# WHAT THE HECK IS ADHERENT DBT?
## A NEW PRAGMATIC MEASURE FOR EVALUATING ADHERENCE IN DBT INDIVIDUAL THERAPY

Melanie Harned, PhD, ABPP & Sara Schmidt, PhD



1

## PRESENTER DISCLOSURES

- Melanie Harned, PhD
  - Receives federal grants to research DBT and DBT PE
  - Is paid to provide training and consultation in DBT and DBT PE
  - Receives royalties from Guilford Press for the DBT PE manual
- Sara Schmidt, PhD
  - Is paid to provide training and consultation in DBT and DBT PE

The research to develop this measure was funded by a grant from the National Institute of Mental Health to Dr. Harned (R56MH117085).



2

## GOALS OF THIS PRESENTATION

| 01 | 02 | 03 | 04 |
|---|---|---|---|
| Review current knowledge about adherence in DBT | Discuss the development and psychometric properties of the DBT AC-I | Provide recommendations for how to use the DBT AC-I in clinical practice | Describe how to rate the items in the DBT AC-I and discuss common rating errors. |



3

## OVERVIEW OF DBT ADHERENCE

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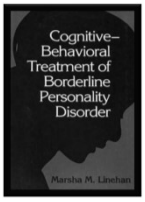
4

## DBT ADHERENCE: WHAT DOES IT REALLY MEAN?

- The extent to which treatment was delivered in accord with the DBT manual in a single session
  - The therapist used the prescribed strategies and did not use the proscribed strategies of DBT
- Not a quality of a therapist
  - No such thing as an "adherent" DBT therapist (or program)
- Not (entirely) a measure of competence
  - Can be adherent and not highly competent

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## DBT ADHERENCE: DOES IT MATTER?

Higher therapist adherence predicts better client outcomes and retention.

**Fewer Suicide Attempts**
**20%** decrease in subsequent suicide attempts per SD increase in adherence

**Lower Risk of Dropout**
**22%** decrease in treatment dropout per SD increase in adherence

**Fewer Hospitalizations**
**41%** decrease in subsequent hospitalizations per SD increase in adherence among community therapists

Harned, Schmidt, Korslund, & Gallop, under review

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6

## OTHER REASONS TO STRIVE FOR ADHERENCE

- Quality assurance for administrators, programs, therapists, and consumers
- Required for DBT-LBC clinician certification
- Potential for enhanced reimbursement rates

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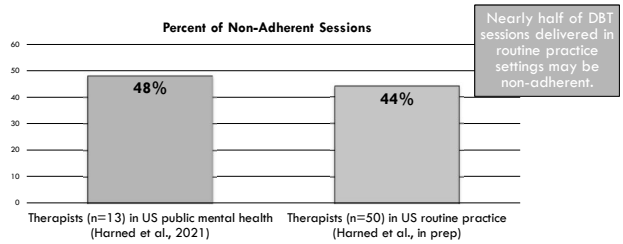
## DBT IN ROUTINE PRACTICE: WHAT'S THE DATA?




Nearly half of DBT sessions delivered in routine practice settings may be non-adherent.

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Efforts to improve the quality of DBT services in routine practice settings have been hampered by the lack of a pragmatic measure to evaluate therapist adherence.


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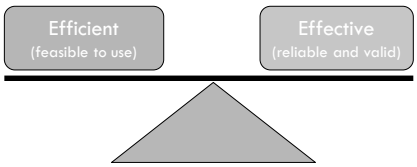
## THE CHALLENGE OF ADHERENCE MEASUREMENT

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10

## THE DBT ADHERENCE CODING SCALE
(DBT ACS; LINEHAN & KORSLUND, 2003)

- Has been the only validated measure of DBT adherence (the "gold standard")
- Observational measure used to rate DBT individual & group sessions
- Includes 66 items across 12 subscales
- Uses a 0-5 rating scale, where 4.0 and higher is adherent
- Current uses:
  - Clinical trials research
  - DBT-LBC Clinician Certification

