

CHAPTER 1

DBT Teams

An Introduction

Dialectical behavior therapy (DBT) is a principle-driven, modular, cognitive-behavioral treatment originally developed for chronically suicidal individuals diagnosed with borderline personality disorder (BPD). Most typically consisting of a combination of individual psychotherapy, group skills training, telephone coaching, and a therapist consultation team, DBT has been shown through randomized controlled trials (RCTs) to be efficacious for BPD, with emerging evidence suggesting that it is useful with a wide range of other problems related to emotion dysregulation (see Rizvi, Steffel, & Carson-Wong, 2013, for a review of this research).

This book assumes at least a basic knowledge of DBT. There are many books and resources on DBT; some follow DBT principles and theory closely, and some do not. To learn about DBT, we recommend starting with the DBT treatment manuals (Linehan, 1993, 2015a, 2015b), which are the manuals used in the RCTs on DBT. They will provide the best basis for learning DBT, and for understanding this book. We refer to these treatment manuals throughout this book.

The Functions of DBT

As a comprehensive treatment, DBT has several functions or jobs it must serve in order to be effective with the high-risk, challenging clients, with multiple, chronic problems, it was designed to treat. As described in the original treatment manual (Linehan, 1993), they include:

- Increasing capability (i.e., teaching skills; typically accomplished via skills training group).
- Increasing motivation (i.e., arranging variables such that the client is more likely to engage in effective behavior and less likely to engage in ineffective behavior; most often addressed in individual therapy).
- Generalizing skills to the client's environment (i.e., utilizing strategies to get the new behavior to occur in the client's own environment; this usually includes phone calls and texts with the provider outside of session as well as homework assignments, and can include additional strategies such as listening to recordings of the previous session at home).
- Structuring the environment (i.e., there are a variety of ways to arrange the environment such that it supports DBT; this may be done with the individual therapist, a family therapist, a case manager, and/or other providers or strategies).
- Building team members' motivation, capability, and adherence to the treatment manual (i.e., "hold the therapist inside the treatment"; Linehan, 1993, p. 101; providers typically address this function within a DBT team).

In RCTs focused on the efficacy of DBT, all of these functions were addressed in some way (most often in the standard arrangement described above; however, there is flexibility in how these functions are met). In order to be considered "full" or "comprehensive" DBT, each of these functions must be addressed.

The DBT Team

The concept of a "treatment team" in DBT started in research trials, where a team approach was utilized to ensure that therapists followed the treatment manual and other research protocols. While this started as a practical strategy, it quickly became clear that the team was an *active* component of the treatment. It was evident in the early development of DBT that, in dealing with very-high-risk, emotionally dysregulated clients, providers could become so frightened of suicide risk that they were

prone to make decisions based on emotion, rather than on the treatment plan. DBT providers also at times became frustrated or burned out with clients who engaged in aversive interpersonal behavior. Providers' own personal problems (e.g., health issues, relationship problems) at times also impacted the treatment they provided. Clients also inadvertently reinforced nontherapeutic interventions and avoidance, and even punished effective strategies. Overall, providers inadvertently drifted from the treatment manual, without realizing they had drifted. It became abundantly clear that having team members who provided each other with support, encouragement, and validation while doing this difficult work, along with feedback and guidance regarding adherence to the manual, was essential in keeping these providers on track. It was due to this discovery that DBT formally included the treatment team as an essential component.

Despite its importance, DBT teams have received relatively less focus in books, workshops, and webinars compared to training on DBT individual therapy and skills. This dearth is notable, as the team is considered the fulcrum of the treatment, a place where team members can recalibrate and center themselves to provide the best treatment possible. After training and consulting to many DBT programs around the world, we determined that while DBT programs were highly motivated to have a team, they were left with many questions and challenges. Teams can be incredibly helpful, supportive, and comforting; they can also cause frustration and stress when problems are not managed effectively. In other words, teams take work to establish and maintain. The importance of teams, coupled with the lack of instruction and information, led us to identify the need for a manual for the DBT team.

This book is designed to provide guidance for developing and maintaining a DBT team. It is written for any DBT provider (or non-DBT provider) who wishes to create a DBT team, or who already has a team and would like to further enhance its functioning. When we refer to "team members," this is not limited to individual therapists or skills trainers, but is meant to address anyone who is a member (or wishes to become a member) of a DBT team and is providing an intervention with DBT clients. At times we refer to team members as "therapists" (as in "a community of therapists"), providers, or clinicians; these terms are meant to include *any* member of a DBT team. Team membership is discussed further in Chapter 8.

