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Practical Issues in Psychosocial Skills Training

Psychosocial skills training is necessary when solutions to an individual's problems and attainment of her desired goals require behavioral skills not currently in her 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 "ability," 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 behavior. 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 skills 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.

Individual versus Group Skills Training

Successful psychosocial skills training requires discipline by both client and therapist. In skills training, the therapy agenda is set by the skills to be learned. In typical psychotherapy and in DBT individual psychotherapy, by contrast, the agenda is usually set by the current problems of the client. When current problems are pressing, staying with a skills training agenda requires the therapist to take a very active role, controlling the direction and focus of the session. Most therapists are not trained to take such a directive role; and thus, despite their good intentions, their efforts at skills training often peter out as clients' problems escalate.

Even therapists who are well trained in directive treatment strategies have great difficulty keeping to a directive agenda when treating borderline clients. The inevitable crises and low emotional pain tolerance of such clients constitute a major and continuing problem. It is difficult for the clients, and consequently for their therapists, to attend to anything but the current crises during treatment sessions. For some clients even daily sessions would not solve the problem, since they often seem to be in an unrelenting state of crisis. It is particularly difficult to stay focused on skills when a client threatens to commit suicide if her current pain is not taken seriously. Taking it seriously usually means forgoing the day's skills training agenda in favor of resolving the current crisis.

Other clients may be less demanding of therapist

time and energy, but their passivity, hopelessness, and/or lack of interest in skills training may pose a formidable roadblock. It is easy in such a case for the therapist to get worn out with the client and just give up the effort, especially if the therapist is not a firm believer in skills training anyway. Skills training can also be relatively boring for therapists, especially for those who have done considerable skills training with other clients. It is like doing the same operation over and over and over. Clients' fluctuating moods from week to week and within the therapy session (a characteristic of borderline individuals), together with therapists' wavering interest, can create havoc with the best-laid skills training plans.

Inadequate attention to the actual teaching of behavioral skills, and the resulting therapy drift, are particularly likely in individual as opposed to group skills training. First, in individual therapy there is often nothing outside of the two participants to keep therapy on track. If both client and therapist want to switch to something else, they can do it easily. By contrast, in group therapy other clients—or at least therapists' sense of obligation to other clients—keeps therapists on track, even when one client wants to change track. Second, when one client in group skills training is not in the mood for learning skills, others may be. The reinforcement these other clients give the therapist for continuing skills training can be more powerful than the punishment delivered by the client who is not in the mood.

The crux of the problem is this: Skills training with a borderline individual is often not immediately reinforcing for either her or her therapist. There is rarely a sense of immediate relief. Nor is psychosocial skills training as interesting as having "heart-to-hearts," a topic I have discussed in Chapter 12 of the 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.

Much of the development of DBT was influenced by the dual task of finding a treatment that would be effective in helping borderline individuals and a treatment that therapists could actually apply on a day-to-day basis. As I have noted in Chapter 1 of this manual, the difficulties of conducting skills training within the context of individual psychotherapy led me to split the treatment into components, with the acquisition of skills as the goal of one treatment component and getting the client to use the skills in place of maladaptive behaviors as the goal of another component (i.e., individual psychotherapy). Put in the vernacular, skills training tries to cram the skills into the person and individual psychotherapy tries to pull them out.

For the reasons discussed above, the standard mode of skills training in DBT is group therapy. A number of circumstances, however, 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 a therapist 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 hostile behavior toward other group members should not be put into a group until this behavior is under control. Some clients may have already participated in 1 or more years 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.

Individual Skills Training

Again, focused skills training on an individual basis with a borderline client requires enormous self-discipline and perseverance on the part of the therapist. On the client's side, the major roadblocks are her attempts to divert a skills training session to other, more pressing topics, or her refusal or inability to participate in skills training the therapist is attempting to provide. On the therapist's side, the major roadblocks are discomfort with active, directive interventions, or the therapist's lack of interest, boredom, or inability to provide the skills guidance that the client is begging for. Treatment in these cases can easily become a power struggle between the client and therapist. If the therapist of the client who disrupts skills training can hold out, and maintain his or her focus on the client's long-term needs over the short term needs, I think that individual skills training can work. Such a focus, however, is very difficult to maintain in the face of what are often genuine life crises. As for the therapist roadblocks, the intent of this manual is to generate some interest (and even some enthusiasm) in the therapist who is uninterested, and to provide guidelines and advice for the therapist who feels unable to offer skills training. Even for an interested skillful therapist, however, skills training with borderline clients is difficult. As I have noted in the text, trying to conduct skills training with a borderline 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 the client had more effective skills in her repertoire, she would be able to cope much better with crisis situations. And this is the dilemma: How does the therapist teach the skills necessary to cope, when the client's current inability to cope is so great that she is not receptive to acquiring new behavioral responses? One solution is for the therapist simply to make continuous efforts to incorporate the