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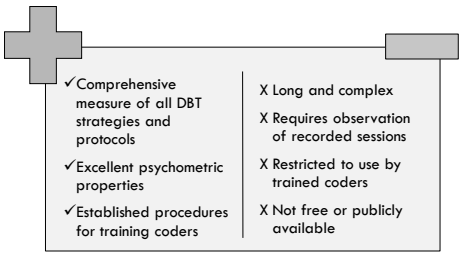
11

## PROS AND CONS OF THE DBT ACS



| | |
|---|---|
| ✓Comprehensive measure of all DBT strategies and protocols | X Long and complex |
| ✓Excellent psychometric properties | X Requires observation of recorded sessions |
| ✓Established procedures for training coders | X Restricted to use by trained coders |
| | X Not free or publicly available |

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12

## PROJECT AIMS

- To develop a measure that:
  - Assesses therapist strategies critical to the adherent delivery of DBT
  - Is brief and easy to use
  - Can be used for multiple purposes (e.g., quality improvement, supervision, research)
  - Can be completed by therapists (self-report) and observers
  - Has good psychometric properties
  - Is freely available

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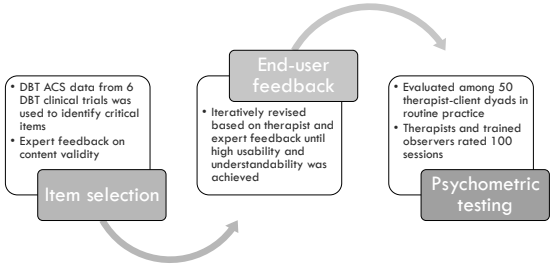
13

## THE DEVELOPMENT OF THE DBT AC-I

 14

14

## THE MEASURE DEVELOPMENT PROCESS

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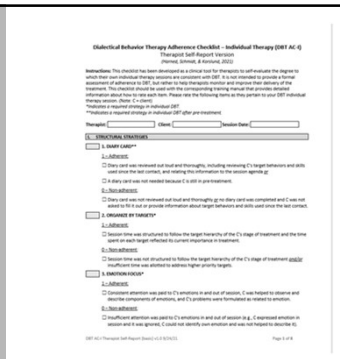
15

## THE DBT ADHERENCE CHECKLIST FOR INDIVIDUAL THERAPY

(DBT AC-I; HARNED, SCHMIDT & KORSLUND, 2021)

- 26 items that draw from all 12 subscales of the DBT ACS.
- Each item is rated on a binary (0/1) scale with behavioral anchors defining adherent vs. non-adherent delivery.
- Therapist self-report and observer-rated versions are available.
- Includes an accompanying training manual.



Dialectical Behavior Therapy Adherence Checklist – Individual Therapy (DBT AC-I)
Therapist Self-Report Version
(Harned, Schmidt, & Korslund, 2021)

Instructions: This checklist has been developed as a clinical tool for therapists to self-evaluate the degree to which their own individual therapy sessions are consistent with DBT. It is not intended to provide a formal assessment of adherence to DBT, but rather to help therapists monitor and improve their delivery of the treatment. This checklist should be used with the corresponding training manual that provides detailed information about how to rate each item. Please rate the following items as they pertain to your DBT individual therapy session. (Note: C = client).
*Indicates a required strategy in individual DBT
**Indicates a required strategy in individual DBT after pre-treatment.

Therapist: _____ Client: _____ Session Date: _____

1. STRUCTURAL STRATEGIES

1. DIARY CARD**

1 – Adherent:
☐ Diary card was reviewed out loud and thoroughly, including reviewing C's target behaviors and skills used since the last contact, and relating this information to the session agenda or
☐ A diary card was not needed because C is still in pre-treatment.

0 – Non-adherent:
☐ Diary card was not reviewed out loud and thoroughly or no diary card was completed and C was not asked to fill it out or provide information about target behaviors and skills used since the last contact.

2. ORGANIZE BY TARGETS*

1 – Adherent:
☐ Session time was structured to follow the target hierarchy of the C's stage of treatment and the time spent on each target reflected its current importance in treatment.

