT-TCTSY able to be empirically tested to ensure an evidence base ($M = 3.89$, $SD = 0.51$, $IQR = 0$). There was one item within clinical relevance: “is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm” ($M = 4.19$, $SD = 0.40$, $IQR = 0$).

The remaining Delphi statements ($n = 6$) did not meet consensus with an IQR of 1 or greater. The two items that did not meet consensus for integrity were: “is this to improve outcomes for specific clients over and above DBT without TCTSY; “are TCTSY facilitators and DBT therapists to have a support system for this collaboration to work well.” The two items that did not meet consensus for feasibility were: “is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment”; “is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery).” Lastly, the two items that did not meet consensus for clinical relevance were: “is it that DBT-TCTSY will be meaningful for your target population”; “is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY.” Results were similar within the DBT therapist and TCTSY facilitator groups with the exception that “is it that DBT-TCTSY will be meaningful for your target population” *did* reach consensus among TCTSY facilitators. See Table 8 for more details on the results for the overall sample. See Tables 9 - 10 and Figure 4 for results separated by DBT and TCTSY experts.

Discussion

The purpose of this study was to gain an understanding of experts’ opinions on a novel protocolized approach of DBT-TCTSY. More specifically, I was interested in facilitating discussion on the likelihood that the integration of DBT-TCTSY is feasible

(Bowen et al., 2009), has integrity (Leff et al., 2009), and is clinically relevant (Lenz, 2021) through determining where the consensus is met among DBT therapists and TCTSY facilitators. Consensus analysis revealed that there was consensus among the majority of feasibility, integrity, and clinical relevance aspects, while the consensus threshold was not met on other aspects of these constructs. These results provide partial support for my hypothesis that consensus was determined among the experts regarding the integration of DBT-TCTSY in that the majority of sub-items within each element (feasibility, integrity, clinical relevance) reach consensus. Overall, the data provide useful insight into the considerations for developing a novel, integrated approach such as DBT-TCTSY.

Relatedly, the qualitative comments solicited from the experts also provided perspectives in consideration of the emerging DBT-TCTSY. With a continual focus on delivering person-centered care in mental health services (Boardman & Dave, 2020), there were themes of making accommodations for clients with disabilities. This concern is consistent with previous research regarding accessibility and yoga, where a meta-analysis revealed that yoga has positive effects of improving quality of life, depression, and anxiety in individuals with multiple sclerosis and experiences with stroke (Veneri et al., 2018). Interestingly enough, and similar to a component of DBT of having a consultation team (Linehan, 2015; Rizvi et al., 2013), some comments noted the importance of collaboration and support between DBT therapists and TCTSY facilitators, including specialized training of on perspective for the other expert group (e.g., specialized training of DBT for TCTSY facilitators). Another main concern was

clarifying the providers involved and how DBT-TCTSY differs from traditional DBT (Linehan, 2015; Rizvi et al., 2013) and protocolized TCTSY (West et al., 2017).

Although there was not any specific qualitative comment toward evidence-based practice, a Delphi statement that was added involves the testability of DBT-TCTSY as an empirically supported approach, demonstrating some concern for this approach as an evidence-based practice. The American Psychological Association defines evidence-based practice as the integration of research, clinical judgment, and client characteristics and preferences (APA, 2006). Given that DBT is a well-established treatment (Linehan, 2015), that TCTSY is also emerging as well-established (Nolan, 2016; van der Kolk et al., 2014; West et al., 2017), and consensus among the experts trained in these approaches, DBT-TCTSY demonstrates promise in being feasible, having integrity, and being clinically relevant as an evidence-based practice.

Limitations

Although this study demonstrates expert perspectives of DBT-TCTSY as promising, there are some limitations that are present. For one, the survey used in this study had to be adapted from prior studies (Bowen et al., 2009; Leff et al., 2009; Lenz, 2021) that measured my constructs of interests (feasibility, integrity, and clinical relevance), as there was not an existing measure for integrated interventions; however, an adapted measure is appropriate in this case given the novelty of the project. Additionally, the sample size just met the minimum suggested for Delphi methods (Beiderbeck et al., 2021), which impacts the generalizability of the findings to the opinions of others in these expert groups. Relatedly, I had to recruit new experts from the DBT therapists group to maintain Beiderbeck and colleagues' (2021) recommended sample size of 15 per expert

group. However, these were best recruitment results given that recruitment procedures maximized nearly all publicly accessible contact information of certified DBT therapists. Furthermore

Additionally, caution should also be exercised in the interpretation of these results as the data was likely influenced by the ratings of TCTSY facilitators, as there were almost double of TCTSY facilitators ($n = 46$) compared to DBT therapists ($n = 25$) in the first round. The discrepancy, however, was lower for Rounds 1 and 2. Furthermore, demographics were not collected for Round 2 and 3 due to error in including these questions on all surveys in each round. Additionally, there were some experts who were certified in DBT and TCTSY, who were further included under the category of DBT due to experts who were solely DBT therapists. Although these experts provide a unique and useful perspective on this integration, the comparison between opinions on DBT-TCTSY among DBT and TCTSY providers may not be particularly warranted, albeit useful in understanding considerations in developing this approach.

Implications

Despite these limitations, the results suggest some research and practical implications. This study may serve as a basis to pilot DBT-TCTSY in applied settings, as it appears that the majority of experts generally agree on this approach as feasible, having integrity, and being clinically relevant. The aspects where there was no consensus also provides important considerations to be addressed in developing DBT-TCTSY. For example, a Delphi statement where the consensus threshold was not met is “is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment.” This prompts future pilot research and practicing DBT-TCTSY

providers to examine considerations in making this approach more accessible (e.g., cost-efficient, time-sensitive) to the target population.

