The Cognitive Behaviour Therapist, 2010, **3**, 71–79
doi:10.1017/S1754470X10000061

Implementing DBT: selecting, training and supervising a team

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Received 27 September 2009; Accepted 15 May 2010; First published online 15 June 2010

Abstract. NICE Clinical Guideline no. 78 recently identified Dialectical Behaviour Therapy (DBT) as an appropriate treatment approach for the effective treatment of suicidal behaviours in the context of borderline personality disorder. Uniquely among the cognitive behavioural therapies DBT is a team-based treatment. This paper focuses on the task of selecting and training a team before considering issues in the training and supervision of therapists learning this approach.

Key words: Dialectical Behaviour Therapy (DBT), supervision, training.

Introduction

NICE (2009) recently recommended Dialectical Behaviour Therapy (DBT) as a treatment to consider for the treatment of suicidal behaviour in women with a diagnosis of borderline personality disorder (BPD). Distinctively, teams, rather than individuals, deliver DBT. Effective implementation of the treatment requires selecting a team with the appropriate skills and capacities to learn the treatment, training them in the treatment and ensuring that the team promotes ongoing learning and supervision of the treatment. This paper discusses issues within these three areas.

What is DBT?

DBT, in addition to being a psychotherapy, is also a comprehensive programme of care (Swales & Heard, 2008). DBT programmes provide multiple treatment modalities that address the key skills and motivational deficits presented by clients with a diagnosis of BPD. Thus, DBT programmes provide skills training for clients, often in a group format; individual DBT psychotherapy, to help clients identify and solve problems in changing their behaviour; and treatment modalities to support generalization of the new skills beyond the treatment environment, most commonly by telephone coaching. In addition, DBT programmes enhance the skills of therapists on the team and maintain their motivation to treat effectively by providing a mandatory weekly consultation team meeting where therapists receive supervision

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and consultation on their clinical work. Programmes for more vulnerable groups, for example adolescents, may also provide additional modalities of treatment involving the family. Therefore, to develop and deliver a DBT programme requires training a team of clinicians (minimum $n = 4$) who will each have dedicated time (minimum $1\frac{1}{2}$ days per week) to deliver the intervention.

Team selection

Arguably, one could consider the selection of staff capable of delivering an effective treatment the most significant aspect of implementation. Yet, as identified by Fixsen *et al*. (2005) in their comprehensive review of implementation, staff selection rarely appears as a focus in implementation research. In the absence of systematic data, the principles of team selection in DBT relate to the structure and content of the treatment and on knowledge of aspects of effective implementation in the literature.

Team capacity

The reallocation of clinician time, of $1\frac{1}{2}$ days per clinician, to deliver a specific intervention presents the first challenge to an organization planning to implement DBT and requires active problem-solving on the part of the team leader to resolve any difficulties regarding this prior to training. Without dedicated time allocated to the DBT programme, learning and delivering the treatment becomes impossible. Other treatment approaches describe the importance of dedicated time from a team in ensuring effective implementation (Fadden, 1997). Rate of learning the treatment is likely to increase with more practice. Thus, a smaller group of clinicians each with a greater proportion of their time dedicated to the team, rather than a large group of clinicians each with a small amount of time, may be more efficient in the long-term in learning and delivering the treatment effectively. This is perhaps especially the case with DBT where each practitioner must dedicate a minimum of 2 hours per week to participation in a consultation team and receiving supervision.

Team commitment

Rarely when planning implementation do organizations make the necessary changes to ensure practitioners can deliver new programmes of care. Fixsen *et al*. (2005) refer to this process as the 'train and hope' strategy. Because of the historical emphasis on this approach to training some practitioners may not anticipate that attending training requires a commitment to implement. Often attendees at DBT training events state directly that they took up the offer of training primarily because it offered an opportunity to escape the workplace or because it offers an opportunity for advancement in another organization. While these objectives are not necessarily problematic, if they are the sole objectives a practitioner has for receiving training, implementation by this practitioner is less likely. The DBT training team encourages managers planning to invest in DBT training to gain commitment from clinicians for a specified time period devoted to implementing DBT beyond the training in order to guard against this problem. Commitment from the organization to the training and implementation is equally important and is discussed elsewhere (Swales & Heard, 2008).