0 – Non-adherent:
☐ Session time was not structured to follow the target hierarchy of the C's stage of treatment and/or insufficient time was allotted to address higher priority targets.

3. EMOTION FOCUS*

1 – Adherent:
☐ Consistent attention was paid to C's emotions in and out of session. C was helped to observe and describe components of emotions, and C's problems were formulated as related to emotion.

0 – Non-adherent:
☐ Insufficient attention was paid to C's emotions in and out of session (e.g., C expressed emotion in session and it was ignored, C could not identify own emotion and was not helped to describe it).

DBT AC-I Therapist Self-Report (basic) v1.0 9/24/21 Page 1 of 8

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16

## A BRIEF REVIEW OF KEY PSYCHOMETRIC INDICES

**RELIABILITY:** DOES IT YIELD ACCURATE AND CONSISTENT SCORES?

- **Inter-rater reliability:** the degree of agreement between raters

**VALIDITY:** DOES IT MEASURE ADHERENCE TO DBT?

- **Convergent validity:** the degree to which it is correlated with the gold standard measure of adherence
- **Criterion validity:** the degree to which it correctly identifies adherent vs. non-adherent sessions according to the gold standard measure of adherence

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17

## PSYCHOMETRICS: OBSERVER-RATED VERSION

| Inter-rater Reliability | Convergent Validity | Criterion Validity |
|---|---|---|
| Excellent inter-rater reliability between trained observers and the gold standard rater (ICC = 0.93). | The observer-rated DBT AC-I score was highly correlated with the DBT ACS score ($r = 0.90$, $p < .001$). | The observer-rated DBT AC-I score correctly identified 91% of adherent and 80% of non-adherent sessions as defined by the DBT ACS. |

The DBT AC-I offers an efficient and effective alternative to the DBT ACS when rated by trained observers.

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18

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## PSYCHOMETRICS: THERAPIST SELF-REPORT VERSION

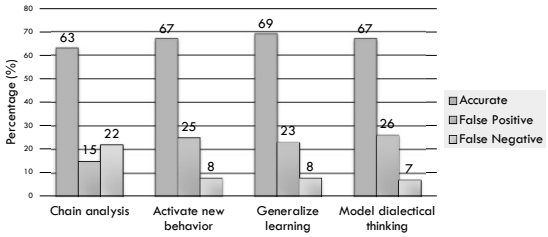
| Inter-rater Reliability | Convergent Validity | Criterion Validity |
|---|---|---|
| Inter-rater reliability between therapists and trained observers was poor (ICC=0.09).<br>• Average item-level agreement = 84.2% (range = 63 – 98%). | Therapists' self-rated DBT AC-I score was not correlated with the DBT ACS score ($r = 0.05$, $p = .63$). | Therapists' self-rated DBT AC-I score did not significantly predict adherent versus non-adherent sessions according to the DBT ACS. |

Therapists' self-rated adherence on the DBT AC-I should not be assumed to reflect their actual adherence to DBT.



19

## ITEMS WITH THE LOWEST THERAPIST ACCURACY






20

## PREDICTORS OF THERAPIST ACCURACY

GREATER OBSERVER-RATED ADHERENCE

MORE DBT KNOWLEDGE

MORE SUICIDAL CLIENTS

Therapists who were more adherent, knowledgeable, and whose sessions were with clients with more severe suicidal ideation were more accurate in rating their own adherence.



21

**Slide 19**

**MH3** Confirm ICC
Melanie Harned, 10/5/2021

## RECOMMENDED USES OF THE DBT AC-I

| Potential Use | Description | Therapist Self-Report | Untrained Observers[a] | Trained Observers[b] |
|---|---|---|---|---|
| Quality Monitoring | Use to monitor the quality of DBT that is being delivered by a therapist or in a program. | ✓ | ✓ | ✓ |
| Quality Improvement | Use the evaluation results to help therapists modify and improve their delivery of DBT when needed. | ✓ | ✓ | ✓ |
| Supervision and Training | Use to inform supervision and identify additional therapist training needs. | ✓ | ✓ | ✓ |
| Team Consultation | Use to obtain/provide consultation during DBT team meetings. | ✓ | ✓ | ✓ |
| Formal Assessment of Adherence | Use to make reliable and valid determinations of the degree to which sessions were adherent to DBT. | ✗ | ✗ | ✓ |
| High Stakes Decisions | Use in situations in which the evaluation results could have serious negative impacts on the therapist or program being rated (e.g., decisions related to salary and promotion, service contract loss, certification). | ✗ | ✗ | ✓ |

