Preface to the Second Edition

The original edition of this skills training manual was published in 1993. At that time, the only research conducted on Dialectical Behavior Therapy (DBT) was a 1991 clinical trial comparing DBT to treatment as usual for the treatment of chronically suicidal individuals meeting criteria for borderline personality disorder (BPD). Since then, an enormous amount of research has been conducted on "standard" DBT, which typically consists of DBT individual therapy, group skills training, telephone coaching, and a therapist consultation team. Research has also been conducted on stand-alone DBT skills training, and on the behavioral practices that together make up the DBT skills. The new skills in this edition are a product of my experience and research using the original skills; the wide-ranging research on emotions, emotion regulation, distress tolerance, and mindfulness, as well as new findings in the social sciences; and new treatment strategies developed within the cognitive-behavioral paradigm. The major changes in the revised skills package are described below.

Skills for Multiple Disorders and Nonclinical Populations

The original skills training manual was focused entirely on treating clients with high risk for suicide and BPD. This was primarily because the research on DBT, including DBT skills, had been conducted with clients meeting criteria for BPD and for high suicide risk. Since the first edition, however, a number of studies have been conducted focusing on skills training with different populations. For example, DBT skills training has been shown effective with eating disorders,[1, 2] treatment-resistant depression,[3, 4] and a variety of other disorders.[5] In my colleagues' and my research, increases in use of skills mediates reductions in suicide attempts, nonsuicidal self-injury, difficulties regulating emotions, and interpersonal problems.[6] A subset of skills was also added to a treatment for problem drinkers and improved outcomes compared to a treatment without the skills.[7] A subset of DBT skills is taught in the evidence-based National Education Alliance for Borderline Personality Disorder's Family Connections program for family members of individuals with BPD. The entire set of core skills is taught in the friends and families skills groups at the University of Washington Behavioral Research and Therapy Clinics, which consist of individuals who want to learn skills for coping with and accepting individuals in their lives who are difficult. This could include friends or relatives with serious mental health problems, employees with problematic colleagues and/or managers, managers with problematic employees, and therapists treating very difficult client populations. Corporate consultants are looking at DBT skills as a way to improve corporate morale and productivity. New sets of specialized skills have been developed for specific disorders, including a module targeting emotion overcontrol,[8] middle path skills developed originally for parents and adolescents but appropriate for many populations,[9] skills for attention-deficit/hyperactivity disorder, and a set of skills specifically designed for individuals with addictions. DBT skills lesson plans are now being used in school systems to teach middle school and high school students,[10] are working their way into programs focused on resilience, and can be applied across work settings. DBT skills are widely taught in general mental health programs in community mental health, inpatient, acute care, forensic, and many other settings. In sum, there are substantial data

and clinical experience suggesting that DBT skills are effective across a wide variety of both clinical and nonclinical populations and across settings.

Of course, it should not come as a surprise that DBT skills are widely applicable. I developed many of the skills by reading treatment manuals and treatment literature on evidence-based behavioral interventions. I then looked to see what therapists told patients to do for each problem, repackaged those instructions in skills handouts and worksheets, and wrote teaching notes for therapists. For example, for the skill "opposite action" (see Chapter 9) for fear, I repackaged exposure-based treatments for anxiety disorders in simpler language. I also applied the same principles of change across other disordered emotions. "Check the facts" is a core strategy in cognitive therapy interventions. DBT skills are what behavior therapists tell clients to do across many effective treatments. Some of the skills are entire treatment programs formulated as a series of steps. The new "nightmare protocol," an emotion regulation skill, is an example of this. The mindfulness skills are a product of my 18 years in Catholic schools, my training in contemplative prayer practices through the Shalem Institute's spiritual guidance program, and my 34 years as a Zen student and now as a Zen master. Other skills came from basic behavioral science and research in cognitive and social psychology. Some came from colleagues developing new DBT skills for new populations.

New Skills in This Edition

There are still four primary DBT skills training modules: mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, and distress tolerance skills. Within these modules, I have added the following new skills.

1. In **mindfulness skills** (Chapter 7), I have added a section on teaching mindfulness from alternative perspectives, including a spiritual perspective.

2. In **interpersonal effectiveness skills** (Chapter 8), I have added two new sections. The first focuses on skills for finding and building relationships you want and ending relationships you don't want. The second focuses on balancing acceptance and change in interpersonal interactions. It closely duplicates the skills Alec Miller, Jill Rathus, and I developed for adolescent multifamily skills training, in which parents of adolescent clients also participate in skills training.[11]

3. The **emotion regulation skills** (Chapter 9) have been expanded greatly and also reorganized. The number of emotions described in detail has expanded from six to ten (adding disgust, envy, jealously, and guilt). A section on changing emotional responses adds two new skills: check the facts and problem solving. Also in that section, the opposite action skill has been extensively updated and expanded. Skills for reducing emotional vulnerability have been reorganized into a set of skills called the ABC PLEASE skills. In the section on accumulating positive emotions, I changed the Pleasant Events Schedule (now called the Pleasant Events List) to be appropriate for both adolescent and adult clients. I also added a values and priorities handout that lists a number of universal values and life priorities. Another new skill, cope ahead, focuses on practicing coping strategies in advance of difficult situations. Optional nightmare and sleep hygiene protocols are also included. Finally, a new section is added for recognizing extreme emotions ("Identify Your Personal Skills Breakdown Point"), including steps for using crisis survival skills to manage these emotions.

4. The **distress tolerance skills** (Chapter 10) now start with a new STOP skill—stop, take a step back, observe, and proceed mindfully—adapted from the skill developed by Francheska Perepletchikova, Seth Axelrod, and colleagues.[12] The crisis survival section now includes a new set of skills aimed at changing body chemistry to rapidly regulate extreme emotions (the new TIP skills). A new set of skills focused on reducing addictive behaviors has also been added: dialectical abstinence, clear mind, community reinforcement, burning bridges, building new ones, alternate rebellion, and adaptive denial.

5. Across modules I have also made a number of changes. Every module now starts with goals for that module along with a goals handout and a corresponding pros and cons worksheet. The worksheet is optional and can be used if the client is unwilling or ambivalent about practicing the skills in the module.

A mindfulness skill has been added to both the interpersonal module (mindfulness of others) and the distress tolerance module (mindfulness of current thoughts). Together with mindfulness of current emotion (emotion regulation), these additions are aimed at keeping the thread of mindfulness alive across time.

More Extensive Teaching Notes

Many people who have watched me teach DBT skills have commented that most of what I actually teach was not included in the first edition of this book. In

this second edition, I have added much more information than was in the previous one. First, as much as possible I have included the research underpinnings for the skills included. Second, I have provided a very broad range of different teaching points that you can choose from in teaching, far more points than either you or I could possibly cover in a skills training class. The teaching notes may, at first, seem overwhelming. It is important to remember that this book is not to be read cover to cover at one sitting. Instead, teaching notes are organized by specific skills so that when teaching a specific skill you can find the notes just for that skill or set of skills. It will be important for you to read over the material for the skills you plan to teach and then highlight just those points that you wish to make when teaching. With practice over time, you will find that you expand your teaching to include different parts of the material. You will also find that some parts of the material fit some of your clients and other parts fit other clients. The material is meant to be used flexibly. With experience, you will no doubt start adding your own teaching points.

More Clinical Examples

A larger number of clinical examples are also included in this second edition. Examples are essential for good teaching. However, you should feel free to modify the examples provided and to substitute new ones to meet the needs of your clients. In fact, this is the major difference in teaching skills for various populations; one set of examples may be needed for clients with high emotion dysregulation and impulse control difficulties, another for those with emotion overcontrol, and another for substance-dependent clients. Differences in culture, ethnicity, nationality, socioeconomic status, and age may each necessitate different sets of examples. In my experience, it is the examples but not the skills that need to be changed across populations.

More Interactive Handouts and Optional Handouts

Many of the handouts have been modified to allow greater interaction during skills training sessions. Most have check boxes so participants can check items of importance to them or skills they are willing to practice in the coming weeks. Each module also now includes a number of optional handouts. These have the same number as the core handout with which they are associated plus a letter (e.g., 1a, 1b). These optional handouts can be given out and taught to participants, given out but not formally taught, used by the skills trainer to teach but not given out, or simply ignored if not viewed as useful. My experience is that these optional handouts are extremely useful for some groups and individuals but not for others.

Improved Worksheets

By popular demand, homework sheets have been relabeled as worksheets. Also, on each handout the corresponding worksheets are listed, and on each worksheet the corresponding handouts are listed.

There are now multiple alternative worksheets associated with many of the handouts. The increase in worksheets is due to a number of factors. First, it became clear over the years that a worksheet that works very well for one person may not be good for another person. As a result, I have developed a range of worksheets for each handout. For most skills sections, there is one set of worksheets that covers the skills in the entire section. This is for clients who are unlikely to complete much homework practice and can help those who have already completed skills training and are now working on maintaining their practice of skills.