Skills mix

As DBT is a cognitive behavioural treatment, teams will need at least one member with a thorough grasp of cognitive principles and behavioural theory and the utilization of these in clinical practice. In Britain, either a clinician with an advanced clinical psychology qualification or a formal qualification in CBT can fulfil this requirement. In other jurisdictions, professional qualifications from other disciplines may supply these skills to the team. DBT incorporates many of the strategies and procedures from the wider cognitive behavioural canon although often with a novel twist (Swales & Heard, 2008); therefore, many practitioners will be familiar at some level with these procedures. Frequently, however, therapists who have trained more recently in CBT are less familiar with behavioural procedures and struggle to understand principles of reinforcement and punishment and the practical application of these in therapy. Therefore, a team may benefit from having a team member with these specific skills or from some additional training in this area. As some team members will have little experience of the basics of structuring a psychotherapeutic treatment episode, a further team member with experience of delivering a structured psychotherapy based on a coherent theoretical model (regardless of orientation) can help these team members to develop the requisite skills. Given the group skills component of the treatment, team members with group therapy skills or teaching experience can also contribute usefully to a team. As the treatment is recursive, all team members must learn and master all components of the treatment relevant to the modalities that they are delivering (including all the skills that clients must learn) and be willing to apply these skills and strategies to themselves throughout the process of learning and delivering the treatment.

Leadership of the DBT team

Successful implementation of changes in practice requires an innovation champion (Rogers, 1995). The innovation champion works primarily at the interface between the treatment team and the organization. The role requires particularly good people skills with the capacity to link skilfully between different individuals in the organization and the ability to persuade and influence. In many cases, the DBT team leader will fulfil the role of champion; however, the team may recruit a champion from within the management structure of the organization. A further consideration in selecting a champion and team leader relates to the seniority of the remaining members of the DBT team. The team leader must command both the respect of the clinical team but must also possess authority from senior management to implement and lead the team. More junior professionals may have a more favourable attitude to evidence-based approaches (Aarons, 2004) but are less likely to possess the skills necessary to lead a team and maintain the confidence of the organization especially in the management of a high-risk group of clients. A team without a senior professional leader remains increasingly open to system pressures to renege on the commitment to the new treatment in the presence of competing organizational goals. In these circumstances, the DBT team may benefit from recruiting an innovation champion from the wider system with more experience and influence to ensure that the DBT team receives the necessary resources and support to deliver the treatment.

In addition to their role with the organization the team leader also fulfils a vital function in ensuring that the DBT programme develops in accordance with treatment principles. During consultation team meetings the team leader will take the main role in promoting and

maintaining adherence to the model. DBT team leaders, therefore, are likely to need more advanced training and supervision in the treatment in order to fulfil this role.

Training in DBT

The treatment originator, Linehan, developed a method of training DBT therapists that has been adopted internationally. This method, 'DBT Intensive Training' accounts for the majority of teams trained in the UK since the inception of the training programme in 1997. DBT Intensive Training is an 8-month commitment which is designed to promote implementation. Part I of the training comprises a 5-day teaching block during which teams are taught the principles of establishing a DBT programme (deciding inclusion and exclusion criteria, developing modalities of treatment to fulfil the functions of a DBT programme; Swales & Heard, 2008) and the core strategies of the individual psychotherapy component of the treatment. Following this first teaching block, teams return to their organization with a comprehensive set of homework assignments to assist them in developing and implementing a DBT programme and to increase their skills in the individual and group therapy components of the treatment. When they return for Part II of the training, a second 5-day block, teams present both their programme and cases currently in treatment to receive feedback and consultation. In addition, further teaching on both the programmatic and therapeutic aspects of the treatment is provided.

As working in a team is an integral part of the treatment it forms a core component of the training both during the formal teaching sessions and during the learning that occurs at the clinical base between Parts I and II of the training. The protected time for the weekly consultation team meeting is vital to the training process. This balance between the taught components and the *in-situ* learning contribute to the cohesiveness of the DBT team, making it more likely that implementation will occur.

Few studies address the type of training required for delivering psychotherapy effectively (Bennett-Levy, 2006) and only sparse literature exists on the effectiveness of training in DBT. What evidence there is indicates that clinicians with a range of backgrounds can acquire a solid grounding in the theory of the treatment (Hawkins & Sinha, 1998) and that intensity of training in DBT increases utilization of the treatment after training (Frederick & Comtois, 2006). Neither of these cited studies reported whether intensity of training related to treatment outcome for clients. A study by Trupin and colleagues reporting outcomes from DBT programmes in two in-patient forensic units for adolescents (Trupin *et al.* 2002) indirectly addressed this issue. On one unit, staff received 80 hours of training (Intensive Training level) and on the other unit 16 hours (workshop level). Adolescents on the unit where staff received 16 hours of training were less likely to improve, although this group also had less severe symptoms at the start of the trial. In addition, staff on this unit engaged more frequently in punitive interventions towards the adolescents. This contrasted with the unit that had received the intensive training. On this unit, the adolescents who at the start of the trial had more severe levels of psychopathology than the first unit had better outcomes and staff were less likely to utilize punitive measures. Although other pre-existent differences between staff on the unit may account for these differences, this study cautions against the tendency to endorse minimal training strategies when implementing a complex intervention.