Methodologically, future qualitative research that implements the Delphi method can benefit from including interviews to obtain richer data for qualitative analyses. Relatedly, future research may consider experts that are certified in both DBT and TCTSY as a mutually exclusive group (vs. DBT therapists vs. TCTSY-F). Furthermore, new participants were recruited in the later two rounds to meet the sample minimum recommended by Beiderbeck and colleagues (2021). Although it is adequate to recruit new members to meet this minimum, it is ideal to keep the same sample over time to facilitate an ongoing forum (Beiderbeck et al., 2021). Participants may have had difficulty in continuing responsiveness due to several reasons. One could be the survey method, as different survey methods (e.g., internet, phone, postal) each have their advantages, such as cost-effectiveness and personalization (Sinclair et al., 2012). Another reason can be attributed to a relatively specialized, low sample pool (e.g., DBT therapists versus therapists from multiple orientations).

Specific to DBT-TCTSY and other therapeutic approaches, future research, if qualitative, can benefit from asking more specific and applied questions (e.g., DBT-TCTSY implementation in residential settings for youth, specific disorders). Future research in DBT-TCTSY may further benefit from soliciting the perspectives of experts in DBT and TCTSY as they provide an educated, trained, and unique perspective on this integration.

Relatedly, this study can serve as a basis for continuing research in this emerging area, such as conducting a pilot study to test the in vivo feasibility of DBT-TCTSY in

addition to expert self-report. That is, three of the six items that did not reach consensus might be best assessed within the *target population* rather than *providers* (i.e., DBT therapists, TCTSY facilitators). That is, the items that did not reach consensus involved DBT therapists and TCTSY facilitators speaking on behalf of the target population, which might be presumptuous. These items include how meaningful DBT-TCTSY would be for their target population, the adaptability of DBT-TCTSY for new target populations, and improvement in outcomes.

The remaining three items that did not reach consensus might be best examined within *institutional* structures rather than *individual* providers. To address two of these items, a pilot study could arrange its procedures to develop a support plan between DBT therapists and TCTSY facilitators and to examine the feasibility of implementing DBT-TCTSY within resource constraints. The items regarding insurance coverage of DBT-TCTSY did not reach consensus, and the policy decisions involved in such a possibility is perhaps outside the scope of the present research, and are more applicable to piloting DBT-TCTSY in existing programs and institutional structures.

Conclusion

Overall, the current study has enhanced our understanding of experts' opinion in the emerging integration of DBT-TCTSY as a promising approach. Although the results of this study are not immediately generalizable to the perspectives of other DBT and TCTSY experts, this can prompt other experts in these areas to explore more top-down and bottom-up approaches. Resultantly, I hope that the current research in this study can prompt further mixed-method research of DBT-TCTSY therapeutic approaches and serve the clientele who would greatly benefit from this integration.

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Tables

Table 1

Sociodemographics of Participants in First Round Survey

Characteristic	DBT		TCTSY		Full Sample	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender						
Cisgender woman	16	80.0	32	88.9	48	85.7
Cisgender man	1	5.0	3	8.3	4	7.1
Non-binary/fluid	1	5.0	1	2.8	2	3.6
Write-in: Demi-Femme	1	5.0	—	—	1	1.8
Decline to answer	1	5.0	—	—	1	1.8
Race/Ethnicity						
White/European Descent	10	76.9	31	68.9	42	75.0
Filipina/o/x	—	—	1	2.6	1	1.8
Hispanic/Latina/o/x/e or Spanish origin	—	—	1	2.6	1	1.8
White, Hispanic origin	—	—	1	2.6	1	1.8
Chilean	—	—	1	2.6	1	1.8
Mexican American	—	—	1	2.6	1	1.8
South American	—	—	1	2.6	1	1.8
Uruguayan	—	—	1	2.6	1	1.8
Decline to answer	1	5.0	1	2.6	2	3.4
Sexual Orientation						

Queer/Monosexual	—	—	1	2.2	1	1.8
Queer/Bisexual	4	20.0	3	6.7	7	12.5
Straight/ Heterosexual	9	45.0	29	64.4	38	67.9
Asexual	—	—	1	2.2	1	1.8
Unsure/Questioning	1	5.0	2	4.4	3	5.4
Decline to answer	1	5.0	—	—	1	1.8
Country of Residence						
Australia	1	5.0	7	15.6	8	14.3
Belgium	—	—	1	2.2	1	1.8
Canada	2	10.0	1	2.2	3	5.4
Denmark	—	—	1	2.2	1	1.8
Germany	—	—	1	2.2	1	1.8
Italy	—	—	2	2.2	2	3.4
New Zealand	—	—	2	4.4	2	3.4
United Kingdom	—	—	1	2.2	1	1.8
United States	16	75.0	20	44.4	36	64.3
Ireland	1	5.0	—	—	1	1.8
Parents Born in Another Country	2	10.0	9	20.0	11	19.6
Type of Community						
Large city	8	40.0	17	37.8	25	44.6
Suburb	5	25.0	7	15.6	12	21.4
Small city or town	4	20.0	10	22.2	14	25
Rural area	3	15.0	2	4.4	5	8.9
Age (years)						

20-30	0	0	3	6.7	3	5.3
31-40	9	45.0	14	38.9	23	63.9
41-50	8	40.0	10	22.2	18	32.1
51-60	1	5.0	7	15.6	8	14.3
61-70	2	10.0	2	4.4	4	7.1
Highest level of formal education						
High school diploma or equivalent	0	0	2	4.4	2	3.4
Technical school / associate degree / some college	0	0	3	6.6	3	5.4
Bachelor's degree completed	3	15.0	11	24.4	14	25.0
Graduate degree	14	70.0	19	42.2	33	58.7
Areas of training/education						
Psychology and/or Human services	19	76.00	39	84.78	58	81.69
Other areas or disciplines	19	76.00	49	-	68	95.77
Current Training/Work						
Vocational training	1	5.0	9	20.0	10	17.9
Part-time	2	10.0	11	24.4	13	23.2
Full-time	13	65.0	17	47.2	30	53.6
Self-employed	13	65.0	17	47.2	30	53.6
Freelancer	—	—	4	8.9	4	7.1
Retired	1	5.0	—	—	1	1.8

Note. Ns = 52-71, due to missing data. Columns might not sum to 100% due to rounding

and participants' option to select multiple choices. DBT = dialectical behavioral therapy. TCTSY = Trauma Center Trauma-Sensitive Yoga.