Second, different clients like different types of practice. There are clients who want to check off what homework they have done, clients who prefer to describe their homework and rate its effectiveness, and those who like to write diaries describing what they have done and how it affected them. I have found it most effective to let clients choose worksheets to fill out from a set.

Multiple Teaching Schedules Outlined

The 1993 edition of the skills manual included the specific skills and worksheets that were used in the first randomized clinical trial of DBT. At that time, DBT had not spread very far, and there were not many examples of how to choose skills for situations in which some but not all of the skills could be taught, nor were skills developed at that time for special populations such as adolescents or individuals with addictions, eating disorders, and so forth. Given the many new skills in this edition, it is not possible to teach all the skills in a 24-week skills group, even when the skills are repeated for a sec-

ond 24 weeks, as in a 1-year DBT treatment program. This edition includes a number of schedules for teaching skills, including schedules for 1-year, 6-month, and briefer skills training in acute care units and nontraditional settings. Schedules for particular populations (such as adolescents and substance abusers) are also provided. As often as possible, the teaching schedules are based on clinical trials that showed that the specific skills schedule was effective. With this in mind, there are now several sets of core DBT skills that are outlined in the appendices to Part I. My general strategy in teaching skills is to give participants all the DBT handouts and worksheets. I then follow a teaching schedule I determine based on the population, the number of weeks of treatment, and current research. Along the way, I tell participants that if we have time I will teach them other skills—if they talk me into it.

A Word about Terms

There are many terms for a person who teaches and coaches behavioral skills: therapist, psychotherapist, individual therapist, marital therapist, family therapist, milieu therapist, group therapist, group leader, counselor, case manager, skills trainer, behavioral coach, skills coach, crisis worker, mental health worker, mental health care provider, and so on. In this manual, the term "therapist" refers to a person who is providing psychotherapy or other mental health services. In standard DBT, this would be the person's individual therapist. The terms "skills trainer," "skills leader," "skills co-leader," and "leader" refer to individuals who are providing skills training either individually or in a group. In standard DBT, this refers to the group skills leaders. On occasion I use the term "provider" as a general reference to any person providing health care services.

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For a quick guide on How to Use This Book, please refer to page xv.

References

1. Telch, C. F., Agras, W. S., Linehan, M. M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*(6), 1061–1065.
2. Safer, D. L., & Jo, B. (2010). Outcome from a randomized controlled trial of group therapy for binge eating disorder: Comparing dialectical behavior therapy adapted for binge eating to an active comparison group therapy. *Behavior Therapy, 41*(1), 106–120.
3. Lynch, T. R., Morse, J. Q., Mendelson, T., & Robins, C. J. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry*, *11*(1), 33–45.
4. Harley, R., Sprich, S., Safren, S., Jacobo, M., & Fava, M. (2008). Adaptation of dialectical behavior therapy skills training group for treatment-resistant depression. *Journal of Nervous and Mental Disease, 196*(2), 136–143.
5. Soler, J., Pascual, J. C., Tiana, T., Cebria, A., Barrachina, J., Campins, M. J., & Pérez, V. (2009). Dialectical behaviour therapy skills training compared to standard group therapy in borderline personality disorder: A 3-month randomised controlled clinical trial. *Behaviour Research and Therapy, 47*, 353–358.
6. Neacsiu, A. D., Rizvi, S. L., & Linehan, M. M. (2010). Dialectical behavior therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behaviour Research and Therapy, 48*(9), 832–839.
7. Whiteside, U. (2011). *A brief personalized feedback intervention integrating a motivational interviewing therapeutic style and dialectical behavior therapy skills for depressed or anxious heavy drinking young adults*. Unpublished doctoral dissertation, University of Washington.
8. Lynch, T. R. (2018). *Radically open dialectical behavior therapy: Theory and practice for treating disorders of overcontrol*. Oakland, CA: New Harbinger.
9. Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford Press.
10. Mazza, J. J., Dexter-Mazza, E. T., Murphy, H. E., Miller, A. L., & Rathus, J. L. (2016). *DBT skills in schools: Skills training for emotional problem solving for adolescents*. New York: Guilford Press.
11. Miller, A. L., Rathus, J. H., Linehan, M. M., Wetzler, S., & Leigh, E. (1997). Dialectical behavior therapy adapted for suicidal adolescents. *Journal of Psychiatric Practice, 3*(2), 78–86.
12. Perepletchikova, F., Axelrod, S., Kaufman, J., Rounsaville, B. J., Douglas-Palumberi, H., & Miller, A. (2011). Adapting dialectical behavior therapy for children: Towards a new research agenda for paediatric suicidal and non-suicidal self-injurious behaviors. *Child and Adolescent Mental Health, 16*, 116–121.

Chapter 2

Planning to Conduct DBT Skills Training

Behavioral skills training is necessary when the skills needed to solve problems and attain desired goals are not currently in an individual's behavioral repertoire. That is, under ideal circumstances (where behavior is not interfered with by fears, conflicting motives, unrealistic beliefs, etc.), the individual cannot generate or produce the behaviors required. The term "skills" in DBT is used synonymously with "abilities" and includes in its broadest sense cognitive, emotional, and overt behavioral (or action) skills together with their integration, which is necessary for effective performance. Effectiveness is gauged by both direct and indirect effects of the behaviors. Effective performance can be defined as those behaviors that lead to a maximum of positive outcomes with a minimum of negative outcomes. Thus "skills" is used in the sense of "using skillful means," as well as in the sense of responding to situations adaptively or effectively.

The emphasis on integration of behaviors to produce a skillful response is important. Very often (indeed, usually), an individual has the component behaviors of a skill but cannot put them together coherently when necessary. For example, an interpersonally skillful response requires putting together words the person already knows into effective sentences, together with appropriate body language, intonation, eye contact, and so forth. The parts are rarely new; the combination, however, often is. In the terminology of DBT, almost any desired behavior can be thought of as a skill. Thus coping actively and effectively with problems, and avoiding maladaptive or ineffective responses, are both considered using one's skills. The central aim of DBT as a whole is to replace ineffective, maladaptive, or nonskilled behavior with skillful responses. The aim of DBT skills training is to help the individual acquire the needed skills. The steps for planning to conduct DBT skills training are outlined in Table 2.1 and discussed in more detail next. How to integrate DBT skills into non-DBT interventions is described at a later point in the chapter.

Forming (or Joining) a DBT Team[1]

DBT assumes that effective treatment, including skills training, must pay as much attention to the behavior and experience of providers working with clients as it does to the clients' behavior and experience. Thus treatment of the providers is an integral part of any DBT program. This is just as important for those teaching skills as it is for all other DBT providers. No matter how well adjusted clients may be, skills training can at times be enormously challenging and/or stressful, and staying within the DBT frame can be difficult. The roles of consultation are to hold the providers within the DBT frame and to address problems that arise. The fundamental team targets relevant to skills trainers are increasing adherence to DBT principles and accuracy of teaching

TABLE 2.1. Organizing DBT Skills Training in Your Practice

1. Form (or join) a DBT team.
2. Select skills training members of your team.
3. Select skills modules and specific skill sets.
4. Plan a skills training curriculum.
5. Decide on:
   a. Massed versus spaced practice in a 1-year program.
   b. Individual versus group skills training.
   c. Open versus closed groups.
   d. Heterogeneous versus homogeneous groups.
6. Clarify the roles of skills trainers, individual therapists, case managers, nurses and line staff, and pharmacotherapists in a skills training program.

and coaching skills; providing ideas for enhancing teaching of skills; troubleshooting problems that arise in the course of skills training; increasing and maintaining skills trainers' motivation; and giving support when providers' limits are crossed (and even when these are not crossed!).

DBT consultation groups require at least two people who meet weekly in person if both are in the same locality; when in-person meetings are not possible, team members may meet in an online learning community or via video conferencing. Because the primary focus of a DBT team is on the treatment providers, *not* the skills training recipients, providers do not have to be treating the same clients. For example, a client could be in individual treatment in one clinic and in a skills training group taking place in another clinic, each clinic with its own DBT team. Coordination of interventions, however, is greater if individual therapists, case managers, pharmacotherapists, and skills trainers are on the same team. (See Sayrs & Linehan, 2019, for more discussion of how to set up, run, and solve problems in a DBT consultation team.[2])

Selecting Skills Training Members of Your Team: Necessary Qualifications and Characteristics

Skills training can be conducted by psychotherapists, counselors, case managers, social workers, milieu staff (in residential settings), and psychiatric nurses (in inpatient settings). Prescribing psychiatrists and nurse practitioners can be very effective skills coaches. For individuals without identified mental disorders, skills training can also be conducted by anyone (teachers, parents, family members, volunteers, and professional trainers) who is well trained in the principles of skills training and in the skills themselves. Clergy, pharmacotherapists, and other health care providers (e.g., psychiatrists, physicians, nurse practitioners, nurses, occupational therapists, and other medical staff in outpatient settings), when trained in the skills, often make excellent skills coaches. In addition, charismatic individuals who themselves have gone through skills training and have overcome their own difficulties can also make excellent co-trainers and skills peer counselors, again, when trained in the skills.

