Initiating a DBT Consultation Team: Conceptual and Practical Considerations for Training Clinics

Laura K. Noll
Northern Arizona University

Leslie Roos
University of Manitoba

Jennifer Lewis, Maureen Zalewski, and Christina Gamache Martin
University of Oregon

Kristen Reinhardt
Duke University Medical Center

As the evidence base for dialectical behavior therapy (DBT) grows, so too does the need for well-trained DBT clinicians, especially in practice settings that serve populations at high-risk for self-injurious behavior or suicide. Despite the increased availability of resources for learning and applying DBT to such high-risk individuals, comparatively little has been written about initiating DBT training for new therapists in settings where DBT services are being established for the first time. The purpose of this paper is to bridge the gap between existing DBT resources and their high-fidelity application in training clinics by focusing on the consultation team as a key component to training therapists in the model. First, advancing the efficacy of dual-generation interventions using innovative program development techniques. Dr. Roos received her PhD in clinical psychology from the University of Oregon in 2018, after completing her internship at the Centre for Addiction and Mental Health in Toronto, Canada.

Nicole Musser, MS, PhD, is a candidate in Clinical Psychology at the University of Oregon. She is completing an internship at the National Psychology Training Consortium HealthPoint site in June 2019 and will start as a postdoctoral fellow at LightHeart Psychological Associates in fall of 2019. Her research focuses on the role of emotional invalidation in the development of borderline personality disorder and bidirectional effects of parent and child psychopathology.

Kristen Reinhardt, PhD, received her PhD from University of Oregon. She completed an internship at Duke University Medical Center, and a postdoctoral fellowship at Durham VA Medical Center. In fall of 2019, she will start as an Assistant Professor in the Western Carolina University Psychology Department. Her research focuses on how embodiment processes (e.g., interoception and dissociation) affect healing from the effects of sexual trauma.

We thank the University of Oregon Psychology Clinic for its support of the dialectical behavior therapy (DBT) practicum; Stephanie Frank for her role in screening clients for DBT skills training and her conscientious care of our clients; Crystal Dehle for her case consultation and support as Clinic Director. Our gratitude extends especially to our DBT skills training group clients who agreed to participate and share their experiences with us—teaching us much about the dialectic between acceptance and change—and three anonymous reviewers whose feedback greatly improved our manuscript.

Laura K. Noll and Jennifer Lewis share first authorship for this article.

Correspondence concerning this article should be addressed to Laura K. Noll, Department of Psychological Sciences, Northern Arizona University, 1100 Beaver Street, Flagstaff, AZ 86001-5106. E-mail: laura.noll@nau.edu
a conceptual overview of DBT and the role of a consultation team to support trainee therapists are presented. Second, elements of the consultation team are reviewed and unique considerations for trainee therapists are highlighted. Finally, the challenges, key strategies for overcoming obstacles, and benefits of initiating DBT training with a consultation team for trainee therapists are discussed via a series of reflections from a new DBT team, which we present as a case example of shared learning on a training team within a university clinic. We address four conceptual and practical domains of the training: the distinction between supervision and consultation, therapist identity development and competency, DBT in clinical training contexts, and embodying a dialectical stance within the university clinic. The implications of these observations for DBT theory and research are discussed.

Public Significance Statement
The manuscript’s focus is on training graduate students to implement high-fidelity dialectical behavior therapy (DBT). We believe this paper will make a significant contribution to the field and help training clinics offer services to underserved populations, as relatively little has been written about setting up DBT training for new therapists in settings where DBT services are just being established.

Keywords: dialectical behavior therapy (DBT), consultation team, therapist training, university clinic, supervision

Doctoral psychology training programs that host in-house clinics often offer low cost, evidenced-based services, making them a valuable and accessible resource for underserved populations. Although a primary mission of these clinics is to train student therapists, there is often a discrepancy between the need for services for high-risk populations (e.g., those at elevated risk for bodily harm or suicide) and an availability of resources for trainee therapists seeking to serve these populations. For example, despite its increasing availability and popularity among clinicians, the demand for dialectical behavior therapy (DBT) in many communities still exceeds the available resources (Linehan et al., 2015). This discrepancy between availability and need poses both a challenge and opportunity for training programs that would like to expand their services to be able to treat higher-risk clients. As more training programs consider launching DBT services within their clinics, more discussion is needed on the required resources to initiate these services, particularly with regard to the types of training and supervision models student DBT therapists require to effectively treat high-risk clients.