Training alone is unlikely to lead to effective delivery of DBT or indeed any psychotherapy. Studies conducted in the last 10–15 years suggest that treatments established as efficacious

in randomized clinical trials can transfer to routine clinical settings and deliver comparable outcomes to those seen in the randomized trials (Henggeler *et al.* 1995; Wade *et al.* 1998; Franklin *et al*. 2000; Turkington *et al*. 2002; Schoenwald *et al*. 2003; Mufson *et al.* 2004; Cukrowicz *et al.* 2005; Foa *et al*. 2005). However, in all of these studies the focus on the training and ongoing supervision of therapists is especially notable. In these studies therapists received intensive training in the treatment manual or protocol and frequent ongoing supervision. In most cases supervision was at least weekly and some studies provided feedback to therapists on their adherence and competence. Therefore, in all of these studies the level of training and expert supervision exceeds what would be typical in most NHS/public healthcare settings. Until there is data to the contrary, a reasonable assumption is that delivering the outcomes seen in efficacy studies may require at least equivalent levels of training and supervision. Without this level of training and support, a reversion to older more well rehearsed and familiar techniques may occur (Wade *et al.* 1998).

Use of the DBT consultation team to train and supervise therapists

In DBT the consultation team plays a significant role in the ongoing training and supervising of therapists and shaping them towards adherence. The DBT consultation team encourages therapists to continue to develop their skills in the treatment and to attend to sustaining their motivation in the challenging task of treating clients with a significant degree of complexity and risk. The DBT team meets regularly, preferably weekly, for up to 2 hours. In the training stage of programme development, the consultation team focuses on learning and applying the principles of the therapy and on developing skills in case conceptualization. As therapists become more competent in the treatment, the team shifts focus towards a greater emphasis on supervision of individual cases.

To assist in developing a supportive environment for learning and supervision, the DBT consultation team members must agree to follow the DBT Consultation Agreements. These agreements embody the key principles of the treatment, structure the discussions within the consultation team, and enable the development of a collaborative and supportive learning environment. Three of these agreements are particularly helpful in facilitating an atmosphere conducive to allowing practitioners to identify difficulties and seek solutions and thus, effective learning and supervision. First, the 'phenomenological empathy agreement' asks a therapist to search for a non-judgemental, empathic description or understanding of clients' responses. A corollary of the agreement is that therapists similarly search for non-judgemental and empathic responses towards themselves and other members of the team. The 'fallibility agreement' assists therapists in this task. This agreement reminds therapists of their fallibility and liability to make mistakes. This agreement aims to promote a non-defensive attitude in therapists towards their work, thus, opening up opportunities for new learning. The third pertinent agreement is the 'dialectical philosophy' agreement. This asks all therapists to accept a dialectical philosophy, which, in this context, means that multiple perspectives on the truth are expected and welcomed. Therefore, no single perspective provides the solution to a problem. Effective problem-solving requires openness to a variety of solutions and a willingness to search for truth in apparently contradictory positions. The DBT consultation team works to solve problems arising in therapy or with the therapist by synthesizing the understandings derived from multiple perspectives on any problem that arises.

The consultation team agreements provide the structure within which the work of the team occurs. Within the context of the consultation team, practitioners conduct behavioural and solution analyses of problems in therapy. These analyses serve two functions; both to support the therapist in developing competence in the treatment and, ultimately, to deliver more effective therapy to the client. To achieve this, therapists must learn to give behaviourally specific feedback, without judgement (either overt or covert) to colleagues about capacities and deficits. In addition, and more challengingly, practitioners in receipt of non-judgemental feedback must learn to accept feedback without applying their own negative self-judgements, i.e. they must embrace the fallibility agreement. All of the skills taught in DBT are useful for practitioners in receiving feedback. Mindfulness assists in both giving and receiving non-judgemental feedback; affect regulation helps in managing emotions arising from receiving unwelcome feedback; interpersonal skills facilitate the delivery of effective feedback; distress tolerance skills assist in coping with not having a skill yet that you could really use.