The Functions of the DBT Team

The overarching goal of the DBT team is to help team members provide the best DBT possible. As far as we know, adhering to the DBT manual is the most effective way to deliver DBT. Adherence to the DBT manual has been a required component of many of the RCTs on DBT (see Rizvi et al., 2013, for examples of such RCTs), and fidelity has been shown in other treatments to be associated with improved client outcomes (e.g., DeRubeis & Feeley, 1990), as well as greater staff retention when fidelity monitoring is presented as supportive consultation (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009). To meet this goal of adherence, Linehan (1993) described the DBT team as having two functions, as mentioned above: to enhance both the motivation and the capability of DBT providers.

1. *Motivation.* Teams work to maximize providers' motivation to deliver effective treatment to their clients. "Motivation" can refer to several things: First, teams can enhance providers' willingness to provide DBT. Teams provide a "safe haven," a confidential environment where team members are comfortable being vulnerable, and where they share and receive support. Teams help each member feel cared about, an "insider" in a group of like-minded individuals. Teams can also help each member balance clients' needs with their own limits, to help prevent burnout. Teams can even be fun! Just as in DBT treatment, motivation also means lining up the controlling variables such that effective provider behaviors are reinforced, and ineffective behaviors are minimized. The DBT team can enhance motivation by helping to set up the environment such that each team member is steered toward the most effective action possible. This includes noticing when members engage in problematic avoidance and making sure they are reinforced for approaching a difficult intervention; it may also mean helping a teammate regulate any intense emotion that interferes with treatment delivery.

2. *Capability.* Teams also aim to increase each member's capability. This refers to the skill with which the overarching treatment is delivered, as well as each DBT strategy and protocol. This goal also includes ongoing monitoring to be sure team members are providing DBT, helping team members learn how to improve their interventions, and highlighting when a member may have drifted from the treatment manual.

The team might recommend seeking consultation, finding a training or treatment manual, or any number of strategies to make the treatment as precise and effective as possible.

This manual will focus on how to attain both of these functions, such that DBT team members are motivated and capable of providing the most effective DBT possible.

Not a Traditional Team

The idea of providers meeting in a team is nothing new. Teams have a long history in mental health, in settings such as hospitals, residential treatment centers, and other places where providers meet daily or weekly to discuss client care. These teams allow for individuals from various disciplines to work together, share information, inform each other of progress and problems, coordinate care, and provide a unified treatment to clients. These teams traditionally focus primarily on the client, not the provider. Additionally, these teams are typically not considered formal parts of the treatment; rather, they are practical, administrative solutions to make sure providers are consistent and informed.

Coordinating care is, of course, extremely important. However, there are several ways in which DBT teams are quite different from traditional consultation teams (Sayrs, 2019). First, a core concept of the DBT team is that of community. A DBT team is considered a *community of therapists treating a community of clients*. In other words, DBT team members work together, as a team, to treat *all* of their clients. This creates a different sense of team, “we are all in this together,” as well as a different level of investment in each other’s clients: each team member is invested in helping each teammate provide excellent care to all the clients associated with the team, and in this way, every teammate is treating every client. This means that if a provider is struggling to provide effective care due to burnout, frustration, or life events, the team moves in and helps in some manner, because their teammate and the team’s client is struggling. If a teammate notices that a member has drifted from the manual or is being shaped into ineffective behavior with a client, it is essential to highlight this problem, because every member of the team is “treating” this client. This idea of community is taken so seriously that if one DBT provider has a client die by suicide,

all members of the team say they had a client die by suicide. It is not “their” client; it is “our” client.

DBT is also set apart from traditional teams in that the DBT team focuses on *therapy for the therapist*, rather than directly on clients. Clients are, of course, discussed in team, but the primary focus is how to help *team members* adhere to the manual, improve their motivation and skills, and enhance the effectiveness of their treatment. In other words, the team provides DBT strategies aimed at the *provider*, to address any obstacles that might arise in client care. For example, in a traditional team, a provider might say, “My client called me too much this weekend,” and the team would focus on the client’s behavior. In a DBT team, the provider would change the focus: “I started to feel frustrated at all the calls I got from one client this weekend. I could use some help getting my frustration level down, and deciding what to do about the calls.” The team then focuses on providing suggestions and recommendations, along with support and validation, to help the provider manage the situation as effectively as possible.