We know in DBT that to do the treatment effectively, skills trainers need to be well trained in what they are doing. They must have a very good grasp of DBT skills, practice the skills themselves, and know how to teach them. They need to know and be able to use basic behavior therapy techniques (such as behavior analysis, solution analysis, contingency management, exposure procedures, and the basics of skills building) and DBT treatment strategies (such as dialectical strategies, validation and problem-solving strategies, irreverent and reciprocal communication strategies, consultation to the patient, and environmental intervention strategies) as well as DBT protocols, particularly the suicide protocol. These strategies and protocols are described in full in the main DBT text and are reviewed in Chapter 5 of this manual. At this time, we have no evidence that type of academic degree is a critical factor in improving skills training outcomes.

Skill trainers' attitudes toward clients are also very important. Clients who fail to behave skillfully, and claim not to know how to behave differently, are viewed by some therapists as resistant (or at least as governed by motives outside awareness). These clinicians see giving advice, coaching, making suggestions, or otherwise teaching new behaviors as encouraging dependency and need gratification that gets in the way of "real" therapy. Other therapists and skills trainers fall into the trap of believing that clients can hardly do anything. At times they even believe that the clients are incapable of learning new, more skillful behaviors. Acceptance, nurturance, and environmental intervention compromise the armamentarium of these clinicians. Not surprisingly, when these two orientations coexist within a client's treatment team, conflict and "staff splitting" often arise. A dialectical approach would suggest looking for the synthesis, as I discuss more fully in Chapter 13 of the main DBT text.

When a DBT team is being started, the criteria for membership on the team are the same for all participants. Each participant must be on the team voluntarily, must agree to attend team meetings, must be committed to learning and applying DBT, and must be equally vulnerable to team influence. The last criterion means that all participants will bring to the team any difficulties and issues related to their attempts to apply DBT principles and interventions (including skills interventions) with the clients they are working with.

Selecting Skills Modules and Specific Skills to Teach

As noted in Chapter 1, there are four separate DBT skills modules: Mindfulness, Interpersonal Effec-

tiveness, Emotion Regulation, and Distress Tolerance. Each module is divided into core sections and supplementary sections with specialized, optional, or advanced skills. The latter sections can be dropped if they do not meet the needs of specific client populations or if time demands it. Sections and specific skills can also be taught separately. (See Table 1.1 for which skills are core and which are supplementary.) A set of general handouts is given out during orientation before the start of each Mindfulness skills module, if there are new members in the group. A set of supplementary skills teaching behavioral analyses is also included in the general skills. In standard DBT, skills training is conducted in groups of 6–8 (10 at the most) participants plus 2 group leaders, once a week for 2.5 hours (2 hours with adolescents). Participants complete one full cycle of core skills through all the modules in 6 months. In a 1-year treatment program, participants then repeat the cycle for a total of 12 months. The core skills modules are each designed to take from 5 to 7 weeks (Interpersonal Effectiveness, 5 weeks; Distress Tolerance, 6 weeks; Emotion Regulation, 7 weeks). The Mindfulness module is designed to take two weeks and is repeated, along with a brief orientation, before the start of each new module. This basic cycle is outlined in Table 2.2. See the Appendices to Part I for a more detailed outline, along with session-by-session outlines of different DBT skills training programs for various disorders, time periods, and settings.

There are no empirical data to suggest how to order the modules. Since the core mindfulness skills are woven throughout the other training modules, Mindfulness obviously has to be the first module presented. In our current program, the Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance modules follow in that order, and that is their order in this manual.

The Interpersonal Effectiveness module focuses on how clients can decrease pain and suffering by effectively interacting with their social environment both to elicit changes in others and (when warranted) to resist unwanted influence from others. The Emotion Regulation module assumes that even though a situation (interpersonal or otherwise) may generate pain and suffering, an individual's responses also have to change and can be changed. The Distress Tolerance module assumes that even though there may be a lot of pain and suffering, it can be tolerated, and life can be accepted and lived in spite of pain. Surely this is a difficult lesson for anyone. One can, however, make a reasonably good case for any order of modules. In many clinics, clients are given the crisis survival strategies handouts (part of the Distress Tolerance module) during the first meeting. These skills are more or less self-explanatory, and many clients find them extremely helpful. They are then reviewed in detail when the Distress Tolerance module is taught. For some clients, their dysregulation and lack of understanding of emotions are so great that a case can be made for starting with the Emotion Regulation module. This is often the case, for example, in our multifamily adolescent groups.

TABLE 2.2. Standard Core DBT Skills Training Schedule: Cycling Twice through All Modules over 12 Months

Orientation + Mindfulness module:	2 weeks
Interpersonal Effectiveness module:	5 weeks
Orientation + Mindfulness module:	2 weeks
Emotion Regulation module:	7 weeks
Orientation + Mindfulness module:	2 weeks
Distress Tolerance module:	6 weeks
	(24 weeks, 6 months)
Orientation + Mindfulness module:	2 weeks
Interpersonal Effectiveness module:	5 weeks
Orientation + Mindfulness module:	2 weeks
Emotion Regulation module	7 weeks
Orientation + Mindfulness module:	2 weeks
Distress Tolerance module:	6 weeks
	(48 weeks, 12 months)

Suggestions for Planning a Skills Training Curriculum

Instructional material in skills training, especially in a group context, should be presented at a pace adapted to the level of participants' understanding. Since the pace of each session will differ, as will the overall pace for particular individuals or groups, the instructional content in Chapters 6–10 of this book is not divided into segments within particular sessions. In my experience, however, the first time trainers teach these skill modules, the amount of material feels overwhelming. New skills trainers tend to spend too much time on early parts of a module and then have too little time later to cover other material that may be more important. What actually is important will necessarily vary with different individuals or groups, depending on their

experience and skill levels. In order to facilitate the coverage of all the material by the end of the time scheduled for the particular module, the skills training leaders should construct lesson plans for each session and should attempt to cover the designated material during the session time allotted. Curricula for 11 different skills programs are outlined in the Appendices to Part I. Most of these are based on outlines that have been used in various research studies using DBT skills. The best strategy the first time through a module is to follow the steps below.

1. Decide how many total weeks your skills training program will last, and how long each session will be. The length of your program and of sessions will depend on whether participants do or do not have mental disorders, the severity of their disorders or other problems, the goals of your treatment program (e.g., stabilization, treatment, skills building), staff availability, financial resources, research data on outcomes of various lengths of treatment, and factors unique to your treatment setting.

2. Decide which skills you definitely want to teach and which skills you want to include as ancillary. Content of skills should be based on the research data for the disorders/problems you are addressing and, when there are few research data to guide your choice, on your beliefs about which skills are most appropriate for your clients. The curricula in the Appendices are organized by the number of weeks each program lasts and by the population each program is intended to treat. Look these over and select the skills curriculum that fits your situation best.

3. Decide which handouts and worksheets you want to use. Do not use them without first reviewing them. Worksheets are associated with handouts; the worksheets for each handout are listed after the number of each handout, and vice versa. Descriptions of the relevant handouts and worksheets are given in the overview box for each skill or set of skills in the teaching notes.

There are several types of worksheets. Overview worksheets cover several skills and can be used when you want to focus primarily on practice of a group of skills, rather than focusing intensively on just the skills taught in a particular session. These worksheets are the first ones in each section and are linked to the handouts that overview each section.

Specific skills worksheets focus on a particular skill or small skills set. In some cases, multiple worksheets focus on the same set of skills (and are given the same worksheet number), but they differ in the amount of practice they provide for. The letters a, b, and c following the worksheet number generally indicate different demands the worksheets put on participants. For example, some of these ask participants to practice a particular skill once or twice between sessions; others ask that each skill in a set be practiced between sessions; and still others ask for daily practice of a skill or set of skills. There are also calendar worksheets for some skills that ask the participants to write about the skills they use each day between sessions.

4. The first time you teach skills, divide each module arbitrarily into sections corresponding to the exact number of weeks available, and try to get through as much of each section as possible. This experience will dictate how to time the modules the second time, and so on. When I teach therapists how to do DBT skills training, I usually recommend that trainers copy the teaching notes covering the skills they will teach in a specific session, and then highlight the main points they plan to cover in that session. With this strategy, it can be useful first to teach the material in the skills modules in the order given in this manual. After the first run-through, modifications in content and order can be made to suit your style or a particular situation.

Massed versus Spaced Practice in a 1-Year Program

Although each training module is designed to take 5–7 weeks to cover, up to a year could be spent on each. The content for each skills area is comprehensive and complex for such a short period of time. Covering the skills training material in this brief number of weeks requires very strict time management. Therapists also have to be willing to go on when some (or even all) clients have not acquired the skills that are currently being taught. Participants are sometimes overwhelmed by the amount of information the first time they go through each module. In a 1-year program, why not expand each module to a series of three 10- to 14-week modules (starting each with 2 weeks of mindfulness skills), rather than two sets of three 5- to 7-week modules? In other words, why not go for massed practice (the

first choice) rather than spaced practice (the second choice)? There are several reasons for the present format.