[a] Observers who have *not* been trained to reliability in the gold standard DBT Adherence Coding Scale.
[b] Observers who have been trained to reliability in the gold standard DBT Adherence Coding Scale.

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22

## THE DBT AC-I: OVERVIEW

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23

## DBT AC-I THERAPIST STRATEGIES

26 items

| | |
|---|---|
| Structural Strategies | (3 items) |
| Problem Assessment | (2 items) |
| Problem Solving | (6 items) |
| Contingency Management | (2 items) |
| Exposure | (1 item) |
| Cognitive Modification | (1 item) |
| Validation | (3 items) |
| Reciprocal Communication | (2 items) |
| Irreverent Communication | (2 items) |
| Dialectical Strategies | (2 items) |
| Case Management | (1 item) |
| Protocols | (1 item) |

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24

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| Category | # of Items | Individual Items |
|---|---|---|
| Structural Strategies | 3 | Diary card, Organize by targets, Emotion focus |
| Problem Assessment | 2 | Define specifically, Chain analysis |
| Problem Solving | 6 | Teach new information, Generate solutions, Activate new behavior, Provide coaching, Generalize new learning, Commitment and troubleshooting |
| Contingency Management | 2 | Reinforcement, aversive contingencies |
| Exposure | 1 | Informal exposure |
| Cognitive Modification | 1 | Challenge cognitions |
| Validation | 3 | V4, V5, V6 |
| Reciprocal Communication | 2 | Warm engagement, Self-disclosure |
| Irreverent Communication | 2 | Direct confrontation, Unorthodox irreverence |
| Dialectical Strategies | 2 | Balanced style and strategies, Model dialectical thinking |
| Case Management | 1 | Consultation to the client |
| Protocols | 1 | Suicidal behaviors protocol |

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25

## TYPES OF ITEMS

**Required (n=13)**
- Strategies that must be used in every session.
- Examples: emotion focus, generate solutions

**Context-dependent (n=13)**
- Strategies that are required only if certain conditions are met.
- Examples: chain analysis, suicidal behaviors protocol

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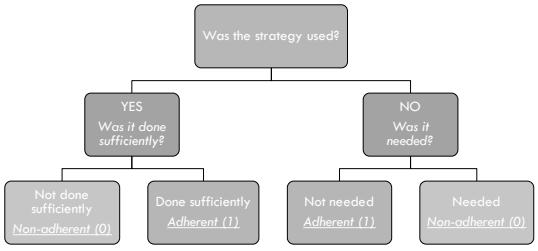
26

## GUIDELINES FOR RATING ITEMS

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**Slide 25**

**MH7** Not sure whether to leave this one in here or not
Melanie Harned, 10/13/2021


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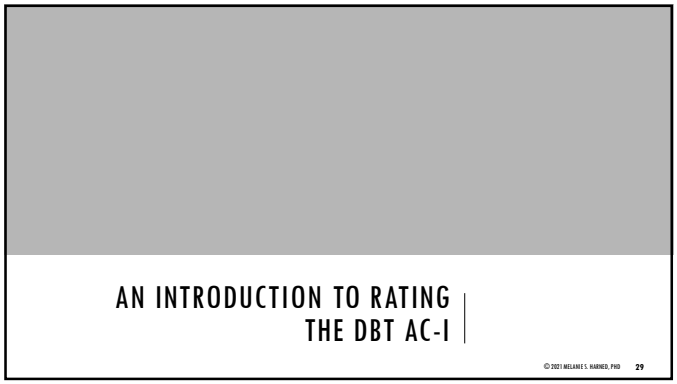