skills training procedures in every session. A problem with this approach is that it is often not apparent to the client in individual therapy what contingencies are operating at any given time in a session; the rules are not clear. 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 or behavioral technician 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, including the application of skills learned to particular crisis situations, are the focus of individual psychotherapy. 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 who meet criteria for BPD but are not able to commit to longer-term individual therapy. Conducting focused skills training is a good opportunity for these students, and, in my experience, has worked out well for the clients. It would be as easy in any setting where psychiatric residents, social workers or psychiatric 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. The difference in DBT is that routine (possibly weekly) meetings between individual psychotherapists and skills trainers are probably essential to the success of psychosocial skills training for borderline clients. I discuss this point further below.

An individual therapist who has no one to refer a client to for skills training, or who wants to do it himself or herself, 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. If possible, the 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 your 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 to audiotape or videotape 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.

Group Skills Training

I have already mentioned a number of disadvantages to individual skills training. The chief disadvantage not yet mentioned is that it is inefficient. Even though in our experience borderline clients almost never want to join a group at the beginning, 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 are, in my opinion, very therapeutic. 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 clients and the group psychotherapist; 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 borderline clients. Finally, skills groups offer a relatively nonthreatening opportunity for individual clients to learn how to be in a group. This can be very important for two reasons. First, people in general, as well as borderline individuals, have to be able to function well in groups. Second, in our treatment program further supportive process groups are offered. These groups not only are very therapeutic when combined with individual psychotherapy, but also offer a long-term treatment that may be more dependable and economical than long-term individual therapy.

In my psychotherapy research program, all clients in individual therapy also participate in group skills training. This requirement is made clear to each client at the initial screening meeting. In my own clinical practice, I may refuse to work individually with clients who are unwilling to participate in group skills training if I believe that their skills deficits are such that individual psychotherapy will be severely hampered without the addition of skills training. Indeed, one of the reasons (among many others) for the focus in DBT on building a strong, positive interpersonal relationship with a client in individual therapy is that the therapist will be able to persuade her to participate in group skills training even when she very much does not want to. In our research program, initial resistance to group skills training has been more the rule than the exception.

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. A number of issues are particularly important in group therapy; I discuss many of these throughout the book. (You can, of course, simply ignore them if you are conducting individual skills training.)

Open versus Closed Groups

In open groups, new members can enter on a continuing basis. In closed groups, a 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, although closed groups may work as well or better for subsequent supportive process therapy groups. Why? There are two reasons. First, in an open group clients have an opportunity to learn to cope with change in a relatively stable environment. Borderline individuals often have enormous difficulty with change; they may also have difficulties with trust. They may implore the therapists to keep the group stable and unchanging. However, keeping the group open, with somewhat controlled but continual change, allows therapeutic exposure to change in a context where clients can be helped to respond to it effectively. I once asked a client how she felt about new members' occasionally entering an open group and older members' leaving. She responded that she figured I had arranged it that way so she could practice her distress tolerance skills. After running a closed group for a year, where we tried to provide constancy and stability, I was shocked to learn that we could not make even minor changes in starting a second year without intense resistance on the part of group members. For example, we tried to move the table around which members sat, and ended up in a 3-week power struggle (until I gave in and agreed to keep the table).

Second, 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 rigorous focus on learning behavioral skills. Although process issues are obviously important and cannot be ignored, there is a definite difference between a behavioral skills training group and an interpersonal process group. The supportive process groups in DBT follow the skills groups; they are not offered until after an individual has gone through all of the skills training. Periodically adding new skills training group members, who expect to learn new behavioral skills, forces the group to get back on task.

Treatment Module Cycles

Four skills training modules have been developed for DBT: (1) core mindfulness skills, (2) interpersonal effectiveness skills, (3) emotion regulation skills, and (4) distress tolerance skills. The rationale for focusing on these particular skills has been discussed briefly in Chapter 1 of this manual and more extensively in Chapter 5 of the text. General group format and therapy strategies and procedures, as well as specific content for each module, are presented in later chapters.