Although many aspects of DBT training lend themselves to rich discussion, in this paper we focus explicitly on the consultation team for four reasons: (1) it is integral to both high-quality DBT training and high-fidelity implementation of the DBT model; (2) it is arguably the most challenging for trainee therapists to engage; (3) it provides a unique support structure, or “therapy for the therapists” (Linehan, 1993; Walsh, Ryan, & Flynn, 2018) for trainees; and (4) compared with the other modes of DBT, the least has been written about establishing a consultation team for trainees in settings where DBT is being established for the first time.

Aims
The primary aim of this paper is to bridge the gap between existing DBT resources and their high-fidelity application in training clinics, by focusing on the consultation team as a key component for training therapists in the model. Specifically, we aim to integrate the theoretical and empirical rationale for DBT consultation team with observations from a DBT team at a doctoral level training clinic initiating DBT skills training for the first time. After providing basic background on DBT and highlighting the importance of consultation team for the trainee therapist, we present reflections about the challenges experienced on consultation team, overcoming those challenges, and the benefits of initiating DBT training at the graduate student level. Finally, we discuss the implications of these conceptual and practical elements of DBT training for theory and research.

Basic Background on DBT
DBT was originally designed to treat chronically suicidal women with a borderline personality disorder (BPD) diagnosis (Linehan, 1993) and represents a “third wave” cognitive-behavioral form of therapy that includes four1 modes of treatment: individual therapy, skills training, phone coaching, and consultation team. Each component of DBT integrates mindfulness strategies (acceptance skills) with behavioral principles (change skills) via clinical interventions that are responsive to dialectics: for example, seemingly opposing realities (Chapman, 2006; Linehan, 1993). For example, a DBT therapist will provide verbal validation that their client is doing the best they can (acceptance), while simultaneously helping them acquire skills to “build a life worth living” (change). Recent reviews describe the evidence-base for DBT’s efficacy (Bendit, 2014; Panos, Jackson, Hasan, & Panos, 2014) and considerations for its implementation (Toms, Williams, Rycroft-Malone, Swales, & Feiguenbaum, 2019).

Due to its modular treatment format, DBT lends itself to being dismantled and implemented differently across diverse treatment settings (Linehan et al., 2015). In some contexts, this is not necessarily a problem, as results from a component study suggest that DBT skills training with a consultation team may perform similarly well to the standard full-model DBT treatment, including reducing suicidality among high-risk individuals (Linehan et al.,

1 Although not originally part of the core model, some clinicians consider case management to be a fifth mode of treatment in DBT (Walsh et al., 2018).
Rationale for DBT Consultation Team and Empirical Support for Its Efficacy

According to the original DBT text (Linehan, 1993), extant handbooks and training guidelines (e.g., Heard & Swales, 2016; Koerner, 2012; Koerner et al., 2007; Sayrs, 2018; Swales, 2010; Lungu, Rodriguez-Gonzales, & Linehan, 2012), and recent reviews (e.g., Prada, Porrout, Rufenacht, & Nicastro, 2018), therapist participation in a consultation team is viewed as integral to the DBT treatment model. Moreover, lacking access to DBT consultation is a known barrier to effective implementation of the DBT (Toms et al., 2019). The rationale for consultation team is that individuals with a BPD diagnosis or other persons experiencing severe emotional dysregulation are often difficult to treat, engaging in behaviors that are endorsed as highly stressful to therapists, such as suicide threats/attempt, therapy interfering behaviors, and hostile communication (Hellman, Morrison, & Abramowitz, 1986; Linehan, 1993). Without preemptive self-care and adequate support, even the most skilled therapists (let alone inexperienced trainee therapists) may be prone to falling into a pattern of distancing behaviors, which may stimulate and reinforce client maladaptive coping behavior (Aviram, Brodsky, & Stanley, 2006). Consistent with core DBT training literatures (e.g., Linehan, 1993, 2014; Sayrs, 2018), we argue that consultation team provides support in this area above and beyond what can be accomplished in supervision and didactic training alone—something that is especially powerful for trainee therapists who are working with high-risk individuals and programs who are offering DBT services for the first time. Furthermore, given concerns that clinical supervisors often compromise case management and quality control issues in favor of emotional experiencing and supervisees’ competence (O’Donovan, Halford, & Walters, 2011), a consultation team may actually enhance the efficacy of competency-based supervision (American Psychological Association [APA], 2014) within training clinics by serving complementary supportive and educational functions.