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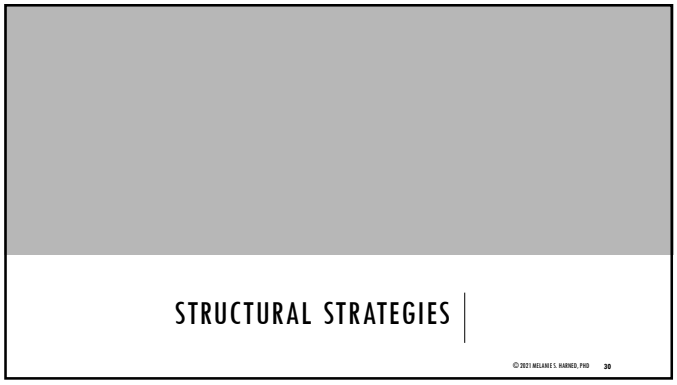


30

## 1. DIARY CARD

Required *(except pre-tx)*

☐ T reviews and conveys the importance of the diary card and C's progress.

**Adherent diary card review:**

Talks about it out loud

Comments on presence/absence of important targets

Reviews and reinforces skills use

Uses it to inform the session agenda

**If diary card is not complete:**

Asks client to complete it in session

or

Verbally reviews important targets and skills use

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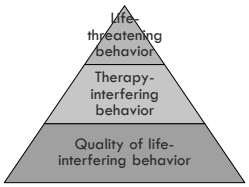
31

## 2. ORGANIZE BY TARGETS

Required

☐ T structures the session time in accord with the target hierarchy.




- Overall session time was organized to follow the target hierarchy (not necessarily sequentially).
- If LTB occurs or urges increase by 3+ points, it must be targeted.
- TIB and QOL may or may not be targeted depending on time and presence of higher-priority targets.

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32

## 3. EMOTION FOCUS

Required

☐ T focuses on the C's emotions throughout the session.

PAYS ATTENTION TO C'S EMOTIONS

HELPS C TO OBSERVE AND DESCRIBE EMOTIONS

FORMULATES PROBLEMS AS EMOTION-RELATED

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33

## PROBLEM ASSESSMENT STRATEGIES

 34

34

## 4. DESCRIBE SPECIFICALLY

Required

T uses, and facilitates the C to use, behaviorally specific language.

- Consistently uses behaviorally specific language to describe emotions, behaviors, and thoughts.
- Describes problems clearly and precisely.
  - Frequency, duration, intensity, topography
- Avoids using:
  - Vague descriptions and terms (e.g., "upset")
  - Judgments (e.g., bad/good, "jerk")
- Coaches client to describe specifically and restate judgments.

 35

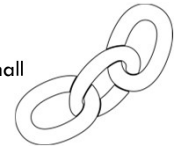
35

## 5. CHAIN ANALYSIS

Context-dependent

T conducts a chain analysis when needed to understand the function of a problem behavior and the barriers to effective behaviors.

- Chain analysis is needed when a primary target behavior or high urges occurred and
  - Controlling variables are not known and/or
  - Prior solutions have not been effective
- An adherent chain analysis must attend to small units of behavior and clearly identify:
  - The function of the problem behavior
  - The barriers to effective behavior



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36

## CHAIN ANALYSIS: COMMON RATING ERRORS

**False Positives (15%)**

- Chain was not done when it was needed (e.g., 3+ increase in suicide urges)
- Chain was done that was overly vague and did not result in:
  - Specifically defined problems
  - Clearly hypothesized controlling variables
  - A complete picture of the event (beginning, middle, end)

**False Negatives (22%)**

- A chain was not done and it was not needed, but therapists thought it was required (e.g., in every session)
- A chain was done that was detailed enough to meet the functions/be adherent, but therapists thought more details were needed



37

## PROBLEM SOLVING STRATEGIES

 

38

## TEACH NEW INFORMATION

Context-dependent

T taught the C new behaviors or skills and/or provided psychoeducation on relevant topics.