The interpersonal effectiveness, emotion regulation, and distress tolerance modules can be covered in 8 weeks (if training stays focused). Core mindfulness skills can be covered in two to three sessions, and then are reviewed and expanded upon further at the beginning of each of the other modules. Clients in my clinic generally stay in psychosocial skills training for at least 1 year. This means that each client goes through each eight week module twice. Because mindfulness skills are reviewed at the beginning of each module and are woven through each of the other three modules, the skills taught here are covered many times over the year. Some clients in our clinic have participated for more than 1 year, although usually clients "graduate" to more advanced groups after going through each module twice. A well-functioning client might profitably graduate from skills training after 6 months.

A number of psychiatric inpatient units are presently using DBT. One long-term psychiatric hospital accepts clients for a 6-month structured treatment program. Clients go through each skills module once; they can also review the videotaped sessions as often as they wish. The modules can then be repeated as necessary in outpatient therapy. Day treatment settings may offer several modules concurrently, with clients attending more than one at a time. Short-term, acute inpatient units, may offer just one or two of the modules. For example, a number of such units offer a package combining mindfulness and distress tolerance skills. Other units have taken a few skills from each module and constructed a shortened version of DBT skills training. As these examples indicate, the treatment modules lend themselves to mixing and matching to suit particular needs and treatment philosophies. All other things being equal, however, I would suggest teaching straight from the manual a few times

before beginning to change and modify the skills treatment.

Massed versus Spaced Practice

Although each training module is designed to take 8 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 even when some (or even all) clients have not acquired the skills that are currently being taught. Clients are often overwhelmed with the amount of information the first time they go through each module. So why not expand each module to one 16-week module (massed practice) rather than two 8-week modules (spaced practice)? There are several reasons for the present format.

First, borderline individuals are variable in their mood and functionality. They often 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 clients have different needs; thus, the modules are differentially relevant and preferred by various individuals. Having to sit though a disliked module for 16 weeks is very difficult. Sitting though 8 weeks of a disliked module is also hard, but not as hard.

Third, in a 16-week format, the modules scheduled second and third get less practice time than in an 8-week format. 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 skills-oriented behavioral therapy is that acquisition of behavioral skills requires extensive practice. Even though the material often feels overwhelming the first time when presented in the 8-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 having 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 clients 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 16 weeks are allotted to cover a treatment module, it is far easier to divert therapy time to attending to individual clients' crises and process issues. 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.

Even though I see several advantages for the 8-week format, there is no *a priori* reason for it. And moving so quickly through each module depends on very close coordination with each client's individual therapist (when this person is not a skills trainer). Again, in DBT it is the task of the individual psychotherapy to help the client use the new behaviors she is learning in the everyday situations where they are needed, including crises. The individual psychotherapy is also charged with analyzing motivational problems that interfere with replacing maladaptive behaviors with the DBT behavioral skills.

Ordering of Modules

At this writing, there are no empirical data to suggest how to order the modules. Since the core mindfulness skills are woven throughout each of the three 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. The rationale for this is based on the increasing abstractness of the skills and principles over the three modules. In addition, the three modules in this order can be viewed as decreasing in their degree of validation of a client's sense of emotional pain.

The interpersonal effectiveness module is presented as teaching skills in changing pain-producing environments. The situation is so pain-producing that it has to be changed. The emotion regulation module assumes that even though the situation may be generating pain, the individual's response is so painful that it also has to change, and can be changed. The distress tolerance module assumes that even though there may be a lot of pain, it can be tolerated, and life can be accepted and lived in spite of pain. Surely, this is a difficult lesson for anyone, especially for our clients. One can, however, make a reasonably good case for any order of modules. In my own clinic now (some other centers do the same), we give clients the "Crisis Survival Strategies" handout (part of the distress tolerance module) during the first meeting with the client. These skills are more or less self-explanatory, and many clients find them extremely helpful. We then go over them in detail when we teach the distress tolerance module.

Heterogeneous versus Homogeneous Groups

DBT skills training group members in my clinic are homogeneous with respect to diagnosis: they are restricted to individuals who meet criteria for BPD and who have engaged in recent parasuicidal acts (intentional self-injurious behaviors; see Chapter 1 of the text for a full explanation of this term). Group members are not particularly homogeneous in other ways. Ages range from 16 to 48 years; some groups include clients of both sexes; and socioeconomic, marital, and parental statuses vary. For all of our clients so far, our group has represented 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 therapy with this population, the choice obviously has its pros and cons.