First, all individuals—but particularly those who have trouble regulating their emotions—can be variable in their mood and functionality. They may go through periods of several weeks where they may miss meetings or, when present, pay attention minimally (if at all). Presenting material twice increases the probability that each person will be present, both physically and psychologically, at least once when a particular segment is covered.

Second, different participants have different needs; thus the modules are differentially relevant and preferred by various individuals. Having to sit through a disliked module for 10–14 weeks is very difficult. Sitting through 5–7 weeks of a disliked module is also hard, but not as hard.

Third, in a 10- to 14-week format, the modules scheduled second and third get less practice time than in a 5- to 7-week format taught twice. If I could make a case that one module is indeed the most important and needs the most practice, this would not be a liability. However, I have no controlled empirical data to use in choosing which module that would be. In addition, it is doubtful that one module would be best for all clients. The central premise of a behavioral skills-oriented approach is that acquisition of new skills requires extensive practice. Even though the material often feels overwhelming the first time when presented in the 5- to 7-week format, clients nonetheless seem able to practice the skills in their everyday lives. Thus presenting each module once during the first 6 months of treatment leaves a minimum of 6 months for continued practice before skill training ends.

Fourth, going over the material after clients have had a chance to practice the skills for several months can be beneficial. The material makes more sense. And it offers the chance for the participants to learn that problems that seem really hard at one point may not always seem so hard if they persevere in their attempts to overcome them.

Finally, my experience has been that when 10–14 weeks are allotted to cover a treatment module, it is far easier to divert therapy time to attending to individual participants' crises and process issues. It is easy for the leaders to start thinking that they have plenty of time for digressive topics. Although some attention must be given to these issues, it is easy to drift out of skills training and toward supportive process therapy, when time is not of the essence. In my experience, once this has happened, it is extremely difficult to get back control of the therapy agenda.

Individual versus Group Skills Training

Successful DBT skills training requires discipline by both participants and skills trainers. In skills training, the session agenda is set by the skills to be learned. In typical psychotherapy and in DBT individual therapy, by contrast, the agenda is usually set by a client's current problems. When current problems are pressing, staying with a skills training agenda requires the skills trainers to take a very active role, controlling the direction and focus of the session. Many therapists and skills trainers are not trained to take such a directive role; thus, despite their good intentions, their efforts at skills training often peter out as participants' problems escalate. Inadequate attention to the actual teaching of skills, and the resulting drift in focus, are particularly likely in individual as opposed to group skills training.

Even trainers who are well trained in directive strategies have great difficulty keeping to a directive agenda when participants have pressing problems or crisis situations and want immediate help or advice. The inevitable crises and high emotional pain of such clients constitute a major and continuing problem. It is difficult for the participants, and consequently for their skills trainers, to attend to anything but the current crises during sessions. It is particularly difficult to stay focused on skills when a participant threatens to attempt suicide or otherwise quit if their current problem is not taken seriously. Taking it seriously (from the participant's point of view) usually means forgoing the day's skills training agenda in favor of resolving the current crisis.

Other participants may be less demanding of session time and energy, but their passivity, sleepiness, fidgetiness, and/or lack of interest in skills training may pose a formidable roadblock. It is easy in such a case for a therapist or skills trainer to get worn out with the client and just give up the effort, especially if a trainer is not a firm believer in skills training anyway. Skills training can also be relatively boring for those doing it if participants are nonresponsive, especially for trainers who have done considerable skills training with other participants. It is like a surgeon's doing the same operation over and over and over. Clients' fluctuating moods from week to

week and within the skills training sessions (a characteristic of individuals who have trouble regulating their emotions), together with therapists' wavering interest, can create havoc with the best-laid skills training plans.

Skills training is difficult with clients who have multiple problems, serious difficulties regulating their emotions, frequent crises, or intense desire to change the behavior of another person. Trying to conduct skills training with such an individual is like trying to teach a person how to put up a tent in the middle of a hurricane. Nonetheless, it is also the case that if participants had more effective skills in their repertoires, they would be able to cope much better with crisis situations. And this is the dilemma: How does a trainer teach the skills necessary to cope, when a participant's current inability to cope is so great that they are not receptive to acquiring new behavioral responses? In individual treatment, there is often nothing beyond the two participants to keep therapy on track. If both participant and skills trainer want to switch to something else, they can do it easily.

Keeping skills training on track can also be extremely difficult when the participants are friends and family members of other people who are having very serious difficulties. This is particularly the problem when participants are parents or spouses/partners of individuals who are at high risk for suicide or are engaging in dysfunctional behavior patterns that the participants are having extreme difficulties tolerating. In groups for friends and family members, it is very important for the leaders to make it clear during orientation that the focus of skills training is always on increasing the skills of the *participants*. The focus is *not* on how to change other people. This can be a particular problem for any relative who is in skills training principally to get consultation on how to manage a family member, with the expectation that the relative will be able to help the other person change. A similar problem can occur when any group member insists on help with changing another person (a boss, an employee, etc.). If the difficulty is persistent or is interfering with skills training for others, we have found that one or two individual consultation meetings can be helpful. Clearly, some DBT skills are aimed at influencing others. The DBT interpersonal effectiveness skills focus on developing influential behavior with others, including effective assertiveness with others and behavioral skills such as reinforcement, extinction, flooding, and punishment aimed at increasing or decreasing the behaviors of others. The line between this focus on participants' interpersonal skills and ability to influence others on the one hand, and a focus on changing specific others, may be thin—but it is important nonetheless. Staying dialectical can be critical here in managing these two polarities.

For many of the reasons discussed above, the standard mode of skills training in DBT is a group intervention. In a group, other participants—or at least therapists' sense of obligation to other participants—keeps skills trainers on track, even when one participant wants to change course. When one participant in group skills training is not in the mood for learning skills, others may be. The reinforcement these other clients give the skills trainers for continuing skills training can be more powerful than the punishment delivered by the participant who is not in the mood.

The crux of the problem is this: Skills training with an individual who does not see its benefits right away is often not immediately reinforcing for either the participant or the person teaching the skills. For many individuals, there is not a sense of immediate relief or problem solving. Skills training is like teaching tennis: A student does not usually win the first game after the first lesson. Winning takes practice, practice, practice. Nor is behavioral skills training as interesting as having "heart-to-hearts," a topic I have discussed in Chapter 12 of the main DBT text. Skills training requires much more active work for both client and therapist. Thus, for individual skills training to work, special precautions must be made for arranging events so that *both* therapist and client will find it reinforcing enough to continue.

Individual Skills Training

A number of circumstances may make it preferable or necessary to conduct skills training with an individual client rather than in a group. In a private practice setting or a small clinic, there may not be more than one client needing skills training at any one time, or you may not be able to organize more than one person at a time for skills training. Some clients are not appropriate for groups. Although in my experience this is very rare, a client who cannot inhibit overt aggressive behavior toward other group members should not be put into a group until this behavior is under control. It is also usually preferable to treat social anxiety disorder (social phobia) before asking a client to join a skills training group. Some clients may have already participated in 1 year

or more of a skills training group, but need further focused attention to one category or set of skills.

Finally, a client may not be able to attend the offered group sessions. In primary care settings, or when skills training is being integrated into individual therapy, skills may be taught during individual therapy sessions. In these situations, having the skills handouts and worksheets readily available will make it easiest for the individual practitioners to slip skills training into the fabric of ongoing individual care. In such a case, the therapist can make continuous efforts to incorporate the skills training procedures in every session. A problem with this approach is that the rules are not clear: It is often not apparent to the client what contingencies are operating at any given time in an interaction. The client who wants to focus on an immediate solution to an immediate crisis, therefore, has no guidelines as to when insisting on such attention is appropriate and likely to be reinforced and when it is not. A problem for the therapist is that it is extremely difficult to remain on track. My own inability to do just this was one of the important factors in the development of DBT as it is today.

A second alternative is to have a second therapist do individual skills training with each client. The rules for client and therapist behavior in this case are clear. In this format, general behavioral skills are learned with the skills trainer; crises management and individual problem solving, including the application of skills learned to particular crisis or problem situations, are the focus of sessions with the primary therapist or case manager. This approach seems especially advantageous in certain situations. For example, in our university clinic a number of students are eager to obtain experience in working with individuals with severe disorders who need long-term therapy, but the students are not able to commit to longer-term individual therapy. Conducting focused skills training for a period of time is a good opportunity for these students, and in my experience it has also worked out well for the clients. This would be an option in any setting where residents, social workers, or nurses are in training. In a group clinical practice, therapists may conduct skills training for each other; a large practice may hire some therapists with specific talents in this area. The treatment model here is somewhat similar to a general practitioner's sending a client to a specialist for specialized treatment.