In order to provide effective therapy for the therapist, a DBT team also requires a different level of vulnerability than traditional teams. The team emphasizes, in a confidential environment, being open about mistakes and uncertainty, in order to obtain support and help. To get this type of help, DBT team members openly discuss challenging or unsuccessful moments in therapy, even when they involve shame, frustration, or other difficult emotions. It may also involve sharing personal events that could affect therapy (while still observing their own limits).

And finally, DBT teams are different from traditional consultation teams in that there is a strong emphasis on dialectics. The DBT team emphasizes the same dialectic as DBT therapy: acceptance and change. And just as in DBT, this is not a dilution of either pole, nor a compromise, nor a 50:50 balance. This means holding both poles, acceptance and change, in their full intensity throughout the team: deep validation, understanding, and phenomenological empathy for teammates and clients are essential in team, as is the strong emphasis on continuously improving and enhancing the effectiveness of the therapy provided. This means not only discussing what interventions to provide to clients, but pushing the team member to provide more precise, scientifically driven, generally better DBT, addressing obstacles to adherent treatment, while simultaneously providing the emotional support, validation, and caring needed to do so.

Teammates may intervene with validation or change strategies as needed, while emphasizing the importance of both throughout the team. Team members need to feel cared for, understood, and supported, while at the same time given the (at times tough) feedback that they may need to do something differently. For certain teammates, being corrected and challenged decreases motivation, so the team must find a delicate balance where there is a strong push for change, along with a strong sense of support and acceptance. And once again, while the team holds both of these poles as essential, they intervene with exactly what is needed in any given moment. For example, a team member may only need validation: “I already have a solution, but I am still feeling really frustrated with one particular client. Can you validate the frustration?” The team may want to confirm that the solution is effective, but most of the time in team will then be spent on validating the member and reinforcing the effective strategies already implemented. Alternatively, a provider may want very little validation and a lot of practical help: “Let’s not spend any time on validating me, I just need a solution and fast!” In either case, teams remain dialectical, holding both poles as fully important in every team meeting. There are other important dialectics that may also arise in team; teammates focus on finding the validity in both poles, searching for what is left out, and striving for synthesis.

The Culture of DBT Teams

To support DBT teams and the elements that make DBT unique from other types of consultation teams, we now discuss how to develop and maintain a DBT team culture, or set of shared goals and practices, to enhance the team’s functioning and each member’s ability to provide effective DBT. DBT team culture focuses on the elements described above, with an overarching emphasis on acceptance and change. In order to achieve this goal, there are a number of practices DBT teams implement, including team agreements, assumptions about clients and therapy, team roles, and a team agenda, which bring the team together around a similar perspective and value system. It will be important to avoid becoming rigid about these agreements and practices. They are guidelines that are designed to help the team function well, and while the team will benefit from attending to them regularly, it may at times be more effective to ignore certain problems, or delay dealing with them, depending

on the team's priorities at any given time. The team can discuss at times whether not attending to certain problems is effective and helpful, or if it is ineffective (e.g., due to avoidance of conflict or emotion).

Core DBT Team Agreements

First, to help maintain the culture in the team, DBT team members agree to follow DBT team agreements.* The core agreements were originally described in Linehan (1993, pp. 117–119). These agreements are widely used in DBT teams (see Handout 1). They can help provide the backbone to the team's culture; they form the principles for team functioning.

1. *Dialectical Agreement.* The DBT team agrees to accept, at least pragmatically, a dialectical philosophy. There is no absolute truth; therefore, when polarities arise, the task is to search for the synthesis rather than for the truth. The dialectical agreement does not proscribe strong opinions, nor does it suggest that polarities are undesirable. Rather, it simply points to the direction team members agree to take when passionately held polar positions threaten to divide the team.

2. *Consultation-to-the-Client Agreement.* The DBT team agrees that team members do not serve as intermediaries for clients with other professionals, including other members of the team. The team agrees that clients will have more opportunity to learn when a DBT provider consults with clients on how to interact with other team members. When providers intervene on behalf of clients, clients lose that opportunity to learn to resolve problems themselves. Thus, when a clinician says things that are unhelpful or ineffective to the client, the task of the other team members is to help their clients cope with this provider's behavior, not necessarily to reform the provider. This does not mean that the team members do not conduct therapy for the therapist, plan treatment for their clients together, exchange information about the clients (including their problems with other members of the team), and discuss problems in treatment. DBT providers strive to provide such learning opportunities, and only intervene on behalf of clients when it is effective to do so.