Arguments Against a Homogeneous Group

There are a number of rather strong arguments against a homogeneous group of suicidal, borderline clients. First, such a group is risky on an outpatient basis. Any kind of therapy, individual or group, can be very stressful for borderline clients. Their extreme emotional reactivity all but insures 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 are often misinterpreted, or interpreted in a way that the therapist did not mean and insensitive comments have a strong impact. With even the most vigilant and sensitive therapist, there will often be times when a client leaves an individual therapy session in more emotional turmoil than when she came in. Frequent phone calls are often needed to resolve the issue.

These problems are simply compounded in group therapy. It is impossible for one or two 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 a client to express her 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 to become emotionally involved with one anothers' problems and tragedies. Clients often become anxious, angry, depressed, and hopeless not only about the problems in their own lives, but also about the problems of those close to them. Thus, just listening to others' life descriptions can precipitate intense, painful emotional responses. This problem has been a very difficult issue for us staff members to handle among ourselves; 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 is based on the notion that in a group with only borderline clients, 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. The one area where an absence of appropriate modeling does seem to exist is in the area of coping with extreme negative feelings. Especially 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.

A fourth argument against homogeneous groups has to do with the active passivity of borderline individuals (see Chapter 3 of the text for a description of this behavioral pattern), their ability to "catch" others' 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 (for further discussion, see below) is that when this happens, each therapist will have someone to keep him or her functioning at an energetic level. It can be very difficult.

Finally, it is sometimes said that the borderline clients 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 offered specifically for problems of suicidal behaviors and BPD. Most of the skills taught are applicable

for many client populations. However, a heterogeneous group would require a much more generic presentation of the skills, and the application of the skills to each person's central problems would have to be worked out individually. A common conceptual scheme would be difficult to present 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. As noted above, however, they have not had the experience of being around others who actually understand the often inexplicable urges to injure themselves, the desire to be dead, the frustration of being unable to control emotions and behavior, and the pain of emotional invalidating experiences. All know intimately the difficulty of confronting emotional pain in anything other than a maladaptive way.

A factor that can complicate the advantage of having an entire group of suicidal individuals has to do with different rates of individual progress in treatment. When one client is engaging in frequent self-injury and suicide attempts, 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 for herself if others are still engaging in the self-injurious behaviors. Hearing about others' self-injury and overdoses seems to cause a greater urge to do the same thing; this is, of course, a threatening experience for the person who is working hard at avoiding self-harm. In addition, we have found that as a client progresses in therapy, she often begins to change her self-image from that of "borderline person" to that of "nonborderline person." Especially if she is still judgmental, she can find it very hard to stay in a group defined as a group for borderline individuals. These two issues—the urge to imitate suicidal behavior, and the need to change one's self-image from borderline to nonborderline—must be dealt with effectively by the group leaders if an individual is to continue with the group.

The Role of Individual Psychotherapy in Psychosocial Skills Training

As I have said previously, skills training with suicidal, borderline clients is an adjunct to individual psychotherapy. It is a part of DBT; it is not the total treatment. The key idea in DBT skills training is that it is the servant of individual psychotherapy, so to speak. It provides the clay that the individual therapist and client can use together to mold a functional figure. With severely dysfunctional borderline clients skills training cannot stand alone. This point is crucial to keep in mind.

What kind of individual psychotherapy works best with skills training? Our research data suggest that DBT individual therapy plus DBT skills training is superior to non-DBT individual therapy plus skills training (Linehan, Heard, & Armstrong, 1993). Therapists conducting skills training, however, may not always have control over the type of individual psychotherapy their clients get. This is especially likely in community mental health settings and inpatient psychiatric units. In settings where DBT is just being introduced, there simply may not be enough DBT individual therapists to go around. Or a unit may be trying to integrate different approaches to treatment. For example, a number of psychiatric inpatient units have attempted an integration of DBT skills training with individual psychodynamic therapy. Acute inpatient units may structure psychosocial treatment primarily around milieu and skills training, with individual therapy consisting of pharmacotherapy.

When skills training is offered outside of standard DBT, some modifications in the actual conduct of the skills training may be necessary. The exact modifications necessary depend somewhat on what kind of individual psychotherapy is being offered, as well as on the skills trainers' relationship with the individual psychotherapists.