Table 2

Descriptive Statistics of Overall Sample in Round 1

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	3.96	0.67	4	4	2	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	3.89	0.61	4	4	3	5	0
are participants to respond positively to DBT-TCTSY	4.09	0.63	4	4	3	5	0
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.07	0.77	4	4	2	5	1
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their	4.15	0.82	4	4	2	5	1

work

Feasibility

is there to be a demand for DBT-TCTSY	4.04	0.87	4	4	2	5	1
is DBT-TCTSY to be a successful integration	4.00	0.60	4	4	3	5	0
is it that intended recipients will accept DBT-TCTSY	3.98	0.54	4	4	2	5	0
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.41	0.86	4	4	1	5	1
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	4.00	0.56	4	4	3	5	0
is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.87	0.65	4	4	2	5	0
is DBT-TCTSY able to expand to other populations other than the target population	3.93	0.74	4	4	2	5	1

Clinical Relevance

is it that DBT-TCTSY	4.17	0.85	4	4	1	5	1
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will be meaningful
for your target
population

is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	3.98	0.86	4	4	1	5	1
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Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 3*Descriptive Statistics of DBT Therapists in Round 1*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.18	0.41	4	4	4	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	4.00	0.63	4	4	3	5	0
are participants to respond positively to DBT-TCTSY	4.18	0.60	4	4	3	5	1
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.18	0.87	4	4	2	5	1
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	4.18	0.87	4	4	2	5	1
Feasibility							
is there to be a	4.09	0.94	4	4	2	5	1

demand for DBT-TCTSY							
is DBT-TCTSY to be a successful integration	4.27	0.65	4	4	3	5	1
is it that intended recipients will accept DBT-TCTSY	4.36	0.51	4	4	4	5	1
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.82	0.87	4	4	2	5	1
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	4.09	0.70	4	4	3	5	1
is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.82	0.87	4	4	2	5	1
is DBT-TCTSY able to expand to other populations other than the target population	4.00	0.78	4	4	3	5	2
Clinical Relevance							
is it that DBT-TCTSY will be meaningful for your target population	4.36	0.51	4	4	4	5	1

is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	4.27	0.79	4	5	3	5	1
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Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 4*Descriptive Statistics of TCTSY Facilitators in Round 1*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	3.92	0.72	4	4	2	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	3.88	0.61	4	4	3	5	1
are participants to respond positively to DBT-TCTSY	4.04	0.62	4	4	3	5	0
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	3.92	0.78	4	4	3	5	2
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	4.13	0.74	4	4	3	5	1
Feasibility							
is there to be a	4.00	0.83	4	4	2	5	1

demand for DBT-TCTSY								
is DBT-TCTSY to be a successful integration	3.96	0.55	4	4	3	5	0	
is it that intended recipients will accept DBT-TCTSY	3.96	0.36	4	4	3	5	0	
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.29	0.81	3	4	1	4	1	
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	4.00	0.51	4	4	3	5	0	
is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.88	0.68	4	4	3	5	1	
is DBT-TCTSY able to expand to other populations other than the target population	3.75	0.74	4	4	2	5	1	
Clinical Relevance								
is it that DBT-TCTSY will be meaningful for your target population	4.08	0.83	4	4	2	5	1	

is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	3.96	0.75	4	4	2	5	0
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Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 5*Descriptive Statistics of Overall Sample in Round 2*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.03	0.32	4	4	3	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	4.00	0.45	4	4	3	5	0
are participants to respond positively to DBT-TCTSY	4.06	0.37	4	4	3	5	0
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	3.90	0.76	4	4	2	5	1
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	3.87	0.57	4	4	3	5	.25
are TCTSY facilitators and DBT therapists able to balance the	3.33	0.96	3	3	1	5	1

dialectics of TCTSY
and DBT when
implementing
DBT-TCTSY

Feasibility

is there to be a demand for DBT-TCTSY	4.03	0.76	4	4	1	5	0
is DBT-TCTSY to be a successful integration	4.17	0.53	4	4	3	5	.25
is it that intended recipients will accept DBT-TCTSY	3.93	0.52	4	4	3	5	0
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.67	0.71	4	4	2	5	1
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	3.83	0.70	4	4	2	5	1
is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.90	0.66	4	4	2	5	0
is DBT-TCTSY able to expand to other populations other than the target population	3.93	0.74	4	4	2	5	.25
is DBT-TCTSY able to be on par with	3.20	0.92	3	3	1	5	1

present offerings for differently-abled persons in DBT and TCTS, as each is currently delivered

is DBT-TCTS able to be empirically tested to ensure an evidence base	3.63	1.07	4	4	1	5	1
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Clinical Relevance

is it that DBT-TCTS will be meaningful for your target population	4.27	0.69	4	4	2	5	1
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is it that DBT-TCTS will be worthwhile considering the expected costs, inconveniences, and possible harm	4.10	0.61	4	4	3	5	.25
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is it that insurance that covers traditional mental health treatment will also cover DBT-TCTS	2.33	1.24	2	1	1	5	2
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Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 6*Descriptive Statistics of DBT Therapists in Round 2*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.13	0.35	4	4	4	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	4.13	0.64	4	4	3	5	.75
are participants to respond positively to DBT-TCTSY	4.00	0.53	4	4	3	5	0
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.00	0.76	4	3	3	5	1.50
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	4.00	0.53	4	4	1	5	1.50
are TCTSY facilitators and DBT therapists able to balance the	3.75	1.28	4	4	1	5	1.50