Supporting this stance, a growing body of empirical literature suggests that the DBT consultation team plays a key role in improving therapist motivation, emotion regulation, and adherence to the DBT model (Walsh et al., 2018; see Toms et al., 2019 for a recent review). Despite this, DBT skills training groups are increasingly offered without the support of a DBT consultation team, partially due to challenges with implementation (Toms et al., 2019). For example, a systematic review of 17 trials examining implementation of DBT skills training outside the full DBT model found that only three included a consultation team (Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015). This disconnect between theory and practice arguably sets an unclear precedent for training clinics searching the literature for guidance on how to initiate a DBT skills training program for trainee therapists. Given concerns about the sustainability of implementing DBT in routine clinical practice (King, Hibbs, Saville, & Swales, 2018) and evidence indicating that new DBT programs are at increased risk for failure in their second and fifth years (Swales, Taylor, & Hibbs, 2012), addressing this disconnect may be particularly important when initiating DBT training in a doctoral program or university clinic that have historically served lower-risk clients.

Unique Elements and Structure of DBT Consultation Team

To help the consultation team treat difficult clients in a sustainable manner, DBT therapists make a commitment that, when offering DBT, they will adhere to several therapist consultation agreements, which aim to increase adherence to the DBT model and prevent burnout. For example, the dialectical agreement, DBT therapists agree to adopt a “dialectical philosophy” by acknowledging that there is no absolute truth and, further, agree to work together find an effective synthesis between opposing realities by asking “what’s being left out?” (Linehan, 1993). Reading of such agreements is built into the weekly structure of a consultation team, along with additional practices recommended in the DBT literature. For example, consultation teams may elect to open with brief DBT mindfulness activities (i.e., those that are taught to clients during DBT skills training), have an observer (i.e., a team member that keeps time and calls attention to the team’s use of judgmental language, polarization of opinions, deviation from the agenda, or lack of adherence to the DBT agreements), rank agenda items for priority, and rotate consultation team roles (e.g., leader, note taker, observer)—all of which combine to help maintain dialectical balance (e.g., an effective balance between acceptance and change strategies on the team). See Koerner (2012), Linehan (1993), and Sayrs (2018), for in-depth discussions of the DBT consultation team’s unique agreements, components, and structure.

By adhering to the consultation agreements and working together, the consultation team in effect applies the same treatment principles to the individual therapists, as each therapist does with his or her clients. In this way, the consultation team represents the regulatory backbone of DBT: a structure and functioning unit that contains and negotiates challenging tensions that inevitably emerge during treatment with high-risk individuals, thereby providing dialectical balance for the treatment system as a whole. Thus, DBT consultation team is an invaluable resource that helps therapists utilize DBT skills to stay regulated and avoid burnout and, ultimately, continue to provide a high level of care and support for their clients.

Reflections on Consultation Team From a New Doctoral DBT Training Team

After recognizing the need for DBT within our own community, our university training clinic embarked on initiating a DBT skills training program that had two main goals: to train doctoral-level graduate students in clinical psychology and to provide high-quality DBT skills training within our community to individuals struggling with emotion and behavioral dysregulation, including,
but not limited to, those with a BPD diagnosis. Given the empirical support for DBT skills training plus consultation team (Linehan et al., 2015), we launched our DBT training program with these two components of DBT. In its first year, our DBT consultation team was comprised of six doctoral student therapists, all of whom were deemed ready for practicum in accordance with competency benchmarks established for professional practice in psychology (e.g., Fouad et al., 2009) but none of whom had prior experience with the DBT model or consultation team, and a faculty member/licensed clinical psychologist with extensive training in DBT. Together, we ran three small skills training groups (each co-led by a team of trainees comprised of a leader with more clinical experience working with general mental health clients and a less experienced co-leader), which served a total of 13 DBT clients. Prior to initiating consultation team and leading DBT skills groups, trainee therapists received DBT didactics and participated in a peer DBT skills group led by the team supervisor—both of which continued during the DBT practicum year.

In the sections that follow, we articulate four challenges we experienced when initiating a DBT consultation team within a training context, describe how we overcame those challenges, and illustrate how our understanding and application of the model was facilitated by consultation teams’ grappling with these challenges, thereby improving our adherence to the DBT model. Finally, based on these reflections, we offer several concrete suggestions for how core DBT mindfulness skills may be applied while initiating and maintaining DBT consultation team in the context of doctoral training (Table 1). Consistent with the spirit of full participation on the consultation team, all members of the team contributed these reflections via a series of semistructured group conversations, and as authors. Although these reflections include those of both the trainees and licensed supervisor on our team, for reading ease we have elected to present our observations in the voice of the trainees.