When the Individual Psychotherapist Does Not Incorporate Skills Coaching Into Psychotherapy

Although some effort is made to integrate into current everyday life the new behaviors taught in skills training, the lack of time and the complexity of achieving such an integration require that each clients' individual therapist be actively engaged in helping the client apply the skills. The individual therapist is the day-to-day coach for the client.

One task of the DBT therapist is to apply the lens of behavioral skills when helping the client generate solutions to the problems she is confronting. Thus, when distress tolerance is the current treatment module (or a skill 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 therapist 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 change her emotional response to the situation. An effective response may also be cast in terms of core mindfulness skills.

The ability to apply any one of the behavioral skills to any problematic situation is at once important and very difficult. Individual therapists must themselves know the behavioral skills inside and out and be able to think quickly in a session or a crisis. When the individual therapist is not familiar with the skills being taught, the solution is to do what is possible to inform the therapist. Strategies for this are discussed below.

The required active intervention and 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 starting DBT, individual psychotherapists (who were physicians) told clients that they had to get coaching from the nurses in how to replace maladaptive behaviors with skills. In my experience, clients with such therapists will need extra help in using the skills they are learning. They also need help in accepting the idea that the new skills are actually important, since their individual therapists are communicating that the "real therapy" is taking place with them.

Skills trainers can make a number of optional modifications to address these issues. They might set up an extra weekly training skills 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, they 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, 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 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 any time during office hours for advice. (This variation was developed by Charles Swenson at Cornell Medical Center/New York Hospital at White Plains.) 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 use of skills by the clients (Barley et al., in press).

When the Individual Therapist Ass mes That the Skills Trainer Will Help with Suicidal Crises

One of the key differences between DBT and many non-DBT individual therapies is the emphasis in DBT on modifying current maladaptive behaviors before ameliorating long-standing interpersonal conflicts and effects of early trauma and abuse. In fact, the DBT stance is that current high-risk suicidal behaviors (including all instances of parasuicide), therapy-interfering behaviors, and extreme quality-of-life-interfering behaviors must be modified before any sustained attempt is made to explore and resolve intensely disturbing interpersonal conflicts and previous abuse or trauma. Therapeutic exposure to stress requires, at a minimum, the ability to tolerate stress without resorting to suicide, parasuicide, extreme suicidal ideation, excessive therapy-interfering behaviors, or other extremely dysfunctional behaviors.

But—and this is the most important point—reduction of these maladaptive behaviors is *not* the goal specific to 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, and to other severely dysfunctional behaviors is not necessarily attempted in the first year by skills training therapists.

In fact, as I discuss later, discussion of current parasuicidal behavior is actively discouraged in skills training. The application of skills to very high-stress situations is not encouraged during early stages of skills training because it violates principles of shaping. Therapy-interfering behaviors, including extreme problems with skills training, are relegated to the individual therapists primarily because of time constraints in conducting skills training.

Problems with this skills training orientation arise when an individual therapist wants to ignore current maladaptive behaviors in favor of attending to long-term conflicts and early childhood experiences. Such an individual therapy emphasis, in the absence of a corresponding emphasis on coping skills, can lead to an exacerbation of current dysfunctional behaviors. The problems can be especially intense if the individual therapist misunderstands the goals of DBT skills training, mistaking it for a treatment focused directly on modifying current severely dysfunctional and suicidal behaviors.

In my experience, many non-DBT therapists do not

want to attend to the direct modification of current behaviors—an understandable reluctance if they are not behaviorally trained, and instead are relying on behaviorally oriented skills training therapy to do the job. Unfortunately, the skills training therapists in DBT are relying on the individual therapists in a similar manner. And therein lies the problem: In this case, no one is helping the clients modify their current style of coping with intensely disturbing experiences (posttraumatic stress, intrapsychic conflicts, interpersonal conflicts, or other major life stresses).

The problem is even worse when the individual therapists, relying on the skills training to develop the client's everyday coping abilities, begin to increase the stress level of individual therapy material while simultaneously reducing efforts at teaching coping skills. When this occurs, it seems reasonable to predict that the addition of DBT skills training to non-DBT individual therapy may be iatrogenic rather than therapeutic.

In these instances, it would seem necessary to conduct skills training for clients not receiving DBT individual therapy separately from skills training for the standard DBT clients. In this separate context, the pace should be slowed considerably, and a mechanism must be developed for discussion of suicidal behaviors in the skills training setting. One option is to schedule a second weekly session for just this purpose. Since such a discussion is often very disturbing to other clients, care must be taken to frame the discussion in a context of positive coping behaviors; to pay attention to silent clients who may be getting more suicidal without being able to express it; to plan work on individual coping strategies for after skills training meetings; and to make resources available after meetings for clients who become more suicidal during meetings.