3. *Consistency Agreement.* Failures in carrying out treatment plans can be problematic; at the same time, they present opportunities for

*Adapted from Linehan (1993, pp. 117–119). Copyright © 1993 The Guilford Press. Adapted by permission.

clients to learn to deal with the real world. The job of the DBT team is not to provide a stress-free, perfect environment for clients. Thus, the DBT team, including all members of the team, agrees that consistency of team members with one another is not necessarily expected; each member does not have to teach the same thing, nor do all have to agree on what are “proper rules” for therapy. Team members can each make their own decisions about how to proceed in therapy, within the DBT frame. Similarly, although it can make for smooth sailing when all members of an institution, agency, or clinic communicate the rules accurately and clearly, mix-ups are viewed as inevitable and isomorphic with the world we all live in. Any time a team member, team, or agency delivers treatment inconsistently (both in relation to other providers and to themselves), it is seen as a chance for clients (as well as team members) to practice the skills taught in DBT.

4. *Observing-Limits Agreement.* The team agrees that all members are to observe their own personal and professional limits. Furthermore, team members agree not to judge limits different from their own as too narrow or too broad, and instead determine if the limits are effective in a given situation. The team may suggest that a member broaden or narrow limits to become more effective, and at the same time will accept each other’s differing limits without judgment. Team members will do their best to communicate their limits effectively to clients and teammates, and at the same time, clients are expected to ask about, learn, and accept providers’ limits.

5. *Phenomenological Empathy Agreement.* DBT team members agree, all other things being equal, to search for nonpejorative or phenomenologically empathic interpretations of clients’ behavior. The agreement is based on the fundamental assumption that clients are trying their best and want to improve, rather than to sabotage the therapy or “play games” with their provider. When a teammate is unable to come up with such an interpretation, other team members agree to assist in doing so, meanwhile also validating any frustration or other emotions that may arise for the provider. Thus, DBT team members agree to hold one another nonjudgmentally in the DBT frame. They agree to also search for a nonpejorative interpretation of the behavior of teammates, clients’ family members, and any other relevant individuals, as well.

6. *Fallibility Agreement.* There is an explicit agreement in DBT teams that all team members are fallible. Thus, there is little need to be defensive, since it is agreed ahead of time that team members have

probably done whatever problematic things they are accused of doing. The task of the team is to apply DBT principles to one another, in order to help each member stay within DBT. As with clients, however, problem solving with team members must be balanced with validation of the inherent wisdom of their stances. Because, in principle, all team members are fallible, it is agreed that they will inevitably violate all of the agreements discussed here. When this is done, they will rely on one another to point out the polarity and will move on to search for the synthesis.

To these original core agreements, there are several additional agreements that we have found help teams to function well* (see Handout 2). These additions summarize the other practices typical to DBT teams, incorporating observer tasks and other strategies and guidelines most teams utilize to help maintain the team culture. These are outlined here and addressed in more detail throughout the book.

7. Consider oneself part of a community of therapists treating a community of clients. This means each teammate's clients are everyone's clients, and it is each person's responsibility to say something if a teammate has veered away from effective treatment.

8. Provide "therapy for the therapist" in the team; address each member's own and others' obstacles to providing DBT with fidelity to the manual. This means embodying DBT philosophy and strategies in team, including both acceptance and change, with oneself and each other. In other words, team members create an environment rich in validation, warmth, and acceptance, while at the same time giving feedback and addressing one's own and others' obstacles to providing DBT with fidelity to the manual. This is a commitment to search for what is valid in each teammate's experience even when it is difficult to do so, and to give feedback even when it is difficult to do so (e.g., when a teammate has more experience, or might get upset, or is another team member's boss, or is not sure about being "right"). Team members are vulnerable, share mistakes, and experience and express emotion in team; they accept validation and change-focused feedback. There is also a commitment to maintaining the confidentiality of any information disclosed in the team meeting, just as one would for a therapy session.

* Adapted with permission from Marsha M. Linehan, unpublished, University of Washington Behavioral Research and Therapy Clinics.