- This strategy is needed if the client:
  - Displays inaccurate understanding of a skill, or
  - Is clearly lacking knowledge about a relevant topic
- New information can be taught:
  - Using skill acquisition procedures (e.g., instructing the C in a skill, modeling how to use a skill)
  - By providing psychoeducation (e.g., about the biosocial model, behavioral theory, or evidence-based treatments)



39

## 7. GENERATE SOLUTIONS

Required

T helps the C generate and evaluate new solutions to problems.

- Solutions may include DBT skills and general problem-solving strategies
- Potential solutions should be:
  - Well-matched and adequate to address the main problems
  - Well-matched to the client's current abilities
  - Adaptive, realistic, and feasible to implement
- An effort should be made to get the client active in generating solutions

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40

## 8. ACTIVATE NEW BEHAVIOR IN SESSION

Required

T compels an active, new response from the C in session.

- Goal is to get the C to do something differently in session, not just talk about doing something differently.
- Examples may include having the client:

Generate new solutions → Role-play → Practice a new skill → Re-state judgments → Commit to new behavior → Actively participate in session

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41

## ACTIVATE NEW BEHAVIOR: COMMON RATING ERRORS


**False Positives (25%)**

- Therapists often (mis)rated themselves as activating new behavior when they asked the client to do something new outside of session (e.g., practice a skill)
  - To count, the new behavior must occur in session
- This does not include talking about new behavior, must actually do new behavior

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42

## 9. PROVIDE COACHING FEEDBACK

Context-dependent

T gives behaviorally specific feedback to shape, refine, and increase C's skillful behaviors.

- This strategy is needed if the C used a specific skill or generally engaged in skillful behavior that was not fully effective.
- Involves giving behaviorally specific feedback to:
  - Clarify effective behavior (what worked) and
  - Shape more skillful behavior (what could be improved)

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43

## 10. GENERALIZE NEW LEARNING

Required *(except pre-tx)*

T actively works to transfer new learning from therapy to the C's real-world environment.

- Must give <u>at least one</u> behavioral assignment to practice or review new learning from session in relevant contexts in the client's life.
- Examples may include:
  - Practice a specific skill (e.g., paced breathing when anxious)
  - Implement solutions generated in session (e.g., dispose of lethal means)
  - Review new learning (e.g., listen to a recording of the session)

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44

## GENERALIZE NEW LEARNING: COMMON RATING ERRORS


**False Positives (23%)**

- Therapists often (mis)rated themselves as generalizing learning when they:
  - Discussed skills or solutions the client could use (e.g., during solution analysis), but did not specifically assign them to do anything
  - Gave overly vague assignments (e.g., "practice mindfulness this week")

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45

## 11. COMMITMENT AND TROUBLESHOOTING

Context-dependent

T attempts to get a commitment from C when needed and troubleshoots barriers to doing what they agree to do.

**An attempt to get a commitment is needed when:**

- C is in pre-treatment
  - *Commitment to work on targets and engage in DBT*
- C is suicidal or has engaged in LTB
  - *Commitment to not kill/harm self*
- T & C have decided on solutions to implement
  - *Commitment to complete behavioral assignments*

**If a commitment is obtained, it must be troubleshot:**

- "What might get in the way?"
- "What can you do about that if it happens?"



46

## CONTINGENCY MANAGEMENT STRATEGIES

47

## 12. REINFORCEMENT

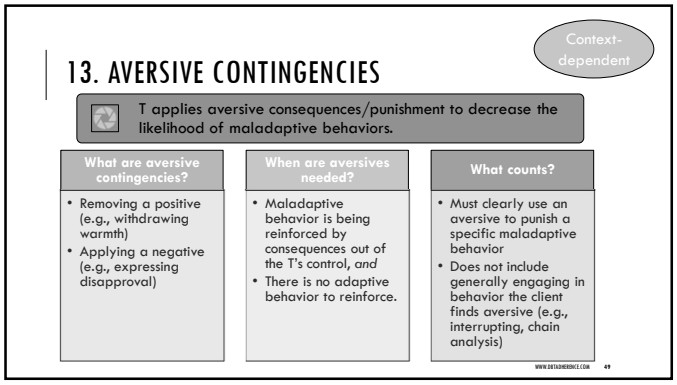
Required

T reinforces the C's adaptive behaviors.