**Distinction Between Supervision and Consultation**

**Challenges.** A training clinic consultation team necessarily has a trainee-supervisor distinction, whereas consultation teams

<table>
<thead>
<tr>
<th>WHAT</th>
<th>HOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Supervision and consultation distinction.</strong>&lt;br&gt;A. Observe: pay attention on purpose to the present moment.</td>
<td>A. Non-Judgmentally: let go of evaluating and judging reality.</td>
</tr>
<tr>
<td>B. Describe: non-judgmentally put words to experience.</td>
<td>B. One-mindfully: be completely present to the moment, doing one thing at a time.</td>
</tr>
<tr>
<td>C. Participate: enter wholly into the team itself.</td>
<td>C. Effectively: do what works to achieve our goals.</td>
</tr>
<tr>
<td><strong>2. Trainee identity and competency.</strong>&lt;br&gt;A. Identify creative ways to promote self-care and remain accountable to one another; observe what’s helpful in the moment.</td>
<td>A. Therapist identity and competency.</td>
</tr>
<tr>
<td>B. Describe moments of effectiveness to build confidence in developing therapeutic skill.</td>
<td>B. Assess the other on team; validate self, including non-judgmentally observing one’s limits.</td>
</tr>
<tr>
<td>C. Participate in wise mind by balancing ‘being mind’ versus ‘doing mind’ as graduate trainees are prone to existing in doing mind exclusively.</td>
<td>B. Keep the focus on using consultation team as therapy for the therapist and mindfully. Return to this focus if team wanders.</td>
</tr>
<tr>
<td><strong>3. DBT in a broader clinical training context.</strong>&lt;br&gt;A. Observe the policies, norms, and attitudes of the training program and institution.</td>
<td>C. Ask for help from team if overwhelmed.</td>
</tr>
<tr>
<td>B. Describe the DBT model and training components to other clinical staff members. Describe the rationale for intervention techniques.</td>
<td><strong>3. DBT in a broader clinical training context.</strong>&lt;br&gt;A. Non-judgmentally observe and describe existing institutional constraints.</td>
</tr>
<tr>
<td>C. Start small and build participation incrementally so that practice is conducted safely and in wise mind.</td>
<td>B. When engaged in DBT program-building activities, be present and avoid multi-tasking.</td>
</tr>
<tr>
<td><strong>4. Dialectical stance and how to teach it.</strong>&lt;br&gt;A. Supervisor(s) observes dialectics in all relevant contexts (group, client management, consultation team, supervision).</td>
<td>C. Team supervisor (licensed and trained DBT leader) may want to seek independent consultation for issues related to initiating a training team.</td>
</tr>
<tr>
<td>B. Supervisor(s) encourage trainees to describe use of dialectical strategies.</td>
<td><strong>4. Dialectical stance and how to teach it.</strong>&lt;br&gt;A. Non-judgmentally approach using “what” and “how” skills for learning dialectics.</td>
</tr>
<tr>
<td>C. Embrace participation in consultation team with humility and a willingness to make mistakes.</td>
<td>B. Maintain a focus on the ‘function within the dysfunction’ when discussing challenging client behavior.</td>
</tr>
</tbody>
</table>
| **Table 1** Suggested Application of Dialectical Behavior Therapy (DBT) Mindfulness Skills When Initiating Consultation Team in a Training Program
Established in the community may be comprised of a network of peers with minimal implicit power hierarchy (Bernard & Goodyear, 2013). In academic training programs, such as our own, the supervisor may also serve dual roles as a research or teaching mentor, adding an additional layer of complexity to the team’s dynamics. Regardless, in a training clinic, the supervising therapist necessarily has both didactic responsibilities and supervision responsibilities (O’Donovan et al., 2011) that are themselves intertwined with the clinical responsibilities shared by all team members. Having such didactic and supervisory roles embedded in the portion of the treatment system designed as a peer model poses challenges for the dynamics of the consultation team itself. For example, in the beginning, trainee therapists on our team often deferred to the supervisor for guidance. Likewise, less experienced trainees deferred both to the supervisor and to more experienced trainees. This hierarchical deference was most pronounced when discussing high-risk client behavior (e.g., nonsuicidal self-injury, substance abuse) or novel problems the group had not previously encountered. In this way, after the supervisor provided a clinical opinion, discussion of the issue essentially stopped—something that could potential stymie trainee DBT skill acquisition and interfere with team participation. Further manifestations of these hierarchical dynamics included a general agreeableness, initial hesitancy to ring the observer bell when warranted, and persistent lack of polarization (e.g., disagreement) on the team. Although validating other therapists in training and leaning toward agreement may be more comfortable than working with divergent views for many trainees (something that is perhaps the opposite of what is true for experienced therapists learning DBT for the first time), it is crucial for DBT therapists to learn to effectively search for agreement, which can only be realized after observing disagreement and identifying seemingly incompatible realities. In this way, conflicting realities can facilitate desirable outcomes and, as such, this lack of polarization posed a significant hurdle to both trainee therapist DBT skill development and the ability of trainees to bring the dialectics of their work with clients effectively to the consultation team. Conversely, although not the case on our team, too much unresolved conflict (e.g., around clinical issues or program development) between a single supervisor and trainees could be equally detrimental. On our team, the DBT supervisor took responsibility for all program development decisions, and facilitated all DBT training experiences, which arguably reduced the likelihood of detrimental team conflict around program decisions but increased the likelihood of hierarchical deference to the supervisor.