9. Provide DBT; not combine, alternate between, or add in other treatment modalities unless doing so effectively and mindfully (e.g., in DBT one might add another cognitive-behavioral therapy [CBT] manual while treating quality-of-life-interfering targets such as obsessive-compulsive disorder [OCD] or binge eating). This allows for a common language and conceptualization of the treatment.

10. Conceptualize clients' and each other's behavior from a behavioral perspective; do not combine or add in other theoretical models. Many providers prefer eclecticism rather than a single theoretical approach. In DBT, maintaining a consistent, single, comprehensive philosophical approach with compatible theories is essential to inform the conceptualization of client and provider behaviors and related treatment decisions. The overarching theory for DBT and the DBT team is behaviorism, which will be discussed extensively in this book. Dialectics, biosocial theory, Zen practice, acceptance strategies, and change strategies are all viewed through a behavioral lens. Changing theories within a client's treatment (e.g., from behavioral to psychodynamic and back again) can lead to less precise explanations for behavior and therefore less leverage when generating solutions. Again, consistency allows the team to speak in the same language, communicate clearly, and approach the intervention from the same perspective.

11. Treat team meetings as importantly as any other therapy session; that is, attend weekly as often as possible, do not double schedule, arrive on time, stay until the end, come to meetings adequately prepared, speak in every team meeting (although not everyone needs to be on the agenda in every team), and participate in team by sharing the roles of meeting leader, observer, and/or any other roles essential to the team.

12. Be available to fulfill the role for which one joined the team (e.g., individual therapist, skills trainer, pharmacotherapist); all members of the DBT team have client contact and clinical responsibility. If one takes a break from seeing clients, one would also take a break from attending team.

13. Be willing to call out the "elephant in the room" when others do not. Each member will work to address unspoken "elephants," including speaking up if team is frustrating or not useful, broaching topics even when afraid of another team member's response, and not treating each other or oneself as too fragile to handle the discussion. This does not mean addressing every single problem in team; it emphasizes the

importance of communicating directly about problems interfering with providing DBT or with effective team functioning, when it is effective to do so.

14. Remain one-minded in team, rather than doing two things at once; for example, do not attend to phone calls, texts, notes, or other distractions during team, nor engage in side conversations in team.

15. Assess sufficiently before offering solutions.

16. Strive to follow the assumptions about clients (Linehan, 1993) and therapy (see “DBT Assumptions” below).

17. Follow team policy regarding providing coverage for each other, missing team, and missing appointments with clients.

18. Continue focusing on all of the above, even when feeling burned out, frustrated, tired, overworked, underappreciated, hopeless, ineffective, etc.

DBT Assumptions about Clients*

In addition to these agreements, DBT team members choose to adhere to a set of assumptions about their clients and the therapy (see Handout 3). Adopting these assumptions affects how one thinks about the team’s clients and their treatment and are therefore an integral part of the culture of the DBT team. These are assumptions, not facts; they cannot be proven “true” or “false”; rather they are a set of assumptions DBT team members *choose* to believe in to make their work more effective.

1. *Clients are doing the best they can.* It can be very tempting to believe clients are not trying, particularly when they engage in behavior that is frustrating to the provider or harmful to the treatment. Returning to this assumption can reduce team members’ frustration and burnout. The team can help each team member maintain this stance, even in the face of very difficult behaviors. The team can provide reminders that even though the client was capable of engaging in this new, more skillful behavior last week, the client could not this week.

2. *Clients want to improve.* This is closely related to the first assumption. This assumption means that when a client is not improving, it is

*See Linehan (1993) for a full description.

due to emotion, lack of skill, cognitions, learning history, and other factors that are interfering with improving the client's life. The team can remind each member that it is more effective to believe the client wants to improve, and that there are factors interfering with such improvement. The team can also facilitate assessment and effective intervention when improvement is not occurring.

3. *Clients need to do better, try harder, and be more motivated to change.* This may seem to contradict the first two assumptions, but in actuality both poles are true. While clients may be doing the best they can and want to improve, it is typically the case that their current efforts are not sufficient to change their lives. It is each provider's job to analyze and understand the obstacles to the client making progress; in turn, it is the team's job to help the team member assess those obstacles and facilitate solutions.