dialectics of TCTSY and DBT when implementing DBT-TCTSY							
Feasibility							
is there to be a demand for DBT-TCTSY	4.25	0.71	4	4	3	5	1
is DBT-TCTSY to be a successful integration	4.25	0.71	4	4	3	5	1
is it that intended recipients will accept DBT-TCTSY	4.13	0.35	4	4	4	5	0
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.63	0.92	4	4	2	5	1
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	3.75	0.89	4	4	2	5	.75
is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.75	0.89	4	4	2	5	.75
is DBT-TCTSY able to expand to other populations other than the target population	4.00	0.53	4	4	3	5	0
is DBT-TCTSY able to be on par with	3.38	1.19	3.50	3	1	5	1

present offerings for differently-abled persons in DBT and TCTSY, as each is currently delivered							
is DBT-TCTSY able to be empirically tested to ensure an evidence base	3.75	1.16	4	4	1	5	0
Clinical Relevance							
is it that DBT-TCTSY will be meaningful for your target population	4.38	0.52	4	4	4	5	1
is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	4.25	0.46	4	4	4	5	.75
is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY	2.63	1.69	2.5	1	1	5	3.50

Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 7*Descriptive Statistics of TCTSY Facilitators in Round 2*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.00	0.34	4	4	3	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	4.06	0.24	4	4	4	5	0
are participants to respond positively to DBT-TCTSY	4.06	0.24	4	4	4	5	0
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.00	0.69	4	4	3	5	.50
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	3.89	0.58	4	4	3	5	.25
are TCTSY facilitators and DBT therapists able to balance the	3.22	0.65	3	3	2	4	1

dialectics of TCTSY and DBT when implementing DBT-TCTSY							
Feasibility							
is there to be a demand for DBT-TCTSY	4.17	0.38	4	4	4	5	0
is DBT-TCTSY to Be a successful integration	4.17	0.51	4	4	3	5	.25
is it that intended recipients will accept DBT-TCTSY	3.83	0.62	4	4	3	5	1
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.67	0.69	4	4	2	5	1
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	3.89	0.68	4	4	3	5	1
is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	4.00	0.59	4	4	3	5	0
is DBT-TCTSY able to expand to other populations other than the target population	3.89	0.83	4	4	2	5	1.25
is DBT-TCTSY able to be on par with	3.11	0.83	3	3	1	4	1

present offerings for differently-abled persons in DBT and TCTSY, as each is currently delivered								
is DBT-TCTSY able to be empirically tested to ensure an evidence base	3.72	0.95	4	4	1	5	1	
Clinical Relevance								
is it that DBT-TCTSY will be meaningful for your target population	4.28	0.83	4	4	2	5	1	
is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	4.06	0.73	4	4	3	5	1.25	
is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY	2.33	1.08	2	1	1	4	2	

Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 8*Descriptive Statistics of Overall Sample in Round 3*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.07	0.27	4	4	4	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	3.93	0.47	4	4	3	5	0
are participants to respond positively to DBT-TCTSY	4.19	0.40	4	4	4	5	0
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.00	0.68	4	4	2	5	0
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	4.15	0.53	4	4	3	5	0
are TCTSY facilitators and DBT therapists able to	3.93	0.55	4	4	3	5	0

balance the dialectics of TCTS Y and DBT when implementing DBT-TCTS Y							
is this to improve outcomes for specific clients over and above DBT without TCTS Y	3.37	1.01	4	4	1	5	1
are TCTS Y facilitators and DBT therapists to have a support system for this collaboration to work well	3.07	1.11	3	3	1	5	1
Feasibility							
is there to be a demand for DBT-TCTS Y	4.07	0.38	4	4	3	5	0
is DBT-TCTS Y to be a successful integration	4.11	0.42	4	4	3	5	0
is it that intended recipients will accept DBT-TCTS Y	4.00	0.55	4	4	3	5	0
is DBT-TCTS Y able to be implemented when considering constraints of resources, time, and commitment	3.44	0.64	3	3	2	5	1
is DBT-TCTS Y able to adapt to new situations (e.g., target population, environment, format of delivery)	3.78	0.64	4	4	2	5	1

is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.89	0.58	4	4	2	5	0
is DBT-TCTSY able to expand to other populations other than the target population	4.00	0.55	4	4	3	5	0
is DBT-TCTSY able to be on par with present offerings for differently-abled persons in DBT and TCTSY, as each is currently delivered	3.22	0.42	3	3	3	4	0
is DBT-TCTSY able to be empirically tested to ensure an evidence base	3.89	0.51	4	4	3	5	0
Clinical Relevance							
is it that DBT-TCTSY will be meaningful for your target population	4.19	0.74	4	4	2	5	1
is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	4.19	0.40	4	4	4	5	0
is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY	2.00	1.00	2	1	1	4	2

Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 9*Descriptive Statistics of DBT Therapists in Round 3*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.10	0.32	4	4	4	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	3.80	0.63	4	4	3	5	1
are participants to respond positively to DBT-TCTSY	4.20	0.42	4	4	4	5	.25
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.10	0.57	4	4	3	5	.25
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	4.40	0.52	4	4	4	5	1
are TCTSY facilitators and DBT therapists able to	4.10	0.57	4	4	3	5	.25

balance the dialectics of TCTSY and DBT when implementing DBT-TCTSY								
is this to improve outcomes for specific clients over and above DBT without TCTSY	3.70	1.06	4	4	1	5	.25	
are TCTSY facilitators and DBT therapists to have a support system for this collaboration to work well	3.10	1.37	3.5	3	1	5	2.25	
Feasibility								
is there to be a demand for DBT-TCTSY	4.00	0.00	4	4	4	4	0	
is DBT-TCTSY to Be a successful integration	4.10	0.32	4	4	4	5	0	
is it that intended recipients will accept DBT-TCTSY	3.90	0.57	4	4	3	5	.25	
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.50	0.85	3.5	3	2	5	1	
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	3.80	0.63	4	4	2	4	0	

is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	3.80	0.63	4	4	2	4	0
is DBT-TCTSY able to expand to other populations other than the target population	4.10	0.57	4	4	3	5	.25
is DBT-TCTSY able to be on par with present offerings for differently-abled persons in DBT and TCTSY, as each is currently delivered	3.10	0.32	3	3	3	4	0
is DBT-TCTSY able to be empirically tested to ensure an evidence base	3.80	0.42	4	4	3	4	.25
Clinical Relevance							
is it that DBT-TCTSY will be meaningful for your target population	4.30	0.67	4	4	3	5	1
is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	4.20	0.42	4	4	4	5	.25
is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY	2.30	1.16	2	1	1	4	2.25

Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 10*Descriptive Statistics of TCTSY Facilitators in Round 3*

Delphi Question (how likely...)	<i>M</i>	<i>SD</i>	Median	Mode	Min	Max	IQR
Integrity							
are facilitators able to effectively implement DBT-TCTSY	4.08	0.28	4	4	4	5	0
is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions	4.00	0.41	4	4	3	5	0
are participants to respond positively to DBT-TCTSY	4.23	0.44	4	4	4	5	.5
are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY	4.08	0.64	4	4	3	5	.5
are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY and how DBT-TCTSY is implemented in their work	4.08	0.49	4	4	3	5	0
are TCTSY facilitators and DBT therapists able to balance the	3.85	0.55	4	4	3	5	.5

dialectics of TCTSY and DBT when implementing DBT-TCTSY								
is this to improve outcomes for specific clients over and above DBT without TCTSY	3.46	0.78	4	3	2	4	1	
are TCTSY facilitators and DBT therapists to have a support system for this collaboration to work well	3.31	0.63	3	4	2	4	1	
Feasibility								
is there to be a demand for DBT-TCTSY	4.23	0.43	4	4	4	5	.5	
is DBT-TCTSY to be a successful integration	4.15	0.55	4	4	3	5	.5	
is it that intended recipients will accept DBT-TCTSY	4.00	0.58	4	4	3	5	0	
is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment	3.31	0.48	3	3	3	4	1	
is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)	3.77	0.73	4	4	3	5	1	

is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs	4.00	0.58	4	4	3	5	0
is DBT-TCTSY able to expand to other populations other than the target population	3.92	0.64	4	4	3	5	.5
is DBT-TCTSY able to be on par with present offerings for differently-abled persons in DBT and TCTSY, as each is currently delivered	3.23	0.44	3	3	3	4	.5
is DBT-TCTSY able to be empirically tested to ensure an evidence base	4.00	0.58	4	4	3	5	0
Clinical Relevance							
is it that DBT-TCTSY will be meaningful for your target population	4.08	0.76	4	4	2	5	.5
is it that DBT-TCTSY will be worthwhile considering the expected costs, inconveniences, and possible harm	4.15	0.38	4	4	4	5	0
is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY	1.9	0.86	2	2	1	4	1

Note. IQR values that are less than 1 indicate that the consensus threshold was met, IQR values greater than 1 indicate that the consensus threshold is not met. Means rounded to the nearest whole number indicate the point where consensus was met on a scale of 1-5 (1 = Not very likely, 5 = Very likely).

Table 11*Qualitative Themes and Example Quotes Across Rounds*

Themes across Rounds	Example Quotes
Power dynamics and expertise	“I’m curious about how a facility might manage the power dynamic when using elements of DBT. The expert position required for any psychoeducation needs considering.”
Client perspectives	“DBT’s biggest complaint from clients is it’s ‘boring’ (e.g., worksheets) that mirrors homework, especially for ADOS [American descendants of slavery] ... So experiential integration is a great option. However, the non-violence and non-directive, choice elements of TCTSY might be a tricky combination with DBT, as it is about learning specific skills after which clients can choose which skill they want...”
Clarification on the aspects of each approach involved	“Is there any individual therapy component to this or when you say DBT, are you specifically referring to the skills component of the treatment modality?”
Training	“My concern is that you get a watered-down version of both, and that you can for example, doing a body scan from DBT Skills in a TCTSY way (e.g., inviting language, are facilitators clear on the way they are offering in this way). I guess I am saying - don’t just slap them together, additional training will be needed.”
Insurance concerns	“Insurance ... will only cover the cost if [facilitated] by a registered clinical counselor.”
Incorporation into in existing programs	“I think if offered in skills group, it is feasible. If offered as an adjunct to skills group, not as feasible. I find clients eager to complete if it is threaded through not as a choice, but a part of the program, then most feasible.”

Accessibility

“DBT has not been proven to be effective with the Deaf population and is often modified to provide this. This may happen in collaboration with TCTSY.”