All this is needed because, in my experience, suicidal individuals typically experience increased urges to engage in parasuicide when the topic of prior suicidal behavior (including urges) is discussed. It is precisely this escalation of risk, of course, that keeps many individual therapists from addressing the topic directly with their clients. Unfortunately, when the responsibility is shifted to the skills training therapists, the potential for trauma increases enormously.

Consultation Between Individual Psychotherapists and Skills Trainers

The problems discussed above sometimes result from poor communication between individual therapists and skills trainers. If the expectations of each group of therapists for the other are not spelled out and frequently reviewed, it is no wonder that the two treatments do not enhance each other. Among the most important aspects of DBT are the supervision/consultation strategies (described in Chapter 13 of the 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 frame of DBT.

In my clinic, a supervision/consultation meeting is held each week for 2 hours. During the meeting, individual clients are discussed. The skills training therapists review for the individual therapists which skills are the current focus of group sessions. When necessary, the skills trainers actually teach the other therapists the skills. In this context, it is helpful for clients and decreases the potential for confusion if the individual and skills training therapists share a common language in discussing application of behavioral skills. 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 meetings are also mentioned. Individual therapists both consult with the skills trainers and take such information into account in planning the individual treatment.

My emphasis on the importance of meetings between individual and skills training therapists may seem to contradict the "consultation-to-the-patient" strategies, which are also integral to DBT. (See Chapter 13 of the text for a discussion of these strategies; they are also discussed briefly in Chapter 5 of this manual.) 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 (including the individual and skills training therapists), a clinic, an inpatient unit, or some such entity where multiple therapists interact with particular clients in a 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.

A particularly difficult situation arises when a client's individual therapist works separately from the skills trainers and does not want to consult with them or does not have the time to do so. Can progress be made? The answer depends on the individual therapist's willingness and ability to assist the client in integrating skills independently. A therapist with good behavioral treatment skills could probably do a creditable job un-

der some circumstances. First, the individual psychotherapist needs to elicit from the client sufficient information about the skills taught in skills training to be able to help the client apply the skills in troublesome areas. Second, the therapist needs to know and be able to apply the skills himself or herself; this is not as simple as it might seem. Third, the therapist needs to resist the temptation to rely on the skills trainer to conduct interventions aimed at reducing current suicidal and other severely dysfunctional behaviors. In my clinic, when skills training is offered to individuals with non-DBT individual therapists, we inform the therapists that we cannot accept their clients if they do not agree to coach the clients in applying skills. We then send the therapists our skills training materials. I discuss the issue of guidelines for handling suicidal and crisis behaviors at greater length later.

Group Leaders

In my experience, two leaders are essential for the conduct of group skills training in DBT. The primary reason for this is therapist burnout, which can happen very quickly to a therapist trying to conduct a group alone. The constant passivity, hopelessness, emotional vulnerability, and invalidation that pervade group skills training in the early months are all but impossible for a lone therapist to tolerate. The tendency of group members to withdraw emotionally in the face of group tension or conflict, including attempts by the therapist to "push" individual members along, creates a countertendency in the therapist to pull back, blame the victims, and then lash out at group members. Resisting this tendency alone is next to impossible over the long haul. The primary function of the second leader is to provide the dialectical balance and personal support that keeps the teeter-totter (of acceptance and change; see Chapters 2 and 7 of the text) balanced for yet another week.

In our groups, we use a model of a primary group leader and a coleader. The functions of the two leaders during a typical session differ somewhat. The primary leader begins the meetings, conducts the initial behavioral analyses of homework practice, and presents new skills material. The primary group therapist 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 coleader's functions are more diverse. First, he or she mediates 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 coleader 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 coleader serves as a coteacher and tutor, offering alternate explanations, examples, and so on.

Generally, if there is a "bad guy" it is the primary group leader, who enforces the group norms, and if there is a "good guy" it is the coleader, who always tries to see life from the point of view of the 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 coleader. 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 therapist supervision/consultation strategies can be especially important here. The supervision group serves as the third point providing the dialectical balance between the two coleaders, much as the coleader does between the primary leader and a group member in a group session. Thus, the function of the DBT supervision/consultation group is to highlight the truth in each side of an expressed tension, fostering reconciliation and synthesis.