Overcoming challenges. In the beginning, as the trainee therapists were being socialized to the norms of the peer consultation team model, the supervisor led by example—modeling effective responses, describing their observations nonjudgmentally, and providing input on what strategies they might use as a team to address issues that arose. After trainees were oriented to team, the supervisor explained that they would refrain from providing their opinion until others had provided their input. At first, members continued to look to the supervisor for reassurance that they were on the right track or for confirmation that they identified a suitable plan for a difficult situation. Over time, similar to the process of shaping behaviors between a therapist and a client, the team looked to the supervisor for reassurance less often. Consequently, as the team continued to grow and members became increasingly practiced at making use of DBT consultation team, trainees grew to see the team itself as the agent of support, rather than the supervisor alone. On occasion when the supervisor was unavailable, the consultation team occurred without the presence of the supervisor, which allowed for rapid growth of therapists participating fully in the consultation team processes. During one such instance, the team discussed how to proceed following a client’s disclosure of an interaction that might necessitate mandatory reporting of child maltreatment. Had this discussion occurred with the supervisor present, it is likely that some trainee therapists would have felt more hesitant in articulating conflicting views and less responsible for the group’s decision about how to proceed. By arriving at a plan that balanced respect for the client’s agency and concern for the child’s safety to be presented to the licensed clinical supervisor, the team successfully moved forward with increased confidence in one another and in the group’s ability to navigate sensitive clinical issues. This experience suggests that it may be useful for the supervisor to intentionally sit out of the consultation team several times during the training process.

As trainees became more confident discussing areas of disagreement, trainees also became better able to recognize and describe what type of feedback they were looking for from other team members. In fact, it was after members began to preface their description of agenda items with a statement about what specifically they needed from group (e.g., validation or help with problem solving) that the team’s efficacy was markedly catalyzed. Finally, to differentiate the function between supervision and consultation, during individual supervision the supervisor and therapists began to jointly delineate what topics would benefit more from consultation team. These included brainstorming strategies for helping a client stay awake during group, identifying potential causes and consequences of a therapist becoming less attached to a particular group member, or a therapist’s strategies to avoid burnout at the end of an academic term. As both consultation team and supervision became more defined, supervision itself became more efficient as each trainee therapist developed an increasingly clear sense of what issues are most effective for peer consultation and which require discussion with someone with greater expertise—a skill that in and of itself may be difficult for trainee therapists to develop.

Development of Therapist Identity and Competency

Challenges. Developing the competency to treat high-risk clients as a trainee therapist is inherently challenging. In contrast to other training contexts, therapists on a DBT consultation team share responsibility for one another’s clients, such that if a client dies by suicide while under the care of a therapist on the team, all members should regard this as the suicide of one of their clients (Linehan, 1993). In contrast to therapist training that occurs in didactic settings or group supervision, undertaking such shared responsibility requires unique therapeutic skills and introduces added complexity to trainee therapists’ identity development as a members of the mental health community. Further complicating this identity negotiation is the fact that, ultimately, the legal responsibility for client well-being lies with the licensed clinician and site (APA, 2014). As with other aspects of DBT training, trainee therapists on the consultation team thus must enter a paradoxical position in that for treatment to be effective, they must fully embrace being responsible for their client and act with
confidence in treatment decisions, while simultaneously being aware of their role as a trainee who is new to providing therapy. Although many trainees who self-select into DBT training have a strong interest in working with high-risk populations (as was the case for everyone on our team), it is not uncommon for trainee therapists to have some uncertainty about what population(s) they would most like to work with after they complete their training and, similarly, whether specializing with high-risk clients is a good fit for their desired career trajectory. This uncertainty may pose a challenge for trainees insofar as it may not always be clear to the trainee therapist whether their experience of difficulty in treating high-risk clients is a function of soluble problems that can be fully addressed through better application of the DBT model to themselves or, conversely, that they applied DBT effectively but the therapy itself was not a good fit for the client. or, conversely, a function of a lack of fit between the theoretical underpinnings of DBT and the trainee therapist’s emerging theoretical orientation or personal qualities (Toms et al., 2019).