- Reinforcement must be used to increase target-relevant adaptive behaviors.
  - Includes reinforcing small steps toward desired behavior (shaping)
- Reinforcers vary by client but often include:
  - Praise
  - Attention/contact
  - Increasing warmth
  - Expressing approval



48

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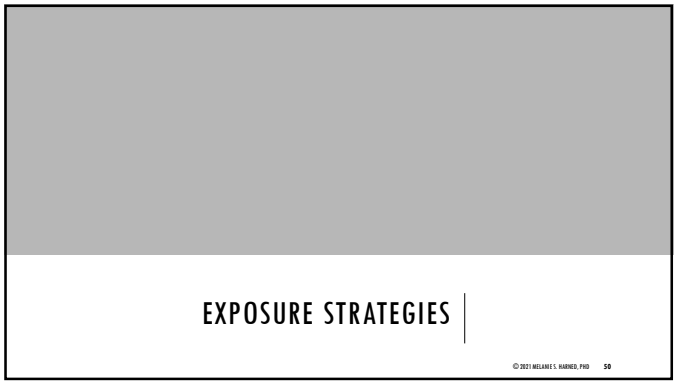


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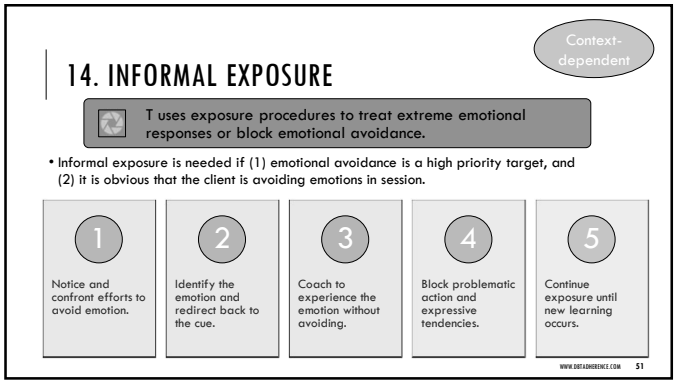



51

## COGNITIVE MODIFICATION STRATEGIES

 52

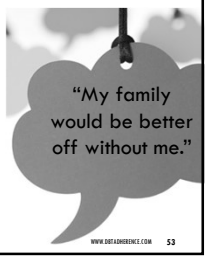
52

## 15. CHALLENGE COGNITIONS

Context-dependent

☐ T confronts and challenges the C's maladaptive thoughts.

- Challenging cognitions is needed when maladaptive cognitions are:
  - Functionally related to target behaviors
  - Having a severe negative impact on the client
- Cognitive strategies may include:
  - Directly confronting maladaptive thoughts
  - Using Socratic questioning
  - Helping the client to generate more adaptive thoughts

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53

## VALIDATION STRATEGIES

 54

54

* Required

## VALIDATION STRATEGIES

**16. V4 Learning History/Biology**

- T conveys that C's reactions make sense in the context of the C's learning history or biology.

**17. V5 Current Events***

- T conveys that C's reactions make sense in the current context.

**18. V6 Radical Genuineness***

- T interacts with the C in an ordinary and natural manner that conveys that the C is a person of equal status.