However, giving feedback alone (i.e. just talking), is not enough. At its core DBT is a behavioural treatment, therefore teams must not neglect developing plans to shape and implement new skills. Again applying treatment principles is useful here. Just as with a client, analysing whether the therapist has a skills deficit or whether he/she has the necessary skills although emotions, cognitions or reinforcement contingencies are interfering in the utilization of the requisite skill, provides a useful framework for selecting interventions to treat the therapist. Respectively, exposure, cognitive modification or contingency management (i.e. comprehensive solution analyses) are the relevant procedures to remedy the problems. A vital strategy here, in the treatment of the therapist just as much for the client – is rehearsal, rehearsal, rehearsal! Although always a challenge, behaviour change becomes especially difficult when working with high-risk clients with complex problems, and with such clients therapist competence tends to drop (Rounsaville, 1998). For these reasons, attention to supervision of the therapist is especially important with this client group. To ensure behaviour change by therapists, frequent rehearsal within the context of the team and supervision, with regular feedback, may prove essential. Team members need to push each other to ensure this rehearsal happens – otherwise the team will revert to just talking and the assumption that insight and understanding alone will change things. In terms of skills development, role-playing increases the likelihood that therapists will have the capacity to utilize suggested treatment strategies as solutions in therapy. Due to the unreliability of therapists' verbal reports of therapy sessions (Rounsaville, 1988), review by the therapist or consultation team of audio- or video-taped segments of therapy sessions may provide more accurate feedback of problems in therapy.

Clinical example

During a consultation team meeting a therapist asked for help with a client who was frequently phoning her in a distressed state and then refused suggestions she made. The therapist described experiencing burnout with the client but had not discussed this with him. On analysing the therapist's failure to address this therapy-interfering behaviour, the team noticed that judgemental thinking inhibited the therapist from discussing the problem with the client. The therapist would both make judgements about the client ('he shouldn't phone me and refuse help from me') and about herself ('I'm a useless therapist'). The judgemental thinking led to an increase in anger and frustration with the client that the therapist was afraid would appear if she discussed the problem with the client. The team worked with the therapist on

first just noticing the judgemental thoughts and then simply describing the facts of the situation ('often when he phones, he refuses my suggestions', 'he has refused the suggestion I have made', 'I find it difficult when he refuses my suggestions') and then on increasing validation for the client's predicament. The therapist undertook to practise these strategies when next the problem arose. The following week she reported that these strategies had both helped to manage her affect during crisis calls and enabled her to discuss the problem with the client. She helped the client use the same strategies to manage his own self-critical thinking that arose during crisis calls.

The reallocation and prioritization of learning a specific model within the consultation team presents a challenge for clinicians. For many clinicians DBT may be the first specific therapeutic model they have learnt in any depth and, in particular, the first therapeutic model to emphasize adherence and fidelity to a series of principles. Professional training may provide an introductory *smorgasbord* of multiple models and encourage practitioners to draw from these different models when treating any given client. Learning and applying one model consistently in the treatment of a given client, and not deviating from this model during the course of the treatment episode, challenges many therapists in the initial stages of learning. Therapists volunteering to learn DBT need a willingness to learn a model that may challenge previous ways of working, particularly in regard of delivering treatment to a high degree of fidelity.

To maintain the treatment frame, consultation team members must learn to notice when fellow team members drift 'off-model'. For therapists who persistently move out of the treatment frame, conducting a comprehensive behavioural and solution analysis of factors leading and maintaining a decrease in treatment fidelity may assist therapists to improve their adherence to the model. For teams to function effectively in this way Intensive Training level alone will not be sufficient. As with any psychotherapy developing competence requires close supervision from someone with recognized expertise in the therapy. Therapists in receipt of such supervision are a vital resource to their team in promoting fidelity and supervisors actively encourage sharing of their learning within the wider DBT team. Teams may also seek external consultation for their team as a whole to ensure that their team process remains adherent to the principles of the therapy.

Summary

DBT is a team-based treatment that requires careful selection of staff, with the requisite skills, that are committed to learning the treatment model. The treatment is recursive and requires that practitioners willingly apply the treatment to themselves both when they are learning the treatment and also as they identify problems within their delivery of the treatment. Frequently, this challenges therapists but also provides an opportunity for them to shape their practice to be more effective.

Acknowledgements

The writing of this paper was supported by a grant from the Knowledge Transfer Programme (grant no. 1265), funded by the ESRC.

Declaration of Interest

Dr Swales is Director of BIDBT that delivers licensed training in DBT in the UK. She is married to the Managing Director of the company that produces BIDBT training events. She is a supervisor and consultant in DBT.

Recommended follow-up reading

Swales MA, Heard HL (2008). *Dialectical Behaviour Therapy: Distinctive Features.* London: Routledge. Chapters 12 and 29 provide more information on both consultation team and on treating the therapist using the principles of the treatment.

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Learning objectives

(1) To understand what issues to consider in setting up a DBT team.
(2) To understand more about the training process in DBT.
(3) To understand the role of the consultation team in training and supervising staff in DBT.
(4) To understand the recursive nature of DBT.

https://doi.org/10.1017/S1754470X10000061 Published online by Cambridge University Press