Individual therapists who have no one to refer clients to for skills training, or who want to do it themselves, should make the context of skills training different from that of usual psychotherapy. For example, a separate weekly meeting devoted specifically to skills training may be scheduled, or skills training and individual therapy can alternate weekly. The latter choice is particularly likely to work when the client does not need weekly individual sessions focused on crises and problem solving. If possible, the skills session should be conducted in a room different from that used for individual psychotherapy. Other possibilities include switching chairs; moving a table or desk near (or between) the therapist and the client to put the skills training materials on; using a blackboard; turning up the lighting; having skills training sessions at a different time of day than psychotherapy sessions, or for a shorter or longer time period; arranging for audio or video recordings of the sessions if this is not done in individual psychotherapy, or vice versa; and billing differently. For a therapist with a particularly difficult client, participation in a supervision/consultation group is important in keeping up motivation and focusing on skills. Even for those individuals who are in group skills training, a task of individual therapists is to reinforce the use of skills and also to teach skills "ahead of time," so to speak, as needed. Many therapists in our clinic also give clients skills homework assignments related to current problems, using the DBT skills training worksheets.

Group Skills Training

The chief advantage of group skills training is that it is efficient. A group can include as few as two people. In our clinic, with very dysfunctional clients, we try to have six to eight persons in each group. Group treatment has much to offer, over and above what any individual therapy can offer. First, therapists have an opportunity to observe and work with interpersonal behaviors that show up in peer relationships but may only rarely occur in individual therapy sessions. Second, clients have an opportunity to interact with other people like themselves, and the resulting validation and development of a support group can be very therapeutic. DBT encourages outside-of-session relationships among skills group clients, as long as those relationships—including any conflicts—can be discussed inside the sessions. Third, clients have an opportunity to learn from one another, thus increasing avenues of therapeutic input. Fourth, groups typically reduce the intensity of the personal relationship between individual cli-

ents and the group leaders; in dynamic terms, the transference is diluted. This can be very important, because the intensity of therapy sometimes creates more problems than it solves for clients who have problems regulating their emotions. Fifth, if a norm of practicing skills between sessions can be established, such a norm can increase skills practice in individuals who on their own might be much less likely to do the skills homework practice ordinarily assigned weekly. Finally, skills groups offer a relatively nonthreatening opportunity for individual clients to learn how to be in a group.

In my ongoing DBT research programs, we have offered a variety of different treatment programs. In our 1-year standard DBT program, clients in individual therapy also participate in group skills training. In our 1-year DBT case management program, clients have a DBT case manager as well as group skills training. In our adolescent program, each adolescent sees an individual therapist, and the parents or other caregivers and the adolescent attend the skills group. We also offer a 6-month skills training program for friends and family members of individuals who either are difficult to be with or have difficult mental disorders. We have offered a similar skills training group for individuals with emotion dysregulation.

A number of issues need to be considered in setting up a skills group—whether to have open or closed groups; whether groups should be heterogeneous or homogeneous; and how many group leaders or trainers there should be and what these persons' roles should be. I discuss these issues next.

Open versus Closed Groups

In an open group, new members can enter on a continuing basis. In a closed group, the group is formed and stays together for a certain time period; new members are not allowed once the group composition is stable. Whether a group is open or closed will often depend on pragmatic issues. In many clinical settings, especially inpatient units, open groups are a necessity. In outpatient settings, however, it may be possible to round up a number of people who want skills training and who will agree to stay together for a period of time. If a choice is available, which type of group works better?

I have tried both types of groups and believe that open groups work better for skills training. There are two reasons. First, in a closed group it becomes progressively easier to deviate from the skills training agenda. Process issues frequently become more prominent as members get more comfortable with one another. The group as a whole can begin to drift away from a focus on learning behavioral skills. Although process issues may be important and cannot be ignored, there is a definite difference between a behavioral skills training group and an interpersonal process group. Periodically adding new skills training group members, who expect to learn new behavioral skills, forces the group to get back on task.

Second, in an open group new clients have the capacity to reenergize a group or allow a change of norms when needed. In addition, for individuals with difficulty with change and/or trust, an open group allows clients an opportunity to learn to cope with change in a relatively stable environment. A somewhat controlled but continual rate of change allows therapeutic exposure to change in a context where clients can be helped to respond to it effectively.

Heterogeneous versus Homogeneous Groups

DBT skills training group members in my clinic are largely (but not completely) homogeneous with respect to diagnosis. Depending on the training needs of my students or the research studies currently in progress, we have restricted entry to individuals who (1) meet criteria for BPD; (2) have BPD and are highly suicidal; (3) have BPD with serious anger problems; (4) have BPD and substance use disorders; (5) have BPD and PTSD; (6) are suicidal adolescents together with their parents; (7) have disordered emotion regulation; or (8) are friends or family members of individuals with serious disorders. In most groups, we will also allow in one or two participants who are being treated in our clinic but meet criteria for other disorders (e.g., depression, anxiety disorders). Group members are not particularly homogeneous in other ways. Ages range from 13 to 18 years in the adolescent groups and from 18 up in other groups; some groups include clients of both sexes. Socioeconomic, education, marital, and parental statuses vary.

With the exception of groups designed for friends and families and for adolescents and their families, we prohibit sexual partners from being in the same skills training group. Sexual partners are placed

into different groups at intake. If a sexual relationship develops among two members of a group, we have a rule that one must drop out. Such relationships can create enormous difficulties for the partners.

For many of our clients so far, our group represents their first experience of being with other individuals sharing very similar difficulties. Although from my perspective a homogeneous group is an asset in doing group skills training, the choice obviously has pros and cons.

Arguments against a Homogeneous Group

There are a number of rather strong arguments against a homogeneous group of clients who have severe disorders, including severe emotion dysregulation, suicidal behaviors, or behaviors that might elicit contagion. First, such a group for suicidal and/or highly impulsive individuals can be risky on an outpatient basis. Any kind of therapy, individual or group, can be very stressful for clients with disordered emotion regulation. Extreme emotional reactivity all but ensures that intense emotions will be aroused, requiring skillful therapeutic management. A therapist has to be very good at reading and responding to nonverbal cues and indirect verbal communications—a difficult task under the best of circumstances. Therapeutic comments can be misinterpreted, or interpreted in a way that the therapist did not mean, and insensitive comments can have a strong impact.

These problems are compounded in group therapy. It is impossible for therapists to track and respond individually to each group member's emotional responses to a therapy session. With more clients and a faster pace than in individual therapy, there are more opportunities for therapists to make mistakes and insensitive remarks, as well as for clients to misconstrue what is going on. In addition, it is more difficult for clients to express their emotional reactions to a group therapist in front of other group members. Thus the possibility for clients leaving in turmoil, with emotional responses they cannot handle, is greatly increased in group over individual therapy.

A second, related drawback to homogeneous groups has to do with the tendency of clients with high emotion regulation problems to become emotionally involved with one another's problems and tragedies. These clients often become anxious, angry, depressed, and hopeless not only about the problems in their own lives, but about the problems of those close to them. Thus just listening to others' life descriptions can precipitate intense, painful emotional responses. This has also been a very difficult issue for our staff members; we also have to listen to painful story after story from our clients. Imagine how much more difficult it is for individuals who have little capacity to modulate their responses to emotionally charged information.

Another argument against homogeneous groups of clients who have trouble regulating their emotions or impulses is based on the notion that in such a group there will be no one to model appropriate, adaptive behaviors—or, similarly, that there will be extensive modeling of inappropriate behaviors. I have simply not found this to be the case. In fact, I am frequently amazed at the capacity of our clients to be helpful to one another in coping with life's problems. In difficult therapy protocols such as exposure-based procedures, it is not unusual for clients to help each other cope with getting through the treatment. The one area where an absence of appropriate modeling does seem to exist is in the area of coping with extreme negative feelings. Especially with suicidal individuals at the beginning of treatment, it is often necessary for the group leaders to take much of the responsibility for modeling how to cope with negative emotions in a nonsuicidal manner (see Chapter 5 of this manual).

A fourth argument against homogeneous groups—particularly with individuals who have BPD or major depression—has to do with their passivity, their ability to "catch" other's moods and behavior, and their inability to act in a mood-independent fashion. Contagion of suicidal behavior can be a particularly difficult problem. At times, if one group member comes to a session in a discouraged or depressed mood, all members of the group will soon be feeling the same way. If group leaders are not careful, even they can sink down with the members. One of the reasons why we have two leaders for each group in our clinic is that when this happens, each therapist will have someone to keep them functioning at an energetic level. It can be very difficult.

Finally, it is sometimes said that some client populations (e.g., adolescents or those with BPD) are more prone to "attention seeking" than are other clients, and that this tendency will be disruptive to any group process. Once again, I have not found this to be the case.

Arguments for a Homogeneous Group

From my perspective, there are two powerful arguments for a homogeneous group. First, homogeneity allows the group leaders to tailor the skills and theoretical conceptions they offer to the specific problems of group members. Most of the skills taught are applicable for many client populations. However, a heterogeneous group requires a much more generic presentation of the skills, and the application of the skills to each person's central problems has to be worked out individually. With a homogeneous group, examples can be given that reflect their specific problems and situations. A common conceptual scheme would be difficult to present in a heterogeneous group unless it was very general.