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55

## RECIPROCAL COMMUNICATION STRATEGIES

 56

56

* Required
** Context-dependent

## RECIPROCAL COMMUNICATION STRATEGIES

| | |
|---|---|
| 19. Warm Engagement* | Communicates warmth and caring verbally and/or non-verbally. |
| 20. Self-Disclosure** | Shares information about self and/or their reactions to the client (e.g., "When you do X, I feel Y"). |

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57

## IRREVERENT COMMUNICATION STRATEGIES

 58

58

## IRREVERENT COMMUNICATION STRATEGIES

Context-dependent

| | |
|---|---|
| 21. Direct Confrontation | Confronts problematic behavior in a manner that gets C's attention and conveys its seriousness. |
| 22. Unorthodox Irreverence | Used to help the C get unstuck from dysfunctional responses. (It's not just being funny.) |

 59

59

## DIALECTICAL STRATEGIES

 60

60

## 23. BALANCED STYLE AND STRATEGIES

Required

T balances acceptance- and change-oriented strategies and communication styles.

- Goal is to use therapist style and strategies that are balanced in terms of acceptance and change across the course of the session.

**Change Strategies** ⟷ **Acceptance Strategies**

**Irreverent Communication** ⟷ **Reciprocal Communication**

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61

## 24. MODEL DIALECTICAL THINKING

Required

T models dialectical thinking and works to find a synthesis when polarization occurs.

- Goal is for T to adopt and model a dialectical world view by highlighting polarities and working towards synthesis.
- Ways to model dialectical thinking:
  - Use "both-and" statements
  - Actively work to find synthesis by searching for a middle path
  - Highlight transaction and natural change

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62

## MODEL DIALECTICAL THINKING: COMMON RATING ERRORS


**False Positives (26%)**

- Common ways that therapists thought they modeled dialectical thinking when they did not:
  - By putting "and" between two statements that are not actually related or opposed.
    - e.g., "You're feeling sad and you're feeling afraid."
  - By making both validation and change statements about a problem.
    - e.g., first validating (e.g., "It's understandable that you cut yourself") and later pushing for change (e.g., "You need to stop cutting yourself")

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63

## CASE MANAGEMENT STRATEGIES

 64

64

## 25. CONSULTATION TO THE CLIENT

Context-dependent

T consults to the C about how to interact effectively with their environment rather than intervening on the C's behalf.

- Goal is to help the client to act as their own agent in managing their environment.
- This strategy is only relevant to other professionals and key people in the client's life with whom it may be typical for a therapist to have direct contact.
  - Common examples: skills group leaders, parents, prescribers
  - Does not apply to coaching a client to interact with people who are not involved in their treatment (e.g., friends, coworkers, neighbors)

 65

65

## PROTOCOLS

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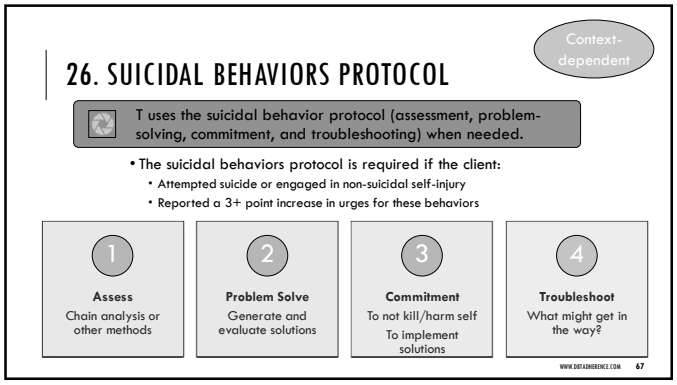


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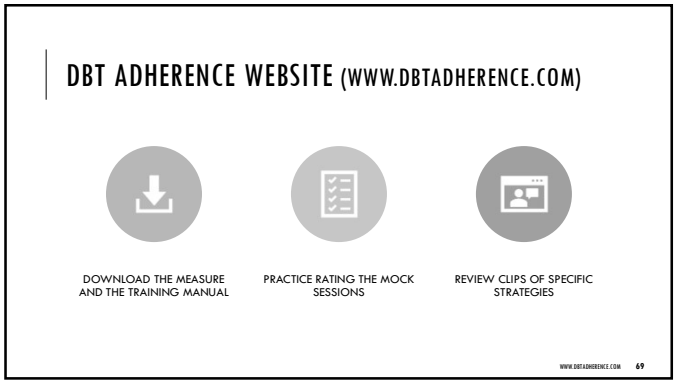
68




69