Excitement for DBT-TCTSY
integration

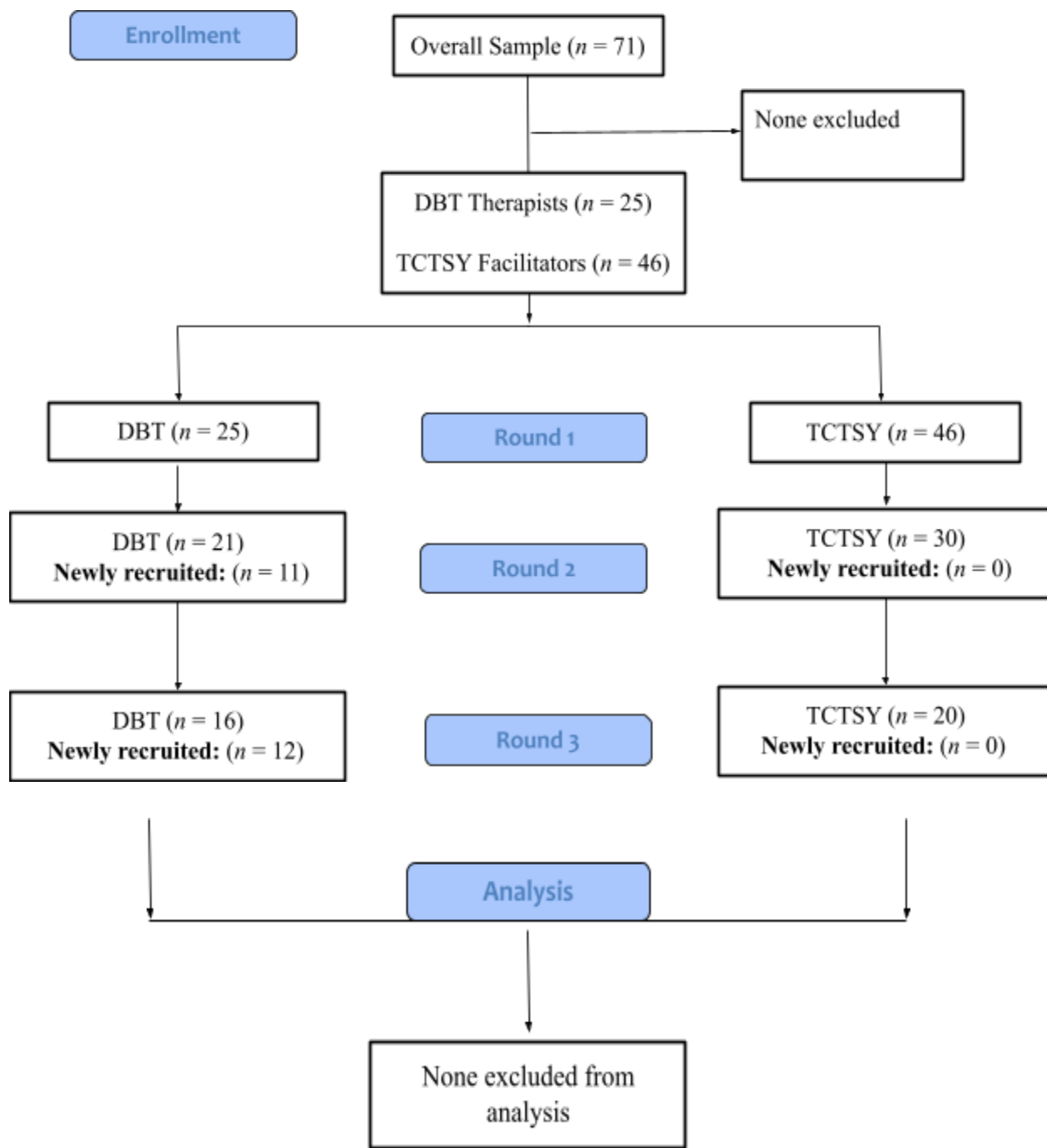
“I’m very excited about this as a DBT clinical and as a RYT yoga teacher!”

Note. Themes were included in multiple rounds and example quotes listed here are representative of similar comments stated in other rounds. For example, there were comments regarding training and expertise in multiple rounds.

Figures

Figure 1

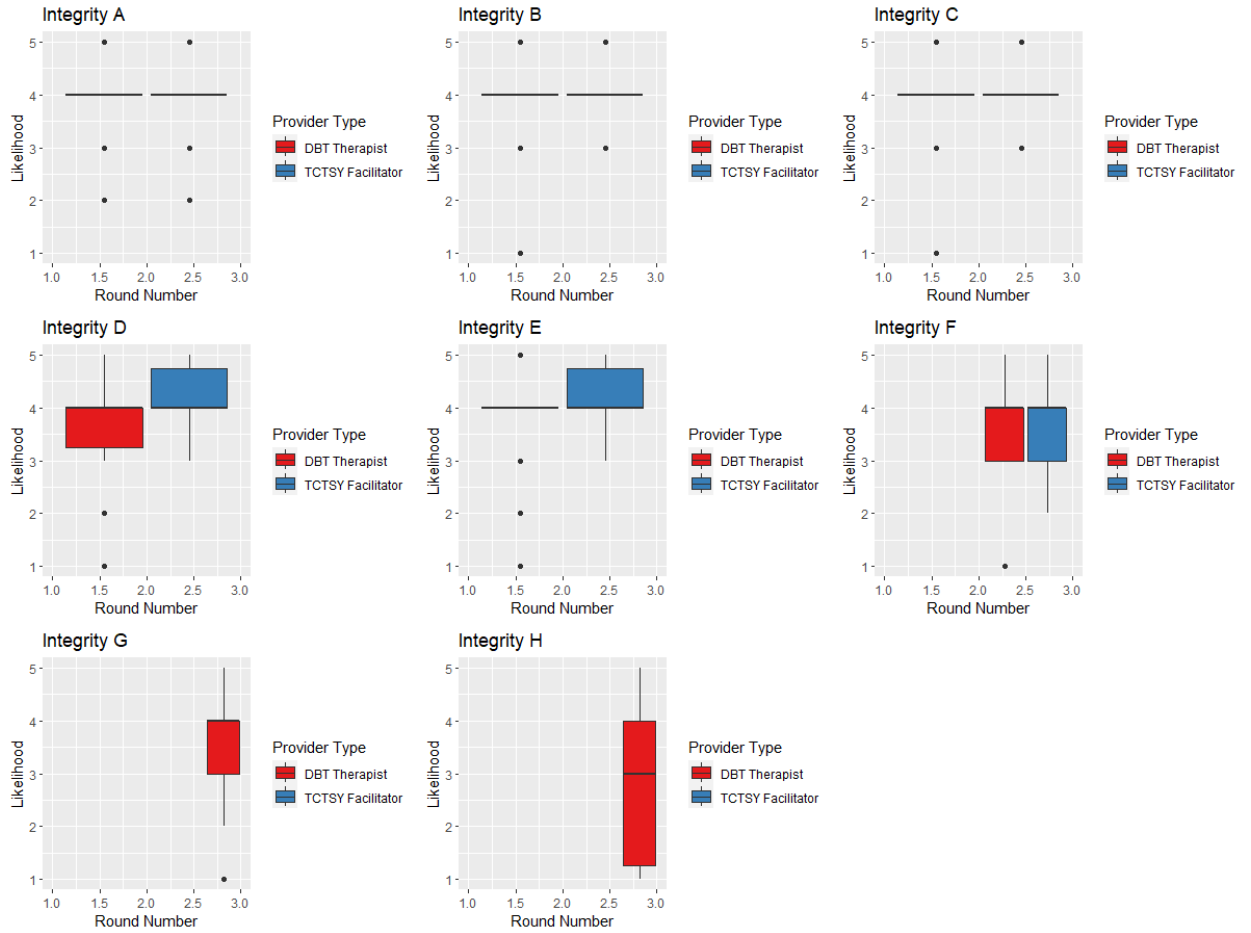
CONSORT Diagram of Recruitment Process in Each Round



Note. Some participants in this study were experts in DBT and TCTSY. These experts were included in the DBT expert category. “Newly recruited” refers to new experts in the corresponding round (e.g., n for new DBT experts for Round 2 is 11).