A second argument for a homogeneous group is the opportunity for clients to be with a group of individuals who share the same problems and concerns. In my experience, this is a very powerful validating experience for our clients. Many have been in other groups but have not had the experience of being around others like themselves. For those with BPD and other severe disorders, they may have finally found others who actually understand the often inexplicable urges to injure themselves, the desire to be dead, the inability to regulate anger, the power of urges to use drugs, the inability to pop out of a depressed mood, the frustration of being unable to control emotions and behavior, or the pain of emotionally invalidating experiences. Adolescents have found others who understand their difficulties with parents, the pain of being bullied, their intense desire to be acceptable, and their beliefs that they are not. In a group for friends and family members, clients share the pain of having loved ones suffering and the frequent sense of desperation and helplessness.

A factor that can complicate the advantage of having an entire group of individuals with the same disorder or problem has to do with different rates of individual progress in treatment. When one client is engaging in dysfunctional behaviors, it is very validating to have other group members struggling with the same issue. However, once the client has stopped such behaviors, it can be very hard if others are still engaging in the same behaviors. Hearing about others' out-of-control behavior seems to cause a greater urge to do the same thing; this is, of course, a threatening experience for a person who is working hard at avoiding dysfunctional patterns of behavior. In addition, we have found that as clients progress in therapy, they often begin to change their self-image from that of "person with a disorder" to that of "normal person." Especially if they are very judgmental, they can find it very hard to stay in a group defined as a group for disordered individuals. These two issues—the urge to imitate dysfunctional behavior, and the need to change one's self-image from "disordered" to "not disordered"—must be dealt with effectively by the group leaders if an individual is to continue with the group.

Clarifying Providers' Roles

Skills Group Leaders

In standard DBT groups, we use a model of a primary group leader and a co-leader. The functions of the two leaders during a typical session differ. The primary leader begins the meetings, conducts the initial behavioral analyses of homework practice, and presents new material about skills. The primary group leader is also responsible for the timing of the session, moving from person to person as time allows. Thus the primary group leader has overall responsibility for skills acquisition.

The co-leader's functions are more diverse. First, they mediate tensions that arise between members and the primary leader, providing a balance from which a synthesis can be created. Second, while the primary group leader is looking at the group as a whole, the co-leader keeps a focus on each individual member, noting any need for individual attention and either addressing that need directly during group sessions or consulting with the primary leader during breaks. Third, the co-leader serves as a co-teacher and tutor, offering alternative explanations, examples, and so on. The co-leader may move their seating around the group as needed to assist participants in finding the right handouts or worksheets or to provide needed support. The co-leader is often the person who keeps track of the homework assignments. This is especially important when special individual assignments are given to one or more participants in the group. In these cases, it is also the co-leader who is charged with remembering the various assignments.

Generally, if there is a "bad guy," it is the primary group leader, who enforces the group norms; if there is a "good guy," it is the co-leader, who always tries to see life from the point of view of a person who is "down." More often than not in a group meeting, though not always, the person who is "down" is a group member; thus, the "good guy" image emerges for the co-leader. As long as both leaders keep the

dialectical perspective of the whole, this division of labor and roles can be quite therapeutic. Obviously, it requires a degree of personal security on the part of both therapists if it is to work.

The DBT consultation strategies can be especially important here. The DBT consultation team serves as the third point providing the dialectical balance between the two co-leaders, much as the co-leader does between the primary leader and a group member in a group session. Thus the function of the DBT consultation team is to highlight the truth in each side of an expressed tension, fostering reconciliation and synthesis.

Over the years, many DBT teams have tried to convince me that one skills leader is all that is needed for most groups. I remain unconvinced. With highly dysregulated and/or suicidal individuals, a co-leader is invaluable as a person who can leave the room if needed to block a suicidal person from carrying out a suicide threat, go and get an ice pack for a person with extreme arousal, validate a person who feels attacked by the leader, or coach one person during a break while the leader coaches another. In a multifamily group, the co-leader can coach the adolescent while the leader nudges a parent to practice their skills with the adolescent. In groups for friends and family members, as well as other groups where participants have no identified mental disorders, it is surprising how helpful a co-leader can be in attending to the process issues that often arise. In sum, managing a group in skills training is a complex task. Finally, there is no substitute for having an observer of one's own behavior and skills as a group leader or co-leader. For example, due to my work schedule and one skills training group's meeting in the evening, I was coming into group sessions as the primary leader with very little energy, looking tired and sounding uninteresting. Naturally, this did not bode well for a successful skills training session. My co-leader brought it up with me, and we decided on a plan to "rev me up" each week (drinking a cold cola right before group). Now my co-leader not only reminds me each week, but also gives me feedback at break if I need to make a greater effort at "coming alive."

Individual Skills Trainers

In individual skills training, the skills trainer plays the role of both the skills leader and the co-leader as described above. It is extremely important in individual work that the skills trainer stick to the role of teaching skills, while balancing teaching with necessary troubleshooting of problems in learning skills and skills use that arise. Although an individual skills trainer is not an individual therapist, it is appropriate for such a trainer to suggest specific skills for problems that clients present, such as opposite action when a client is avoiding something or cope ahead when a client is afraid of failing at something. That said, it is important for an individual skills trainer not to fall into the role of being an individual therapist. The best way to avoid this is always to keep in mind the mantra of "What skills can you use?"

DBT Individual Therapists

An individual therapist for a person in skills training is the primary treatment provider and as such is responsible for overall treatment planning; for management of crises, including suicidal crises; for taking as-needed coaching and crisis calls or arranging for another provider to take these calls; and for making decisions on modifications to treatment, including how many complete rounds of skills training the individual should be in, whether admission to a higher level of care is necessary, and so forth. Except in a crisis to avoid serious injury or death, skills trainers turn crisis management over to individual therapists.

The task of the therapist with an individual in skills training also includes applying the lens of behavioral skills to helping clients generate solutions to their problems. Indeed, when confronted with a client's problem, a well-trained clinical provider can find an approach to problem solving by using skills from each skills module. Thus, when Distress Tolerance is the current treatment module (or a distress tolerance skill is what the therapist wishes the client to practice), problems may be viewed as ones where distress tolerance is needed. If interpersonal effectiveness is the focus, then the individual provider may ask how the problem (or the solution) might be related to interpersonal actions. Generally, problems become "problems" because the events are associated with aversive emotional responses; one solution may be for the client to work on changing emotional responses to a situation. An effective response may also be cast in terms of radical acceptance or core mindfulness skills.

DBT Case Managers

If a client has no individual psychotherapist, a DBT case manager is the primary provider and is responsi-

ble for all the tasks outlined above for the individual therapist. In addition, although both psychotherapists and case managers focus on clinical assessment, planning, and problem solving, case managers are ordinarily more active in facilitating care in the client's living environment. Thus the case manager's role also includes identification of service resources, active communication with service providers, care coordination, and advocacy for options and services to meet an individual's and family's needs. In this role, the case manager not only helps identify appropriate providers and facilities throughout the continuum of services, but also actively works with the client to ensure that available resources are being used in a timely and cost-effective manner. In sum, in contrast to a DBT therapist, a case manager does much more environmental intervention. As a DBT case manager, however, the task is to move more to the center and increase use of "consultation-to-the-patient" strategies (see below). The idea here is to coach clients to actively engage in the tasks that the case managers ordinarily do for the clients—in other words, to teach the clients to fish rather than catch the fish for them. This then involves coaching the clients in the interpersonal, emotion regulation, distress tolerance, and mindfulness skills necessary to be successful.[3]

DBT Nurses and Line Staff

The primary role of DBT nurses and line staff is to manage contingencies on inpatient and residential units, to coach clients in the use of skills, and to use DBT skills to problem-solve difficulties. Their role in skill strengthening and generalization is often critical in milieu-based treatment programs. These providers often make extensive use of the chain analysis skill (described in Chapter 6), as assisting patients with understanding the factors that prompt and drive their behaviors is typically accomplished with more accuracy in the situation where the behaviors occur. From this analysis, a nurse or line staff member can more effectively provide suggestions for a more skillful response or can more clearly intervene in the contingencies surrounding the behavior.

DBT Pharmacotherapists

The primary duties of a pharmacotherapist (whether a psychiatrist or a nurse practitioner) are to provide evidence-based medications matched to the needs of each client, and to monitor compliance with the prescribed medication regimen as well as outcomes and side effects. For a DBT pharmacotherapist, a further essential task is to coach the client whenever possible in relevant DBT skills. DBT skills aimed at treating physical illness, insomnia/nightmares, poor nutrition, effects of drugs and alcohol, and lack of exercise may seem to fit the role best, but it is equally important to focus on the wide array of other DBT skills as well. Like other providers, the pharmacotherapist (except in emergencies) also turns crisis intervention over to the primary provider (therapist or case manager), but until then often asks, "What skills can you use until you get hold of them?" In some settings, when there is no individual therapist or case manager, the DBT pharmacotherapist assumes the role of primary provider responsible for the tasks outlined above. In other settings, particularly when contact with the pharmacotherapist is infrequent and clients are not known to have serious disorders, the skills leader assumes the role of primary therapist. It is important that these roles be discussed and clarified within the DBT team.