Working with individuals with severe or high-risk symptoms of psychopathology, including suicidal ideation or self-harm behaviors, can be emotionally taxing for all clinicians, even under the best circumstances (Perseus, Käver, Ekdahl, Åsberg, & Samuelsson, 2007). Burnout can occur when therapists do not recognize their own limits or cross them too frequently (Ludgate, 2016), thus posing a threat to the development of trainee therapist competency and identity as an effective therapist. For therapists training for the first time in DBT, what it means to know one’s limits may be significantly different than it was when working in different treatment modalities or with lower-risk populations. This is especially true when a major life event or struggle in the therapist’s own life poses its own set of regulatory challenges, as was inevitably the case on our team.

**Overcoming challenges.** In learning, practicing, and teaching DBT skills to clients, we became better equipped to navigate our growth as therapists. For example, by engaging with the concept of radical acceptance in our own lives, we were better able to accept the reality that one day we might lose a client to suicide—one of the biggest fears trainee therapists face (Jahn, Quinnett, & Ries, 2016) and a possibility that every therapist must confront whether they choose to work within a DBT framework or not. By honing our own mindfulness skills, we became more accepting and less judgmental, not only of our clients but also of our emotional reactions and of one another as well. We learned to rely on one another to normalize our thoughts and emotions, and to ask for help completing tasks when needed, such as sharing responsibilities between the group skills training leader and coleader, or asking for help from another consultation team member. Similar to validation strategies used by therapists, we commonly applied validation strategies with each other on the team to validate member’s experiences, behaviors, emotions, and thoughts. Consistent with Linehan’s (1993) biosocial model for how change may occur in DBT treatment, the validation that we received from each other, and internalized over time, fostered self-validation. Furthermore, the growth of the individual therapists on the team and the team itself was dialectically transactional in nature. As the individual therapists grew more confident and aware, the team grew more confident, which, in turn, led to even greater therapist identity development and team cohesion. By utilizing DBT mindfulness skills (e.g., participation), we were able to generate original and creative solutions from team members. For example, team would periodically suggest and collaboratively agree to schedule and complete positive life events during the week. Members were held accountable through the sharing of “self-care selfies,” that is, photos that included the team member completing their assigned self-care activity. In line with behaviorist principles, the team would then reinforce each other for following through with their values-consistent behavior. The assignment of homework, as well as the accountability from team, created a system of support and care for team members. The creation and distribution of such strategies provided a degree of light-heartedness that fostered positive feelings among team, thereby decreasing burnout.

**DBT in a Clinical Training Context**

**Challenges.** The academic calendar also imposes challenges to a team run within a university-operated training clinic that differ from those of teams operating within the community. The ebb and flow of teaching and research responsibilities, programmatic deadlines, and our ever-evolving multilayered professional identities added additional regulatory challenges for our team. This was evident through many members of the group sharing similar external sources of stress on a similar time frame. For example, at the start of each academic term many members of our team shared an increase in their overall workload associated with new teaching assignments, more meetings in their research groups, and an increased caseload of individual therapy clients. Similarly, the end of each term brought with it increased graduate course assignments, grading, and our clinic’s quality assurance paperwork—all of which combined to increase overall stress level and risk for burnout. Student trainees are often accustomed to taking academic breaks that clients not receiving DBT can typically tolerate. Yet trainees also need to have time off in order to sustain the workload of graduate school. Finally, a challenge of introducing a DBT program within a university-run training clinic is that the clients entering into the program are often much higher risk than those traditionally seen in such settings. Even if a clinic is initiating DBT in order to accommodate high-risk clients, actually having such a program will inevitably raise the overall risk profile of the clinic.

**Overcoming challenges.** Safeguards that protect clients, trainee therapists, supervisors, and the training clinic itself need to be in place prior to initiating DBT training with graduate student trainees. Following the recommendations of others in the field, we initiated a skills training program with the condition that all skills-group clients be enrolled in concurrent individual therapy (either with a therapist in our clinic or elsewhere in the community) that could provide an adequate level of support for the individual’s needs for the duration of their treatment by our team. Although not a requirement for participation, some members of our groups also received services for medication management, addiction, and social service case management.