4. *Clients may not have caused all of their own problems, but they have to solve them anyway.* This assumption highlights the fact that it is the clients themselves who will have to solve their problems, even if they did not create them. While it is true that clients do not know how to solve their problems on their own (or they would not need DBT!), expecting a provider or the world to take care of clients' problems for them will not provide a long-term solution to the client's problems. The team can help each member stick to this assumption by balancing working hard for clients while encouraging clients to also work hard to solve problems themselves.

5. *The lives of our clients can be unbearable.* It can be tempting, when a client does not engage in therapy as fully as we wish, to assume the client simply does not want to change. This assumption reminds everyone in team that the client is suffering, and there are obstacles interfering with change that can be solved once they are identified.

6. *Clients must learn new behaviors in all relevant contexts.* Clients will need to learn new skills and ways of coping in all possible settings (including contexts outside the therapy room), as well as across different emotional contexts they may experience. Helping the client tolerate stress without ineffective escape (e.g., effectively making it through a crisis instead of getting hospitalized, taking drugs, or using other escape strategies) requires a great deal of skill on the provider's part. This may require phone contact, structural changes in the environment, and other interventions that help clients learn to change not just in the therapy

room, but in their own environment. Because this can lead to more time spent on client care outside of session, as well as more opportunities to inadvertently reinforce ineffective behavior, and possibly more burnout for the provider, the team is essential in helping balance the client's needs with the provider's limits, in order to provide the best care.

7. *Clients cannot fail in therapy.* When clients do not progress or improve, or they leave therapy before meeting their goals, this assumption states that either the treatment was not sufficient for them or the provider did not apply the treatment as it was designed to be delivered. In DBT, a client's lack of progress is not considered the client's "fault." This assumption can be quite emotional for team members; it often feels as though the client simply does not step up to the plate to make the necessary changes, which can be frustrating and disappointing. Providers themselves can also feel blamed by this assumption, as if the client's lack of engagement is *their* fault. The purpose of this assumption is not to blame any member of the team; it is actually to remove blame altogether. Blame and judgment cloud our ability to assess and determine where the problem lies. For example, if I assume my client "just doesn't want to change," I stop assessing, and I don't realize that there is significant reinforcement for staying the same, and little reinforcement for changing certain behaviors. And by missing that information, I will feel frustrated with my client instead of solving the contingency management problem. The best any DBT provider can do is to follow the manual and provide treatment to fidelity. Assuming the provider follows the manual, and the team helps to hold the provider to the manual, when the treatment does not work it is because the treatment is insufficient for the client. No treatment works for everyone, and our understanding of human behavior is limited. We do not have solutions for every person and problem. It may be that that we simply do not know how to get a particular client to engage in treatment, or how to keep certain clients alive. That is a failure of the treatment and of the state of our science, not of the client, nor of the provider. It is also important to remember that "fail" has no moral judgment attached to it, it simply means "it did not work," that the goals were not attained. The team can monitor the culture of the team to ensure that such blame does not surface, and the focus remains on solid assessment and the provision of the most effective treatment possible.

8. *DBT team members need support.* This assumption forms the backbone of this book. DBT providers will make mistakes, and many

times those mistakes can interfere with the client's progress. DBT providers, just like our clients, will get pulled toward actions that reduce distress in the short run, but are not always effective in the long run. Clients will inadvertently shape providers toward ineffective choices at times. Even at their most skillful, team members need emotional support to provide effective DBT. Working in isolation, a provider can drift far from the manual, and face burnout and other difficulties. As we will discuss throughout this book, the primary functions of the DBT team are to continuously help each member to come back to the best care possible, as well as to maintain sufficient motivation to engage in this difficult work.

DBT Assumptions about Therapy*

1. *The most caring thing a DBT provider can do is help clients change in ways that bring them closer to their own ultimate goals.* This means the provider may push for change even when it is difficult for the client (e.g., continuing with exposure even when it is aversive) or slow down the push for change because to do so is deemed more effective for the client's care. The team will focus on this as its main goal: to help the team member effectively move clients toward their goals. If the team notices the team member has been shaped out of targeting certain behaviors, the team will highlight this problem, even if it is uncomfortable or difficult. With respect to the team, this might be restated to read, "The most caring thing a team can do is help its team members help clients change in ways that bring them closer to their own ultimate goals."