Figure 2

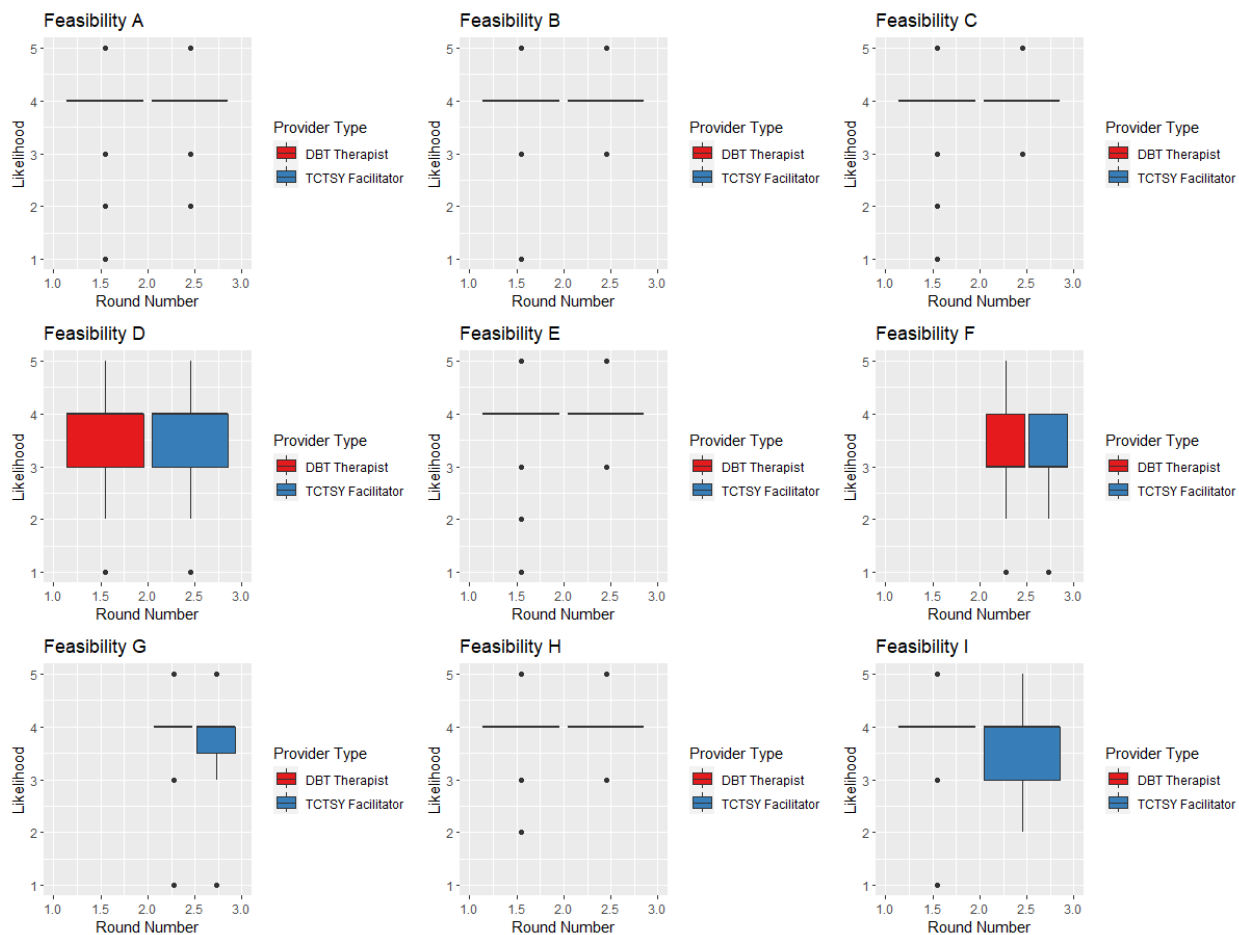
Boxplot of Integrity IQR Values by Expert Group and Round



Note. $N_s = 36-71$, dependent on round. Each boxplot corresponds to an individual item under the category of Integrity. Items A-E are included in Round 1, A-F in Round 2, and A-H in Round 3.