To best assess the clinical needs of each individual entering skills training group and to ensure she or he was receiving adequate care prior to entering skills training, we conducted a full diagnostic assessment regardless of whether they were already under the care of other providers. Alongside in-house consultation with other licensed clinicians within the training clinic and outside consultation with experienced DBT practitioners in the field, the team’s supervisor also utilized a community peer consultation
Embodying a Dialectical Stance and How to Teach It

Challenges. Dialectical thinking and practice do not lend themselves easily to didactic instruction, thus raising important pedagogical questions for programs wishing to train their students in DBT. Dialectics, in DBT, is defined as a world view that emphasizes themes of interrelatedness, the function within dysfunction, and searching for the synthesis between opposing truths (Linehan, 1993). Dialectical dilemmas depict key client struggles as dialectical failures that have resulted from transactions between clients’ own emotional vulnerability and an invalidating environment over time (for rich discussions of dialectics in DBT treatment and DBT supervision, see Linehan, 1993; Sayrs, 2018; Waltz, Fruzzetti, & Linehan, 1998). In contrast to other training modalities designed for work with lower-risk clients, maintaining a therapeutic stance when working with very challenging clients, such as those with severe emotional dysregulation, requires additional skills that trainees must develop experientially—ideally within a treatment system that is intentionally structured to provide dialectical balance. This presents a challenge for student training programs: how do doctoral programs offer their trainees opportunities to learn these skills while working with high-risk clients, when the stakes are so high and when the training structure has been developed to provide other (non-DBT) types of clinical services? How do you teach new therapists who have never worked within a DBT framework to seek and maintain dialectical balance under conditions in which even highly skilled therapists with many years of experience often make mistakes?

Overcoming challenges. During didactic training and peer DBT skills training sessions (both of which were initiated prior to beginning trainee-led skills training with DBT clients), the supervising therapist described the dialectics that they observed in the group in real time and group members had the opportunity to observe, describe, and participate in dialectic processes via conscious application of the DBT mindfulness “how” skills (i.e., nonjudgmentally, one-mindfully, effectively). Thus, each pair of skills group leaders (i.e., all trainees on the team) had the opportunity to receive didactic instruction in skills training through modeling and active experiential participation before teaching each skills session to their group of DBT clients.

In contrast to DBT skills training groups, the supervisor of our training group combined modeling with frequent brief discussion of key clinical techniques (e.g., identifying effective “midlevel” self-disclosures for group, contingency management, behavior chain analysis, validation strategies), thereby scaffolding trainees’ learning of the DBT skills and therapist competency, while simultaneously providing conversational stepping stones that deepened the team’s understanding of what it means to embody a dialectical stance. Alongside specific clinical techniques, we discussed how a dialectical framework might inform our understanding of broader topics discussed in core DBT literatures (e.g., Linehan, 1993) including the team’s orientation toward acceptance and change, consultation to the client versus intervening for the client, and balancing a “benevolent demanding” versus “nurturing” stance. These conversations formed a crucial backdrop and reference points for our discussion of clinical work on the consultation team once trainees initiated skills training with clients.

As DBT team members, we also received experiential learning about what it means to hold a dialectical worldview, while seeking help from consultation team for challenging client behaviors (e.g., homework refusal, clients who continually criticized the training worksheets). Together we learned to search for the function of the behavior within the dysfunction—a clinical stance that became increasingly automatic on team and is consistent with the core dialectical principles in DBT (Linehan, 1993). By practicing this, the team was able to provide therapists with examples of how to incorporate a dialectical stance when understanding behavior. Our consultation team also played a powerful role in fostering a dialectical stance by highlighting for us how everything is interrelated: the consultation team impacted us as therapists, who, in turn, impacted our clients. By observing our clients change as a result, we were impacted as clinicians and, by virtue of these reciprocal exchanges, were better able to bring a new perspective to the team. As therapists in training who were being shaped by new experiences, the layers of interrelatedness between consultation team, therapists, and clients became evident quickly.

Benefits of Initiating DBT Training With Consultation Team for Trainee Therapists

For some programs, initiating DBT training and expanding existing services to treat high-risk clients may seem daunting, and we acknowledge that practicing within the limits of one’s training and institutional constraints is a key part of ethical professional conduct (APA, 2002). However, we believe the benefits of initiating DBT training with the consultation team for trainee therapists are as follows:

First, since it can be difficult to address the many issues that arise while working with high-risk clients, during weekly supervision meetings, having the consultation team as a resource means that the supervisor-trainee dyad does not have to come up with all of the “solutions” during supervision. Since each individual brings their own unique perspective, experiences, and knowledge to team, having a team of people—who are all invested in the outcomes for each client—increases the likelihood that the trainee therapist will consider diverse and creative solutions that may not be possible for an individual or even an individual-supervisor dyad to generate on their own. In doing so, supervision then helps scaffold the development of the trainee therapist’s ability to seek help from other professionals outside the therapist-supervisor relationship within a context where the supervisor has direct contact with the resource the therapist is accessing—something that is beneficial for both the supervisor and the trainee.