2. *Clarity, precision, and compassion are of the utmost importance in the conduct of therapy.* This means that not only is a provider warm and supportive, but also has precise, strategic interventions whenever possible, with a clear conceptualization, treatment plan, and rationale for each move in therapy. For example, a provider validating for an entire therapy session may be seen as compassionate but not helpful; however, if the provider mindfully chooses to avoid requesting change for a strategic reason for one full session, this choice could be considered effective DBT. We have seen many DBT providers emphasize clarity and precision over compassion and vice versa; team members often need help to synthesize

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the two poles. The team can help maintain the balance with its focus on building empathy for the client as well as helping the clinician provide the most precise, clear interventions and strategies possible. The team can also help maintain this balance in team, when providing therapy for the therapist.

3. *The therapeutic relationship is a real relationship between equals.*

4. *Principles of behavior are universal, affecting DBT providers no less than clients.* The assumption of equality often creates an emotional reaction for DBT providers. Assumptions 3 and 4 assume that we, provider and client, are equal in that we are both susceptible to the principles of behaviorism, we both can be shaped toward effective and ineffective behaviors, and we are both a product of our biology and our environment. This is not to ignore the inherent power differential in the provider–client relationship; this discrepancy exists because the provider was fortunate enough to learn skills and interventions, and perhaps was born with a different biology than the client, and therefore has certain knowledge and abilities that the client does not possess. The team can monitor when members drift from this assumption, and help them return to the notion that the client is operating within the same principles as the provider, and in that respect, they are indeed equals. This can increase the team member's compassion and ability to conceptualize a case skillfully.

5. *DBT providers can fail.* This is yet another provocative assumption for many DBT providers. When we teach this to DBT providers, many start worrying about suicide and lawsuits if they are unable to perform perfectly all of the time, a high bar indeed! The idea of failing is highly charged for most of us. DBT does not, however, expect or require providers to be perfect. As mentioned in the assumptions about clients, if we can define the term “fail” in nonjudgmental terms, meaning simply that the goal was not reached (in this case, the manual was not followed exactly), this assumption can be easier to grasp. Any DBT provider can fail to provide the treatment as it is described in the treatment manual; this is actually expected, given the many obstacles that may arise. This is considered so typical, in fact, that this was one of the primary reasons the DBT team was developed. The team helps the team member identify, assess, and intervene each time the member stops doing DBT. This is a failure in the sense that the treatment was not provided as designed,

as opposed to a reflection on anyone's capability or character, or any sense of "fault." It is simply a statement of fact. The team participates by acknowledging that this is true, and being willing to identify it when they see it, in order to help each member tolerate the inevitable emotion and turn back toward the treatment if drift has occurred.

6. *The treatment can fail even when DBT providers do not.* The team can also remind each member that just because a treatment is not working does not mean the provider has failed to do something. Just as chemotherapy does not always work for cancer patients, our best interventions do not always work, even when delivered with fidelity. As described previously, the state of the science of behavior change is limited; if a DBT provider is utilizing the manual and the team, the most likely obstacle is that we do not have ideal interventions for all of our clients. The team can lend support around this assumption, as well as offer suggestions for when it might be time to stop the treatment or change strategies.

Other Elements of Team Structure

Along with these agreements and assumptions, DBT teams use roles and an agenda to help maintain the structure and culture of DBT. The roles of team leader, meeting leader, and observer are most common in DBT teams, but some teams also add additional roles to help maintain the structure and culture of the team.

The elements discussed here, including team functions, agreements, assumptions, and structure, together create the heart of the team. While this may seem like an extensive amount of structure, these principles are pulled directly from DBT treatment, and will likely be familiar to DBT providers.

Starting with the foundation of these principles and strategies, teams may need to adapt this structure to meet their specific needs. When teams notice the urge to adapt or eliminate one of these elements, it will be important to consider the dialectic: the validity of the original structure and the validity of the desire to alter it. Considering both of these poles will help teams avoid taking the path of least resistance (e.g., eliminating an agreement because it is difficult to follow or because the team wishes to avoid conflict), and maximize the chances the team will

design a structure that is most beneficial to the team, team members, and clients. Teams can remain alert to urges to change the structure: while flexibility is essential, changing spontaneously may lead to emotion-mind decisions. It is helpful to be flexible and strategic when deciding these elements, then to follow them carefully even when it is challenging to do so. Instead of changing elements when following them feels difficult, teams will likely benefit from reviewing and revising them on a regular basis, such as at an annual retreat.