Skills Trainers' Responsibilities with Primary Care Providers

The ability to apply any one of the behavioral skills to any problematic situation is at once important and very difficult. Individual providers must themselves know the behavioral skills inside and out, and must be able to think quickly in a session or a crisis. Given this role of the individual therapist, it is the responsibility of the skills trainers to be sure that the individual therapist has access to skills the client is being taught. When an individual provider is not familiar with the skills being taught, the solution is to do what is possible to inform the therapist. Generally this information, along with attendance and any other important clinical information, is provided to all DBT therapists at the weekly DBT team meetings. Strategies for this are discussed below.

Consultation between DBT Individual Providers and Skills Trainers

Communication between individual DBT providers and skills trainers is exceptionally important. If

the expectations of each group of providers for the other are not spelled out and frequently reviewed, it is very likely that the two treatments will not enhance each other. Among the most important aspects of DBT are the DBT consultation team strategies (described in Chapter 13 of the main DBT text). These strategies require all DBT therapists to meet on a regular basis. The goals of these meetings are to share information and to keep therapists within the framework of DBT.

In my clinic, a consultation meeting is held each week for 1–1.5 hours. During the meeting, skills trainers review for the team which skills are the current focus of group sessions. When necessary, the skills trainers actually teach the other team members the skills. In this context, it is helpful for clients if their primary providers and skills trainers share a common language in discussing application of behavioral skills. This also decreases the potential for confusion. Although consistency and conformity between various treating agents are not particularly valued in DBT, such consistency here can be useful, since the number of new skills to be learned is quite large. The weekly meetings increase this communality. In addition, any problems individual clients may be having in applying skills and/or interacting in skills training group meetings are mentioned. A client's primary provider consults with the skills trainers and takes such information into account in planning the individual treatment.

My emphasis on the importance of meetings between individual therapists and skills trainers may seem to contradict "consultation-to-the-patient" strategies, which are also integral to DBT. First, I must point out that these consultation strategies do require DBT therapists to walk a very fine line. The issues are somewhat complex. When the therapeutic unit is defined as a group of people, such as a DBT team, a clinic, an inpatient unit, or some such entity where multiple therapists interact with and treat particular clients in a single coordinated treatment program, then consultation between therapists is essential, provided that the clients are informed of and consent to such collaboration. Applying the consultation strategies in these cases simply requires that therapists refrain from intervening with each other on *behalf* of a client. Thus therapists must be careful not to fall into the trap of serving as intermediaries for a client. (See Chapter 13 of the main DBT text for a discussion of consultation-to-the-patient strategies; they are also discussed briefly in Chapter 5 of this manual.)

When the Primary Provider Is a Skills Trainer

It is not uncommon that skills trainers are also individual therapists or case managers for some of the clients in a skills training group. Less often, a pharmacotherapist may also be a skills trainer for their clients. When either of these is the case, it is important to keep roles clear. In other words, when one is teaching skills it is important to focus on skills, and to wait until after the skills session ends to revert to one's other role. This is not only because of time constraints in a skills class, but also because as soon as skills trainers start managing crises, individual clients (particularly those whose lives involve constant crises) are likely to bring up more crises to discuss and problem-solve. Focusing on learning new behaviors can take a lot more effort than sitting back and discussing the crises of life.

DBT Skills Training outside Standard DBT

Standard DBT combines skills training with individual therapy or intensive case management, plus phone coaching by the individual provider and weekly treatment team meetings. When DBT skills training is offered without the individual provider component, some modifications in the conduct of skills training may be necessary. For example, without an individual therapist, skills trainers may decide to provide phone, text, or email coaching between sessions. There may also be a greater emphasis on use of DBT smartphone coaching apps and other DBT apps and websites, including the Guilford Digital *for Dialectical Behavior Therapy* app, which was developed based on this manual. At times, skills trainers may offer individual consultation sessions to group members. This may be particularly necessary in groups for friends and family members, at times when group members are extremely distraught about a friend or relative and want and need more coaching in use of skills than can occur in a single group session.

Clarifying Individual Therapists' versus Skills Trainers' Roles in Suicidal Crises

Standard DBT—including individual therapy, skills training, as-needed phone coaching/crisis intervention, and the DBT consultation team—was designed

specifically for highly suicidal individuals with high emotion dysregulation. Reduction of suicidal and other maladaptive behaviors is *not* the immediate goal of DBT skills training. Instead, skills training is focused on teaching *general* skills that the clients can apply to current problems in living. Application of these skills to current suicidal behavior, to behaviors interfering with therapy progress (except on occasion behaviors interfering with skills training), and to other severely dysfunctional behaviors is not necessarily attempted by skills trainers.

In fact, as I discuss later, discussion of current self-injurious behavior, substance use, and other contagious behaviors is actively discouraged in skills training. Reports of suicidal ideation, prior self-injury, and other maladaptive behaviors/behaviors interfering with therapy—including extreme problems with skills training—are ordinarily relegated to individual therapists, primarily because of time constraints in conducting skills training.

Problems maintaining this skills training orientation arise when an individual therapist sends their clients to DBT skills training because of the strong data on DBT as an effective intervention for highly suicidal individuals. Our non-DBT therapist colleagues know that therapists trained in DBT are also trained in assessment and management of suicidal behavior. Thus a non-DBT therapist may start mistakenly relying on a DBT skills trainer to manage high-risk suicidal behavior, at least when the skills trainer is present or available by phone. Unfortunately, a skills training therapist in DBT is relying on an individual therapist in a similar manner. In some cases a DBT skills trainer, if not trained in DBT as a whole treatment, may not even be trained in management of suicidal behaviors. And therein lies the problem: Skills trainers teach skills.

Managing Working with Clients of Non-DBT Individual Therapists

When a DBT skills client is in therapy (or case management) with a non-DBT therapist, it is particularly important for the skills trainer(s) to have a very clear agreement with the individual therapist. In my clinic, we only agree to accept a client with high suicidality and/or severe disorders if the client's individual therapist agrees to the following:

1. The provider or a designated backup individual therapist must agree to resist the temptation to rely on the skills trainer to conduct interventions aimed at reducing current suicidal and other severely dysfunctional behaviors. This means that the individual therapist must agree to be available for crisis calls from the skills trainer and/or the client during and following skills training sessions. This agreement is intended to ensure that the individual therapist, rather than the skills trainer, makes treatment decisions about the client when problems or crises arise. In essence, a skills trainer calls the individual therapist if a crisis arises, and then follows treatment directions. This policy is based on the presumption that the individual therapist knows the client much better than the skills trainer, and that this knowledge is essential in making decisions about crisis management. The individual therapist must be made aware of this policy, and must also be willing to be responsible for treatment management and decision making about treatment. Although a skills trainer may make sure that a client actually gets to the local hospital emergency department, this is very different from deciding that such a move should be made in the first place. An exception to this policy is made when a client is highly suicidal, and the skills trainer believes medical treatment or emergency evaluation for inpatient treatment is needed, but the individual therapist either disagrees without an adequate rationale or refuses to make the necessary treatment management decision. Individual therapists should be advised also that skills therapists are not available for crisis calls from their clients.

2. The individual therapist must agree to coach the client on use of DBT skills in everyday life. We ordinarily give second copies of all the DBT skills handouts and worksheets to our clients and ask them to give these copies to their individual therapists. To be successful, an individual psychotherapist needs to elicit from a client sufficient information about the skills taught in skills training to be able to help the client apply the skills in troublesome areas. The therapist also needs to know (or learn) the skills and be able to apply the skills themselves; this is not as simple as it might seem. It is important also to advise therapists that skills trainers do not do telephone coaching on skills, as that is viewed as the role for the individual therapist.

3. Therapists must understand and agree that skills trainers will not give them reports about their client's behaviors in group sessions or reports on group attendance. If a therapist wants such reports and a client agrees, a skills trainer may agree to give periodic reports to the client, who can then

give such reports to the therapist. The principle here is contained within the consultation-to-the-patient strategy, which promotes the patient as a credible source of information who can intervene effectively on their own behalf within the health care network. (See Chapter 13 of the main DBT text.)

In our clinic, we use the agreement in Figure 2.1 and ask each non-DBT individual therapist to sign it. The experience in my clinic has been that most individual therapists in private practice will agree to these stipulations to get their clients into our skills groups. However, we have had some therapists who initially agreed to these points but, when serious crises arose, insisted that we make the clinical decisions about their clients. We have also had clients who were seeing therapists who refused to take after-hours calls themselves, and instead used our area crisis line as their "backup therapist." Unfortunately, many crisis clinics are staffed by volunteers with little or no formal clinical training, and so a skills trainer cannot usually turn client responsibility over to a crisis line volunteer. It is critical, therefore, that skills trainers who do not want to take responsibility for managing crises (particularly suicidal crises) discuss crisis management with clients' individual therapists before beginning skills training, and also clarify who will be on call for the clients during and after skills training sessions. Thus we also ask each client's primary therapist to fill out a crisis plan. A form for obtaining a crisis plan and other essential information from a primary therapist is shown in Figure 2.2.