Second, working effectively with high-risk clients during graduate training can be incredibly rewarding—both from the perspective of providing high-quality services to people who need them most and from the perspective of developing one’s identity as a skilled clinician who can handle even the most difficult cases. Developing the DBT skills needed to treat such clients via participation on the consultation team fosters integral individual therapist capacities, a deeper and more nuanced sense of one’s limits, and a fuller understanding of who one is as a therapist in the
context of very serious human challenges. By learning to apply DBT skills to themselves as therapists in a setting with mutually reinforcing layers of support, trainees are better positioned to express their own challenging emotions, which, in turn, allows for more cognitive space to problem solve and otherwise remain helpful when working with their clients. Ultimately, the balance afforded by the consultation team reduces resentment toward difficult-to-treat clients, helps trainee therapists occupy a more balanced therapeutic stance, and makes such work sustainable by offering regulatory alternatives to the iatrogenic parallel processes that often emerge in settings where clinicians are treating individuals with severe emotion dysregulation.

Third, training students in DBT at the graduate student level also helps address problems of service inequality in the community. At present, many students do not learn how to take on high-complexity or high-risk cases, in part, because training clinics are reticent to offer services to such individuals. However, if students do not receive suicide-focused training and learn to take on high-risk clients in graduate school (when their supervision and support are maximal), they are unlikely to feel comfortable treating suicidal individuals after graduating (Jahn et al., 2016). This perpetuates a problem of mental health service scarcity for individuals most in need of help, and likely leads to an overutilization of emergency and primary care services that are less equipped to comprehensively help clients with severe emotion dysregulation. Since many such clients have been rejected, turned away, or invalidated through (often repeated) transactional interactions with the environment, providing high-quality DBT services through doctoral-level training clinics can provide a much needed service for these individuals.2

Finally, by holding in mind the most fundamental paradox of DBT, namely that change occurs in the context of acceptance (Linehan, 1993), training programs and supervisors can programatically embody the dialectical stance of DBT and empower their trainees to develop DBT clinical skills. We found that through nonjudgmentally accepting and fully participating in our learning process of working with high-risk individuals, we were able to change and improve our general clinical competencies. Just as skills training group and individual therapy are important sites of experiential instruction for clients, a consultation team can be an integral site of dialectical learning for therapists training in DBT. In this way, the transactional learning that occurs for trainees on a consultation team, mirrors the learning that occurs for clients in DBT skills training. Moreover, the process of describing and working with dialectical tensions that emerge within the training clinic environment may help address challenges observed in other treatment settings, as trainees move on to practice elsewhere.

Implications for Theory and Research

Previous research on DBT training indicates that didactic training is necessary but not sufficient to train new DBT clinicians to be highly proficient in clinical practice with high-risk clients and that experiential learning is a key component of skill acquisition (Brodsky, Cabaniss, Arbuckle, Oquendo, & Stanley, 2017; Dimeff et al., 2015; Dimeff et al., 2009). Although recent work indicates that it is possible for trainees using the full model to successfully deliver DBT to individuals with BPD (Rizvi et al., 2017), comparatively little research has focused on the value of initiating and maintaining a consultation team for new DBT clinicians. Linehan (1993) conceptualized the consultation team as an integral part of the DBT model and it was our experience that the consultation team was vital for initiating and maintaining the DBT skills training program. However, it remains an open empirical question what specific function(s) the consultation team serves for training and how participation on a consultation team furthers trainee learning over and above supervision and direct clinical experience. Future process-outcome research with consultation teams should investigate the relationship between participation on a consultation team and adherence to the DBT model, as well as trainee therapist skill acquisition and client outcomes. Such research may have important implications for the development and practice guidelines for DBT training programs. Additionally, studies that examine the relative impact of the DBT consultation team structure (e.g., length, format), team composition, and activities on trainee competency may be of particular use to training programs seeking to implement DBT training for the first time.

2 This is of particular value because it may provide the basis for developing empowering transactions between the larger treatment systems and sub-populations of individuals who need help. Alongside implementation of the evidence-based clinical services, these transactions may help us better understand the needs of historically underserved or otherwise vulnerable populations and drive innovative treatment development. Indeed, it was our experience that initiating DBT skills training (supported by consultation team) in our program enabled several clinician-scientist trainees on our team to engage in research focused on parenting with a group of mothers receiving DBT skills training (Martin, Roos, Zalewski, & Cummins, 2017), an endeavor that both furthered the trainees’ individual development as scientists positioned to study high-risk populations and our clinic’s understanding of the experiences and needs of this population in our community. Additionally, one member on our team went on to initiate a DBT skills training group and consultation team with colleagues at a local VA Community Based Outreach Clinic. This enhanced the VA clinic’s treatment offerings for their own high-risk and oft described as treatment resistant veteran patients.

References


Received October 13, 2018
Revision received March 19, 2019
Accepted March 27, 2019