Teams may also want to add structure; for example, a team full of trainees may need to focus more on teaching and modeling during team; a research team may need to add an emphasis on a specific treatment target or on following a particular research protocol. Teams in inpatient or residential settings may need to address the difficulty of working different shifts; while the individual therapist remains the primary provider, these teams may need to create systems to maintain effective communication across multiple staff, such as adding additional meetings, engaging in structured communication and/or occasional formal team meetings with swing and night shift, and creating means to inform the individual therapist of developments in the client's care. Teams may also need to develop strategies for communicating if they are meeting via video conference.

Providers who do not use DBT may also wish to develop a treatment team with similar goals and structure. We are aware of other treatments that use a team approach for treatments other than DBT (e.g., CBT for anxiety); mentalization-based treatment for BPD (Bateman & Fonagy, 2004); treatment for depressed and suicidal adolescents (Brent, Poling, & Goldstein, 2011); and trauma systems therapy (Saxe, Ellis, & Kaplow, 2007), suggesting providers of other treatments may benefit from the DBT team approach. Within the principles and structure discussed in this book, there are many ways to adjust the elements of the DBT team to fit the specific needs of a particular treatment, team members, and clients.

The Structure of This Book

Expanding upon the concepts introduced in this chapter, Chapter 2 describes the systems, roles, and tasks that help DBT teams function well. This includes the jobs the team will need to accomplish to run effectively,

and how the meeting leader, observer, and other roles can help the team maintain the culture.

Chapter 3 focuses specifically on the role of team leader and the unique challenges inherent in that role. This chapter discusses how to guide a program and multiple team members, and associated difficulties that may accompany this role. Team leaders are also in a position of both leading and being a member of the treatment team simultaneously, which can present dilemmas that require particular attention and care.

Chapter 4 addresses the structure of DBT team meetings, and how to use an agenda to support an effective structure. This chapter includes a discussion of time management and prioritization in team meetings.

Chapter 5 goes into more depth on the concept of *therapy for the therapist*, and how team members can provide support and facilitate change for their teammates. This chapter includes DBT strategies and skills, and suggestions for ways teammates can implement them with each other, not just with their clients.

Chapter 6 describes several problems that are common in DBT teams, all of which can present obstacles to an effective team process. Means of assessing and understanding these problems are discussed along with suggestions for the resolution of such problems.

Chapter 7 focuses on one of the most challenging situations in team: when a client, a provider, and therefore a team experience a suicide crisis. The important roles teams play before, during, and after a suicide crisis are discussed.

And finally, Chapter 8 explains how to start a new DBT team, as well as how to bring new members onto a DBT team.

Each chapter ends with “Ideas for Practice,” which provide suggestions for ways to practice the strategies or concepts in each chapter. These exercises are simply starting points for teams to create their own practices that are tailored to their own needs.

It is important to note that this is not intended to be a rule book or a lock-step manual. This book focuses on principles, not mandates, for dealing with a variety of situations flexibly and strategically, with examples and exercises that can be tailored to many teams. While we find the structure provided here is helpful in developing an effective team, there is no one “right” way to structure a team. The principles are much more important than the overt appearance of the team. Each team is so unique that its problems and solutions will vary widely. When teams become

rigid or stuck on rules, while ignoring what is actually helpful to its members, clients, and the team as a whole, they typically run into trouble. We recommend starting as close to the traditional model as possible, learn what works and does not work, then mindfully and strategically adjust as needed, and monitor the effectiveness of those adjustments. The use of tailored application of these principles, as well as creativity and responsiveness to the individuals within each unique team, is emphasized throughout this book.

A Note on Language

We made every effort to use gender-neutral pronouns throughout the text. We relied on plural pronouns wherever possible and used “they” or “one” when a singular pronoun was required. The only exceptions (in which we used “he” and “she” as pronouns) were examples that referred to specific individuals.

Conclusion

DBT teams are considered an essential part of DBT, based on the premise that skillful DBT therapists are essential to delivering effective DBT. This chapter describes the purpose of the DBT team, including an overarching focus on fidelity to the DBT manuals, with an emphasis on enhancing the motivation and capability of the providers on the team. We describe the ways in which DBT teams are different from traditional consultation teams, and we introduce several components that support the culture of the DBT team, including agreements, assumptions, and other structural elements. We expand upon these concepts throughout this book. We hope that by providing these principles for DBT teams, we can help DBT providers create and maintain a community, a place where they find comfort, support, ideas, knowledge, and growth, from which they can provide the best DBT possible.