Figure 3

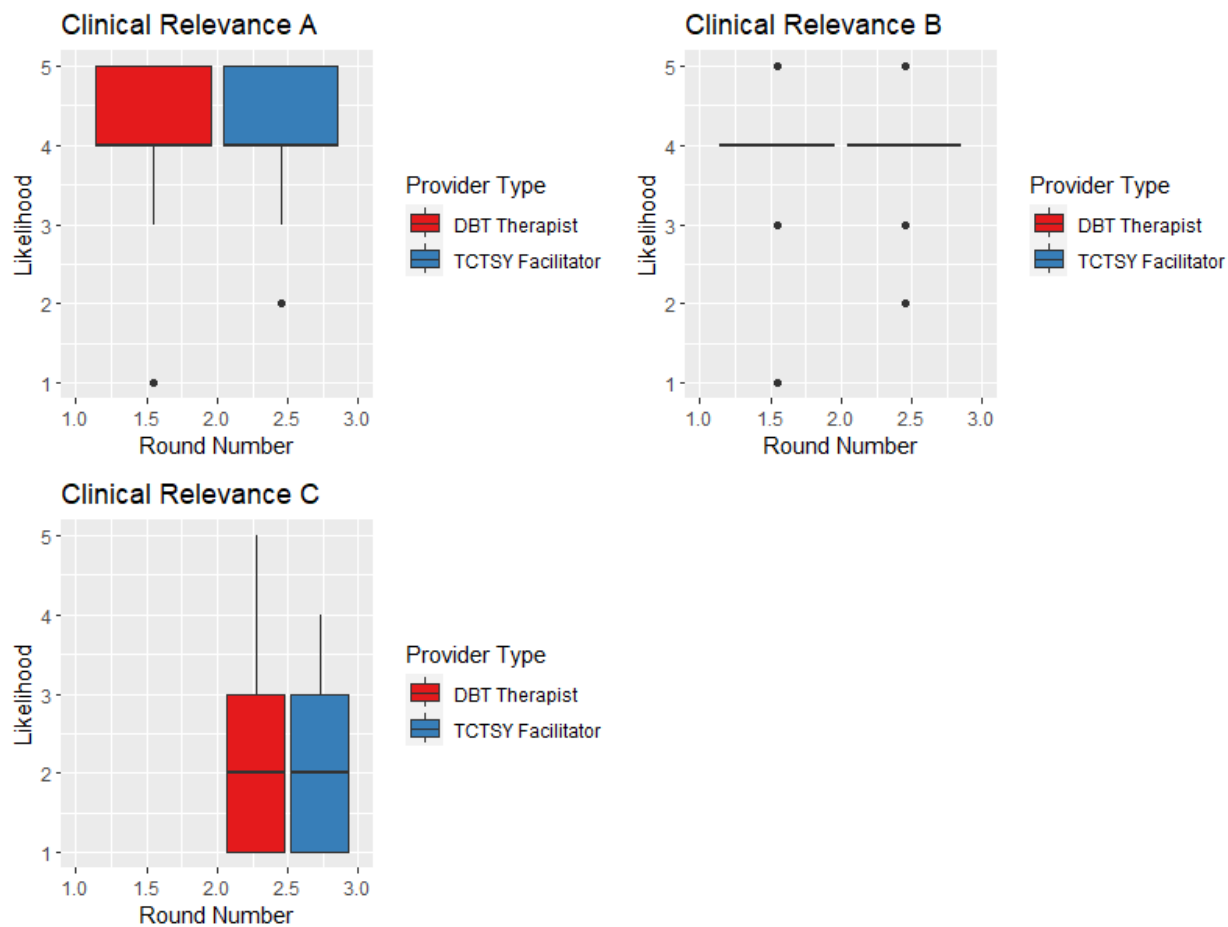
Boxplot of Feasibility IQR Values by Expert Group and Round



Note. $N_s = 36-71$, dependent on round. Each boxplot corresponds to an individual item under the category of Feasibility. Items A-G are included in Round 1, A-I in Round 2, and A-I in Round 3.

Figure 4

Boxplot of Clinical Relevance IQR Values by Expert Group and Round



Note. $N_s = 36-71$, dependent on round. Each boxplot corresponds to an individual item under the category of Clinical Relevance. Items A and B are included in Round 1, A-C in Round 2, and A-C in Round 3.

Appendix

Each round included the survey below. Delphi statements added in Round 2 are denoted with an asterisk (*), and those added in Round 3 are denoted with double asterisks (**).

Rate the likelihood of each statement on a scale of 1 (*very unlikely*) to 5 (*very likely*). If there are any new factors in each domain (integrity, feasibility, and clinical relevance), you are encouraged to add them and rate them on the same scale.

1 = Very unlikely

2 = Unlikely

3 = Neither unlikely or likely

4 = Likely

5 = Very likely

Integrity

How likely...

1. ...are facilitators able to effectively implement DBT-TCTSY
2. ...is the ability to evaluate and compare DBT-TCTSY's effectiveness to other interventions
3. ...are participants to respond positively to DBT-TCTSY
4. ...are TCTSY facilitators and DBT therapists able to effectively collaborate with each other to implement DBT-TCTSY
5. ...are TCTSY facilitators and DBT therapists able to understand DBT-TCTSY

and how DBT-TCTSY is implemented in their work

6. ...are TCTSY facilitators and DBT therapists able to balance the dialectics of TCTSY and DBT when implementing DBT-TCTSY
7. ...is this to improve outcomes for specific clients over and above DBT without TCTSY**
8. ...are TCTSY facilitators and DBT therapists to have a support system for this collaboration to work well**

If you would like to add comments about the integrity of the integration of DBT-TCTSY, please do so here: [insert text box]

Feasibility

How likely...

1. ...is the demand for DBT-TCTSY
2. ...is DBT-TCTSY to be a successful integration
3. ...will intended recipients accept DBT-TCTSY?
4. ...is DBT-TCTSY able to be implemented when considering constraints of resources, time, and commitment
5. ...is DBT-TCTSY able to adapt to new situations (e.g., target population, environment, format of delivery)
6. ...is DBT-TCTSY able to be integrated into existing infrastructures or treatment programs
7. ...is DBT-TCTSY able to expand to other populations other than the target population

8. ...is DBT-TCTSY able to be on par with present offerings for differently-abled persons in DBT and TCTSY, as each is currently delivered*

9. ...is DBT-TCTSY able to be empirically tested to ensure an evidence base*

If you would like to add comments about the **feasibility** of the integration of DBT-TCTSY, please do so here: [insert text box]

Clinical Relevance

How likely...

1. ...will DBT-TCTSY be meaningful for your target population
2. ...will DBT-TCTSY be worthwhile considering the expected costs, inconveniences, and possible harm
3. ...is it that insurance that covers traditional mental health treatment will also cover DBT-TCTSY*

If you would like to add comments about the **clinical relevance** of the integration of DBT-TCTSY, please do so here: [insert text box]