When Individual Psychotherapists Do Not Incorporate Skills Coaching into Psychotherapy

Active intervention and skills coaching may not be compatible with the individual psychotherapy a particular therapist is willing to engage in. Some therapists, for example, view helping clients learn new skillful behaviors as treating the "symptoms" instead of the "illness." In one setting, individual psychotherapists (who were physicians) told clients to get coaching from the nurses in how to replace maladaptive behaviors with skills. This sent the message that the new skills were not important, since the "real therapy" was taking place with their individual therapists. Clients with such therapists will need extra help in using the skills they are learning.

Skills trainers can make a number of optional modifications to address these issues. They might set up an extra weekly skills training meeting where clients can get help in figuring out how to use their skills in troublesome life situations. But people often need help at the moment they are in crisis. Skills training is like teaching basketball: Coaches not only conduct practice sessions during the week, but also attend the weekly game to help the players use what they were practicing all week. With outpatients, this is usually best done via telephone calls. In standard DBT, where clients have individual DBT psychotherapists, phone calls to skills training therapists are severely limited; almost all calls for help are directed to the clients' individual therapists. If an individual therapist does not take calls or give

Client Name: _____
Provider Name: _____ Date (yyyy/mm/dd): _____

I am the primary individual ❑ psychotherapist ❑ case manager ❑ pharmacotherapist for the client referred to above. I understand that my client will not be eligible to participate in the DBT Skills Training Program at _____ unless they attend regular individual treatment sessions on an ongoing basis.
As the primary provider for this client, I agree that I will:

1. Assume full clinical responsibility for my client.
2. Handle or provide backup services to manage client clinical emergencies.
3. Be available by phone or provide a backup provider phone number to call during skills training sessions of my client.
4. Provide and keep updated the Crisis Plan and Information from Primary Therapist form [Figure 2.2] attached.
5. Help my client apply DBT skills to their clinical problems.

FIGURE 2.1. Primary individual provider agreement for clients in DBT skills training.

This must be completed with your client's full awareness of all parties with whom this information may be shared.

Please fill this form out on paper and have client return to the group leaders, or fill out digital copy at: _____ and email to one of the group leaders at: _____

Group Leader's Name: _____ Email: _____

Date (yyyy/mm/dd): _____

Client's Name: _____ Clinical ID: _____ DOB (yyyy/mm/dd): _____

Your client's group meets on: _____ at: _____

Primary Therapist:

Name: _____ Phone (Office): _____ Phone (Cell): _____ Fax: _____

Email: _____ Available Hours: _____

Address: _____

If your client is at high suicide risk or in crisis requiring immediate intervention and you are unavailable, who should be called?

Your Backup Therapist (when you are in town):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Phone (Cell): _____

Address: _____

Your Backup Therapist (when you are in town):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Phone (Cell): _____

Address: _____

Pharmacotherapist/Primary Care Physician/Nurse Practitioner (if applicable):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Phone (Cell): _____

Case Manager (if applicable):

Name: _____ Phone (Day): _____ Phone (Eve): _____ Phone (Cell): _____

Significant Others (to call in an emergency):

Name: _____ Phone: _____ City: _____

Name: _____ Phone: _____ City: _____

CRISIS PLAN

How can you be reached during a crisis if disposition planning is needed?

_____

_____

Who should be called for disposition planning if you are unavailable?

_____

_____

(*cont.*)

FIGURE 2.2. Crisis plan and information from primary therapist (confidential).

1. Brief history of client's suicidal behavior.

2. Recent status of client's suicidal behavior (last 3 months). Please describe the most recent and most severe self-injury/suicide attempt. Describe the form, date, circumstances and what intervention resulted, if any (e.g., ER, medical ward, ICU).

3. **Crisis plan:** Describe crisis plan you and client have agreed to for management of suicidal behavior. Describe the typical emotions, thoughts, and behaviors that may precede self-injury/suicide attempts, and the strategies that a client has used successfully in the past.

(EXAMPLE: My client states that if she gets angry or feels helpless, this causes emotion dysregulation. This then triggers the urge to hurt herself by burning herself. She states that if she has this urge, she has successfully coped by using these distraction strategies: calling her mother, playing with her dogs, going for a walk to the park, crocheting, having a bath, doing vigorous physical exercise, listening to loud music, or praying. As a last resort, she will call me or my backup therapist and discuss ways for her to get through the moment. When she calls, she says that she finds it really helpful when I help her to find a means of distraction, remind her that she has tolerated urges like this before, and help her try to solve the problem that may be leading to her feeling this way. This plan was developed with my client.)

4. If your client is assessed as in imminent risk of suicidal behavior, self-injury, or violence, and neither you nor your backup can be immediately contacted, how should the skills trainers or other professional staff manage your client?

5. Describe any history of violence and use of weapons. Also specifically describe any occasions of violence and use of weapons in the last 3 months. Describe any current plans that you and the client have to deal with this behavior.

6. Describe any history of substance use. Also specifically describe substance misuse history in the last 3 months. Describe any current plans that you and the client have to deal with this behavior.

7. Client medications: Weight (lbs/kg) _____ Height (inches/cm) _____

Medications	Dose	For	Medications	Dose	For

FIGURE 2.2 (*cont.*)

coaching, however, a skills trainer may decide to accept them, at least when the reason for calling is to get such coaching.

On an inpatient unit, milieu staff members should learn the behavioral skills along with the clients. The staff members can then serve as coaches for the clients. One inpatient unit offers weekly skills consultation meetings. The meetings are run like academic office hours; clients can come at any time during office hours for coaching. Ideally, clients can also call on one another for help. In another inpatient setting, one therapist teaches new skills; nursing staff members conduct regular homework review groups, where clients meet together to go over their attempts to practice new skills and get help with areas of difficulty; and individual therapists reinforce the clients' use of skills. In residential settings, it can be useful to offer advanced skills groups where group members help each other apply skills in daily situations.

Skills generalization can also be greatly enhanced if individuals in a client's environment—such as family members—also learn the skills and then help with coaching the client every day.[4] A skills trainer or individual therapist can then assist a family member in coaching the client. Adolescent skills training ordinarily includes both an adolescent and at least one parent, so each can coach the other. Parole officers can be taught the skills so they can coach the parolees on their caseloads. Primary care providers can be taught skills so they can coach their patients. A skills curriculum has been developed for use in school settings, where teachers and school counselors can coach students.[4, 5]

Integrating Skills Training into Non-DBT Individual Therapy

Many non-DBT psychotherapists, counselors, case managers, pharmacotherapists, other mental health providers, nurses, doctors, and other professionals in general medical practice will find it useful at times to integrate DBT skills into their treatment of clients. Providers may want to use only one skill or a variety of skills across different modules. Strategies for incorporating skills into ongoing therapy are as follows. First, carefully read the treatment notes for each of the skills to be used. What is important here is that providers know the skills and know what skills go with what problem or set of problems. Second, decide whether to use a handout and/or worksheet in teaching the skill, or to teach it orally without these materials. If you are planning on occasionally using handouts and/or worksheets, copy them and keep them handy in your office or nearby. When the occasion arises to teach a particular skill, discuss the idea of learning a new skill with the client. Use the orienting strategies discussed in Chapter 6 of this manual, if necessary, to sell the skill you want to teach. Giving a copy of the handout to the client and keeping one yourself, review the skill using the skills training procedures described in Chapter 6. Practice the skill with the client if possible, and give an assignment or suggestion that the client practice the skill before the next visit. As far as possible, be open to the client's calling you between sessions for skills coaching. Be sure to ask about the client's practice in the next visit. Periodically check in with the client to see whether they are still using the skills you have taught. Encourage continued skillful behavior. Although it may seem that the directive quality of DBT skills training would be incompatible with psychoanalytic and supportive treatments, the fact that so many nonbehavioral and analytic therapists teach and/or integrate DBT skills into their therapies suggests that this is not the case (enter "psychoanalytic DBT skills" in your search engine for examples).

References

1. Neacsiu, A. D., Zerubavel, N., Nylocks, K.M., & Linehan, M. M. (2021). Borderline personality disorder. In D. Barlow (Ed.), *Clinical handbook of psychological disorders* (6th ed., pp. 381–442). New York: Guilford Press.
2. Sayrs, J. H. R., & Linehan, M. M. (2019). *DBT teams: Development and practice*. New York: Guilford Press.
3. Case Management Society of America. (n.d.). Retrieved from *https://cmsa.org/who-we-are/what-is-a-case-manager.*
4. Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford Press.
5. Mazza, J. J., Dexter-Mazza, E. T., Miller, A. L., Rathus, J. H., & Murphy, H. E. (2016). *DBT skills in schools: Skills training for emotional problem solving for adolescents (DBT STEPS-A)*. New York: Guilford Press.